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ARTICLES

JUDICIAL STANDARD OF REVIEW IN ERISA BENEFIT CLAIM CASES

KATHRYN J. KENNEDY*

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INTRODUCTION

Congress enacted the Employee Retirement Income Security Act of 1974¹ (ERISA) more than twenty-five years ago to provide protection for participants' employee benefits and to prescribe a uniform set of requirements for employers in the *voluntary* delivery of such benefits. Despite the intention to protect participants' rights consistent with employers' desires, ERISA has left unresolved nearly as many questions as it has resolved.

One particularly important question is the judicial standard of review in ERISA litigation. Since the statute itself is silent, the Supreme Court has rendered a *de novo* standard as the presumed judicial standard of review in benefit denial cases. This allows the court to substitute its decision for that of the plan administrator. The ability to second-guess the findings of a plan administrator can cause unexpected administrative and substantive consequences for an unsuspecting employer, and at the same time afford the participant/beneficiary an opportunity to retry the case on its merits. For the employer, there is an alternative to the *de novo* standard. The federal courts have fashioned a common law which affords plan administrators, in certain circumstances, a more deferential review.² However, the application of this more deferential standard, especially in conflict of interest contexts, is anything but straightforward within the various federal circuits, either for the benefit of the

1. Pub. L. No. 93-406, 88 Stat. 829 (1974) (codified as amended in various sections of 26 and 29 U.S.C.). ERISA is the federal labor law, together with section 401 of the Internal Revenue Code, I.R.C. § 401 (1994 & Supp. III 1997), which regulates the adoption and maintenance of voluntary employer-sponsored retirement and welfare plans. ERISA's provisions were codified in Title 29 of the United States Code, whereas the related tax provisions of the Internal Revenue Code were codified in Title 26 of the United States Code. The Department of Labor has authority under Part 5 of Title I of ERISA to administer and regulate its civil enforcement provisions and claims procedures provisions. See 29 U.S.C. §§ 1132, 1133 (1994 & Supp. 1999) (setting forth the enforcement policies of the Act).

2. See *infra* note 253.

participant/beneficiary or plan sponsor/plan administrator.

The recent release of the Department of Labor's final regulations under ERISA's claim procedures piqued interest in the topic. In response to a presidential memorandum,³ the Secretary of Labor reissued final claim procedure regulations, which will revolutionize ERISA's claim procedures, particularly for health and medical welfare plans.⁴ To the relief of many, the implementation of the rules was delayed until after 2002 because of the complex changes and expense associated with them.⁵ Under these final regulations, the Secretary of Labor has granted participants the administrative right to sue under ERISA for a plan's failure to adhere to the regulations, even if administrative remedies have not yet been exhausted.⁶ The courts will then be faced with benefit claims, which they may have to construe *de novo* because a plan administrator has not had the opportunity to interpret the plan or to develop an administrative record. Such punitive consequences under these regulations may achieve their intended desire to assure full compliance; however, they may also leave the federal courts with another layer of complexity added to the standard of judicial review.

The intent of this Article is to educate the reader on the current case law on the judicial standards of review for ERISA benefit denials

3. See Remarks Announcing the Health Care "Consumer Bill of Rights and Responsibilities," PUB. PAPERS 1618 (Nov. 20, 1997).

4. 29 C.F.R. § 2560.503-1 (2000), published in 65 Fed Reg. 225 (Nov. 21, 2000), effective January 20, 2001, but conveyed a delayed applicability date for claims filed under a plan on or after January 1, 2002. The author believes that the release of these final regulations was in response to the defeat of legislative initiatives to pass a patient's bill of rights, as many of the provisions in the final regulations would have become statutory under a patient's bill of rights. The Bush administration put a 60-day freeze on the effective date of regulations issued during the final months of the Clinton administration, but which had not yet become effective. See Memorandum For the Heads and Acting Heads of Executive Departments and Agencies, Subject: Regulatory Review, January 20, 2001, issued by Andrew H. Card, Jr., Assistant to the President and Chief of Staff. However, since the effective date of the Department of Labor regulations was January 20, 2001, and thus in effect for twelve hours when the release was issued, they presumably are unaffected by the sixty day freeze.

5. In mid-2001, the Department of Labor (DOL) delayed the impending claims procedure regulations between six months and one year from the initial date of January 1, 2002, in order to afford group health plans additional time to come into compliance. See 66 Fed. Reg. 35886 (July 9, 2001).

6. 29 C.F.R. § 2560.503-1(l). It is questionable whether the DOL has overstepped its regulatory authority under these November 2000 regulations by conferring an ERISA right to sue that is not contemplated under ERISA. Under the courts' interpretation of ERISA section 503, in conjunction with the requirements under the claims review procedures, participants/beneficiaries must exhaust the plan's claims procedures before filing suit for benefits. See *Amato v. Bernard*, 618 F.2d 559, 566-68 (9th Cir. 1990) (reviewing the legislative history of ERISA and concluding that the doctrine of exhaustion applies to ERISA claims); see also *infra* text accompanying notes 37-38.

and to propose a viable solution for the conflicts plaguing the circuits. The Supreme Court's presumed *de novo* standard of review may be altered by plan language.⁷ The circuits vary as to what plan language shifts from the *de novo* standard and, if shifted, how and when to apply the more deferential standard of review.⁸ The circuits also disagree as to the application of a more deferential standard of review if the plan administrator is operating under a conflict of interest. These differences among the circuits have made it increasingly difficult to administer plans in a consistent fashion, despite ERISA's intent to present a uniform set of rules applicable to employee benefit plans. The issue will obviously be compounded if the recently released claims procedure regulations are in fact implemented. The cost of compliance and resulting litigation may actually force small- and medium-size employers out of the employee benefits welfare market, thereby jeopardizing the interests of plan participants and beneficiaries. A proper judicial balancing of the plan sponsor's expenses and the protection of employees' benefits under such plans must be achieved to assure that these plans remain viable with substantive benefits for all concerned.

This Article is composed of five parts. Part I examines ERISA and its legislative history. Part II reviews the various judicial standards of review applicable under trust law, labor law, and contract law, as well as the use of such standards by the courts pre- and post-ERISA. Part III critiques the Supreme Court's 1989 decision in *Firestone Tire and Rubber Co. v. Bruch*⁹ and sets forth its remaining lingering questions. Part IV analyzes the application of a more deferential standard in ERISA causes of action post-*Firestone*, both in the contexts of when such standard is applicable and whether such standard should be adjusted if the plan administrator is operating under a potential or actual conflict of interest. Ancillary issues that appear in benefit denial cases (*e.g.*, evidence considered by the reviewing court and judicial standard of review in factual determinations) are also discussed. In Part V, the author recommends a viable standard for use in benefit denial contexts that takes into account the concerns of the various circuits, consistent with ERISA's legislative intent to protect the delivery of expected employee benefits to participants/beneficiaries.

7. See *infra* notes 160, 168-70.

8. See *infra* notes 192-248.

9. 489 U.S. 101 (1988).

I. ERISA: THE LAW AND ITS LEGISLATIVE INTENT

ERISA regulates the voluntary delivery of employee benefits from an employer sponsor to its employees.¹⁰ The employer, not the federal government, as settlor of the plan, defines the types and extent of employee benefits. An employer may decide not to provide certain benefits to some or all of its employees. As employers may need to insure employee benefits, especially certain welfare benefit plans,¹¹ insurance companies may define the type and level of benefits insured under their policies.

Congress has decided as a matter of fairness that the plan sponsor must follow certain rules regarding the delivery of such employee benefits in this voluntary system.¹² Many small- to medium-sized employers may find these rules too cumbersome or expensive and thus decline to provide employee benefits, obviously to the detriment of their employees. While the cost of such lost benefits may be actuarially determined and used to gross up the employees' monthly salary by a nonparticipating employer, the employee may be unable or unwilling to replicate necessary employee benefits with such additional compensation. Unfortunately, employees employed by these small- and medium-sized businesses are thus without necessary medical/health coverage and retirement savings.¹³ Even for large

10. See 29 U.S.C. § 1001 (1994 & Supp. V 1999).

11. Welfare benefit plans are defined as any plan,

fund or program . . . established or . . . maintained [by an employer or employee organization] for the purpose of providing for its participants and their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 302(c) of the Labor Management Relations Act, 1947 . . . (other than pensions on retirement or death, and insurance to provide such pensions).

Id. § 1002(1).

12. See *id.* at § 1001 (setting forth Congress' rationale in enacting such legislation, which includes the desire to require minimum standards be provided assuring the equitable character of such plans and their financial soundness).

13. See research data from the U.S. Bureau of Labor Statistics indicating that 46% of the workers in small firms participate in a retirement plan compared to 79% of the workers in medium and large size firms. U.S. Department of Labor, Bureau of Labor Statistics, Employee Benefits in Small Private Establishments 1996. Bulletin 2507 (Washington D.C.: U.S. Government Printing Office, 1999) and U.S. Department of Labor, Bureau of Labor Statistics, Employee Benefits in Medium and Large Establishments 1997. Bulletin 2517 (Washington D.C.: U.S. Government Printing Office, 1999). See also research produced by the Employee Benefit Research Institute indicating that the percentage of small firms offering health benefits has increased from 1998 to 2000, but still remains below those of large firms. See 2001 Small Employer Retirement Survey, available at <http://www.ebri.org/sers/2001/index.htm> (last visited Aug. 29, 2001). Employee Benefit Research Institute (EBRI) is a nonpartisan, nonprofit public policy research organization whose mission

employers, the cost of compliance with ERISA's rules may prove to be too burdensome, forcing employers to terminate such benefits and replacing them with alternatives.¹⁴ The courts' interpretation of ERISA must be tempered with the consideration that these benefits are provided voluntarily by the employer. If the cost of compliance becomes too high, the employer has no economic advantage in continuing the delivery of the benefit. Such end result would clearly be to the detriment of affected participants and beneficiaries.

ERISA prescribes rules of fairness regarding disclosure and reporting requirements;¹⁵ enunciates fiduciary responsibility standards for plan fiduciaries;¹⁶ sets forth minimal participation, vesting, and funding requirements for pension/profit sharing plans;¹⁷ requires a claims review procedure enabling a participant to perfect an otherwise defective claim;¹⁸ and insures the delivery of pension benefits for underfunded defined benefit plans.¹⁹ While ERISA's initial intent was directed solely to the regulation of pension-type benefits,²⁰ many of its provisions were made equally applicable to any type of employee benefits, from pension-type benefits to welfare-type benefits. Specific rules of Title I under ERISA (*i.e.*, participation, vesting and funding) were directed to pension-type benefits.²¹ However, under Subtitle B of Title I of ERISA, several rules—the reporting and disclosure rules of Part 1, the fiduciary rules of Part 4, and the administration and enforcement rules of Part 5—were made equally applicable to pension plans as well as welfare plans, with certain exceptions.²²

For employers that decided to voluntarily provide employee benefits, ERISA's legislative history envisioned an overall uniform federal regulatory scheme placing such plans under a single set of federal rules and regulations, as opposed to fifty different State law

is to enhance employee benefit programs and to foster sound public policy through research and education. *Id.*

14. See Hearing on Hybrid Pensions, Before the Senate Health, Education, Labor and Pensions Committee 106th Cong. (Sept. 21, 1999) (statement of Jack Vanderhei, Temple University and Fellow, Employee Benefit Research Institute, Washington, D.C.).

15. See 29 U.S.C. §§ 1021-1031 (1994 & Supp. V 1999).

16. See *id.* §§ 1101-1114.

17. See *id.* §§ 1051-1061, 1082.

18. See *id.* §§ 1131-1141.

19. See *id.* § 1301.

20. See *id.* § 1002(2)(A) (defining an employee retirement or pension plan).

21. See *id.* §§ 1051-1086 (setting forth the rules governing pension plans).

22. See *id.* §§ 1021(a), 1024(a), 1101(a), 1132(a) (regulating employee benefit plan); see also *id.* § 1002(a)(3) (defining an employee benefit plan, which includes both an employee welfare benefit plan and an employee pension benefit plan).

requirements.²³ ERISA expressly preempted State regulation as it relates to any employee benefit plan.²⁴ Such preemption was obviously designed to reduce the cost of plan administration. Just as the States had historically regulated insurance, banking and securities law, an express exemption was given to the continued State regulation of these laws.²⁵ Thus ERISA does not preempt such rules, but instead preserves the rights of the States to enforce their laws with respect to the regulation of entities in the insurance, banking and securities businesses. But, ERISA prevents States from deeming employee plans as insurers, banks, trust companies or investment companies engaged in the business of insurance or banking for purposes of regulation under State laws.²⁶

ERISA's preemption clause was drafted very broadly and initially construed by the Supreme Court equally as broadly.²⁷ While this application may have served well in the areas that ERISA addressed, it proved daunting in the areas where ERISA was silent. If ERISA was silent on a particular matter relating to employee benefits, State laws could have been construed to supplement ERISA's rules. However, if State laws were presumed to be preempted, federal courts assumed

23. See 120 CONG. REC. H29197 (daily ed. Aug. 20, 1974) (statement of Rep. Dent) (noting that the legislation's greatest achievement is the "reservation to Federal authority the sole power to regulate the field of employee benefits plans. With the preemption of the field, we round out the protection afforded participants by eliminating the threat of conflicting any inconsistent State and Local regulations"). Senator Williams stated:

[I]t should be stressed that with the narrow exceptions specified in the bill, the substantive and enforcement provisions of the conference substitute are intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans. This principle is intended to apply in its broadest sense to all actions of State or local governments, or any instrumentality thereof, which have the force or effect of the law.

Id. at 29933 (statement of Sen. Williams); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 98 (1983) (quoting Senator Williams).

24. See 29 U.S.C. § 1144(a) (stating that ERISA preempts state law); see also *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983) (commenting that in regards to the interpretation of ERISA's preemption clause "[a] law relates to an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan").

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

26. See *id.* § 1144(b)(2)(B) (referring to what is known as ERISA's "deemer clause").

27. See *Shaw*, 463 U.S. at 98 (stating that Congress intended for the words "relate to" in § 514(a) to have a broad meaning and that "[t]he bill that became ERISA originally contained a limited preemption clause, applicable only to state laws relating to the specific subjects covered by ERISA. The Conference Committee rejected these provisions in favor of the present language, and indicated that the section's pre-emptive scope was as broad as its language.").

the job of fashioning a federal common law in such ERISA matters.²⁸ The Supreme Court's interpretation of ERISA's preemption clause has vacillated *from* that of express and exclusive preemption of the field of employee benefits law *to* that of conflict preemption with State regulation of employee benefits law, leaving the federal courts in a quandary in those areas where ERISA is silent.²⁹

This article focuses on ERISA's enforcement provisions within Subtitle B of Title I, Part 5, generally applicable to *all* employee benefit plans. Section 502 of ERISA prescribes certain causes of actions for the participant/beneficiary, the plan as a whole, a fiduciary under the plan, or the Secretary of the Department of Labor to be levied upon the plan or the plan fiduciaries. Such causes of actions relate to any covered employee benefit plan, regardless of whether it is a pension or welfare type of plan.

To the extent ERISA's preemption clause is construed broadly to restrict and preempt other State tort and contractual causes of action, more emphasis is obviously placed on ERISA's federal causes of

28. See generally Thomas R. McLean, M.D. & Edward P. Richards, *Managed Care Liability for Breach of Fiduciary Duty After Pegram v. Herdrich: The End of ERISA Preemption for State Law Liability for Medical Care Decision Making*, 53 FLA. L. REV. 1, 32-33 (2001) (discussing the impact of the holding in *Pegram* and arguing that the decision will allow plaintiffs to get around the preemption by suing HMO's under common law fiduciary claims); Damon Henderson Taylor, Note, *ERISA Preemption: Will the Elimination of the ERISA Preemption Clause Help or Harm America's Ability to Deal with Its Pending Health Care Crisis? A Selective Analysis of Past Governmental Regulation of the Health Care System and Its Relationship to Current Efforts to Render Moot the ERISA Preemption Clause*, 14 J.L. & HEALTH 133, 141-65 (2000) (reviewing the history of ERISA preemption and the courts' interpretation of the applicability of preemption to the current health care crisis); Tiffany F. Theodos, Note, *The Patient's Bill of Rights: Women's Rights Under Managed Care and ERISA Preemption*, 26 AM. J.L. & MED. 89, 93-104 (2000) (analyzing the current trend among federal courts to circumvent the preemption clause and the impact of the Patient's Bill of Rights on preemption).

29. The Court interpreted the preemption clause quite broadly so that state laws that were consistent with ERISA and indirectly affected employee benefit plans were held preempted. See *Shaw*, 463 U.S. at 96-97; *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985); see also *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 52-53 (1987) (holding that state common law causes of actions for tortious breach of contract, breach of fiduciary duties and fraud in the inducement were preempted as they relate to benefit plans, unless such actions fell within one of the exceptions of ERISA § 514(a)). See generally New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 658-62 (1995) (taking a less expansive view of preemption by permitting state statutes in fields of traditional state regulation to impact employee benefit plans); *District of Columbia v. Greater Washington Bd. of Trade*, 506 U.S. 125, 130 (1992) (holding that a District of Columbia statute compelling employers to continue plan benefits to employees receiving workers' compensation benefits was preempted); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 140 (1990) (holding that a state's wrongful discharge law used to avoid payment under a pension plan was preempted by ERISA); Caleb Nelson, *Preemption*, 86 VA. L. REV. 225 (2000) (providing analysis of the distinction levels of preemption and tracing the development of preemption law through judicial and legislative interpretation).

action which then may be the sole or predominant cause of action and provide the only form of remedy for the participant/beneficiary. Although the intent of the preemption clause was to provide uniformity regarding the administration of plan benefits, it is now being used as a shield for plan fiduciaries and insurers to limit their liability under these plans.³⁰ Such a result is inconsistent with ERISA's overall objective to protect participants' rights. ERISA's enforcement provisions further compound the issue since the federal courts have been severely limited by the *type* of remedy afforded under those actions.³¹

Under ERISA's enforcement rules, the following rights must be afforded at the plan level when a participant or beneficiary has been denied a benefit: (1) a clear explanation of the specific reasons for the denial, (2) the right to appeal that decision internally with the plan administrator, and (3) a full and fair review of the claim on internal appeal.³² The courts generally require the participant to exhaust these internal remedies before proceeding to litigation.³³

30. See generally *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1495 (7th Cir. 1996) (holding negligence claim to be preempted); *Cannon v. Group Health Serv. of Oklahoma, Inc.*, 77 F.3d 1270, 1274 (10th Cir. 1996) (holding that ERISA preempts state law where ERISA provides no remedies); *Rodriguez v. Pacificare of Texas, Inc.*, 980 F.2d 1014, 1017 (5th Cir. 1993) (holding that ERISA preempts state law claim against an HMO and a doctor for failure to provide adequate care); *Kuhl v. Lincoln Nat'l Health Plan of Kansas City, Inc.*, 999 F.2d 298, 302 (8th Cir. 1993) (finding that ERISA preempted malpractice claims due to denial of benefits at a non-HMO hospital); *Spain v. Aetna Life Ins. Co.*, 11 F.3d 129, 131 (9th Cir. 1993) (holding ERISA to preempt state wrongful death claim due to delay in approving treatment); *Corcoran v. United HealthCare Inc.*, 965 F.2d 1321, 1331 (5th Cir. 1992) (finding that ERISA preempted a wrongful death action against the entity providing utilization review services to the plan).

31. See *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 142 (1985) (declining to provide an individual participant with compensatory or punitive damages as a result of a denial of benefits under ERISA §§ 409, 502(a)(2)); see also *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 256-58 (1993) (denying extra-contractual and punitive damages under ERISA § 502(a)(3) causes of action).

32. See 29 U.S.C. § 1133 (1994 & Supp. V 1999); see also *Pilot Life Ins. Co.*, 481 U.S. at 54.

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

This exhaustion doctrine provides the courts with an administrative record that documents a plan administrator's interpretations and final decisions, as well as providing the plan administrator with the opportunity to define and redefine the problem prior to litigation.³⁴ Once such internal remedies have been exhausted and litigation proceeds, ERISA then affords a variety of causes of action.

When a participant/beneficiary perceives that he/she is denied full benefits as promised under a benefit plan, ERISA section 502 sets forth three possible causes of action that appear to be available, each providing different remedies. The first clearly affords a cause of action for the participant/beneficiary to request recovery of plan benefits, enforcement of plan rights or clarification of plan rights.³⁵ This is referred to as a section 502(a)(1) type of action and envisions both legal and equitable relief.³⁶ Recovery of benefits promised under the plan is monetary in nature, whereas injunctive or declaratory relief regarding such benefits is equitable in nature.³⁷ Clearly such cause of action should be invoked in a benefits denials case by the participant/beneficiary.

ERISA grants a second cause of action for breaches of fiduciary duty. This is referred to as a section 502(a)(2) type of action and relates to ERISA section 409 for specific relief.³⁸ While a benefit denial case could be characterized as a breach of fiduciary duty case on the theory that the plan administrator is required to interpret the plan in accordance with its terms, the Supreme Court has held that this second cause of action may not afford individual relief.³⁹ Any claim for relief under this cause of action is intended to benefit the plan as a whole, and not an individual participant or beneficiary.⁴⁰ Thus, this cause of action affords no additional protection to an individual in a benefit denial claim.

There is a third cause of action under ERISA section 502(a)(3)

Co., 846 F.2d 821, 825-26 (1st Cir. 1988).

34. See *Amato v. Bernard*, 618 F.2d 559, 568 (9th Cir. 1990) (articulating the reason for ERISA's exhaustion by explaining that "prior fully considered actions by pension plan trustees interpreting their plans and perhaps also further refining and defining the problem in given cases, may well assist the courts when they are called upon to resolve the controversies.")

35. See 29 U.S.C. § 1132(a)(1)(B) (1994 & Supp. V 1999).

36. See *Pane v. RCA Corp.*, 868 F.2d 631, 636 (3d Cir. 1989) (describing the relief available under section 502(a) as equitable). But see *Novak v. Anderson Corp.*, 962 F.2d 757, 759 (8th Cir. 1992) (noting that section 502(a) relief is a legal remedy).

37. See DAN B. DOBBS, *LAW OF REMEDIES* (2d ed. 1993) (providing a general description of the subject of remedies).

38. See 29 U.S.C. § 1132(a)(2) (1994 & Supp. V 1999).

39. See *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 142 (1985) (establishing when plaintiffs may bring suit under § 1132(a)(2)).

40. See *id.*

that permits relief for an individual participant/beneficiary or a plan fiduciary for general violations under ERISA or for violations under the terms of the plan.⁴¹ This cause of action has been characterized as the catch-all or safety net cause of action since it grants the courts the right to fashion appropriate equitable relief for more general violations.⁴² Such cause of action also permits suits against nonfiduciaries for violation under ERISA or under the terms of the plan, thus expanding the scope of possible defendants.⁴³ However, the Supreme Court in *Mertens v. Hewitt Associates* rejected the payment of monetary damages as a suitable form of equitable relief under this cause of action.⁴⁴ Thus, an individual participant, relying upon this cause of action, will be limited to equitable forms of relief. Hence, the remedy available under this cause of action is severely limited. In addition, courts have prohibited individual participants from seeking relief under both an ERISA section 502(a)(1)(B) and section 502(a)(3) cause of action in a benefits denial case.⁴⁵

In summary, when a participant or beneficiary has been denied a benefit, the best course of action is to pursue an ERISA section 502(a)(1) cause of action, requesting the recovery of promised benefits and the resulting monetary damages. Due to ERISA's preemption provision, section 514(a),⁴⁶ State tort and contractual actions are preempted by ERISA, affording ERISA's remedies as the sole source of relief.⁴⁷ Thus, despite the Supreme Court's statement

41. See 29 U.S.C. § 1132(a)(3) (1994 & Supp. V 1999).

42. See *Varity Corp. v. Howe*, 516 U.S. 489, 509-10 (1996) (examining what relief is appropriate for a violation of ERISA).

43. See *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 256-58 (1993) (elaborating on which parties are subject to suit under ERISA).

44. See *id.* at 256-58.

45. See, e.g., *Turner v. Fallon Cmty. Health Plan, Inc.*, 127 F.3d 196, 200 (1st Cir. 1997) (refusing to provide a remedy under ERISA to beneficiary of benefit plan); *Weiner v. Klais & Co.*, 108 F.3d 86, 90-91 (6th Cir. 1997) (denying damages due to failure of exhaustion of all administrative remedies).

46. See 29 U.S.C. § 1144(a) (1994 & Supp. V 1999) (stating that ERISA "shall supersede any and all State laws").

47. See, e.g., *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987) (holding that ERISA preempts state common law remedies, such as improper processing of claims); *Hermann Hosp. v. MEBA Med. & Benefits Plan*, 959 F.2d 569, 578-79 (5th Cir. 1992) (finding that state tort claims, such as fraud, civil conspiracy, breach of employment contract and negligence are not preempted by ERISA unless such claims are closely related to or intertwined with ERISA); *Settles v. Golden Rule Ins. Co.*, 927 F.2d 505, 509 (10th Cir. 1991) (stating that a wrongful death claim is related to or closely intertwined with ERISA and thus preempted by ERISA); *Brock v. Premedica, Inc.*, 904 F.2d 295, 297 (5th Cir. 1990) (holding that state claims of emotional distress "are precisely what Congress intended to preempt by ERISA"); *Martin v. Pate*, 749 F. Supp. 242, 245 (S.D. Ala. 1990) (finding that a state law claim for bad faith refusal to pay benefits is preempted by ERISA, but that a state law claim for fraud in the inducement is not preempted by ERISA); *Brock v. Self*, 632 F. Supp. 1509, 1518 (W.D. La. 1986) (holding that "it is clear that state law claims for" fraud

that "ERISA provides a panoply of remedial devices' for participants and beneficiaries of benefit plans,"⁴⁸ relief may be extremely limited in the benefit claims context.

A *de novo* or a less deferential judicial standard of review for review of a benefit denial would afford further protection of participants' ERISA rights by "second guessing" the decisions of a plan administrator.⁴⁹ However, to the extent courts begin to rely on a particular judicial standard of review as a method for compensating for the inadequacies in ERISA's remedies, we will be faced with the proverbial tail wagging the dog. Given the stakes for benefit claims for the participant under ERISA, it may well be worth the gamble. This is especially true for welfare benefits cases where the denial of a benefit claim may result in a denial of medical care, not simply a loss of monetary damages. Participants have far more to lose when such benefits are denied and therefore may be far more aggressive in their pursuit of a remedy. If a friendly federal court is willing to second guess the plan administrator's denial, the participant has a second chance for benefits she thinks have been promised under the plan.

Despite the formulations for causes of actions and resulting remedies and the expansive and preemptive scope of ERISA, the statute is silent on a number of important judicial issues, including the appropriate judicial standard of review.⁵⁰ In early decisions, the Supreme Court directed lower courts to develop a uniform federal common law for protecting the benefit rights for participants under ERISA plans.⁵¹ Thus, the lower courts began to invoke elements of

and breach of contract are preempted by ERISA).

48. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 108 (1989) (citations omitted).

49. With respect to the questions of contract interpretation, the *de novo* standard permits the courts to decide the issue "without deference to either party's interpretation and to look to the "terms of the plan and other manifestations of the parties' intent." See *Firestone*, 489 U.S. at 112-13. See also *Kirk v. Provident Life & Accident Ins. Co.*, 942 F.2d 504 (8th Cir. 1991) (the court used state law as a guide for plan interpretation); *Jacobs v. Pikands Mather & Co.*, 933 F.2d 652 (8th Cir. 1991) (*de novo* standard requires courts to interpret ambiguous terms in the same manner as any other contract claim).

50. See *Firestone*, 489 U.S. at 109 ("ERISA does not set out the appropriate standard of review for actions . . . challenging benefit eligibility determinations.").

51. See *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 56 (1987) (noting that under ERISA a uniform federal common law is sought); *Franchise Tax Bd. v. Constr. Laborers Vacation Trust*, 463 U.S. 1, 24 n.26 (1983) (explaining that the federal courts have the exclusive jurisdiction for ERISA claims enforcing rights to benefits); *Menhorn v. Firestone Tire & Rubber Co.*, 738 F.2d 1496, 1499 (9th Cir. 1984) ("Congress realized that the bare terms, however detailed, of [ERISA's] statutory provisions would not be sufficient to establish a comprehensive regulatory scheme. It accordingly empowered the courts to develop, in the light of reason and experience, a body of federal common law governing employee benefit plans. That federal common law serves three related ends. First, it supplements the statutory

labor, trusts, contract and insurance laws in fashioning an ERISA common law, as all of these laws had some relevance in ERISA claim contexts.

Labor laws specifically protect employee benefits in the union context as they are subject to good faith bargaining.⁵² These laws pre-date ERISA and can provide precedents in certain ERISA contexts. As ERISA necessitates that promised benefits be written as part of a plan document and that the fiduciary of the plan administer the plan in accordance with its terms,⁵³ contract law certainly may be relevant in ascertaining the meaning of the terms of the plan document.⁵⁴ Trust laws clearly could be relevant in formulating rules regarding specific fiduciary duties under ERISA plans.⁵⁵ And lastly, since the ERISA preemption clause specifically affirms the continued applicability of insurance law, use of insurance law in the interpretation of insurance policies which insure employee benefits is relevant and affirms the States' historic police powers.⁵⁶ Before reviewing the Supreme Court's interpretation of ERISA's judicial standard, it may be helpful to review the various standards of review available to the federal courts pre-*Firestone*, as remnants of these standards are still used by the courts today.

scheme interstitially. Second and more generally, it serves to ramify and develop the standards that the statute sets out in only general terms . . . Third, Congress viewed ERISA as a grant of authority to the courts to develop principles governing areas of the law regulating employee benefit plans that had previously been the exclusive province of state law.”)

52. See Labor Management Relations (Taft-Hartley) Act § 301, 29 U.S.C. § 185 (1994) (stating that suits between an employer and a labor union for violation of contract are brought in Federal District Court).

53. See 29 U.S.C. § 1103(a) (1994 & Supp. V 1999) (creating trust for employment benefit plan and a plan administrator); Treas. Regs. 1.401-1(a)(2) (same); see also 29 U.S.C. § 1104(a) (establishing fiduciary duties of the plan administrator); cf. 26 C.F.R. § 1.401-1(a)(2) (2000) (defining a stock bonus plan as a written program that is maintained by the employer).

54. See *Matthews v. Sears Pension Plan*, 144 F.3d 461, 465 (7th Cir. 1998) (noting that ordinary principles of contract interpretation govern the interpretation of pension plans covered by ERISA); *Haley v. Paul Revere Life Ins. Co.*, 77 F.3d 84, 88 (4th Cir. 1996) (using standard contract principles when determining whether a plan confers discretion on the administrator to provide benefits).

55. See S. REP. NO. 93-127 (1974), reprinted in 1974 U.S.C.C.A.N. 4838, 4865 (“The fiduciary responsibility section, in essence, codifies and makes applicable to these fiduciaries certain principles developed in the evolution of the law of trusts.”)

56. See 29 U.S.C. § 114(b)(2)(A) (1994 & Supp. V 1999) (creating an exception from ERISA's preemption clause for state laws that regulate insurance); *Bell v. Employee Sec. Benefits Ass'n*, 437 F. Supp. 382, 390 (D. Kan. 1977) (noting the implications of a court finding that an employee benefits plan is an insurance plan instead of an ERISA plan, and vice versa).

II. VARIOUS JUDICIAL STANDARDS PRE-*FIRESTONE*

The appropriate judicial standard of review under ERISA cannot be examined in a vacuum. The courts have grappled with employee benefit denial claims since the creation of employee benefits plans. Prior to ERISA's adoption in 1974, federal courts discussed the applicable judicial standard of review; and even after its adoption, the discussion continued in much the same fashion until 1989.

The Supreme Court decided *Firestone* in 1989 and stated that its interpretation of the appropriate ERISA standard of review was consistent with the contract law standard that had been used *prior to* the advent of ERISA.⁵⁷ This is an overstatement of the standards actually used by the courts in employee benefits causes of action. In reality, there were a variety of pre-ERISA judicial standards of review used by federal courts in employee benefit cases. It is, therefore, helpful to examine and differentiate the effectiveness of the various standards of review, especially since courts are still using many of these differences today.

A. *Applicable Standard of Review under Contract Law*

Before employee benefit rights became protected under any federal statute, the courts invoked contract law as they wrestled with the very basic issue of whether the employer's promise to deliver employee benefits was enforceable.⁵⁸ If the employee benefit was deemed simply a gratuity from the employer, there were no rights to enforce.⁵⁹ However, if employee benefits were created by means of a unilateral contract, the courts would be inclined to enforce such rights.⁶⁰ Thus, the very early employee benefits cases focused on the terms of the plan⁶¹ or promise by the employer,⁶² determining

57. See *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 109 (1989) (noting that federal courts adopted a standard of review for ERISA claims similar to the standard developed under 29 U.S.C. § 186(c) (1994)).

58. See *Hobbs v. Lewis*, 159 F. Supp. 282, 286 (D.D.C. 1958) (resolving a pension eligibility dispute under a contract law standard of review); *Atl. Steel Co. v. Kitchens*, 187 S.E.2d 824, 826 (Ga. 1972) (interpreting a pension contract in favor of the employee); *Conner v. Phoenix Steel Corp.*, 249 A.2d 866, 868-69 (Del. 1969) (construing ambiguous terms in a contract in favor of an employee who was denied rights); *Sigman v. Rudolph Wurlitzer Co.*, 11 N.E.2d 878, 879 (Ohio Ct. App. 1937) (noting that when a contract for a pension system can be construed in two ways fraud is not presumed).

59. See *Menke v. Thompson*, 140 F.2d 786, 790 (8th Cir. 1944) (holding the pension awards as mere gratuities and not contractual promises).

60. See *Parker v. Wakelin*, 123 F.3d 1, 6 (1st Cir. 1997) (finding a trend among state supreme courts to treat pension plans as unilateral, implied-in-fact contracts).

61. See *Sigman*, 11 N.E.2d at 879 (reviewing the terms of the pension pamphlet).

62. See *Conner*, 249 A.2d at 868 (noting that pension plans are a promise to pay deferred compensation).

whether it rose to the level of a contractual promise. These cases were devoted solely to the issue of whether employee benefits were enforceable by the courts, not necessarily the standard of review by the court regarding the denial of the benefit.⁶³

Once employee benefits rights became protected under the federal labor law for union employees, the courts shifted reliance from contract law to that of labor law for the enforcement of benefits rights for union employees.⁶⁴ However, since the labor statute was also silent on the standard of judicial review, courts began to develop common law under labor law. The result was an arbitrary and capricious standard of review for the interpretation of terms or the determination of benefits by the plan's joint board of trustees.⁶⁵ As employee benefit plans continued to develop in non-union contexts, the federal courts began applying the labor law standard outside the union context, to all employee benefit plan situations.⁶⁵ The majority of courts continued the labor law standard of review in ERISA benefit denial cases until 1989, when the Supreme Court decided *Firestone*.⁶⁷

Even before the Supreme Court reached its decision in *Firestone*, the courts had shifted from contract law to labor law in its review of benefit rights.⁶⁸ Once the labor statute stressed the importance of employee benefits as a matter of collective bargaining, the courts in general no longer needed to rely on contract law to justify the enforcement of employee benefits, even in the non-union cases. As employee benefits became a part of the employee's compensation package, benefits were no longer viewed as a gratuity in any context. Therefore, continued use of contract law was limited in fashioning a judicial standard of review.

In non-union contexts, contract law began to lose its appeal. Contract law is concerned with enforcing the terms of a contract, the terms of which are mutually agreed upon by consenting parties.⁶⁹

63. See *supra* note 58 (listing numerous cases that applied contract principles to pension disputes).

64. See, e.g., *Mauer v. Joy Techs., Inc.*, 212 F.3d 907, 914 (6th Cir. 2000) (determining that collective bargaining agreements can vest retirement benefits); *Laborers' Pension Fund v. Concrete Structures*, 999 F.2d 1209, 1210 (7th Cir. 1993) (relying on a standard collective bargaining contract); *Bidlack v. Wheelabrator Corp.*, 993 F.2d 603, 608 (7th Cir. 1993) (finding that extrinsic evidence supported the finding that a collective bargaining agreement conferred lifetime benefits, which survived the expiration of the last collective bargaining agreement).

65. See generally *infra* note 90.

66. See generally *infra* note 135.

67. See *Strubble v. New Jersey Brewery Employees' Welfare Trust Fund*, 732 F.2d 325, 333 (3d Cir. 1984) (applying labor law's arbitrary and capricious standard of review).

68. See cases cited *supra* note 64.

69. See RESTATEMENT (SECOND) OF CONTRACTS § 3 (1981) ("An agreement is a

The point of the written contract is to formalize the terms of the agreement by which both parties agree to be bound.⁷⁰ Rarely are contracts formulated where one party is granted the power to discern and interpret the future terms of the contract, thereby binding the other party to such result.⁷¹ In contrast, employee benefit plans (in non-union contexts) are not mutually agreed upon agreements, but instead could be viewed as unilateral contracts for the benefit of third parties (*e.g.*, the participants and beneficiaries).⁷²

The Supreme Court in *Firestone*, however, directed the courts to use contract law in construing the terms of the trust document as it would any other contract claim “by looking at the terms of the document and other manifestations of the parties’ intent.”⁷³ Two years earlier, in *Van Boxel v. The Journal Co. Employees’ Pension Trust*,⁷⁴ the Seventh Circuit had been sympathetic to the plaintiff’s claim that the ERISA plan should be treated as any ordinary contract and thus the courts should invoke a contractual approach to the trustees’ denial of benefits, especially in cases of conflict of interest.⁷⁵ However, the Seventh Circuit rejected a purely contractual approach in fashioning a judicial standard of review.⁷⁶ It seemed incongruous to the court, viewing ERISA as a “paternalistic piece of legislation, that Congress would infer that the participants and beneficiaries implicitly waived their rights to judicial review of benefit denial claims simply because of a contractual deference afforded to trustees.”⁷⁷

Certainly contract law may be useful in ascertaining the terms of the plan and trust documents. Courts have followed the contracts’ plain meaning rule in interpreting plan terms that are plain and

manifestation of mutual assent on the part of two or more parties.”).

70. See generally *id.* §§ 4, 17, 131, 209 (describing the implications of a written contract).

71. See generally *id.* §§ 45, 206 (stating that terms are interpreted against the party who drafts those terms).

72. See *Landro v. Glendenning Motorways, Inc.*, 625 F.2d 1344, 1347 (8th Cir. 1980); *In re White Farm Equip. Co.*, 42 B.R. 1005, 1017 (N.D. Ohio, 1984), *rev’d by In re White Farm Equip. Co.*, 788 F.2d 1186 (6th Cir. 1986).

73. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 112-13 (1989) (“The extent of the duties and powers of a trustee is determined by the rules of law that are applicable to the situation, and not the rules that the trustee or his attorney believe to be applicable, and by the terms of the trust as the court may interpret them, and not as they may be interpreted by the trustee himself or by his attorney.” (quoting 3 WILLIAM FRATCHER, SCOTT ON TRUSTS § 201, at 221 (4th ed. 1988))).

74. 836 F.2d 1048 (7th Cir. 1987).

75. See *id.* at 1049 (noting the growing skepticism about the arbitrary and capricious standard).

76. See *id.* at 1053 (stating that there is “no urgent need to throw [the arbitrary and capricious standard] overboard”).

77. *Id.* at 1052.

unambiguous.⁷⁸ In addition, for ambiguous plan or trust terms, the courts' use of the *contra proferentem* rule⁷⁹ to construe such terms against the drafter has been useful and protective of employees' rights.⁸⁰

Continued use of contract law in formulating a judicial standard of review for ERISA cases has not met with an enthusiastic response from the courts.⁸¹ Under a contractual standard of review, the courts generally subject the interpretation of the contract to a reasonableness standard. Such standard may or may not consider the intent of the parties. The standard of reasonableness is one that is determined by the courts, rather than the parties to the contract.⁸²

78. See *Santaella v. Metro. Life Ins. Co.*, 123 F.3d 456, 462 (7th Cir. 1997) (“[i]nterpreting the policy terms in ordinary and popular sense . . .”).

79. See BLACK'S LAW DICTIONARY (7th ed. 1999) (defining *contra proferentem* as a “doctrine that, in interpreting documents, ambiguities are to be construed unfavorably to the drafter.”).

80. See, e.g., *Bailey v. Blue Cross*, 67 F.3d 53, 57 (4th Cir. 1995) (noting the interpretation of the policy follow ordinary contract terms); *Wheeler v. Dynamic Eng'g, Inc.*, 62 F.3d 634, 638 (4th Cir. 1995) (applying ordinary contract construction principles of state law to ambiguous terms in ERISA plans); *Todd v. AIG Life Ins. Co.*, 47 F.3d 1448, 1451-52 (5th Cir. 1995) (stating that federal law must follow the rule of *contra proferentem* when construing language of ERISA plans); *Cannon v. Wittek Cos., Int'l*, 60 F.3d 1282, 1284 (7th Cir. 1995) (noting that ambiguous terms are construed for the insured); *Mongeluzo v. Baxter Travenol Long Term Disability Benefit Plan*, 46 F.3d 938, 942 (9th Cir. 1995) (stating that undefined terms are construed against the drafter); *Hughes v. Boston Mut. Life Ins. Co.*, 26 F.3d 264, 268 (1st Cir. 1994) (using the rule of *contra proferentem* in construing ambiguous terms); *Masella v. Blue Cross & Blue Shield*, 936 F.2d 98, 107 (2d Cir. 1991) (stating that a reviewing court is not bound to hornbook definitions with ambiguous terms); *Kunin v. Benefit Trust Life Ins. Co.*, 910 F.2d 534, 541 (9th Cir. 1990) (construing the term “mental illness” in favor of the injured employee); see also RESTATEMENT (SECOND) OF CONTRACTS, *supra* note 69, at § 206 (noting that *contra proferentem* is frequently used in insurance policy constructions). Some courts, however, decline to apply the doctrine of *contra proferentem* under the abuse of discretion standard of review. See *Florence Nightingale Nursing Serv., Inc. v. Blue Cross & Blue Shield of Ala.*, 41 F.3d 1476, 1481 (11th Cir. 1995) (noting that when there is no conflict of interest, the arbitrary and capricious standard will not apply); *Brewer v. Lincoln Nat'l Life Ins. Co.*, 921 F.2d 150 (8th Cir. 1990) (declining to apply *contra proferentem*).

81. See *Herzberger v. Standard Ins. Co.*, 205 F.3d 327, 331 (7th Cir. 2000) (viewing ERISA plans as contracts subject to the same judicial review as any breach of an alleged contract); *Anstett v. Eagle-Picher Indus., Inc.*, 203 F.3d 501, 503 (7th Cir. 2000) (noting “the claim for separation benefits is really a claim to enforce a contract.”); *Matthews v. Sears Pension Plan*, 144 F.3d 461, 465 (7th Cir. 1998) (noting that pension plans are usually not negotiated); see also *Haley v. Paul Revere Life Ins. Co.*, 77 F.3d 84, 88 (4th Cir. 1996) (applying standard contract principles to benefit claims). Judge Posner of the Seventh Circuit appears persuaded by the thinking of John H. Langbein and his contractarian approach to the enforcement of benefits under ERISA. See John H. Langbein, *The Contractarian Basis of the Law of Trusts*, 105 YALE L.J. 625, 657-60 (1995) [hereinafter *Contractarian Basis*] (applying contract terms to a fiduciary's duties). However, the Seventh Circuit appears in the minority with respect to the use of contract law in the determination of the appropriate judicial standard of review. See *Krause v. Modern Group, Ltd.*, No. CIV.A. 00-534, 2000 WL 1858720, *3 n.20 (E.D. Pa. Dec. 20, 2000) (noting disagreement between the courts).

82. See CORBIN ON CONTRACTS § 24.5, at 15 (rev. ed. 1998) (expressing the

Even in those contracts that are conditional upon the satisfaction by one of the parties (*e.g.*, a case where an artist promises to paint a portrait only if the recipient is personally satisfied with the results), the courts still impose a reasonable standard in discerning whether the performance was satisfactory.⁸³

The deficiency in a wholesale use of contract law in all ERISA cases is that employee benefits plans are not contracts between two bargaining parties, except in collective bargaining contexts. The ERISA plan has to be reduced to the form of a document that will bind the employer sponsor and employees as third party beneficiaries rather than parties to the terms of a document.⁸⁴ The terms of the plan are solely within the control of the plan sponsor, within the parameters of the Code and ERISA.⁸⁵ Therefore, any forced contract law analysis which goes to the intent of the parties would have to focus solely on the employer's intent, as the sole drafter of the agreement. Such analysis adds little to the determination of the standard of review or the protection of participants' rights to benefits.

B. Applicable Standard of Review under Labor Law

Once pension benefits became subject to collective bargaining in the 1940s, courts recognized that new standards were to be imposed on the negotiation of wages (which included employee benefits) for collectively bargained employees. Employee benefits could no longer be viewed as gratuities, but were subject to good faith bargaining for union employees.⁸⁶ Such multi-employer plans and trusts were

standard as "in interpreting the words of a contract, the courts seek the meaning and intentions of the parties. In as much as the parties may have attached different meanings and may have attached different intentions, the court must determine to which party's meaning and intention should prevail.")

83. See *Handy v. Bliss*, 90 N.E. 864, 865 (Mass. 1910); *Hawkins v. Graham*, 21 N.E. 312, 313 (Mass. 1889) (applying a reasonableness standard instead of determining the private satisfaction of one party).

84. While ERISA does not explicitly require that an employee benefit plan be written, it presumes such requirement by requiring the plan sponsor to provide a summary plan description to participants/beneficiaries, which is a written summary of the plan provisions, and plan documents to participants/beneficiaries upon written request. See 29 U.S.C. §§ 1022, 1024 (1994 & Supp. V 1999).

85. See 29 U.S.C. §§ 1102-1103 (1994 & Supp. V 1999); see also STEPHEN R. BRUCE, PENSION CLAIMS RIGHTS AND OBLIGATIONS 321-22 (2d. 1993) (noting that the use of a contractual standard of review would undermine ERISA's disclosure requirements).

86. See *Allied Chem. & Alkali Workers, Local 1 v. Pittsburgh Plate Glass Co.*, 404 U.S. 157, 188 (1971) (stating that the "remedy for a unilateral mid-term modification to a permissive term lies in action for breach of contract . . . not in an unfair-labor-practice proceeding."); *Elec. Mach. Co. v. NLRB*, 653 F.2d 958, 964 (5th Cir. 1981) (concluding that the employer instituted unilateral changes to an employment package, which constituted a refusal to bargain collectively); *NLRB v. Imperial House Condo. Ass'n*, 831 F.2d 999, 1007 (11th Cir. 1981) (holding that an employer cannot unilaterally alter the control of employer health benefit plans); *State Distrib. Co.*,

expected to be governed by federal labor statutes and federal courts were directed to develop appropriate federal common law in such contexts.⁸⁷

The federal courts began to fashion a federal common labor law since labor law was silent on the scope of judicial review in cases of participants/beneficiaries suing plan trustees.⁸⁸ However, in crafting a federal common labor law, the circuit courts specifically noted that pension plans were the result of collective bargaining, between parties of relatively equal strength, and thus, unlike contracts of adhesion.⁸⁹ By rejecting a judicial standard of review that assumed benefits were solely contractual in nature and written solely by the employer/settlor, the courts created what has become known as the arbitrary and capricious standard.⁹⁰

Inc., 282 NLRB Dec. (CCH) 1048, 1048 (1987) (finding that the employer was not free to fix the terms of the employment agreement); Arno Moccasin Co., 274 NLRB Dec. (CCH) 1515, 1522 (1985) (stating that the employer engaged in unfair labor practices by unilaterally discontinuing health, life, and accident insurance).

87. See *Textiles Workers Union v. Lincoln Mills*, 353 U.S. 448, 456 (1957) (directing the lower courts to establish a federal common law for claims arising under § 301 of the Labor-Management Relations Act); see also *Wardle v. Cent. States, Southeast & Southwest Areas Pension Fund*, 627 F.2d 820, 829 (7th Cir. 1980) (stating that ERISA's silence on the right to a jury trial reflects an intention that suits for benefits are equitable and to be decided in federal courts under their diversity jurisdiction); *Reiherzer v. Shannon*, 581 F.2d 1266, 1271 (7th Cir. 1978) (stating that federal common law will govern when benefits are denied under benefits plans).

88. See *Reiherzer*, 581 U.S. at 1273 (noting that under federal common law principals, the reviewing court cannot substitute its judgment, rather the court must use an arbitrary and capricious standard).

89. See *Rehmar v. Smith*, 555 F.2d 1362, 1368, 1371 (9th Cir. 1976) (discussing the use of the arbitrary and capricious standard from *Danti v. Lewis*, 312 F.2d 345 (D.C. Cir. 1962), and stating that "decisions may be reserved only where they are arbitrary, capricious or made in bad faith, not supported by substantial evidence, or erroneous on a question of law."); see also *Dennard v. Richards Group Inc.*, 681 F.2d 306, 308 (5th Cir. 1982) (affirming use of the arbitrary and capricious standard to avoid excessive judicial intervention); *Gaydosh v. Lewis*, 410 F.2d 262, 266 (D.C. Cir. 1969) ("[U]nderlying all these determinations is the awareness that the employees are not at a disadvantage vis-a-vis the trustees. The Board of Trustees is chaired by the representative of the Union. He, as well as the other two members [one of whom is neutral], is presumed to conscientiously serve the interests of all parties to the Fund.").

90. See *Danti v. Lewis*, 312 F.2d 345, 349 (D.C. Cir. 1962) (holding that the trustee's decision was arbitrary and capricious in denying the employee's benefits); see also *Dennard*, 681 F.2d at 313 (noting that the arbitrary and capricious standard of review traditionally has been used for review of trusts); *Wardle*, 627 F.2d at 824 (stating that a reviewing court should not resolve eligibility questions on new evidence, but should remand to the trustee for a new determination); *Rehmar*, 555 F.2d at 1371 (continuing to apply the *Danti* standard of review in diversity cases); *Pete v. United Mine Workers of Am. Welfare & Ret. Fund of 1950*, 517 F.2d 1275, 1283 (D.C. Cir. 1975) (stating that the court's role is limited to determining whether the trustee actions are arbitrary and capricious); *Lee v. Nesbitt*, 453 F.2d 1309, 1311 (9th Cir. 1971) (stating that trustees owe fiduciary duty to the employees and may not act arbitrarily); *Gomez v. Lewis*, 414 F.2d 1312, 1313-14 (3d Cir. 1969) (noting the trustee's decisions are subject to review when they are arbitrary and capricious);

Under this arbitrary and capricious standard of review, the multi-employer plan trustees' determinations as to coverage and/or eligibility would be reversed "only where they are arbitrary, capricious or made in bad faith, not supported by substantial evidence, or erroneous on a question of law."⁹¹ Such standard was consistent with the legislative history of labor laws and the protections afforded by such laws.⁹² The exact terms of the plans were free to be determined by the parties involved. The courts were not expected, nor permitted, to rewrite the terms of the agreement.⁹³ Collective bargaining agreements were free to grant absolute discretion to the plan trustees in determining eligibility or coverage or to subject the trustees to the terms of the agreement.⁹⁴ A strict contractual view was not needed since both parties were represented and the employer was not presumed to be the sole drafter of the plan. The parties were free to set forth plan coverage and eligibility provisions in the plan or reserve the interpretation of such provisions by the joint board of trustees, who represented management and employees.⁹⁵

Roark v. Lewis, 401 F.2d 425, 426 (D.C. Cir. 1968) (defining the scope of the reviewing court to determine whether the action was arbitrary and capricious); *Miniard v. Lewis*, 387 F.2d 864, 865 (D.C. Cir. 1967) (limiting scope of review to those actions by the trustee which are arbitrary and capricious); *Kosty v. Lewis*, 317 F.2d 744, 747 (D.C. Cir. 1963) (stating that trustees, like all fiduciaries, are subject to review for actions that are arbitrary and capricious).

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

92. See *United States Mine Workers of Am. Health & Ret. Funds v. Robinson*, 455 U.S. 562, 575 (1982) (using the arbitrary and capricious standard as the proper judicial standard under the Taft-Hartley Act); *Textile Workers Union*, 353 U.S. at 454-55 (interpreting the legislative history of the Taft-Hartley Act to permit federal courts to enforce collective bargaining contracts on both parties and directing them to fashion a federal common law for such purposes); see also *Music v. W. Conference of Teamsters Pension Trust Fund*, 712 F.2d 413, 417 (9th Cir. 1983) (recognizing that the trustees' actions under ERISA are subject to the arbitrary and capricious standard).

93. See *Roark*, 401 F.2d at 429 (refusing to second guess trustee's discretionary decisions in dividing up the benefit when "the size of the pie is fixed"); *Miniard*, 387 F.2d at 865 (refusing to interpret the provision of the benefits plan); *Lowenstern v. Int'l Ass'n of Machinists & Aerospace Workers*, 479 F.2d 1211, 1213 (D.C. Cir. 1973) (finding that, faced with two competing interpretations of the plan, the court was bound by the plan's administrator's interpretation unless arbitrary and capricious).

94. See *Danti*, 312 F.2d at 346 (granting the trustees full authority over questions of coverage and eligibility); *Menke v. Thompson*, 140 F.2d 786, 790 (8th Cir. 1944) (stating that the Board of Pensions did not act upon fraud, implied bad faith or failure to exercise reasonable judgment); *Kennet v. United Mine Workers of Am.*, 183 F. Supp. 315, 317 (D.D.C. 1960) (noting that the payments by the employer are not gifts but part of the union employment agreement); *Hobbs v. Lewis*, 159 F. Supp. 282, 286 (D.D.C. 1958) (noting that the wage agreement gave the trustees full authority over questions of coverage and eligibility); *Hurd v. Illinois Bell Tel. Co.*, 136 F. Supp. 125, 154 (N.D. Ill. 1955) (leaving issues of interpretation to the benefits committee).

95. See *Kosty*, 319 F.2d at 746 (noting that the pension plan gives full authority to the trustees for matters of interpretation); *Danti*, 312 F.2d at 346 (reserving power of

When the trustees had not been given discretion as to coverage and/or eligibility, they were nevertheless subject to the terms of the collective bargaining agreement. The issue then arose as to whether the arbitrary and capricious standard would be altered and replaced by a standard of reasonableness. As section 302(a)(5) of the Labor Management Relations Act (LMRA) required the trustees of the multi-employer plans to maintain funds “for the sole and exclusive benefit of the employees, family members and dependents,”⁹⁵ an argument was made and rejected that such duties imposed a reasonableness standard upon the trustee’s action.⁹⁷ The sole purpose of this clause was to assure that employee benefit funds would be treated as legitimate trust funds and thus used solely for the purpose of providing benefits.⁹⁸ The Supreme Court rejected the use of section 302(a)(5) as a method for the courts to review the benefit schedules of the various employee benefits from a viewpoint of reasonableness.⁹⁹ The Court’s rationale was that eligibility and coverage are entitled to the “same respect as any other provision in a collective-bargaining agreement.”¹⁰⁰ Such logic is certainly consistent with the Supreme Court’s prior decisions that the substantive terms of the collectively bargained contract could not be reviewed by the courts for reasonableness.¹⁰¹ LRMA assures that the participants’ rights are adequately represented and that an impartial panel is used in the administration of the plan.

While clearly not all employee benefit plans were subject to collective bargaining agreements, a number of courts prior to ERISA began to impose the same arbitrary and capricious standard to plans outside the collective bargaining process.¹⁰² Departing from a solely contractual point of view, courts began to view all employee benefits

interpretation with the Trustees).

96. 29 U.S.C. § 186(c)(5) (1994).

97. See *Robinson*, 455 U.S. at 570 (stating that 29 U.S.C. § 186(c)(5) protected worker’s funds from supporting war chests of political factions).

98. See *NLRB v. AMAX Coal Co.*, 453 U.S. 322, 330 (1980) (referring to the legislative history “[a]s explained by Senator Ball, one of the two sponsors, the ‘sole purpose’ of § 302(c)(5) is to ensure that employee benefit trust funds ‘are legitimate trust funds used actually for the specified benefits to the employees of the employers who contribute to them’”) (citing 93 CONG. REC. 4678 (1947)).

99. See *Robinson*, 455 U.S. at 574 (recognizing that former members to a plan might suffer discrimination because the union does not need to take into account their interests). The Court also rejected the notion of challenging the trustees’ practice of balancing a finite amount of contributions among various potential beneficiaries due to financial and actuarial considerations. See *id.* at 575.

100. *Id.*

101. See *id.* at 576 (stating that when the end product of collective bargaining does not violate any law, the federal courts have no authority to modify it).

102. See cases cited *supra* note 89.

within the same context. A series of decisions, referring to such standard as the *Danti* standard, imposed the arbitrary and capricious standard to any denial of benefits, relying on the same standards used in the labor law.¹⁰³ While the courts did not enunciate the rationale for the use of the same standard in non-union contexts, this article proposes that courts implicitly regarded the interpretation of employee benefits plans as a settlor function in the non-collectively bargained context. As a result, the plans would be subject only to deferential review by the courts.¹⁰⁴ Because employee benefits were voluntary for employers in non-union contexts, courts were simply not going to rewrite the terms of the plan or substitute their interpretations for plan provisions.¹⁰⁵ When ERISA was passed in 1974 and was silent on the issue of judicial review, the courts continued to use the labor law standard of judicial review for ERISA claims.¹⁰⁶

C. *Applicable Standard of Review under Trust Law*

After the advent of labor laws intended to protect employee benefits, trusts began to be used as funding vehicles for plan assets. With the enactment of ERISA in 1974, trusts or insurance vehicles were required as funding vehicles for covered retirement plans.¹⁰⁷ As was true in certain limited trust law contexts,¹⁰⁸ a plan sponsor was permitted under ERISA to be a trustee of the trust.¹⁰⁹ However, where a settlor under a trust may declare such a trust, the settlor cannot contract with herself.¹¹⁰ In this respect, ERISA differs from trust law as the former binds the plan sponsor to an ongoing trust

103. See *Rehmar v. Smith*, 555 F.2d 1362, 1371 (9th Cir. 1976) (citing the pre-1976 cases cited *supra* note 89 as the *Danti* cases since they originated with the decision of *Danti v. Lewis*, 312 F.2d 345 (D.C. Cir. 1962)).

104. See Bradley R. Duncan, Note, *Judicial Review of Fiduciary Claims Denials under ERISA: An Alternative to the Arbitrary and Capricious Test*, 71 CORNELL L. REV. 986, 992-94 (1986) (explaining the origins of the LMRA's arbitrary and capricious standard and arguing its inapplicability to ERISA).

105. See *Lowenstern v. Int'l Assoc. of Machinists & Aerospace Workers*, 479 F.2d 1211, 1213 (D.C. Cir. 1973) ("[A]s between two competing interpretations of the Plan, we are bound by that of the Administrators if it is not arbitrary and capricious").

106. See *infra* note 134.

107. See 29 U.S.C. § 1103 (1994 & Supp. V 1999) (outlining the general requirements for employee benefit plans to be held in a trust unless specifically exempted).

108. See AUSTIN WAKEMAN SCOTT, ABRIDGMENT OF THE LAW OF TRUSTS § 141, at 52 (1960) (stating that a transfer by a beneficiary of his interest under a trust can be rescinded or reformed under certain circumstances).

109. See *Sutton v. Weirton Steel Div.*, 724 F.2d 406, 410 (4th Cir. 1983).

110. See *Contractarian Basis*, *supra* note 81, at 625 (arguing that employee benefit trusts are contracts).

relationship with respect to the plan assets.¹¹¹

Using solely trust law principles, the settlor of the trust is permitted to grant broad discretionary powers to the trustee, to which the courts have historically afforded deferential review.¹¹² However, trust law differentiates between a trustee's discretionary and non-discretionary (referred to as mandatory) powers.¹¹³ With respect to mandatory powers, the settlor could require the trustee to perform or not to perform certain acts of trust administration.¹¹⁴ If the trustee failed to carry out the settlor's intent, the courts could order the trustee to perform her duties or find her liable for failure to do so.¹¹⁵ Such review was *de novo* by the court.¹¹⁶

In contrast, the settlor could confer discretionary powers over aspects of trust administration to the trustee, thereby granting judgment to the trustee as to whether or not to carry out such activity.¹¹⁷ The case law shows that courts will not ordinarily disturb the trustee's decision.¹¹⁸ Generally, courts will not substitute their judgment for that of the trustee unless the trustee abused her discretion.¹¹⁹ In cases where the trustee acted in bad faith, arbitrarily, capriciously, maliciously, or from other improper motive, courts are willing to find an abuse of discretion.¹²⁰ In such a case, court can either direct the trustee to reconsider her decision or instruct the

111. See 29 U.S.C. § 1104 (1994).

112. See SCOTT ON TRUSTS, *supra* note 73, at § 201 (discussing what constitutes a breach of a trust, noting that a breach usually occurs if a trustee is personally at fault).

113. See GEORGE GLEASON BOGERT & GEORGE TAYLOR BOGERT, THE LAW OF TRUSTS AND TRUSTEES §§ 558, 560 (2d ed. rev. 1980) [hereinafter LAW OF TRUST AND TRUSTEES] (outlining the general concepts of mandatory and discretionary powers).

114. See RESTATEMENT (SECOND) OF TRUSTS §§ 186, 187, 382 (1959).

115. See *id.*

116. See *Russell v. Hartley*, 78 A. 320, 322 (Conn. 1910) (giving a court of equity power to review and revise a trustee's actions).

117. See *Whitaker v. McDowell*, 72 A. 938, 939 (Conn. 1909) (stating that discretionary power was personal and could be exercised only by the trustee herself); *Safe Deposit & Trust Co. v. Sutro*, 23 A. 732, 733 (Md. 1892) (questioning whether discretionary power is personal to the individual or granted to the mere office).

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

119. See SCOTT ON TRUSTS, *supra* note 73, § 187 (discussing the broad scope of the discretionary powers granted to a trustee and the unwillingness of courts to interfere).

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

trustee with respect to a new decision.¹²¹ Thus, discretion under trust law indicates the settlor's intent that the trustee's decisions were to be entitled to deference by the courts.

Even where the settlor's intent is to grant a broad scope of discretionary powers, the courts still impose a standard of review in deciding whether the trustee should act and when and how the trustee should act; these variables depend on the terms of the trust, the nature of the power and all the surrounding circumstances.¹²² The SECOND RESTATEMENT OF TRUSTS lists the following five factors in determining whether the trustee acted within the boundaries of reasonable judgment: (1) the extent of discretion conferred; (2) the existence of an outside standard by which reasonableness may be judged; (3) circumstances surrounding the exercise of the power; (4) the motives of the trustee; and (5) the existence of a conflict of interest on the part of the trustee.¹²³ With respect to the second factor, if there is a standard to judge the reasonableness of the trustee's decision, the courts will invoke this standard to review the objective reasonableness of her judgement.¹²⁴ This factor is generally invoked where the trustee's decision involves business judgment, *e.g.*, investment decisions.¹²⁵

The meaning of discretionary authority under ERISA has an entirely different meaning than that used in trust law.¹²⁶ For the purposes of ERISA, a person becomes a fiduciary to the extent she holds or exercises discretionary authority.¹²⁷ The Department of Labor and the courts have taken a broad interpretation of the term, requiring more than ministerial functions, in order to find a person acting as a fiduciary.¹²⁸ To the extent someone has management or

121. See RESTATEMENT (SECOND) OF TRUSTS, *supra* note 114, § 187 cmt. i.

122. See SCOTT ON TRUSTS, *supra* note 73, at § 187 (stating that "whether the exercise of a power is permissive or mandatory depends upon the terms of the trust").

123. See RESTATEMENT (SECOND) OF TRUSTS, *supra* note 114, § 187 cmt. d. The American Law Institute compiled a Restatement of the American Law of Trusts in 1935, setting forth the laws applicable to the creation and administration of trusts as the Institute believed to exist. Then in 1957, that Restatement was revised and a Restatement (Second) of Trusts was published. Many states have annotated the Restatement of Trusts with references to their applicable state and case law.

124. See SCOTT ON TRUSTS, *supra* note 73, § 187.2 (stating that if there is a standard to test the trustee's reasonableness, courts will control her actions under this standard).

125. *Id.* at 33 (applying this general principle most frequently to cases where business judgment is involved).

126. See 29 U.S.C. § 1002(21)(A) (1994 & Supp. V 1999) (stating that a person is a fiduciary of a plan when she exercises discretionary authority over the control or administration of a plan).

127. See *id.*

128. See *Donovan v. Mercer*, 747 F.2d 304, 308 (5th Cir. 1984) (stating that a

administrative powers that are more than ministerial, that person will be labeled a fiduciary.¹²⁹ The intent of such interpretation is to extend the scope of individuals accountable under the plan.¹³⁰ Thus, a person may become a fiduciary under ERISA's definition solely because she has management or administrative powers, even though she lacks the granting of discretion envisioned by trust law to justify a fairly deferential standard of review for his decision. The result presents a dilemma in using trust law as the basis of determining ERISA's judicial standard of review for fiduciaries' actions.

While labor law subjected employee benefits to collective bargaining and imposed the use of a trust for the maintenance of such benefits, ERISA did not subject similar rules to non-unionized employees.¹³¹ In non-union contexts, benefits remain solely at the discretion of the employer and only pension benefits have to be prefunded with plan assets that must be held either in trust or under an insurance contract.¹³² And while advanced funding was not required for welfare benefits, many employers began using trusts and insurance contracts as funding instruments for all types of employee benefit plans.¹³³ Once trusts were used for employee benefit plans, courts began to interject the topic of trust law into their construction of ERISA.¹³⁴

fiduciary is defined by considering the authority of an individual); *McNeese v. Health Plan Mktg., Inc.*, 647 F. Supp. 981, 985 (N.D. Ala. 1986) (holding that if a person exercises discretionary administrative control, he is a fiduciary for ERISA purposes and his own state of mind will have no bearing on his fiduciary status); *Freund v. Marshall & Ilsley Bank*, 485 F. Supp. 629, 635 (W.D. Wis. 1979) (stating that by the very nature of their positions, plan trustees and administrators are fiduciaries with respect to a plan and their state of mind has no bearing on their fiduciary status).

129. *See Pension Benefit Guar. Corp. v. Solmsen*, 671 F. Supp. 938, 943-44 (E.D.N.Y. 1987) (stating that because the defendant could terminate contracts, transfer assets, and sign documents on the company's behalf, he was a fiduciary); *Robbins v. First Am. Bank*, 514 F. Supp. 1183, 1189-91 (N.D. Ill. 1981) (finding no ERISA fiduciary by a bank that was merely a servicing agent for a particular investment); *Eaton v. D'Amato*, 581 F. Supp. 743, 745-47 (D.D.C. 1980) (stating that ERISA's fiduciary requirement should be interpreted liberally and a person exercising any discretionary authority regarding the plan's management or administration is a fiduciary).

130. *See H.R. CONF. REP. NO. 93-1280*, at 323 (1974), *reprinted in 1974 U.S.C.C.A.N.* 5038, 5103 (defining the role of the fiduciary and listing those persons considered fiduciaries by the law).

131. *See 20 U.S.C. § 301* (1994 & Supp. V 1994) (funding rules).

132. *See 29 U.S.C. § 1082* (1994 & Supp. V 1999) (describing the minimum federal funding standards for a plan).

133. *See id.* (stating that federal funding standards are applicable only to pension plans).

134. *See, e.g., Sage v. Automation Inc. Pension Plan & Trust*, 845 F.2d 885, 894 (10th Cir. 1988) (using trust law to determine whether the termination of a benefits plan was consistent with a duty of loyalty to plan participants); *Van Boxel v. Journal Co. Employees' Pension Trust*, 836 F.2d 1048, 1049 (7th Cir. 1987) (applying the arbitrary and capricious standard typical of administrative law to cases of pension

Given the variety of judicial standards of review available, it is understandable that the federal courts would have a problem in fashioning a standard that was applicable in *all* ERISA benefit denial contexts: whether the benefits were pension or welfare benefits; whether the benefits were funded under a trust or an insurance policy, or paid on a pay-as-you-go basis from the employer's general assets; whether the benefits were negotiated through a collectively-bargained agreement or provided voluntarily by the employer. Thus the courts face an understandable dilemma in deciding when and where to interject factors from contract, labor, trust or insurance laws.

D. Summary of Caselaw Pre-Firestone

After the advent of ERISA but before the Supreme Court's *Firestone* decision in 1989, virtually all circuit courts applied the labor law arbitrary and capricious standard in the review of all ERISA benefit denial causes of actions, regardless of whether the benefits were subject to collective bargaining.¹³⁵ Many courts viewed ERISA as simply codifying the protections once afforded to collectively-bargained plans, to all covered plans.¹³⁶ As the legislative history of

fund trustees); *Holland v. Burlington Indus., Inc.*, 772 F.2d 1140, 1148-49 (4th Cir. 1985) (stating that the arbitrary and capricious standard applies to all persons who create and administer company plans, whether formal trustees or not).

135. See, e.g., *Bachelor v. Communications Satellite Corp.*, 837 F.2d 519, 522 (1st Cir. 1988) (applying the arbitrary and capricious standard to the procedure used in a cash distribution from a stock ownership plan); *Accardi v. Control Data Corp.*, 836 F.2d 126, 128 (2d Cir. 1987) (using the arbitrary and capricious standard to examine the denial of severance pay in the context of a division sale); *Whipp v. Seafarers Vacation Plan*, 832 F.2d 853, 855 (4th Cir. 1987) (stating that the standard of review for acts of trustees in the administration of pension plans is an arbitrary and capricious standard); *Nevill v. Shell Oil Co.*, 835 F.2d 209, 212 (9th Cir. 1987) (holding that Shell's denial of Special Separation Allowance to its employees was not arbitrary and capricious); *Naugle v. O'Connell*, 833 F.2d 1391, 1393 (10th Cir. 1987) (noting that even though eligibility requirements were not the subject of collective bargaining, denial would be reviewed under the arbitrary and capricious standard); *Deak v. Masters, Mates & Pilots Pension Plan*, 821 F.2d 572, 577 (11th Cir. 1987) (discussing the application of the arbitrary and capricious standard); *Berry v. Ciba-Geigy Corp.*, 761 F.2d 1003, 1008 (4th Cir. 1985) (applying the arbitrary and capricious standard to review the actions of a private plan trustee, and indicating that remand should be done sparingly); *Denton v. First Nat'l Bank*, 765 F.2d 1295, 1300 (5th Cir. 1985) (noting that the judicial review of the action or inaction of fiduciaries uses the arbitrary and capricious standard); *Pokratz v. Jones Dairy Farm*, 771 F.2d 206, 208 (7th Cir. 1985) (stating that a plan's denial of disability benefits may not be denied unless the action was arbitrary and capricious); *Bayles v. Cent. States, S.E. & S.W. Areas Pension Fund*, 602 F.2d 97, 99 (8th Cir. 1979) (noting that a trustee's actions must be sustained unless arbitrary and capricious); see also *Duncan*, *supra* note 104, at 986-87 n.8 (citing cases that illustrate that each federal circuit has adopted the arbitrary and capricious test).

136. See *NLRB v. AMAX Coal Co., Inc.*, 453 U.S. 322, 332 (1981) (stating that ERISA codified the strict fiduciary standards imposed on trustees by LMRA, 29 U.S.C.

ERISA neither suggested an overhaul of the rules applicable to collectively bargained plans, nor a disparate treatment between the administration of collectively bargained and non-collectively bargained employee benefit plans, courts continued the pre-ERISA standard of arbitrary and capricious. The courts have mandated that many of the protections afforded under labor law for employee benefits had now been applied to all plans by virtue of ERISA.¹⁵⁷

The applicable arbitrary and capricious standard in ERISA benefit denial cases was regarded as highly deferential. Courts upheld the decision of the plan administrator as long as it was rationally justifiable and made in good faith, not necessarily whether it was the best decision under the circumstances nor whether the court would have made a similar decision.¹⁵⁸ But as the circuits began to adopt this standard, a growing criticism developed in some circuits where the plan administrator or employer was not necessarily impartial in the determination of benefit eligibility or construction of plan terms.¹⁵⁹ In the collectively bargained context, the joint board of trustees administering the plan had equal representation of management and union and thus negated any bias.¹⁶⁰ In the case of single employer benefits, ERISA did not require equal representation of employer and employees in the appointment of the plan

§ 302(c)(5)).

137. *See id.* (holding that “whatever may have remained implicit in Congress’s view of the employee benefit fund trustee . . . became explicit when Congress passed [ERISA]”).

138. *See, e.g.,* *Atkinson v. Sheet Metal Workers’ Trust Funds*, 833 F.2d 864, 865 (9th Cir. 1987); *Whipp v. Seafarers Vacation Plan*, 832 F.2d 853, 855 (4th Cir. 1987); *Severs v. Allied Constr. Servs.*, 795 F.2d 649, 650 (8th Cir. 1986); *Hancock v. Montgomery Ward Long Term Disability Trust*, 787 F.2d 1302, 1307 (9th Cir. 1986); *Lawrence v. Westerhaus*, 780 F.2d 1321, 1322 (8th Cir. 1985); *Blakeman v. Mead Containers*, 779 F.2d 1146, 1150 (6th Cir. 1985); *Morse v. Stanley*, 732 F.2d 1139 (2d Cir. 1984); *LeFebre v. Westinghouse Elec. Corp.*, 747 F.2d 197 (9th Cir. 1984), *amended*, 6 EB Cases 1264 (9th Cir.), *cert. denied*, 474 U.S. 865, 106 S. Ct. 183 (1985); *Wolf v. Nat’l Shopmen Pension Fund*, 728 F.2d 182, 187 (3d Cir. 1984); *Johnson v. Franco*, 727 F.2d 442, 447 (5th Cir. 1984); *Allen v. UMW 1979 Benefit Plan & Trust*, 726 F.2d 352, 354 (7th Cir. 1984); *Dennard v. Richards Group*, 681 F.2d 306 (5th Cir. 1982); *Miles v. New York Teamsters Pension Fund*, 698 F.2d 593 (2d Cir. 1983), *cert. denied*, 464 U.S. 829 (1983).

139. *See Struble v. New Jersey Brewery Employees’ Welfare Trust Fund*, 732 F.2d 325, 333 (3d Cir. 1984) (stating that there should not be a blanket use of the arbitrary and capricious standard, but rather it should depend on the type of challenge to fiduciary loyalty); *Harm v. Bay Area Pipe Trades Pension Plan Trust Fund*, 701 F.2d 1301, 1305 (9th Cir. 1983) (discussing instances where the burden of persuasion will shift to the trustee); *Dennard v. Richards Group Inc.*, 681 F.2d 306 (5th Cir. 1982) (holding that when a trustee’s interpretation of a plan is in direct conflict with the express language of a plan, there is a strong indication that the action is arbitrary and capricious).

140. *See* section 302(c)(5) of the Labor Management Relations Act of 1947 (29 U.S.C. § 186(c)(5) (1994)), which requires an equal number of trustees be appointed by management and union.

administrator or trustee. The circuits split on the application of the arbitrary and capricious standard in cases of a conflict of interest on the part of the decision-maker.¹⁴¹ With that backdrop, the Supreme Court granted *certiorari* in *Firestone* and plan sponsors eagerly awaited advice as to the application of the standard in conflict of interest situations. Unfortunately, *Firestone's* usefulness has been limited and it appears to have muddied the waters, instead of clarifying them.

While the plaintiff and the Department of Labor had urged the Supreme Court to adopt a *de novo* standard of review for the case at hand, neither had urged use of trust law in the determination of the applicable standard of review.¹⁴² In fact, both stressed to the Court that trust law was inadequate in its approach given the goals of ERISA.¹⁴³ In their briefs before the Supreme Court in *Firestone*, both the plaintiff and Department of Labor urged the Court to use contract law standards of judicial review.¹⁴⁴ Thus, the Supreme Court's disregard of other alternative standards of review came as a surprise to everyone.

141. See *Brown v. Blue Cross & Blue Shield of Ala., Inc.*, 898 F.2d 1556, 1560 (11th Cir. 1990) (noting that before *Firestone*, circuits varied the deference given to trustee or fiduciary decisions depending on the presence or absence of conflicting interests); *Sage v. Automation, Inc. Pension Plan & Trust*, 845 F.2d 885, 895 (10th Cir. 1988) (relying on the arbitrary and capricious standard as flexible enough to review trustee bias); *Van Boxel v. Journal Co. Employees' Pension Trust*, 836 F.2d 1048, 1052-53 (7th Cir. 1987) (stating that the arbitrary and capricious standard is flexible enough to account for possible trustee bias); *Holland v. Burlington Indus., Inc.*, 772 F.2d 1140, 1149 (4th Cir. 1985) (deciding that there is no "less deferential" application of the arbitrary and capricious standard, and only one standard applies to claim eligibility); *Gilbert v. Burlington Indus., Inc.*, 765 F.2d 320, 328-29 (2d Cir. 1985) (reviewing the denial of severance pay in the context of failure to meet ERISA's requirement as part of arbitrary and capricious standards); *Jung v. FMC Corp.*, 755 F.2d 708, 711-12 (9th Cir. 1985) (using the arbitrary and capricious standard although granting less deference to the trustee's decision); *Dennard v. Richards Group, Inc.*, 681 F.2d 306, 314 (5th Cir. 1982) (outlining certain key factors to consider when using the arbitrary and capricious standard, including the good faith of the trustee); *Maggard v. O'Connell*, 671 F.2d 568, 571 (D.C. Cir. 1982) (stating that while the courts still uses an arbitrary and capricious standard of review, this case requires "review with greater care" than ordinary).

142. See Brief for Respondents at 23, *Firestone Tire & Rubber Co. v. Richard Bruch*, 489 U.S. 101 (1989) (No. 87-1054); Brief for the United States as Amicus Curiae Supporting Respondents at 17, *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989) (No. 87-1054).

143. See Brief for Respondents, *supra* note 142, at 23; Brief for the United States as Amicus Curiae Supporting Respondents, *supra* note 142, at 17.

144. See Brief for Respondents, *supra* note 142, at 23; Brief for the United States as Amicus Curiae Supporting Respondents, *supra* note 142, at 17.

III. THE SUPREME COURT'S *FIRESTONE* DECISIONA. *Facts in Question*

In *Firestone*, the Supreme Court was confronted with the specific issue of judicial review in a benefits denial cause of action where the employer (who was also the plan administrator) was interpreting the terms of the plan in its benefits denial determination.¹⁴⁵ The ERISA plan in question involved an unfunded severance pay plan, maintained and administered by the employer.¹⁴⁶ As such, plan benefits did not have to be pre-funded; thus neither a trust nor insurance contract had to be maintained pursuant to the rules of ERISA.¹⁴⁷ Under the contractual terms of the plan, eligibility for severance benefits was conditional upon a reduction in work force.¹⁴⁸ In the case at hand, the employer, as plan administrator, determined that such reduction in work force had not occurred, and thus denied plaintiffs' request for severance benefits under the terms of the plan.¹⁴⁹

In a request for summary judgment, the district court applied the labor law arbitrary and capricious standard of review and upheld the employer's decision to deny benefits.¹⁵⁰ While the Third Circuit agreed that the majority of circuit courts had applied the arbitrary and capricious standard of review in benefit denial claims, it questioned the usefulness of this standard where the plan administrator had an apparent conflict of interest in making such determination under an unfunded ERISA plan.¹⁵¹ In such cases, the court suggested that use of the arbitrary and capricious standard should be softened.¹⁵² Thus, the court reversed and remanded,

145. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 109 (1988) (addressing federal courts' willingness to adopt the LMRA standard of review for ERISA challenges to benefit eligibility determinations).

146. *See id.* at 105 (stating that Firestone maintained three pension and welfare benefit plans for its employees and was the sole source of funding, although it did not establish separate trust funds to cover payment of benefits).

147. *See id.* at 105 (stating that Firestone was not aware that the termination plan was governed by ERISA and therefore had not created a claims procedure).

148. *See id.* at 105-06 (quoting the termination pay plan as stating "you will be given termination pay if released because of a reduction in work force").

149. *See id.* at 106 (stating Firestone denied the claim on the grounds that the sale of the Plastics Division to Occidental was not a "reduction in work force").

150. *See Bruch v. Firestone Tire & Rubber Co.*, 640 F. Supp. 519, 526 (E.D. Pa. 1986) (finding that Firestone's actions were not unreasonable and were supported by law).

151. *See Bruch v. Firestone Tire & Rubber Co.*, 828 F.2d 134, 144-45 (3d Cir. 1987).

152. *See id.* (finding it appropriate for the plaintiff to show the trustee was influenced by improper motives even though the initial presumption is the trustee's

holding that the *de novo* standard should be used where the employer was both the fiduciary and administrator of an unfunded ERISA benefit plan.¹⁵³

Upon appeal, the specific question before the Supreme Court in *Firestone* was whether the arbitrary and capricious standard of review in ERISA benefit denial cases was still appropriate if there was a conflict of interest.¹⁵⁴ While acknowledging that the various circuit courts had adopted the labor law standard of arbitrary and capricious in ERISA cases, the Supreme Court rejected a wholesale approach to using such labor law standards in ERISA causes of action.¹⁵⁵ The Supreme Court reasoned that the labor law arbitrary and capricious standard had been developed under labor law as a means of establishing a jurisdictional basis for employee suits against plan trustees.¹⁵⁶ Since ERISA established its own causes of action, courts clearly did not have to justify their jurisdiction and therefore did not need to rely upon a labor law analysis of the issue.¹⁵⁷ The Court went so far as saying LMRA principles offer no support for the adoption of the arbitrary and capricious standard in the context of the ERISA case in question.¹⁵⁸ It is interesting to note that while the Supreme Court rejected the labor law arbitrary and capricious standard in this case, it has equated this standard with the trust law abuse of

impartiality). Prior to the Supreme Court's decision in *Firestone*, virtually all of the Third Circuit had adopted the arbitrary and capricious standard in reviewing the benefit claims decisions made by plan administrators. *See generally* *Bachelor v. Communications Satellite Corp.*, 837 F.2d 519 (1st Cir. 1988); *Accardi v. Control Data Corp.*, 836 F.2d 126 (2d Cir. 1987); *Whipp v. Seafarers Vacation Plan*, 832 F.2d 853 (4th Cir. 1987); *Adcock v. Firestone Tire & Rubber Co.*, 822 F.2d 623 (6th Cir. 1987); *Van Boxel v. Journal Co. Employees Pension Trust*, 836 F.2d 1048 (7th Cir. 1987); *Nevill v. Shell Oil Co.*, 835 F.2d 209 (9th Cir. 1987); *Naugle v. O'Connell*, 833 F.2d 1391 (10th Cir. 1987); *Deak v. Masters, Mates, & Pilots Pension Plan*, 821 F.2d 572 (11th Cir. 1987); *Denton v. First Nat'l Bank*, 765 F.2d 1295 (5th Cir. 1985); *Pokratz v. Jones Dairy Farm*, 771 F.2d 206 (7th Cir. 1985).

153. *See Bruch*, 828 F.2d at 136 (holding "that the decision of *Firestone* to deny benefits under the Termination Pay plan should be reviewed *de novo* by the court and that there should be deference to neither the plan administrator's nor the participants' construction of plan terminology").

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

155. *See id.* at 109 (finding that the "wholesale importation of the arbitrary and capricious standard into ERISA [to be] unwarranted").

156. *See id.* at 109-10.

157. *See id.* at 110 ("Unlike the LMRA, ERISA explicitly authorizes suits against fiduciaries and plan administrators to remedy statutory violations, including breaches of fiduciary duty and lack of compliance of benefit plans"); 29 U.S.C. §§ 1132(a), 1132(f) (1994 & Supp. IV 1999); *see also Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 52-57 (1987) (describing the scope of section 1132(a)); *Duncan*, *supra* note 104, at 994 n.40 (addressing the contrasting basis of review under both ERISA and the LMRA).

158. *See Firestone*, 489 U.S. at 110 (stating the lower court improperly relied upon jurisdictional analogy).

discretion standard in other contexts.¹⁵⁹ However, in the context of ERISA denial claims, the Court rejected the use of labor law principles in order to create an appropriate judicial standard of review.

The Supreme Court noted instead that “ERISA abounds with the language and terminology of trust law.”¹⁶⁰ Thus, by referring to ERISA’s fiduciary provisions and the legislative history behind such provisions, the Supreme Court concluded that trust law should dictate the appropriate judicial standard of review.¹⁶¹ As it turned to trust law, the Court focused on the explicit terms of the plan/trust to determine if there was a grant of appropriate discretionary powers.¹⁶² Interestingly, although trust law does distinguish between discretionary and mandatory powers, it does not always require that the grant of such powers be explicitly written in the trust.¹⁶³ In fact, if the language of the trust does not explicitly confer such powers, trust law generally permits the courts to go beyond the trust language and to examine the “general scope and purpose of the trust” or the intent of the settlor in such situations to determine intent.¹⁶⁴ This point was highly relevant in *Firestone*, as such examination by the Court may well have inferred that the employer, who was both settlor of the plan and plan administrator, intended to retain discretionary powers to interpret the terms of the plan.¹⁶⁵ In the case, the defendant *Firestone* actually argued that it assumed the interpretation of the terms of the plan was inherently discretionary and thus intended

159. See *Citizens to Preserve Overton Park, Inc. v. Volpe*, 401 U.S. 402, 416 (1971) (construing the scope of the Secretary of Transportation’s authority under section 706(2)(A) of the Department of Transportation Act of 1966 with a finding that her actual choice was not “arbitrary, capricious, and abuse of discretion, or otherwise not in accordance with the law.”) (citations omitted).

160. *Firestone*, 489 U.S. at 110.

161. See *id.* at 110-11 (“In determining the appropriate standard of review for actions under § 1132(a)(1)(B), we are guided by principals of trust law.”).

162. See *id.* at 111 (emphasizing the importance of the interpretation of the terms of the trust).

163. See SCOTT ON TRUSTS, *supra* note 73, § 186, 6-7 (describing the extent of the trustee’s powers).

164. See *id.* (showing this broader interpretation of the trust). While the Supreme Court cited section 187 of the RESTATEMENT (SECOND) OF TRUSTS for the proposition that the extent of granting of powers was dependent upon the terms of the trust, such section followed section 186 which concluded that the extent of such powers was not solely dependent upon the language, but also upon other factors. In the context of the *Firestone* case, use of section 186 may have been relevant as the intent of the employer (settlor) in the context of a self funded and self administered plan could have inferred to confer discretionary powers to itself. See *Firestone*, 489 U.S. at 111 (discussing only section 187).

165. See *Firestone*, 489 U.S. at 115 (showing that the court enforced a *de novo* review standard).

under the terms of the plan.¹⁶⁶

In its use of trust law, the Supreme Court noted that the resulting standard was consistent with the judicial standard pre-ERISA, which applied principles of contract law in lieu of labor law.¹⁶⁷ In ascertaining the judicial standard, the Supreme Court interjected the principles of contract law by requiring that the discretionary powers be conferred only through the express terms of the plan document.¹⁶⁸ While such interpretation may be consistent with ERISA's public policy to fully disclose to participants the terms of the written plan and the powers of the fiduciaries, it is certainly not consistent with trust law where such powers may be implied.¹⁶⁹ It also detracts from ERISA's public policy concerns regarding the fairness afforded to participants and beneficiaries in the claims review process by permitting the plan sponsor, merely through appropriate plan language, to confer upon itself a more deferential judicial standard of review. In the context of the *Firestone* facts, such express discretionary authority was absent under the terms of the plan.¹⁷⁰ Therefore, the

166. See Brief for Petitioner, *supra* note 142, at 10. See also John H. Langbein, *The Supreme Court Flunks Trusts*, 1990 S. CT. REV. 207, 219 [hereinafter *Court Flunks Trusts*], in which the author argues that the Supreme Court's use of an arbitrary and capricious review with discretionary decisions and a *de novo* review with nondiscretionary decisions has no basis in common trust law. That author predicted that plan sponsors would quickly redraft their documents to confer discretionary powers to the plan administrator to receive the more deferential standard of review.

167. See *Firestone*, 489 U.S. at 112-13 ("The trust law *de novo* standard of review is consistent with the judicial interpretation of employee benefit plans prior to the enactment of ERISA. Actions challenging an employer's denial of benefits before enactment of ERISA were governed by principles of contract law. If the plan did not give the employer or administrator discretionary or final authority to construe uncertain terms, the court reviewed the employee's claim as it would have any other contract claim B by looking to the terms of the plan and other manifestations of the parties' intent."). The Court cites *Conner v. Phoenix Steel Corp.*, 249 A.2d 866 (Del. 1969), *Atlantic Steel Co. v. Kitchens*, 187 S.E.2d 824 (1972), and *Sigman v. Rudolph Wurlitzer Co.*, 57 Ohio App. 4, 11 N.E.2d 878 (1937) for its proposition; however, those cases invoked the use of contract law for the enforcement of the participant's claim, not the extent of the employer's or administrator's discretion under the plan. See *id.*

168. See *Firestone*, 489 U.S. at 112 (showing that before the enactment of ERISA, actions challenging the denial of benefits were governed by contract law); see also *supra* note 73 and accompanying text.

169. See THE LAW OF TRUSTS AND TRUSTEES, *supra* note 113, §§ 551 et seq. and at 3; RESTATEMENT (SECOND) OF TRUSTS, *supra* note 114, § 186 (1959) (discussing where a trustee's powers may be implied if not set forth in the trust document but determined by the court as intended by the settlor as convenient or necessary to carry forth the purposes of the trust); see also *Luby v. Teamsters Health, Welfare & Pension Trust Funds*, 944 F.2d 1176, 1180 (3d Cir. 1991) ("Discretionary powers may be implied by a plan's terms even if not granted expressly."); *De Nobel v. Vitro Corp.*, 885 F.2d 1180, 1187 (4th Cir. 1989) (ruling in favor of administrators' interpretation of plan); *Donato v. Metro. Life Ins. Co.*, 19 F.3d 375, 379 (7th Cir. 1994) (applying the arbitrary and capricious standard of review).

170. See *Firestone*, 489 U.S. at 115 (rejecting application of the arbitrary and

Supreme Court invoked a *de novo* standard of review, which resulted in a plenary review of the plan administrator's decision.¹⁷¹

In cases where the plan language grants appropriate discretionary power to the plan administrator, the Supreme Court in *Firestone* referred the lower courts to the use of the trust law's abuse of discretion standard and specifically referred to the SECOND RESTATEMENT OF TRUSTS in such contexts.¹⁷² The RESTATEMENT OF TRUSTS affirms the power of the settlor of the trust to confer discretionary authority to the trustee regarding the interpretation of the trust provisions.¹⁷³ However, even in those cases where discretionary authority has been conferred, the courts are to apply an abuse of discretion standard, which is not a fixed standard, but one that is dependent upon a number of factors.¹⁷⁴ As the Third Circuit had fashioned its judicial standard of review in the *Firestone* case based on the apparent conflict of interest, the Supreme Court expressly addressed this issue.¹⁷⁵ In the context of a conflict of interest on the part of the trustee, the Supreme Court noted that such conflict of interest must be weighed as a "factor in determining whether there is an abuse of discretion," referring specifically to section 187 of the Second Restatement of Trusts.¹⁷⁶ The Supreme Court left the application of these factors in ERISA causes of actions for the lower courts to resolve.¹⁷⁷ As a result, the existence or nonexistence of an interest in the fiduciary conflicting with that of the beneficiaries has

capricious standard of review).

171. *See id.* at 115 ("Consistent with establishing principles of trust law, we hold that a denial of benefits challenged under § 1132(a)(1)(B) is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan.").

172. *See id.* ("If a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'factor in determining whether there is an abuse of discretion.'").

173. *See* SCOTT ON TRUSTS, *supra* note 73, § 187, and at 14.

174. *See Firestone*, 489 U.S. at 115.

175. *See id.* As the plan language in *Firestone* was silent, the default standard of review was the *de novo* standard and thus the standard need not be altered due to a concern for impartiality.

176. *See id.* *See also* RESTATEMENT (SECOND) OF TRUSTS, *supra* note 114, at § 187 cmt. (d) ("In determining the question whether the trustee is guilty of an abuse of discretion in exercising or failing to exercise a power, the following circumstances may be relevant: (1) the extent of the discretion conferred upon the trustee by the terms of the trust; (2) the purposes of the trust; (3) the nature of the power; (4) the existence or non-existence, the definiteness or indefiniteness, of an external standard by which the reasonableness of the trustee's conduct can be judged; (5) the motives of the trustee in exercising or refraining from exercising the power; (6) the existence or nonexistence of an interest in the trustee conflicting with that of the beneficiaries.").

177. *See Firestone*, 489 U.S. at 115 (leaving these questions for the Court of Appeals on remand).

been the most controversial in ERISA benefit denial cases, as the employer/insurer is often the plan administrator and funding source of the ERISA plan and, thus, there is an inherent conflict of interest.

Since the Supreme Court's judicial standard was contingent on the proper discretionary and deferential authority granted by the plan, its relevance has been viewed as narrow and limiting, focusing solely on the language of the plan.¹⁷⁸ As the sponsor could certainly insert the necessary proper discretion and deferential authority to avoid the *de novo* standard, such a mechanical solution seemed to beg the larger question. Once the magical language is provided under the plan, the courts still had to fashion an appropriate judicial standard of review for these cases, particularly in those involving a conflict of interest.

B. *Learning from Firestone*

After *Firestone*, employer sponsors were alerted to the fact that employee benefit plans must be properly drafted in order to retain appropriate discretionary powers for the plan administrator. From a practical standpoint, most non-prototype pension and profit sharing plans and self-funded welfare benefit plans could have been easily amended to reserve the appropriate discretionary power to the plan administrator in terms of eligibility and determination of benefit payments. Even if a third party administrator is used, the employer may decide to reserve the power to interpret provisions of the plan and to determine eligibility. In fact, third-party administrators not wishing to become fiduciaries may insist that such discretionary powers be reserved to the plan sponsor.¹⁷⁹

178. See *Court Flunks Trusts*, *supra* note 166; Kevin Walker Beatty, Comment, *A Decade of Confusion: The Standard of Review for ERISA Benefit Denial Claims as Established by Firestone*, 51 ALA. L. REV. 733, 740-44 (2000); Dahlia Schwartz, Note, *Breathing Lessons for the ERISA Vacuum: Toward a Reconciliation or ERISA's Competing Objectives in the Health Benefits Area*, 79 B.U. L. REV. 631, 657-58 (Apr. 1999) ("Unfortunately in *Firestone Tire and Rubber Co. v. Bruch*, the Supreme Court opened Pandora's box by suggesting *in dicta* that nothing 'forecloses parties for agreeing upon a narrower standard of review.'" (citing *Firestone*, 489 U.S. at 115)); Nola A. Kohler, Note, *An Overview of the Inconsistency Among the Circuits Concerning the Conflict of Interest Analysis Applied in an ERISA Action with an Emphasis on the Eighth Circuit's Adoption of the Sliding Scale Analysis in Woo v. Deluxe Corporation*, 75 N.D. L. REV. 815, 820-27 (2000) (discussing the fact that inconsistency over the standard of review for conflict of interest situations still exists).

179. See *Balancing the Benefits*, BUS. L. TODAY, Vol. 9, No. 6 (July/Aug. 2000) (asserting that the language "final and conclusive" may have been deliberately avoided for use in insurance and third party administration contracts due to the Department of Labor's regulations that a person or entity "who has the final authority to authorize or disallow benefit payments in cases where a dispute exists as to the interpretation of plan provisions relating to eligibility for benefits" would be a fiduciary due to such discretion) (citations omitted); 29 C.F.R. § 2509-8, Q&A D-3 (1975) (showing that insurers and third party administrators may have avoided such

In contrast to retirement plans, welfare benefits present different issues for an employer sponsor. A greater percentage of welfare benefits are fully or partially insured and thus subject to insurance policies.¹⁸⁰ For large-size employers who use insurers for stop-loss coverage, discretion should certainly be reserved to the named plan administrator under the terms of the plan. Small- to medium-size employers who fully insure their welfare benefits may have little control over the express terms of the policies used to insure a package of covered benefits. When faced with the choice between two insurance policies—one without discretionary power and thus subject to the *de novo* standard, the other containing discretionary power and a more deferential standard—the employer may be more likely to choose the latter since it costs the insurer less to administer and results in a lower premium. The result may provide an inherent conflict of interest for the insurer, but the situation is no different than a large-size employer retaining the administration of the plan in order to reduce costs.

Despite what appears to be an admonition in *Firestone* to solely use a trust law standard, all the circuits have continued post-*Firestone* to use the arbitrary and capricious standard in benefits denial cases.¹⁸¹ In deference to the *Firestone* decision, most are quick to equate the arbitrary and capricious standard with the trust law standard of abuse of discretion, and to use the terms interchangeably.¹⁸² However, there is a lack of agreement as to whether the two standards are really equal in the ERISA context.¹⁸³ In any event, the post-*Firestone* result is that federal courts appear to be in much the same place as they were

finality language so as to avoid the label of plan fiduciary).

180. See *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2000 Current Population Survey*, Employee Benefits Research Inst., December 2000 Issue Brief B, available at www.ebri.org/ibex/ib228.htm (providing information regarding the insured and uninsured populations in the United States).

181. See, e.g., *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377 (3d Cir. 2000); *Pitnam v. Blue Cross & Blue Shield of Okla.*, 217 F.3d 1291 (10th Cir. 2000); *Kinstler v. First Reliance Standard Life Ins. Co.*, 181 F.3d 243 (2d Cir. 1999); *Vega v. Nat'l Life Ins. Servs.*, 188 F.3d 287 (5th Cir. 1999); *Barnhart v. UNUM Life Ins. Co. of Am.*, 179 F.3d 583 (8th Cir. 1999); *Kearney v. Standard Ins. Co.*, 175 F.3d 1084 (9th Cir. 1999); *Doyle v. Paul Revere Life Ins. Co.*, 144 F.3d 181 (1st Cir. 1998); *Ellis v. Metro. Life Ins. Co.*, 126 F.3d 228 (4th Cir. 1997); *Helwig v. Kelsey-Hayes Co.*, 93 F.3d 243 (6th Cir. 1996); *Donato v. Metro. Life Ins. Co.*, 19 F.3d 375 (7th Cir. 1994); *Block v. Pitney Bowes, Inc.*, 952 F.2d 1450 (D.C. Cir. 1992); *Brown v. Blue Cross & Blue Shield of Ala., Inc.*, 898 F.2d 1556 (11th Cir. 1990).

182. See, e.g., *Rombach v. Nestle USA*, 211 F.3d 190 (2d Cir. 2000); *Booth v. Wal-Mart Stores, Inc.*, 201 F.3d 335 (4th Cir. 2000); *Vega*, 188 F.3d 287; *Hunter v. Caliber Sys.*, 220 F.3d 702 (6th Cir. 2000); *Pitman v. Blue Cross & Blue Shield*, 217 F.3d 1291 (10th Cir. 2000); *Adams v. Thiokol Corp.*, 231 F.3d 837 (11th Cir. 2000); *Stewart v. Nat'l Shopmen Pension Fund*, 795 F.2d 1079 (D.C. Cir. 1986).

183. See *infra* note 252.

prior to *Firestone*.

This article asserts that the federal courts, following *Firestone*, have rejected a wholesale use of trust law for a number of reasons. First, not all employee benefit plans covered under ERISA use trusts as the funding medium. In fact, even for those plans that are not required to be prefunded under ERISA, many use insurance funding vehicles, especially in the welfare benefit context, in order to shift the insurance risk. While the latter may create the potential for a conflict of interest, such conflict is permitted under ERISA, even though it may not have been permitted under trust law.¹⁸⁴ As ERISA permits the employer and/or insurer to place itself in such a conflict of interest position, it becomes unclear to the courts how they should soften the standard of judicial review in such contexts and whether they should presume an actual conflict of interest in such cases.¹⁸⁵ Courts also are unclear whether the ERISA judicial standard should be altered in the multi-employer plan context, where the benefits are subject to both NLRA labor law and ERISA, and also subject to a jointly administered trustee board.¹⁸⁶

The author believes that the federal courts' rejection of pure trust

184. See 29 U.S.C. § 1002 (1994) (showing that the plan administrator is the person or entity named by the plan document, and if none is named, the plan sponsor is the plan administrator by default); see also RESTATEMENT (SECOND) OF TRUSTS, *supra* note 114, at §§ 170, 206; THE LAW OF TRUSTS AND TRUSTEES, *supra* note 113, at § 543 (noting that the trustee owes his/her entire duty of loyalty to the beneficiaries and may not place himself/herself in a position of conflict).

185. See *Doyle*, 144 F.3d at 184 (analyzing how conflict of interest cases should be reviewed); *Sullivan v. LTV Aerospace & Defense Co.*, 82 F.3d 1251, 1255-56 (2d Cir. 1996) (discussing what actions the court should take in determining whether the administrator acted in an arbitrary and capricious manner); *Pinto*, 214 F.3d at 379 ("We side with the majority of courts of appeals, which apply a sliding scale method, intensifying the degree of scrutiny to match the degree of the conflict."); *Doe v. Group Hospitalization & Med. Serv.*, 3 F.3d 80, 87 (4th Cir. 1993) ("We hold that when a fiduciary exercises discretion in interpreting a disputed term of the contract where one interpretation will further the financial interest of the fiduciary, we will not act as deferential as would otherwise be appropriate."); *Van Boxel v. Journal Co. Employees' Pension Trust*, 836 F.2d 1048, 1052 (7th Cir. 1988) (the arbitrary and capricious standard must be a range, not a point); *Barnhart*, 179 F.3d at 588-90 (applying the test from *Woo* in determining whether a conflict of interest exists); *Snow v. Standard Ins. Co.*, 87 F.3d 327, 331 (9th Cir. 1996) ("In this case there was no formal conflict because Standard was both the insurance company and the administrator. If that formal conflict led to a true conflict, the standard of review would not exactly change, but scrutiny of Standard's decision would become more searching."); *Chambers v. Family Health Plan Corp.*, 100 F.3d 818, 825-26 (10th Cir. 1996) (adhering to an arbitrary and capricious standard of review); *Brown*, 898 F.2d at 1562 (holding that the arbitrary and capricious standard applied, but the "application of the standard [was] shaped by the circumstances of the inherent conflict of interest").

186. See *Van Boxel*, 836 at 1052 (stating that the Taft-Hartley Act permitted employers to create plans jointly with unions, however it was silent as to the judicial review of the plan administrator's decisions).

law in the context of judicial review reflects their implicit understanding that ERISA common law should involve elements of labor, contract and trust laws, not solely trust law. The Supreme Court's adoption of a trust law judicial review standard may have been an attempt to strike a balance between the goals of protecting both participants' rights under a plan and the employer's freedom to administer the plan in accordance with the plan document. However, the grant of discretionary powers under an employee benefits plan is inherently a settlor function that presumes deference on the part of the settlor, even if the settlor administers the plan.¹⁸⁷ Such result places the participants and beneficiaries at the mercy of the plan sponsor in determining who has discretion.¹⁸⁸

The purpose of this article is to critique the courts' applications of the *de novo* and the abuse of discretion standards of review, particularly in the context of certain conflict of interest situations. An examination of the circuits will illustrate the current confusion in this area, not only with respect to the application of the standards, but also the necessary plan language to avoid the *de novo* standard of review.

IV. THE CIRCUITS' RESPONSE AFTER *FIRESTONE*

A. *Appropriate Plan Language to Avoid De Novo Review*

In the *Firestone* decision, the Supreme Court stated that the *de novo* standard of review is the default standard unless appropriate plan language confers discretionary authority to the fiduciary.¹⁸⁹ Relying upon the SECOND RESTATEMENT OF TRUSTS, the Supreme Court in *Firestone* stated that the written document controlled in determining whether the requisite discretionary powers had been granted, not the intent of the settlor or other circumstances.¹⁹⁰ Thus, lower courts are

187. See *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989) (holding that "a denial of benefits challenged under § 1132(a)(1)(B) is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan").

188. See *id.* (showing, however, that if a benefit plan gives discretion to an administrator who has a conflict of interest, that conflict must be reviewed in determining whether an abuse of discretion occurred).

189. See *id.* ("Because we do not rest our decision on the concern for impartiality that guided the court of appeals . . . we need not distinguish between types of plans or focus on the motivations of plan administrators and fiduciaries.").

190. See *id.* at 112 (holding "[t]he terms of the trusts created by written instruments are 'determined by the provisions of the instrument as interpreted in light of all the circumstances and such other evidence of the intention of the settlor with respect to the trust is not admissible'" (quoting RESTATEMENT (SECOND) OF

to determine whether the necessary plan language is enough to escape the plenary standard; such determination is to be made *de novo* by the courts.¹⁹¹ In the wake of *Firestone*, the first issue that arises is what is the appropriate plan language necessary to shift from the *de novo* standard to a more deferential standard. The circuits are split on whether the language conferring discretionary powers must be explicit; if so, what specific language is required to be stated; and if the language is not explicit, whether discretionary powers may be inferred from other powers.¹⁹²

Obviously, plan language that clearly and explicitly grants to a fiduciary discretionary powers, the power to interpret ambiguous plan provisions and the power to determine eligibility for benefits will bypass the *de novo* standard of review.¹⁹³ As the courts pre-*Firestone* had never focused on the specific plan language in ascertaining the applicable standard of review, plan sponsors and insurers paid little attention to the specific terms under the plan regarding grants of such discretionary powers. Thus, post-*Firestone*, most courts rejected the notion that *Firestone* required the use of specific words, such as “discretionary” or “deference” or other such magic words to invoke the more deferential standard of review.¹⁹⁴ Use of such words is certainly helpful in deciding the issue,¹⁹⁵ but not mandated by *Firestone*. While the courts concur that magic language is not necessary, obviously the more clear and explicit the grant of

TRUSTS § 201, cmt. b (1959)).

191. See *Mers v. Marriott Int'l Group Accidental Death and Dismemberment Plan*, 144 F.3d 1014, 1019-20 (7th Cir. 1997) (stating “[w]e review the language of the plan *de novo* just as we would review the language of any contract.”).

192. See *Perez v. Aetna Life Ins. Co.*, 150 F.3d 550, 558 (6th Cir. 1998) (Boggs, J., dissenting) (analyzing the clarity of the plan’s language).

193. See *Kinstler v. First Reliance Standard Life Ins. Co.*, 181 F.3d 243, 251 (2d Cir. 1999) (requiring clear language and declining to search in semantic swamps); see also *Ellis v. Metro. Life Ins. Co.*, 126 F.3d 228, 233 (4th Cir. 1999) (finding such language to be “crystal clear”); *Yeager v. Reliance Standard Life Ins. Co.*, 88 F.3d 376, 380 (6th Cir. 1996) (requiring the grant of discretionary authority to be express); *Donaha v. FMC Corp.*, 74 F.3d 894, 898 (8th Cir. 1996); *Bogue v. Ampex Corp.*, 976 F.2d 1319, 1325 (9th Cir. 1992) (requiring the discretionary grant of power to be unambiguous); *Brown v. Blue Cross & Blue Shield of Ala., Inc.*, 898 F.2d 1571, 1562-63 (11th Cir. 1990) (applying the arbitrary and capricious standard); *Chojnacki v. Georgia-Pacific Corp.*, 108 F.3d 810, 815 (7th Cir. 1997) (equating the words construe or interpret to convey the power to interpret plan provisions). Note, however that grants of discretion contained within the summary plan description, but not the plan document, have not been sufficient to avoid the *de novo* standard of review. See *Wilczynski v. Kemper Nat'l Ins. Cos.*, 178 F.3d 933, 934 (7th Cir. 1999).

194. See *Perez v. Aetna Life Ins. Co.*, 150 F.3d 550, 555 (6th Cir. 1998); *Trombetta v. Cragin Fed. Bank for Sav. Employee Stock Ownership Plan*, 102 F.3d 1435, 1437-38 (7th Cir. 1996); *Jordan v. Retirement Comm. of Rensselaer Polytechnic Inst.*, 46 F.3d 1264, 1271 (2d Cir. 1995); *De Nobel v. Vitro Corp.*, 885 F.2d 1180, 1187 (4th Cir. 1989); *Block v. Pitney Bowes, Inc.*, 705 F. Supp. 20 (D.D.C. 1989).

195. See *Jordan*, 46 F.3d at 1271.

discretionary authority (e.g., using such words as discretionary,¹⁹⁶ final and binding,¹⁹⁷ full power,¹⁹⁸ or full and exclusive¹⁹⁹) in referring to the grant of power, the greater the likelihood of avoiding the *de novo* standard of review. Although plan sponsors and insurers have been given a clear understanding of the requisite language to insert in the plan document to avoid the *de novo* standard of review, case law abounds in this area.²⁰⁰

In ascertaining the meaning of the terms of the plan, most circuits are in agreement that the courts should fashion a federal substantive law, invoking both trust and contract principles to interpret ERISA plans.²⁰¹ In the absence of explicit language, many of the circuits

196. See *Donaho v. FMC Corp.*, 74 F.3d 894, 898 (8th Cir. 1996) (holding the following language acceptable: "FMC, as Plan Administrator, has discretionary authority to construe and interpret the terms of the Plan, including, but not limited to, deciding all questions of eligibility"); see also *Friedrich v. Intel*, 181 F.3d 1105, 1110 (9th Cir. 1999) (affirming that the language "shall have the sole discretion to interpret the terms of the Plan and to determine eligibility for benefits" conveyed the discretionary powers); *McDaniel v. Chevron Corp.*, 203 F.3d 1099, 1107 (9th Cir. 2000) (showing the language providing the administrator with sole discretion to interpret the terms of the plan as sufficient).

197. See *Kotrosits v. Gatz Corp.*, 970 F.2d 1165, 1168 (3d Cir. 1992) (affirming language making the plan administrator's decisions final and binding upon all persons); see also *Bendixen v. Standard Ins. Co.*, 185 F.3d 939, 943 n.1 (9th Cir. 1999) (affirming the use of the language conclusive and binding); *Duhon v. Texaco, Inc.*, 15 F.3d 1302, 1305 (5th Cir. 1994) (finding that language granting the plan administrator powers to make final and conclusive decision of the claim was a sufficient grant of discretionary powers).

198. See *Batchelor v. Int'l Broth. of Elec. Workers Local 861 Pension Retirement Fund*, 877 F.2d 441, 443 (5th Cir. 1989) (approving language where the trustees are given "full power to construe the provisions of [the] agreement"); *Guy v. Southeastern Iron Workers' Welfare Fund*, 877 F.2d 37, 38-39 (11th Cir. 1989).

199. See *Bendixen*, 185 F.3d at 943 & n.1 (holding acceptable plan language acknowledging to the plan administrator "we have full and exclusive authority to . . . interpret the Group Policy and resolve all questions arising in the . . . interpretation, and application of the Group Policy"); *Batchelor*, 877 F.2d at 443 (showing that grants of discretion were present due to plan language conferring "full and exclusive authority to determine all questions of coverage and eligibility"); *Guy*, 877 F.2d at 38-39 (finding that language conferring to the trustees "full and exclusive authority to determine all questions of coverage and eligibility" was sufficient).

200. Given the legislative changes requiring amendments to be made to qualified pension and profit sharing plans and the Department of Labor's recently released claim procedure regulations under ERISA section 503, *supra* note 4, requiring amendments to be made to group health and disability plans, plan sponsors should certainly review the terms of their plans to see that the requisite language is present to confer discretionary powers to the named fiduciaries. See Rev. Proc. 2000-27, 26 I.R.B. 1272.

201. See *Herzberger v. Standard Ins. Co.*, 205 F.3d 327 (7th Cir. 2000); *Kearney v. Standard Ins. Co.*, 175 F.3d 1084 (9th Cir. 1999) (*en banc*); *I.V. Servs. of Am., Inc. v. Trs. of Am. Consulting Eng'rs Council Ins. Trust Fund*, 136 F.3d 114, 121 (2d Cir. 1998); *Threadgill v. Prudential Secs. Group, Inc.*, 145 F.3d 286 (5th Cir. 1998); *Bailey v. Blue Cross*, 67 F.3d 53 (4th Cir. 1995); *Todd v. AIG Life Ins. Co.*, 47 F.3d 1448 (5th Cir. 1995); *Mansker v. TMG Life Ins. Co.*, 54 F.3d 1322 (8th Cir. 1995); *Lee v. Blue Cross/Blue Shield*, 10 F.3d 1547 (11th Cir. 1994); *Heasley v. Belden & Blake Corp.*, 2 F.3d 1249, 1258 (3d Cir. 1993); *Allen v. Adage, Inc.*, 967 F.2d 695 (1st Cir. 1992);

have used the contract principles of plain meaning and *contra proferentum*, if appropriate, to interpret plan provisions, affording the plan language its “plain meaning” and construing ambiguous language against the drafting party.²⁰² As courts read *Firestone* as prescribing the *de novo* as the default standard, the burden of proof effectively shifts to the fiduciary to prove the discretionary grant of authority in the plan document.²⁰³

The majority of circuit courts require that the grants of discretionary powers to the plan administrator be explicit in order to shift from the *de novo* to a more deferential standard of review.²⁰⁴ This issue has arisen as to whether discretionary interpretation powers may be implied in the context where the fiduciary has been granted explicit powers to make all benefit determinations, but not given explicit interpretative powers. The argument is made that the fiduciary’s decisions regarding benefit eligibility implicitly relies upon the fiduciary’s ability to interpret plan provisions. However, even those circuits willing to imply the grant of discretionary powers reject such argument.²⁰⁵ Likewise, the courts have rejected the argument

Burnham v. Guardian Life Ins. Co. of Am., 873 F.2d 486, 489 (1st Cir. 1989).

202. See *Kinsler v. First Reliance Standard Life Ins. Co.*, 181 F.3d 243, 252 (2d Cir. 1999); *Regents of the Univ. of Michigan v. Agency Rent-A-Car*, 122 F.3d 336, 339 (6th Cir. 1997); *Schachner v. Blue Cross*, 77 F.3d 889 (6th Cir. 1996); *Hughes v. Boston Mut. Life Ins. Co.*, 26 F.3d 264, 268 (1st Cir. 1994); *Barlett v. Martin Marietta Operations Support, Inc. Life Ins. Plan*, 38 F.3d 514, 517 (10th Cir. 1994); *Heasley v. Heldon & Blake Corp.*, 2 F.3d 1249, 1257-58 (3d Cir. 1993); *Delk v. Durham Life Ins. Co.*, 959 F.2d 104, 105-06 (8th Cir. 1992); *Pitcher v. Principal Mut. Life Ins. Co.*, 870 F. Supp. 903 (S.D. Ind. 1994).

203. See *Sharkey v. Ultramar Energy Ltd.*, 70 F.3d 226, 230 (2d Cir. 1995) (holding that the pension committee had the burden of proof); *Kinsler*, 181 F.3d at 249-51 (ruling against the insurer); *McDonald v. Provident Indem. Life Ins. Co.*, 60 F.3d 234, 237 (5th Cir. 1995) (ruling in favor of the insurer).

204. See *Brown v. Seitz Foods Inc. Disability Benefit Plan*, 140 F.3d 1198, 1200 (8th Cir. 1998) (requiring “express discretion granting language”); *Wildbur v. ARCO Chem. Co.*, 974 F.2d 631, 636 (5th Cir. 1992) (holding that “[d]iscretionary authority cannot be implied”); *Cathey v. Dow Chem. Co. Med. Care Program*, 907 F.2d 554, 559-60 (5th Cir. 1990) (holding that the plan did not grant discretion expressly, thus *de novo* review should be applied to the fiduciary’s denial of claims); *Perry v. Simplicity Eng’g*, 900 F.2d 963, 965 (6th Cir. 1990) (requiring an “express grant of discretion”); *Brown v. Ampco-Pittsburgh Corp.*, 876 F.2d 546, 550 (6th Cir. 1989) (requiring the grant of discretion to be “clear”); *Moon v. Am. Home Assur. Co.*, 888 F.2d 86, 88 (11th Cir. 1989) (requiring the discretionary authority to be “expressly give[n] by the plan”). A couple of circuits, however, may be willing to imply grants of discretionary powers. See *Luby v. Teamsters Health, Welfare & Pension Trust Funds*, 944 F.2d 1176, 1180 (3d Cir. 1991) (concluding that the plan at issue “neither expressly nor impliedly grant[ed] such discretion”); *De Nobel v. Vitro Corp.*, 885 F.2d 1180, 1187 (4th Cir. 1989) (applying the abuse of discretion standard).

205. See *Kirwan v. Marriott*, 10 F.3d 784, 788-89 (11th Cir. 1994) (claiming the language at issue “falls short of the express grant of discretionary authority necessary to trigger the arbitrary and capricious standard of review”); *Dzingslki v. Weirton Steel Corp.*, 875 F.2d 1075, 1079 (4th Cir. 1989) (holding that the plan fiduciary was not required to disclose the reasons for the employee discharge); *Baxter v. Lynn*, 886

that various grants of administrative powers under the plan to fiduciaries convey discretionary powers.²⁰⁵ Thus powers to control and manage the operation and administration of the plan or to promulgate rules and regulations or to interpret and administer have been construed as mere grants of administrative powers, not discretionary powers to interpret ambiguous provisions of the plan.²⁰⁷

The language that has resulted in the most judicial ink on the topic is the standard proof of loss or satisfactory proof of loss found in typical insurance contracts. As a conduit for payment, insurance contracts require the insured to submit written proof of loss or satisfactory proof of loss to the insurer in order to process and pay the claim. Consequently, insurers have argued that such language has granted them discretionary authority to determine benefits eligibility under the plan, (*i.e.*, the claim is conditional upon acceptable or satisfactory proof to the insurer). However, the Eighth Circuit has had no sympathy for such argument, acknowledging that a typical insurance policy is devoid of proper language to justify the deferential standard of review.²⁰⁸

F.2d 182, 188 (8th Cir. 1989) (stating “language requiring trustees to make a final determination of an employee’s eligibility under the plan does not necessarily confer discretionary authority to render decisions with regard to ambiguous provisions of the plan.”); *see also* *Adams v. Blue Cross & Blue Shield of Md., Inc.*, 757 F. Supp. 661, 667 (D. Md. 1991) (holding that the phrase “as decided by us” in the context of determining what procedures or treatments were experimental and thus excluded under the policy was vague and uncertain and therefore, would not be construed as a grant of interpretative powers). *But see* *Whittaker v. Bell S. Telecomms., Inc.*, 206 F.3d 532, 534 (5th Cir. 2000) (inferring discretionary authority because the committee had been delegated the sole and complete discretionary authority to resolve benefit claim appeals); *Boyd v. Trs. of United Mine Workers Health & Ret. Funds*, 873 F.2d 57, 59 (4th Cir. 1989) (affirming that the language “full and final determination” as to all issues concerning eligibility for benefits as a full grant of all discretionary); *Bogue v. Ampex Corp.*, 976 F.2d 1319, 1325 (9th Cir. 1992) (holding that the power to determine eligibility was inherently a discretionary power).

206. *See* *Luby*, 944 F.2d at 1180-81 (claiming that general grants of administrative power does not confer any specific powers to decide disputes between beneficiaries nor to determine fact-based beneficiary determinations); *Kirwan*, 10 F.3d at 788-89 (rejecting a broad grant of administrative powers as insufficient to trigger the deferential standard of review); *Cathey*, 907 F.2d at 558-59 (holding that the “authority to control and manage the operation and administration of the Plan” was insufficient to infer discretionary authority to make benefit determinations); *Michael Reese Hosp. & Med. Ctr. v. Solo Cup Employee Health Benefit Plan*, 899 F.2d 639, 641 (7th Cir. 1990) (holding that the “authority to control and manage the operation and administration of the Plan was an insufficient grant of discretionary powers”).

207. *See Kirwan*, 10 F.3d at 788-89 (showing that the powers “to promulgate rules and regulations” and “to interpret and administer the plan” were insufficient); *Cathey*, 907 F.2d at 558-59; *Michael Reese Hosp. & Med. Ctr.*, 899 F.2d at 641 (showing that the power to control and manage the operation and administration of the plan was held to be insufficient).

208. *See Ravenscraft v. Hy-Vee Employee Benefit Plan & Trust*, 85 F.3d 398, 402 (8th Cir. 1996) (concluding that a *de novo* standard is applied in reviewing denial of

The Second, Fourth, and Ninth Circuits, and just recently, the Seventh Circuit, have endorsed the Eighth Circuit's conclusion that particular plan phraseology, including satisfactory evidence, satisfactory written proof and submission of satisfactory proof, is alone insufficient to confer upon the insurer a more deferential standard of review for eligibility determinations.²⁰⁹ The Ninth Circuit was initially sympathetic to insurers, thus affirming insurance language that simply required satisfactory proof of the claimed loss, as evidence of discretionary powers.²¹⁰ However, the Ninth Circuit reversed itself in the *Kearney* decision, thus requiring a more explicit

benefits unless the plan grants the insurer discretionary authority over eligibility determination. Since the court found no provision conferring such authority, it held the application of deferential standard of review was improper); *Bounds v. Bell Atl. Enters. Flexible Long-Term Disability Plan*, 32 F.3d 337, 339 (8th Cir. 1994) (holding that the proof-of-loss provision common in insurance policies lacks explicit discretion-granting language and does not trigger deferential standard of review).

209. See *Kinsler v. First Reliance Standard Life Ins. Co.*, 181 F.3d 243, 251-52 (2d Cir. 1999) (emphasizing the important use of unequivocal language in benefit plans that conveys the idea that a plan administrator has discretionary authority and demonstrates insulation from *de novo* review); *Haley v. Paul Revere Life Ins. Co.*, 77 F.3d 84, 87-89 (4th Cir. 1996) (indicating that *de novo* review is proper in deciding whether an ERISA plan's language prescribes the benefit or whether it grants discretionary authority to the administrator to determine the benefit); *Bounds*, 32 F.3d at 339 (stating that the proper way to secure deferential review of an ERISA plan administrator's claims decision is through express discretion-granting language); *Brown v. Seitz Foods, Inc. Disability Benefit Plan*, 140 F.3d 1198, 1200 (8th Cir. 1998) (asserting that phrases such as, "to be considered disabled," "normally," "as long as the definition of total disability is satisfied," and "due . . . proof of loss" do not imply the plan administrator's discretionary authority to decide claims. Such provisions typical in an insurance policy do not justify a deferential standard of review); *Kearney v. Standard Ins. Co.*, 175 F.3d 1084, 1089-90 (9th Cir. 1999), *cert. denied*, 528 U.S. 964 (1999) (holding that the phrase "satisfactory written proof" in the long term disability insuring clause has alternative readings which do not confer discretionary authority on the insurer). Compare *Herzberger v. Standard Ins. Co.*, 205 F.3d 327, 332 (7th Cir. 2000) (holding that a plan requiring a determination of eligibility or entitlement by the administrator or requiring satisfactory proof of the applicant's claim or requiring both does not adequately notify an employee that the plan administrator has discretionary authority, which is insulated from judicial review), with *Patterson v. Caterpillar, Inc.*, 70 F.3d 503, 505 (7th Cir. 1995) (holding that if a plan provides that the benefits decision shall be based on proof "as shall be from time to time required" by the plan administrator, then the language implies that the administrator shall have discretion to determine sufficiency of proof), and *Donato v. Metro. Life Ins. Co.*, 19 F.3d 375, 379 (7th Cir. 1994) (rejecting an approach that requires a plan's language to contain an explicit grant of discretionary authority in order to apply a discretionary standard of review), and *Bali v. Blue Cross & Blue Shield Ass'n*, 873 F.2d 1043, 1047 (7th Cir. 1989) (finding that discretionary authority is apparent in the program's definition of "disabled" and holding that the language, "medical evidence satisfactory to the Committee," grants discretion "as to what sort of evidence may be required from an applicant to provide a basis for the subsequent disability determination.").

210. See *Snow v. Standard Ins. Co.*, 87 F.3d 327, 330 (9th Cir. 1996) (finding no distinction between "satisfactory written proof of the claimed loss" and plan language that declared the plan administrator's ability to determine eligibility and acknowledging that both types require the administrator to decide whether an applicant has become eligible as a result of presenting satisfactory proof).

grant of discretionary power to invoke the deferential standard.²¹¹

Similarly the Seventh Circuit vacillated on the issue by originally holding that the policy language, "proof must be satisfactory to us," was a discretionary grant of power,²¹² but later retreating from such position.²¹³ While citing the Second, Fourth, Eighth and Ninth Circuits that rejected such language as an implicit grant of discretionary powers, the Seventh Circuit noted that a number of its decisions, the *Patterson*²¹⁴ case being the closest, viewed such language as conferring a subjective standard, eligible for a deferential review.²¹⁵ In an effort to promote a uniform national rule, the Seventh Circuit in *Herzberger v. Standard Insurance Co.* proposed safe harbor plan language to assure that discretionary powers were conferred upon the plan administrator.²¹⁶ The court recommended the following safe harbor language for inclusion under the plan: "Benefits under this plan will be paid only if the plan administrator decides in his discretion that the applicant is entitled to them."²¹⁷ While the court

211. See *Kearney*, 175 F.3d 1084, 1089-90 (affirming the use of *de novo* review and indicating that receipt of satisfactory written proof of loss was not sufficient to provide for a deferential standard of review); see also *Sandy v. Reliance Standard Life Ins. Co.*, 222 F.3d 1202, 1207 (9th Cir. 2000) (upholding the *Kearney* rule through application of a *de novo* review unless plan documents clearly state that the plan administrator has discretionary authority to determine eligibility or to construe the terms of the plan); *Newcomb v. Standard Ins. Co.*, 187 F.3d 1004, 1006 (9th Cir. 1999) (finding that the use of the word "determine" in the policy does not confer appropriate discretion and holding that *de novo* standard of review was appropriate).

212. See *Bali*, 873 F.2d at 1047 (holding that disability determinations based on medical evidence satisfactory to the National Employee Benefits and Compensation Committee was sufficient to vest discretionary control with the Committee); *Donato*, 19 F.3d at 379 (construing the plan language, "all proof must be satisfactory to us," as conveying discretionary powers of interpretation to the plan administrator); *Patterson*, 70 F.3d at 505 (affirming the plan language, "benefits will be payable only upon receipt by the Insurance Carrier or Company of . . . due proof . . . of such disability," as sufficient to defer to the arbitrary and capricious standard of review); *Ramsey v. Hercules Inc.*, 77 F.3d 199, 205-06 (7th Cir. 1996) (concluding that the insurance language, "as determined by the Company," sufficiently granted discretionary power).

213. See *Herzberger v. Standard Ins. Co.*, 205 F.3d 327, 329 (7th Cir. 2000) (rejecting the language, "benefits shall be paid when the plan administrator upon proof (or satisfactory proof) determines that the applicant is entitled," as sufficient to confer upon the administrator a power of discretionary judgment); see also *id.* at 332 (requiring discretion to be made in clearer terms, affirming the cases from the Second, Fourth, Eighth, Ninth, and Eleventh Circuits). The Seventh Circuit concludes that proof of loss language is standard insurance contract language, agreeing with the Eighth Circuit's conclusion in *Ravenscraft v. Hy-Vee Employee Benefit Plan*, 85 F.3d 398, 402 (8th Cir. 1997). *Id.*

214. See *Patterson*, 70 F.3d at 505.

215. See *Herzberger*, 205 F.3d at 329-30 (noting a trend in the Seventh Circuit that requires the plan language conferring discretion to be in more unequivocal terms).

216. See *id.* at 330-31.

217. See *id.* at 331 (proposing a clearer language in ERISA plans so to establish a better system for the court in deciding between *de novo* and deferential standard of review); see also *Cozzie v. Metro. Life Ins. Co.*, 140 F.3d 1104, 1106-07 (7th Cir. 1998)

neither makes such safe harbor language mandatory nor will it infer that its absence in a plan is indicative of the conclusion that the plan administrator has no discretion, the intent is to provide some guidance as to what language would be sufficient.²¹⁸ Currently in the Seventh Circuit, the mere fact that the plan administrator determines eligibility and/or may require satisfactory proof of a claim is insufficient to confer discretionary powers.²¹⁹ Moreover, the judicial concern with plan language formulation originated from the need to address the practical problems of unilaterally amending thousands of insurance contracts to include appropriate language rather than from mere insertion of appropriate language.²²⁰

A lingering issue after *Herzberger* was whether insurance policy language explicitly reserving the determination of eligibility to the plan administrator inferred discretionary authority of interpretation. The Seventh Circuit has put this question to rest in a subsequent decision by holding that the language, "written proof acceptable to us," was neither a grant of discretion to interpret the policy or to determine eligibility.²²¹

The only circuit now willing to construe satisfactory proof language as authorizing discretion appears to be the Sixth Circuit. Beginning in 1991, the Sixth Circuit in *Miller v. Metropolitan Life Insurance Co.* held that language permitting the insurer to decide if the participant was disabled "on the basis of medical evidence satisfactory to the Insurance Company" was sufficient to grant discretion with respect to eligibility.²²² In rationalizing its decision, the Sixth Circuit determined that the plan language in *Miller* was similar to the

(finding the language, "the insurance companies have discretionary authority," in the plan as clearly justifying an arbitrary and capricious standard of review); *Hightshue v. AIG Life Ins. Co.*, 135 F.3d 1144, 1147 (7th Cir. 1998) (applying a *de novo* standard where the plan language stated that "[c]laims Administrator shall be entitled to use its discretion in good faith"); *Anderson v. Operative Plasterers' & Cement Masons' Int'l Ass'n Local No. 12 Pension & Welfare Plans*, 991 F.2d 356, 358 (7th Cir. 1993) (holding that the language that authorizes the plan administrator to "determine the existence, extent, cause and continuance of disability from time to time . . ." as vesting discretionary authority and thus employing deferential review unless the administrator's determination was "downright unreasonable"); *Terry v. Baker Corp.*, 145 F.3d 28, 37 (7th Cir. 1998) (employing a deferential standard of review where the court found that the plan language specifically allocated to the insurer the right of discretion).

218. See *Herzberger*, 205 F.3d at 330-31.

219. See *id.* at 332.

220. See *id.*

221. See *Postma v. Paul Revere Life Ins. Co.*, 223 F.3d 533, 538-39 (7th Cir. 2000) (holding *de novo* standard as appropriate by extending the *Herzberger* ruling to insurance proof of loss language even if the determination of loss had been explicitly reserved to the insurer).

222. See *Miller v. Metro. Life Ins. Co.*, 925 F.2d 979, 983 (6th Cir. 1991).

language found in *Bali v. Blue Cross & Blue Shield Ass'n*,²²³ where receipt of benefits in the latter situation was conditioned upon “furnish[ing] to the Employer true and correct information as the Committee may reasonably request.”²²⁴ However, the Seventh Circuit in *Bali* did not address the issue of whether such language gave sufficient discretion with respect to benefit determinations. Instead, the court stated that such language granted discretion as to the type of evidence that may be required in making a disability determination.²²⁵ The court expressly stated that it did not need to reach the issue of whether such language conferred sufficient discretion to construe the terms of the plan.²²⁶ Thus, the *Miller* court’s reliance on *Bali* was misconstrued.

Two subsequent *en banc* panels in the Sixth Circuit came to different conclusions regarding proof of loss or satisfactory proof of loss language. In the *Yeager* decision, an *en banc* panel for the Sixth Circuit was faced with the plan language “satisfactory proof of Total Disability to us.”²²⁷ The court applied its prior holding in *Miller* as it found no meaningful distinction between this language and the one in *Miller*.²²⁸ According to the court, the determination that evidence be satisfactory is a subjective decision requiring discretion on the part of the plan administrator.²²⁹ However, in another *en banc* panel decision, the court reached a contrary holding. In *Perez v. Aetna Life Insurance Co.*,²³⁰ the court was confronted with plan language giving the plan administrator “the right to require as part of the proof of claim satisfactory evidence . . . that [the claimant] has furnished all required proofs for [receipt of] benefits.”²³¹ The *en banc* panel in *Perez* held that such language did not grant discretion regarding benefits determinations.²³² Due to the conflict between *Yeager* and

223. 873 F.2d 1043, 1047 (7th Cir. 1989).

224. *See id.* at 1047 n.6.

225. *See id.* (noting that the plan provision did not grant discretion regarding benefit determinations but instead granted discretion regarding the type of evidence that was required to provide a basis for a disability determination).

226. *See id.* at 1047 n.7.

227. *See Yeager v. Reliance Standard Life Ins. Co.*, 88 F.3d 376, 380 (6th Cir. 1996).

228. *See id.* at 381 (holding that the district court should have applied an arbitrary and capricious standard of review just as the *Miller* court did in determining the adequacy of proof).

229. *See id.* (emphasizing that it would be irrational to authorize someone other than the plan administrator to determine satisfactory proof).

230. 96 F.3d 813 (6th Cir. 1996), *vacated*, 106 F.3d 146 (1997), and *remanded en banc*, 150 F.3d 550 (1998), and *cert. denied*, 121 S. Ct. 49 (2000).

231. *See Perez v. Aetna Life Ins. Co.*, 150 F.3d 550, 552 (6th Cir. 1998).

232. *See id.*

Perez, the Sixth Circuit decided to rehear the *Perez* case.²³³

In affirming the *en banc Perez* decision, the Sixth Circuit pointed to its earlier decisions in *Yeager* and *Miller* and to other Seventh and Ninth Circuit cases as confirmation of its holding that such plan language conferred discretionary authority on the plan administrator to determine benefits.²³⁴ The insurance applicant distinguished these cases by indicating that the plan language found in prior cases required proof of claim to be “satisfactory to us” (*i.e.*, the plan administrator) and by asserting that in absence of such language, the *Perez* language should be deemed insufficient.²³⁵ However, the Sixth Circuit established that clearly discretion-granting words, “to us”, “to the insurer”, or “to the company” were not explicitly necessary to bestow discretion.²³⁶ Applying the common law rules of contract interpretation, the court inferred that the only reasonable interpretation of the plan language in *Perez* was that Aetna, being the only named party with the right to request the evidence, had to be the one to review the determination of benefits.²³⁷ The court also noted that other contractual principles directed the courts not to supplement the contract with additional words in order to rewrite the plan.²³⁸

There was a vigorous dissent in the full panel *Perez* decision, joined by six of the justices. Justice Boggs, writing for the dissent, argued that while the plan language required proof of disability to be made to Aetna, such language was silent as to whether Aetna was the one who determined if proof was satisfactory.²³⁹ The dissent also noted

233. *See id.*

234. *See id.* at 556 (referring to similar discretion-granting language in other federal courts); *see also* *Snow v. Standard Ins. Co.*, 87 F.3d 327, 330 (9th Cir. 1996) (“company must be ‘presented with what it considers to be satisfactory proof of the claimed loss’”); *Patterson v. Caterpillar, Inc.*, 70 F.3d 503, 505 (7th Cir. 1995) (“benefits will be payable only upon receipt by the Insurance Carrier or Company of . . . due proof . . . of such disability”); *Donato v. Metro. Life Ins. Co.*, 19 F.3d 375, 379 (7th Cir. 1994) (“all proof must be satisfactory to us”); *Bali v. Blue Cross & Blue Shield Ass’n*, 873 F.2d 1043, 1047 (7th Cir. 1989) (“disability determined on the basis of medical evidence satisfactory to the Committee”).

235. *See Perez*, 150 F.3d at 556.

236. *See id.*

237. *See id.* at 557.

238. *See id.* (stating “in short, reading the contractual language in an ordinary and popular sense as we must, the only reasonable interpretation of the Plan is that Aetna requests the evidence, reviews it, and then makes a benefits determination. To reach any other conclusion would violate the basic principle of contract law that courts are not permitted to rewrite contracts by adding additional terms.”). The court then cites *Phico Ins. Co. v. Providers Ins. Co.*, 888 F.2d 663, 667 (10th Cir. 1989) for validation of the rule that “courts will not make contracts under the guise of judicial interpretation.”

239. *See Perez*, 150 F.3d at 558 (Boggs, J., dissenting) (emphasizing the importance of straightforward interpretation of the meaning of words and arguing that the

that the majority's reliance upon *Miller* and *Donato* was misplaced.²⁴³ *Miller* construed the language, which stated that the evidence was to be "satisfactory to the Insurance Company," as discretionary.²⁴¹ Likewise, *Donato* found that plan language requiring proof of loss to be "satisfactory to us" was discretionary.²⁴²

The Sixth Circuit's decision in *Perez* stands on weak ground. Its reliance upon the *Miller* decision was ill advised. In *Miller*, the court stated that its language was indistinguishable from the language in *Yeager*, and thus, it was bound by that decision.²⁴³ However, the *en banc* panel in *Yeager* relied on the Seventh Circuit's holding in *Bali* in making its decision;²⁴⁴ yet *Bali* never had to address the issue as to whether discretionary authority to determine benefits had been conferred.²⁴⁵ Given the Seventh Circuit's recent decision in *Herzberger*²⁴⁶ and the Ninth Circuit's recent decision in *Kearney*,²⁴⁷ the *Perez* decision has little support for the holding that typical insurance language confers the necessary powers to avoid the *de novo* standard for review.²⁴⁸

B. Applicable Judicial Standard of Review with Discretionary Language

1. Majority view

All the circuits affirm that there are two applicable judicial standards of review in ERISA benefit denial claims—the *de novo*

plan's language, "furnish written proof," does not grant an affirmative discretion).

240. See *id.* at 559 (Boggs, J., dissenting)

When faced with the language 'satisfactory proof' (or 'written proof' or 'due proof' or simply 'proof'), the immediate response of any half-trained lawyer is 'satisfactory to whom' (or, 'proof' in whose judgment). In this case, the Aetna drafter did not supply an answer, and it seems much more plausible that the default reading should be an objective standard, satisfactory to a neutral arbiter, or satisfactory in terms of the over-all meaning of the contract, rather than satisfactory to one of the two interested parties.

Id.

241. See *Miller v. Metro. Life Ins. Co.*, 925 F.2d 979, 983 (6th Cir. 1991).

242. See *Donato v. Metro. Life Ins. Co.*, 19 F.3d 375, 379 (7th Cir. 1994).

243. See *Miller*, 925 F.2d at 983 (noting that the main issue in the case was whether the insurance company had discretion to determine eligibility for disability benefits).

244. See *id.* (citing the Seventh Circuit's definition of disability as one "determined on the basis of medical evidence").

245. See *supra* note 225 and accompanying text (asserting the administrator receives discretionary authority from the program's definition of disabled).

246. See *supra* note 213 (stating that a uniform standard of judicial review is highly desirable and holding that plenary review was the appropriate standard).

247. See *supra* note 211 (holding that the trial court was correct in reviewing the appellant's claim *de novo*).

248. The Sixth Circuit still continues to apply the holding in *Perez* as witnessed in its unpublished decisions of *Osborne v. Cyprus Mountain Coals Corp.*, No. 97-6344, 1998 U.S. App. LEXIS 30021 (6th Cir. Nov. 19, 1998) and *Torello v. Unum Life Ins. Co. of Am.*, No. 98-4338, 1999 U.S. App. LEXIS 36768 (6th Cir. Dec. 3, 1999).

standard and the more deferential standard—abuse of discretion.²⁴⁹ Although the Supreme Court, in *Firestone*, rejected a wholesale approach of the labor law standard of judicial review in ERISA cases,²⁵⁰ most circuits continue to use the labor law review terminology of arbitrary and capricious to describe this second judicial standard, but are quick to equate it with the trust law standard of abuse of discretion.²⁵¹ Only the Fourth Circuit views a distinction between the two standards and opts for use of a less deferential standard (abuse of discretion) in benefit denial cases.²⁵² All the circuits are in agreement though that a federal common law must be developed for fashioning an ERISA's judicial review standard in benefit denial cases.²⁵³

While the circuits are quick to equate the labor law arbitrary and capricious standard with the trust law abuse of discretion standard, the application of this deferential standard is hardly uniform throughout the circuits. In addition, there is even more confusion regarding the application of the more deferential standard if an inherent or actual conflict of interest exists on the part of the plan administrator. In this section of the article, the author will first

249. The Fourth, Fifth, Eighth, Ninth, and Tenth Circuits prefer the abuse of discretion standard over the *de novo* standard. See *Booth v. Wal-Mart Stores, Inc.*, 201 F.3d 335, 341-42 (4th Cir. 2000); *Meditrust Fin. Servs. Corp. v. Sterling Chems., Inc.*, 168 F.3d 211, 214-16 (5th Cir. 1999); *Barnhart v. Unum Life Ins. Co. of Am.*, 179 F.3d 583, 587 (8th Cir. 1999); *Vizcaino v. Microsoft Corp.*, 120 F.3d 1009, 1013 (9th Cir. 1999); *McGraw v. Prudential Ins. Co. of Am.*, 137 F.3d 1253, 1258-59 (10th Cir. 1998). Compare, however, the Eleventh Circuit holding in *Marecek v. Bellsouth Servs., Inc.*, 49 F.3d 702, 705 (11th Cir. 1995), which states that there are three standards of review: (1) *de novo* review which applies where the plan administrator is not afforded discretion; (2) arbitrary and capricious review where the plan administrator possesses discretion; and (3) heightened arbitrary and capricious review where the administrator has discretion, but there is also a substantial conflict of interest.

250. See *supra* note 155 (noting that ERISA does not declare the appropriate standard of review for challenging benefit claims).

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

252. See *Booth*, 201 F.3d at 341 (opting for the abuse of discretion standard, not the arbitrary and capricious standard, as the "appropriate one for judicial review of a fiduciary's discretionary decision under ERISA."). Under the abuse of discretion standard, the Fourth Circuit will not disturb the fiduciary's discretionary decision if it is reasonable. *Id.* at 342.

253. See *supra* note 249 (noting cases across all circuits that have developed a federal common law under ERISA in benefit denial cases).

discuss the circuits' interpretation of the abuse of discretion standard and then show how the standard is being altered in the conflict of interest context.²⁵⁴

Assuming the appropriate plan language is present in the document to grant full discretion to determine eligibility and/or to interpret plan provisions, the arbitrary and capricious standard is regarded by most circuits as highly deferential.²⁵⁵ Under this standard, the majority of the circuits will affirm the plan administrator's decision, unless it was arbitrary, capricious, or made in bad faith, . . . not supported by substantial evidence.²⁵⁶ This standard has been equated to one which affirms the administrator's decision unless "totally unreasonable,"²⁵⁷ "whimsical, random, or unreasoned,"²⁵⁸ or "downright unreasonable."²⁵⁹

Some courts will question the plan administrator's decision if it is rendered without explanation, if there are gross procedural irregularities,²⁶⁰ or if the administrator did not follow her own

254. The term abuse of discretion will be used interchangeably with the term arbitrary and capricious, except in the Fourth Circuit context.

255. See *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 392-93 (3d Cir. 2000); *Pagan v. NYNEX Pension Plan*, 52 F.3d 438, 443-44 (2d Cir. 1995); *Killian v. Healthsource Provident Adm'rs, Inc.*, 152 F.3d 514, 520 (6th Cir. 1998); *Maune v. Int'l Bd. of Elec. Workers*, 83 F.3d 959, 962-63 (8th Cir. 1996); *Pozzie v. United States Dep't of Housing and Urban Dev.*, 48 F.3d 1026, 1029 (7th Cir. 1995); *Kisser v. Cisneros*, 14 F.3d 615, 618 (D.C. Cir. 1994); *Ershick v. United Missouri Bank*, 948 F.2d 660, 666 (10th Cir. 1991); *Brown v. Blue Cross & Blue Shield of Ala., Inc.*, 898 F.2d 1556, 1562-63 (11th Cir. 1990); *Davis v. Kentucky Fin. Cos. Retirement Plan*, 887 F.2d 689, 693 (6th Cir. 1989) (noting that "the arbitrary and capricious standard was the least demanding form of judicial review").

256. See *Pagan*, 52 F.3d at 442, citing *Van Boxel v. Journal Co. Employee's Pension Trust*, 836 F.2d 1048, 1049 (7th Cir. 1988); *Meditrust Fin. Servs. Corp. v. Sterling Chems., Inc.*, 168 F.3d 211, 214 (5th Cir. 1999); *Brogan v. Holland*, 105 F.3d 158, 161 (4th Cir. 1997); *Donaho v. FMC Corp.*, 74 F.3d 894, 898 (8th Cir. 1996); *Bernstein v. CapitalCare, Inc.*, 70 F.3d 783, 788 (4th Cir. 1995); *Abnathya v. Hoffman-LaRoche, Inc.*, 2 F.3d 40, 45 (3d Cir. 1993); *Millensifer v. Retirement Plan*, 968 F.2d 1005, 1009 (10th Cir. 1992); *Baker v. United Mine Workers of Am. Health & Retirement Funds*, 929 F.2d 1140, 1144 (6th Cir. 1991).

257. See *Allen v. United Mine Workers of Am.*, 726 F.2d 352, 354 (7th Cir. 1984) (noting that under ERISA only when an allocation is made that strikes the court as totally unreasonable will the decision be set aside).

258. See *Teskey v. M.P. Metal Prods. Inc.*, 795 F.2d 30, 32 (7th Cir. 1986) (stating that the arbitrary and capricious standard was quite narrow).

259. See *Carr v. Gates Health Care Plan*, 195 F.3d 292, 294 (7th Cir. 1999) (citing *Butler v. Encyclopedia Britannica, Inc.*, 41 F.3d 285, 291 (7th Cir. 1994)) (affirming the district court's decision that the administrator's decision was not arbitrary and capricious).

260. See *Doe v. Travelers Ins. Co.*, 167 F.3d 53, 57 (1st Cir. 1999) (finding the plan administrator's actions unreasonable "because of other procedural errors by Travelers or improper delegations of authority by it to others"); *McGraw v. Prudential Ins. Co. of Am.*, 137 F.3d 1253, 1262-63 (10th Cir. 1998) (noting that the plan administrator's denial of benefits was unreasonable in light of the fact he never reviewed medical records in making his determination; arbitrary and capricious standard of review may apply if the beneficiary shows serious procedural

policy.²⁶¹ Other courts require there be a showing of a principled reasoning process²⁶² or uniformity in the decision-making process²⁶³ on the part of the plan administrator in order to affirm the decision.²⁶⁴ The consensus among courts is that a given court will not substitute its decision for that of the plan administrator if the plan administrator's interpretation of the plan or determination of eligibility was rationale.²⁶⁵ Thus, the plan administrator's decision does not have to be the *only* reasonable or sensible interpretation; in fact, it need not even be the best interpretation.²⁶⁶ A useful example demonstrating the application of this standard may be found in the

irregularities); *Buttram v. Cent. States Health & Welfare Fund*, 76 F.3d 896, 900 (8th Cir. 1996) (alluding that a less deferential standard may be applicable if the beneficiary could show serious procedural irregularities involved in processing the denial of benefits).

261. See *Filipowicz v. Am. Stores Ben. Plans Comm.*, 56 F.3d 807, 813 (7th Cir. 1995) (holding that the plan administrator's denial of benefits was arbitrary and capricious as it did not adhere to its own claims procedures). This issue will become of even greater importance if the Department of Labor's recent regulations on claims procedures become effective for all claims filed on or after January 1, 2002. See *supra* note 4 (indicating that, under these final rules, participants and beneficiaries will not have to exhaust administrative remedies before proceeding to litigation if the employer or plan administrator is not complying with the mandated Department of Labor claims procedures). Thus, the matter of procedural irregularity or failure to follow Department of Labor policies will become a factor in the court's review process as it may or may not have any record or decision to review. *Id.*

262. See *Brogan v. Holland*, 105 F.3d 158, 161 (4th Cir. 1997), *citing* *Bernstein v. CapitalCare, Inc.*, 70 F.3d 783, 788 (4th Cir. 1995) (noting that decisions by trustees will not be overturned when there is proof of a principled reasoning process); see also *Baker v. United Mine Workers of Am.*, 929 F.2d 1140, 1144 (6th Cir. 1991), *citing* *Boyd v. Trs. of the United Mine Workers of Am. Health & Retirement Funds*, 873 F.2d 57 (4th Cir. 1989) (ruling that trustees decisions must be reviewed under an abuse of discretion standard). *But see Carr v. Gates Health Care Plan*, 195 F.3d 292, 295-96 (7th Cir. 1999) (asserting that under the arbitrary and capricious standard, a court evaluates several factors including "the impartiality of the decision making body, the complexity of the issues, the process afforded the parties, the extent to which the decision makers utilized the assistance of experts when necessary, and finally, the soundness of the Fiduciary's ratiocination"); *Mers v. Marriott Int'l Group Accidental Death & Dismemberment Plan*, 144 F.3d 1014, 1021 (7th Cir. 1997) (affirming the district court's decision to deny benefits and ruling that the decision was not arbitrary and capricious).

263. See *Hoover v. Blue Cross & Blue Shield of Ala.*, 855 F.2d 1538, 1541 (11th Cir. 1988); *Lutheran Med. Ctr. v. Contractors, Laborers, Teamsters & Eng'rs Health & Welfare Plan*, 25 F.3d 616, 621-22 (8th Cir. 1994).

264. See *Bernstein*, 70 F.3d at 788 (affirming the trustee's decision because it "[was] the result of a deliberate, principled reasoning process and [was] supported by substantial evidence.>").

265. See *Terry v. Bayer Corp.*, 145 F.3d 28, 40 (1st Cir. 1998); *Miller v. United Welfare Fund*, 72 F.3d 1066, 1072 (2d Cir. 1995); *Ellis v. Metro. Life Ins. Co.*, 126 F.3d 228, 233 (4th Cir. 1997); *Vega v. Nat'l Life Ins. Servs., Inc.*, 188 F.3d 287, 296-97 (5th Cir. 1999); *Carr*, 195 F.3d at 294-95; *Donaho v. FMC Corp.*, 74 F.3d 894, 899 (8th Cir. 1996); *Stewart v. Nat'l Shopmen Pension Fund*, 795 F.2d 1079, 1083 (D.C. Cir. 1986).

266. See *Donaho*, 74 F.3d at 898; *Woolsey v. Marion Lab., Inc.*, 934 F.2d 1452, 1460 (10th Cir. 1991).

Second Circuit's decision in *Jordan v. Retirement Committee of Rensselaer Polytechnic Institute*.²⁶⁷ The retirement committee interpreted a cost of living adjustment provision in a plan amendment as modifying earlier increases so that all participants would receive benefits as if the same cost of living formula had always been in place, regardless of the date of retirement.²⁶⁸ As the committee had discretionary power to interpret the plan, the court affirmed its interpretation and refused to upset that interpretation as it was reasonable.²⁶⁹

2. *Minority views*

In contrast, five of the circuits (the Fourth, Fifth, Seventh, Eighth and District of Columbia) employ different applications of the arbitrary and capricious standard, such that the plan administrator's decision must overcome various hurdles in order to be granted deference.²⁷⁰ These circuits either redefine the judicial standard in terms of the application of various factors or by describing the judicial standard as a multi-step process.²⁷¹ The results are anything but uniform.²⁷² But, in defense of these circuits, they are trying to disseminate various sets of factors for lower courts to utilize in ERISA benefit denial cases, in lieu of a rubber stamp of the plan administrator's decision.

a. *Fourth Circuit's approach*

The Fourth Circuit early on maintained that *Firestone* required the total abandonment of the 'arbitrary and capricious' formulation, and thus applied, what it perceived to be a less deferential standard, the abuse of discretion approach.²⁷³ While initially reiterating the five factors under the RESTATEMENT (SECOND) OF TRUSTS from *Firestone*

267. 46 F.3d 1264 (2d Cir. 1995).

268. *See id.*

269. *See id.* at 1270 (noting that caselaw "suggests that . . . the Retirement Committee had broad discretion to interpret the Plan so that the arbitrary and capricious standard would apply in any court review").

270. *See, e.g.,* Clapp v. Citibank, N.A. Disability Plan, 2001 WL 946557, at *5-6 (8th Cir. June 14, 2001); *De Nobel*, 885 F.2d at 1185-86; *Elliot v. Sara Lee Corp.*, 190 F.3d 601, 605 (4th Cir. 1999); *Spacek v. Mar. Ass'n, ILA Pension Plan*, 134 F.3d 283, 291 (5th Cir. 1998); *Ellis v. Metro. Life Ins. Co.*, 126 F.3d 228, 233 (4th Cir. 1997); *Bedrick v. Travelers Ins. Co.*, 93 F.3d 149, 153 (4th Cir. 1996); *Booth*, 201 F.3d at 342-43; *Egert v. Connecticut Gen. Life Ins. Co.*, 900 F.2d 1032 (7th Cir. 1990); *Exsom*, 900 F.2d at 1142; *Donoaho*, 74 F.3d at 899-900; *Maggard v. O'Connell*, 671 F.2d 568, 571 (D.C. Cir. 1982).

271. *See supra* note 270 (citing cases from the Fourth, Fifth, Seventh, Eighth, and D.C. Circuits that apply the judicial review standard in ERISA benefit cases).

272. *See supra* note 265 (noting cases from the Fourth, Fifth, Seventh, Eighth, and D.C. circuits to illustrate the differences in the standard of review of each circuit).

273. *See De Nobel*, 885 F.2d at 1185-86 (finding that such standard is consistent with the established principles of trust law).

in its application of the abuse of discretion standard, the Fourth Circuit reformulated such factors into the ERISA context as: (1) scope of discretion conferred, (2) purpose of the plan provision, (3) the existence of an external standard, (4) motives of the plan administrator, and (5) existence of a potential for a conflict of interest.²⁷⁴ Hence, the RESTATEMENT (SECOND) OF TRUSTS' factor relating to the nature of the power was eliminated, presumably because the courts assume such interpretative powers of the plan administrator are discretionary, not mandatory. It was replaced with a new factor, purpose of the plan provision.²⁷⁵

In its interpretation of the fifth factor, conflict of interest, the Fourth Circuit held ERISA required that the fiduciary operate free of any conflict of interest and that such standard was absolute, not one that balanced interest, nor permitted any divided loyalty to employees.²⁷⁶ One would expect such a broad-brush approach to elevate conflict of interest to something beyond a factor to be considered; however, the Fourth Circuit continues to treat it as simply another factor in its overall analysis.²⁷⁷ More recently, the Fourth Circuit has interjected a sixth factor, one which requires that the plan administrator's decision be supported by a deliberate principled reasoning process and supported by substantial evidence, something akin to the plaintiff's full and fair review process of benefit claims.²⁷⁸

Combining all of these various factors, the most recent decision from the Fourth Circuit listed eight non-exhaustive factors for a court to consider when determining the reasonableness of the fiduciary's discretionary decision, interjecting two new factors: the adequacy of the materials used by the plan administrator and the degree to which it supports the decision and the consistency of such decision with its prior interpretations.²⁷⁹ In so doing, the Fourth Circuit, seeks to

274. See *Haley v. Paul Revere Life Ins. Co.*, 77 F.3d 84, 89 (4th Cir. 1996) (holding that the administrator properly denied claim for benefits).

275. See *De Nobel*, 885 F.2d at 1190 (affirming that the plan administrator's interpretation of "actuarial equivalent" that enhanced benefits for early retirees under non-life annuity forms of payments as it furthers a plan's purpose to encourage such retirees to elect options that guaranteed lifetime income).

276. See *Bedrick v. Travelers Ins. Co.*, 93 F.3d 149, 153 (4th Cir. 1996) (reversing the administrator's denial of benefits because the administrator never evaluated claimant's therapy).

277. See *Ellis v. Metro. Life Ins. Co.*, 126 F.3d 228, 233 (4th Cir. 1997); *Elliott v. Sara Lee Corp.*, 190 F.3d 601, 605 (4th Cir. 1999) (modifying standard from usual abuse of discretion standard to reflect the conflict of interest); *Booth*, 201 F.3d at 343.

278. See *Brogan*, 105 F.3d at 159; *Bernstein*, 70 F.3d at 783.

279. See *Booth*, 201 F.3d at 342 (setting forth the following factors: "(1) the language of the plan; (2) the purposes and goals of the plan; (3) the adequacy of the materials considered to make the decision and the degree to which they support it; (4) whether the fiduciary's interpretation was consistent with other provisions in the

weave many of the factors used by the other courts into a cohesive framework to assist lower courts in the application of the abuse of discretion standard.²⁸⁰

The author believes that the Fourth Circuit's current set of reasonable factors can be more easily understood as a three-part test: (1) examination of the plan language for the scope of discretion intended to be conferred upon the plan administrator; (2) assuming full and expansive discretion has been conferred, then the plan administrator's interpretation of ambiguous plan provision should be judged as follows: (a) as a result of reasoned and principled process (b) consistent with any prior interpretations by the plan administrator (c) reasonable in light of any external standards and (d) consistent with the purposes of the plan; and (3) if there exists a conflict of interest, further justification is required to rebut any bias or motives.²⁸¹ Such approach certainly affords direction to lower courts, as well as being true to the legislative intent of ERISA in protecting the rights of the participants/beneficiaries.

b. Seventh Circuit's approach

While describing its application of the arbitrary and capricious standard as deferential, the Seventh Circuit uses specific factors to determine whether the plan administrator's decision was reasonable and, therefore, should be affirmed. The Seventh Circuit initially interpreted the arbitrary and capricious standard post-*Firestone* as highly deferential.²⁸² However, beginning in 1995 with the *Chalmers*

plan and with earlier interpretations of the plan; (5) whether the decision making process was reasoned and principled; (6) whether the decision was consistent with the procedural and substantive requirements of ERISA; (7) any external standard relevant to the exercise of discretion; and (8) the fiduciary's motives and any conflict of interest it may have").

280. See H. Brent McKnight, *Assessing the Impact of Conflict of Interest on the Decisions of ERISA Fiduciaries*, 13 REGENT U. L. REV. 1, 18 (2000) (noting that the "sliding scale" approach taken by the Fourth Circuit is favored over other court's approaches because they adopt various aspects of conflict of interest inquiry).

281. See *supra* notes 273-80 and accompanying text (explaining the Fourth Circuit's handling of the issue).

282. See *Egert v. Connecticut Gen. Life Ins. Co.*, 900 F.2d 1032, 1035 (7th Cir. 1990) (defining the standard as one embodying the highest level of deference); see also *Exbom*, 900 F.2d at 1142 (stating that it was to review the trustee's decision under "a standard embodying the highest level of deference . . . [T]hat standard is the arbitrary and capricious [standard]"). Such standard affirms the trustee's decision as final "if the trustee makes an informed judgment and articulates an explanation for it that is satisfactory in light of the relevant facts, i.e., one that makes a 'rational connection' between the issue to be decided, the evidence in the case, the text under consideration, and the conclusion reached . . ." *Id.* at 1143. The court then proceeded to review the trustees' actions, noting that the Board of Trustees was impartial (as it had equal representation of management and union), that it gathered all the relevant information, afforded exemplary process, examined all the

case,²⁸³ the Seventh Circuit noted that various factors were to be evaluated under the arbitrary and capricious standard (*i.e.*, “the impartiality of the decision-making body, the complexity of the issues, the process afforded the parties, the extent to which the decision makers utilized the assistance of experts where necessary, and finally the soundness of the fiduciary’s ratiocination”).²⁸⁴

The Seventh Circuit stated that its factors were derived in the earlier case of *Exbom v. Central States Southeast and Southwest Areas Health and Welfare Fund*.²⁸⁵ However, when the *Exbom* court mentions the use of these factors, it concludes that the trustee’s actions in the case at hand would pass muster under any standard of deferential review.²⁸⁶ Therefore, it is not clear whether the court in *Exbom* was espousing the use of all these factors under the arbitrary and capricious standard of review or whether the court further justified its opinion due to the fact that the trustee’s action would have passed all of them.²⁸⁷ The Seventh Circuit has continued the use of some of these factors in its later opinions.²⁸⁸

evidence, became advised by experts, formed a reasonable construction of the plan’s language and reached a judgment that was informed and supported by sound ratiocination. *Id.*

283. *Chalmers v. Quaker Oats Co.*, 61 F.3d 1340, 1343 (7th Cir. 1995).

284. *See Chalmers*, 61 F.3d at 1343, *quoting Exbom*, 900 F.2d at 1142 (detailing the principles of trust law in determining the scope of the abuse of discretion standard).

As in trusts law, whether something constitutes an abuse depends on the terms of the instrument; the more discretion that is conferred upon the trustee or fiduciary, the more deference the consequent decision is entitled When, as is the case here, the amount of discretion is virtually unconstrained, the court should review the decision under an arbitrary and capricious standard Under that standard we evaluate several factors: the impartiality of the decision making body, the complexity of the issues; the process afforded the parties; the extent to which the decision makers utilized the assistance of experts where necessary, and finally the soundness of the fiduciary’s ratiocination.

Id.

Note only one of these factors coincides with the factors mentioned by the Supreme Court in *Firestone* under the abuse of discretion standard from the RESTATEMENT (SECOND) OF TRUSTS (*i.e.*, the conflict of interest). *See supra* note 175 and accompanying text; *see also Carr*, 195 F.3d at 295; *Cozzie*, 140 F.3d at 1107. Note these additional factors considered by the court are applicable in the health/disability context in lieu of the pension context; yet the court does not make such distinction.

285. 900 F.2d at 1142-44 (declaring that, under the arbitrary and capricious standard, a trustee’s decision should not be overturned absent special circumstances).

286. *Id.* at 1143 (holding that the trustees’ decision was not arbitrary and capricious because it was well grounded in reason and supported by evidence).

287. *See id.*

288. *See Carr*, 195 F.3d at 295 (mentioning the five *Chalmers* factors, including, “impartiality of decision making body, the complexity of the issues, the process afforded the parties, the extent of the use of experts where necessary, and the soundness of the fiduciary’s ratiocination”); *Pinto v. Reliance Std. Life Ins. Co.*, 214

Similar to the Seventh Circuit, the Second, Third, Fourth and Eighth Circuits have interjected the *process* afforded the plaintiff as a factor to be considered in deciding whether to defer to the plan administrator's interpretation.²⁸⁹ The Second Circuit has even gone as far as holding that the denial of a "full and fair review" to the participant is evidence that the plan administrator's decision was arbitrary and capricious.²⁹⁰ The author asserts that the use of this factor (*i.e.*, the process afforded to the participant/beneficiary) confuses the scope of review with the standard of review. Under the guise of standard of review, the court engages in a plenary scope of review to examine whether the plan administrator adequately reviewed the medical records, made an informed and rationale decision, consulted with independent medical experts, and afforded the participant an adequate review process. All of these factors may be required under ERISA and/or the plan; however, they relate to the scope of review, and not necessarily the standard of review.²⁹¹ The author acknowledges that the complete failure of a plan administrator to adhere to the plan's claims procedure could certainly be indicative that it acted arbitrarily and capriciously; however, to invite the courts to determine whether the plan administrator's review of the medical records, its consultation with medical experts, and its documentation and explanation of its decision is sufficient to affirm the plan administrator's interpretation will unduly clog the court system and is certainly not what is envisioned under the highly deferential arbitrary and capricious

F.3d 377, 394 (3d Cir. 2000) (taking into account the "procedural anomalies" in deciding to apply the far end of the arbitrary and capricious range); *Ross v. Indiana State Teacher's Ass'n*, 159 F.3d 1001, 1010 (7th Cir. 1998) (considering the following factors, for example, the interpretation of the plan in light of ADA's requirements); *Hightshue v. AIG Life Ins. Co.*, 135 F.3d 1144, 1147-48 (7th Cir. 1998) (stating the following factors, for example, impartiality of decision maker; the process afforded the parties, use of independent experts, conclusion supported by the evidence) *Chojnacki v. Georgia-Pacific Corp.*, 108 F.3d 810, 815-16 (7th Cir. 1997) (noting the following factors, for example, impartiality of decision making body, inconsistency in interpretations).

289. *See Crocco v. Xerox Corp.*, 137 F.3d 105, 108 (2d Cir. 1998) (holding that denial of a "full and fair review" to the plaintiff constituted an arbitrary and capricious decision, and thus conflict of interest need not be considered); *Marolt v. Alliant Techsystems, Inc.*, 146 F.3d 617, 621 (8th Cir. 1998) (holding that denial of the plaintiff's benefits based on an obscure passage in a 115-page divestiture document that only lawyers will read and understand was arbitrary and capricious).

290. *See Crocco*, 137 F.3d at 108. Such result is consistent with the Department of Labor's recently released claim procedure regulations. *See supra* note 4 (noting that every benefit plan must establish and maintain reasonable claims procedures).

291. *See* 29 C.F.R. § 2560.503-1(l) (2000) (stating that failure to establish or follow claims procedures that are consistent with the regulations constitutes an exhaustion of administrative remedies and permits the claimant to pursue remedies under ERISA's causes of actions).

standard of review. Assuredly ERISA was designed to afford participants an adequate claims review process; however, permitting courts to consider any and all aspects of such review process as a factor to usurping the fiduciary's discretionary powers is certainly putting the cart before the horse.²⁹²

c. Approach used by the Eighth, District of Columbia, and Fifth Circuits

The Eighth, District of Columbia, and Fifth Circuits' application of the arbitrary and capricious standard has evolved post-*Firestone* into substantially different types of judicial standards of review. What began as a highly deferential standard has evolved into a reasonable standard (*i.e.*, whether "a reasonable person could have reached a similar decision, given the evidence before him")²⁹³ or a standard that requires a multi-step process.²⁹⁴

For the Eighth Circuit, the deferential standard of review begins with an inquiry as to whether the plan administrator's decision was reasonable, *i.e.*, whether a reasonable person could have reached a similar decision, supported by substantial evidence.²⁹⁵ In the context of the proper reading of "reasonableness for ERISA benefit claims, the standard for the Eighth Circuit was explained as, whether a reasonable person [*could*] have reached a similar decision given the same evidence, not whether a reasonable person [*would*] have reached the same decision."²⁹⁶ The substantial evidence requirement was used to ascertain whether a reasonable person would affirm that the evidence on record supported the decision.²⁹⁷ However, in the development of this standard, the Eighth Circuit interjected various

292. *See id.* (setting out the minimum requirements for claims procedures under ERISA).

293. *See Donaho v. FMC Corp.*, 74 F.3d 894, 899-900 (8th Cir. 1996) (defining reasonableness in the context of trusts and ERISA); *Maggard v. O'Connell*, 671 F.2d 568, 571 (D.C. Cir. 1982) (describing a highly deferential standard under which the reviewing court may be more inclined to give the fact-finder the benefit of the doubt).

294. *See Branson v. Greyhound Lines, Inc., Amalgamated Council Ret. & Disability Plan*, 126 F.3d 747, 755 (5th Cir. 1997) (outlining a two-step inquiry in determining whether a trustee abused his discretion); *Spacek v. Mar. Ass'n, I.L.A. Pension Plan*, 134 F.3d 283, 291 (5th Cir. 1998) (noting that application of the abuse of discretion standard may involve a two-step process).

295. *See Donaho*, 74 F.3d at 899 (quoting the RESTATEMENT (SECOND) OF TRUSTS, which notes "the court will not interfere unless the trustee, in exercising or failing to exercise the power . . . acts beyond the bounds of a reasonable judgment").

296. *Id.* (describing the reasonableness standard in the ERISA context).

297. *Id.* at 900 (concluding that "substantial evidence is only a quantified reformation of reasonableness").

factors into the determination of reasonableness.²⁹⁸

When reviewing the reasonableness of the plan administrator's interpretation, the Eighth Circuit uses the following five factors: (1) whether such interpretation is consistent with the plan's goals; (2) whether such interpretation renders other plan language meaningless or inconsistent; (3) whether such interpretation conflicts with the substantive and procedural requirements of ERISA; (4) whether such construction interprets the words at issue consistently; and (5) whether such interpretation is contrary to the plan's clear language.²⁹⁹ In the circuit's application of these five factors, it also notes that the unreasonableness of the plan administrator's decision may be ascertained by the quantity and quality of the evidence supporting it.³⁰⁰ Such review is hardly deferential, as it requires the court to review the quality and quantity of evidence in deciding whether to afford deference to the plan administrator's decision. As noted before, interjection of the process of review afforded the parties confuses the concept of scope of review with the standard of review.³⁰¹ In comparison with the Fourth Circuit's approach, the Eighth Circuit interjects the substantive and procedural requirements of ERISA into the equation, which appears to mandate the courts' interjection as a matter of law.

Similarly, the District of Columbia Circuit has interjected a number of factors in its application of the arbitrary and capricious standard. Such a result is not surprising as the D.C. Circuit has defined the arbitrary and capricious standard as one that "defies generalized application" and one that "must be contextually tailored."³⁰² Thus, there is little guidance for lower courts or the plan sponsor. Beginning with its decision in *Donovan v. Carlough*,³⁰³ the District of Columbia Circuit invoked the following four factors in its application of the deferential arbitrary and capricious standard of review: (1) whether the plan administrator's interpretation was contrary to the clear language of the plan or whether it rendered other

298. See *infra* notes 299-301 and accompanying text (discussing the Eighth Circuit's factors).

299. See *Finley v. Special Agents Mut. Ben. Ass'n*, 957 F.2d 617, 621 (8th Cir. 1992) (holding that the board's denial of benefits was not arbitrary and capricious).

300. See *Donaho*, 74 F.3d at 900 (determining that evidence was lacking on both quantitative and qualitative grounds).

301. See *supra* notes 289-90 and accompanying text (noting the court's engagement in scope of review under the rubric of standard of review).

302. See *Maggard v. O'Connell*, 671 F.2d 568, 571 (D.C. Cir. 1982) (noting that the same principle applies to substantial evidence standard).

303. 576 F. Supp. 245 (D.D.C. 1983), *aff'd mem.*, 753 F.2d 166 (D.C. Cir. 1985) (holding that the trustee's interpretation was arbitrary and capricious and granting plaintiff's motion for summary judgment).

provisions superfluous; (2) whether it was consistent with the plan's purposes; (3) whether it was consistent with the purpose of the provision in question; and (4) whether it was consistent with prior interpretations and whether the participants had notice of such interpretation.³⁰⁴ The first factor appears directed at the issue of ambiguous versus unambiguous plan provisions. If the plan language is unambiguous, its plain meaning should be followed; only if the language is ambiguous is the plan administrator's interpretation worth considering.³⁰⁵ The second and third factors look to the intent of the settlor in creating the plan and in drafting the particular provision in question which, at least under trust law analysis, are to be given deference by the courts.³⁰⁶

The District of Columbia's final factor, consistency of prior interpretations and notification of such interpretation to beneficiaries, is totally unique. While consistency of prior interpretations has been interjected as a factor in determining whether the plan administrator's current interpretation is arbitrary and capricious, such interpretation has not been required to be circulated and disseminated among the participants.³⁰⁷ In fact, ERISA has no mandate in its disclosure requirements to disseminate the plan administrator's on-going interpretative conclusions regarding plan provisions.³⁰⁸ Such result is certainly inconsistent with ERISA's policy of allowing employer sponsors, especially in the welfare benefit

304. See *id.* at 248 (ruling that the appropriate standard of review in this case was whether the trustees acted arbitrarily, capriciously, or in bad faith); see also *Foltz v. U.S. News & World Report, Inc.*, 663 F. Supp. 1494, 1514 (D.D.C. 1987) (outlining the four factors for determining whether a fiduciary's interpretation was arbitrary and capricious).

305. See *Donovan v. Carlough*, 576 F. Supp. 245, 249-50 (D.D.C. 1983) (rejecting the trustee's interpretation and stating "[t]his interpretation cannot be supported by a literal reading of the forfeiture provision, as it clearly focuses upon the date that the obligation to make contributions ceases and not on the day that the Trustees are notified of a decision to end that obligation at some future date").

306. See *Robinson v. Chance*, 213 F.2d 834, 835-36 (3d Cir. 1954) (discussing general principles of trust law); *Offutt v. Offutt*, 102 A.2d 554, 559 (Md. 1954) (discussing factors to be considered in determining whether a trustee abused his/her discretion); *Dumaine v. Dumaine*, 16 N.E.2d 625 (Mass. 1938) (discussing general principles of trust law).

307. See *supra* note 279 and accompanying text (discussing various factors used to determine abuse of discretion).

308. See 29 U.S.C. § 1024(b) (1994 & Supp. V 1999) (requiring disclosure to participants and beneficiaries of summary plan descriptions and summaries of material modifications made to the plan); 29 U.S.C. § 1022(b) (1977) (including such things in the summary plan description as: name of plan; name, address and telephone number of the plan administrator; the agent for service of legal process; the names, addresses and titles of plan trustees (if any); summary of the plan's claims procedures; description of benefits; circumstances under which benefits may be lost, forfeited or suspended).

context, to remain flexible as to amending plan provisions that alter coverage in light of increasing cost considerations.³⁰⁹ Unlike pension and profit-sharing plans, welfare benefit plans are amended by the employer sponsor almost annually to adjust benefits and coverage as a result of increased medical care costs.³¹⁰

The Fifth Circuit has a unique two-step process in its application of the deferential arbitrary and capricious standard of review. Originating in a pre-*Firestone* decision, the Fifth Circuit stated that the arbitrary and capricious standard applied to the plan administrator's interpretations of both unambiguous and ambiguous plan language.³¹¹ Because *Dennard* involved an allegation that the plan provision in question was unambiguous and that the plan administrator acted in direct conflict with such meaning, the court responded that, if such was the case, it "would result in an unwarranted and arbitrary construction of the [p]lan."³¹² However, the court then directed the lower court to apply a two-step test: (1) determine the correct interpretation of the plan provision in question and (2) even if the plan administrator's interpretation was incorrect, examine whether the administrator acted arbitrarily and capriciously in making such interpretation.³¹³ Accordingly, regardless of whether the plan language was ambiguous or not, the lower court must apply the two-step test. Subsequent Fifth Circuit cases continued this two-step test after *Firestone*, even in cases where the plan administrator had been granted discretion to make such interpretations.³¹⁴

309. See *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995) ("In interpreting § 402(b)(3), we are mindful that ERISA does not create any substantive entitlement to employer-provided health benefits or any other kind of welfare benefits. Employers or other plan sponsors are generally free under ERISA, for any reason at any time, to adopt, modify, or terminate welfare plans.") (quoting *Adams v. Avondale Indus., Inc.*, 905 F.2d 943, 947 (6th Cir. 1990)).

310. See *id.* at 75 (presuming that the rising cost of health care was the reason the summary plan was revised).

311. See *Dennard v. Richards Group, Inc.*, 681 F.2d 306, 314 (5th Cir. 1982) (stating clearly that "federal courts have applied the arbitrary and capricious standard both to ambiguous and unambiguous terms").

312. See *id.* (quoting *Morgan v. Mullins*, 643 F.2d 1320, 1321 (8th Cir. 1981)).

313. See *id.* at 308.

"[w]here, as here, one party is arguing that the Plan's provisions are not ambiguous and that the Committee has applied the provisions of the Plan in direct contradiction to its terms, the District Court should have determined first the correct interpretation of the Plan. From that finding, the court should have proceeded to determine if the Committee, even if incorrect in its interpretation, acted arbitrarily and capriciously as that term has been used in other ERISA cases."

314. See *Spacek v. Mar. Ass'n, I L A Pension Plan*, 134 F.3d 283, 292 (5th Cir. 1998); *Branson v. Greyhound Lines, Inc., Amalgamated Council Ret. & Disability Plan*, 126 F.3d 747, 756 (5th Cir. 1997); *Chevron Chem. Co. v. Oil, Chem. & Atomic*

In answering the first part of the two-step process, *i.e.*, whether the plan administrator's interpretation was the legally correct one, the Fifth Circuit, in *Dennard*, refers back to its decision in *Bayles*,³¹⁵ which required three factors to consider: (1) whether such interpretation gives the plan a uniform construction; (2) whether such interpretation is a fair reading of the plan; and (3) whether other interpretations will result in unanticipated costs.³¹⁶ The third factor regarding unanticipated costs was added by the *Bayles* court because the case involved a defined benefit pension plan in which funding considerations were an important issue, as opposed to profit sharing plans.³¹⁷ As costs were actuarially determined in advance, the *Bayles* court did not wish to usurp the funding patterns of the plan unnecessarily.³¹⁸ Unfortunately, this third factor continues to be applied in Fifth Circuit cases irrespective of the type of ERISA plan at issue.³¹⁹

The use of the first two factors is certainly consistent with the other circuits in determining that the plan administrator's interpretation rendered the provision in question rational and internally consistent with other plan provisions.³²⁰ However, use of the third factor is

Workers Local Union 4447, 47 F.3d 139, 145 (5th Cir. 1995); *Wildbur v. ARCO Chem. Co.*, 974 F.2d 631, 637-38 (5th Cir.), *modified*, 979 F.2d 1013 (5th Cir. 1992); *Jordan v. Cameron Iron Works, Inc.*, 900 F.2d 53, 55 (5th Cir. 1990); *Batchelor v. Int'l Bhd. of Elec. Workers Local 861 Pension & Ret. Fund*, 877 F.2d 441, 445 (5th Cir. 1989); *see also* *Donovan v. Carlough*, 576 F. Supp. 245, 248 (D.D.C. 1983). *But see* *Duhon v. Texaco, Inc.*, 15 F.3d 1302, 1307 n.3 (5th Cir.), *reh'g en banc denied*, 20 F.3d 471 (Mar. 22, 1994). The Fifth Circuit states that "the reviewing court is not rigidly confined to this two-step analysis in every case." *Id.* In that case, where the plan administrator's interpretation was legally correct, there was no need to pursue the second prong of the test in determining whether such interpretation was arbitrary and capricious. *Id.*

315. *See* *Bayles v. Cent. States, S.E. & S.W. Areas Pension Fund*, 602 F.2d 97, 100 (5th Cir. 1979) (finding for the trustees when they had uniformly denied benefits to truck drivers and when permitting such benefits would result in unanticipated costs).

316. *See* *Dennard*, 681 F.2d at 314; *see also* *Chevron Chem. Co.*, 47 F.3d at 145; *Branson*, 126 F.3d at 756.

317. *See* *Bayles*, 602 F.2d at 100.

318. *Id.*

319. *See* *Kennedy v. Electricians Pension Plan, IBEW No. 995*, 954 F.2d 1116, 1121 (5th Cir. 1992) (finding that the Trustees' interpretation of the Plan was legally incorrect and constituted an abuse of discretion); *Wildbur*, 974 F.2d at 637-38; *Duhon*, 15 F.3d at 1307; *Jordan*, 900 F.2d at 56.

320. *See* *Booth v. Wal-Mart Stores, Inc.*, 201 F.3d 335, 342 (4th Cir. 2000) (considering as factors, the fiduciary's interpretation in light of prior decisions and the quality of the decision making process); *Trujillo v. Cyprus Amax Minerals Co. Ret. Plan Comm.*, 203 F.3d 733, 736 (10th Cir. 2000) (affirming the committee's interpretation where "it was based on a reasonable interpretation of the plan's terms and was made in good faith"); *Doe v. Travelers Ins. Co.*, 167 F.3d 53, 57 (1st Cir. 1999) (characterizing reasonableness as the basic touchstone to the arbitrary and capricious standard); *Jordan*, 46 F.3d at 1270-72 (affirming the committee's interpretation as reasonable and consistent with its prior interpretations); *Yeager v. Reliance Standard Life Ins. Co.*, 88 F.3d 376, 381 (6th Cir. 1996) (deciding to affirm

unique to the Fifth Circuit; while initially affording more deference to pension plans than profit sharing plans, continued use for all ERISA plans would afford even greater deference in the context of welfare plans.³²¹

Assuming that the first step has been answered and that the court has determined a legally correct interpretation of the plan, the second step compares the plan administrator's interpretation with the court's legally correct interpretation.³²² Obviously, if the plan administrator's interpretation is consistent with the court's interpretation, the court will affirm the plan administrator's decision.³²³ However, if the administrator's interpretation is inconsistent with the court's interpretation, such result is merely a factor for the court to consider in deciding whether such interpretation is arbitrary and capricious.³²⁴ In this determination, the court considers a variety of factors in ascertaining the good faith of the plan administrator's interpretation: (1) the internal consistency of the plan under such interpretation; (2) any relevant

the benefit determination if it is "rational in light of the plan's provisions"); *Donaho v. FMC Corp.*, 74 F.3d 894, 900 (8th Cir. 1996) (taking into consideration the consistency in interpretations and reasonableness of the decisions); *Chalmers v. Quaker Oats Co.*, 61 F.3d 1340, 1344 (7th Cir. 1995) (considering the soundness of the fiduciary's ratiocination); *Kotrosits v. GATX Corp. Non-Contributory Pension Plan for Salaried Employees*, 970 F.2d 1165, 1176 (3d Cir. 1992) (affirming the reasonableness of the Committee's interpretation by remarking that "looking at the benefit provisions of the Plan as a whole, construing the plan as the Committee does provides a coherent *raison d'être* for the enhancement bestowed by § 4.2"); *Guy v. Southeastern Iron Workers' Welfare Fund*, 877 F.2d 37 (11th Cir. 1989) (considering uniformity in construction, fair reasoning of the plan and the reasonableness of the interpretation in deciding whether to affirm the plan administrator's decision); *Foltz v. U.S. News & World Report, Inc.*, 663 F. Supp. 1494, 1514 (D.D.C. 1987) (using factors such as consistency with prior interpretations and with the purposes of the plan in the application of the arbitrary and capricious test).

321. See *Chevron Chem. Co.*, 47 F.3d at 145 (applying the third factor in a mental health plan context); *Branson*, 126 F.3d at 757 (applying the third factor in a disability plan context).

322. See *Wildbur*, 974 F.2d at 637 (applying the abuse of discretion standard after determining the administrator had discretion under the plan to make eligibility determinations).

323. See *Spacek v. Mar. Ass'n, I L A Pension Plan*, 134 F.3d 283, 292 (5th Cir. 1998) (affirming the administrator's decision when the court's research revealed no regulations that prohibited or cast doubt on the propriety of the decision).

324. See *Wildbur*, 974 F.2d at 637; see also *Spacek*, 134 F.3d at 298 n.14 (clarifying the fact that the plan administrator provides a reasonable interpretation of the plan provision does not preclude testing whether such reasonable interpretation constitutes an abuse of discretion). The court went on to state that "[a] wrong but apparently reasonable interpretation is arbitrary and capricious if it advances the conflicting interest of the fiduciary at the expense of the affected beneficiary or beneficiaries unless the fiduciary justifies the interpretation on the ground of its benefit to the class of all participants and beneficiaries." *Id.* at 299 n.14 (quoting *Brown v. Blue Cross & Blue Shield of Ala., Inc.*, 898 F.2d 1556, 1566-67 (11th Cir. 1990)).

regulations formulated by appropriate administrative agencies; and (3) factual background of the determination and any inferences of lack of good faith.³²⁵

The Fifth Circuit's adoption of a two-step process in all plan interpretation contexts—unambiguous and ambiguous—discretionary and nondiscretionary—is inconsistent with trust law principles. If the plan language in question is unambiguous and the plan administrator's interpretation is in direct conflict with such meaning, it would appear that the plan administrator should have no discretion in making an alternative interpretation, regardless of the reasonableness of such interpretation.³²⁶ In the context of trust law, the duty to perform certain acts of trust administration is regarded as a mandatory power, which subjects the trustee to a *de novo* standard of review.³²⁷ It is only when the trustee is afforded discretionary powers (*e.g.*, decisions regarding time, amount, and manner of payments) that the standard shifts to the abuse of discretion standard.³²⁸ Hence, only if the plan administrator possessed the discretionary power to interpret the plan language, would the courts use the arbitrary and capricious standard.³²⁹

Under the first part of the two-step test, the Fifth Circuit directs the lower courts to first determine the legally correct interpretation of the plan.³³⁰ If the court must first determine for itself the proper interpretation of the plan, it seems meaningless for the plan administrator to engage in a similar fashion and then defend itself to the satisfaction of the court, especially where the plan has conferred such right upon the plan administrator and not the court. If the intent of such a standard is merely to shift the burden to the plan administrator to defend that administrator's interpretation in each

325. See *Dennard v. Richards Group, Inc.*, 681 F.2d 306, 314 (5th Cir. 1982); *Wildbur*, 974 F.2d at 638; *Spacek*, 134 F.3d at 299; *Batchelor v. Int'l Bhd. of Elec. Workers Local 861 Pension & Ret. Fund*, 877 F.2d 441, 445-46 (5th Cir. 1989).

326. *But see Dennard*, 681 F.2d at 314 (declining to automatically reject the plan administrator's interpretation but cautioning that "[w]hen the trustee's interpretation of the plan is in direct conflict with the express language in a plan, this action is a very strong indication of arbitrary and capricious behavior").

327. See *supra* notes 113-15 (quoting secondary authority that discusses *de novo* review in trust cases).

328. See GEORGE TAYLOR BOGERT, TRUSTS § 89, at 320 (6th ed. rev'd 1987) (stating that courts will usually not upset the decision of the trustee unless it involves a choice made by the trustee regarding time, amount, and manner of payments made or allocation of expenses).

329. *Id.* at 321 (arguing the court will find an abuse of discretion if the trustee acted in bad faith).

330. See *supra* note 313 (setting out the threshold of determining the correct interpretation to reach the second part of the test).

case, the Ninth Circuit's presumptively void theory³³¹ would accomplish the intended result. Under the second part of the test, it appears inconsistent for the court to ascertain the legally correct interpretation but then defer to the administrator's interpretation, especially when the court considers uniformity of construction as a primary factor in interpretation.³³² If the court were to consider a multitude of cases involving the same construction from the plan administrator, after already enunciating its own legally correct interpretation of such provision, it is inconceivable that the court would continue to defer to the plan administrator's ill-conceived interpretation of the plan after the court had been instructing the administrator in the legally correct interpretation.

In distilling a uniform list of factors for the Fifth, Eighth and District of Columbia Circuits in applying the arbitrary and capricious standard, the author presents the following list: (1) the uniformity in construction that the present interpretation lends to the plan's construction as a whole; (2) the consistency of the present interpretation with prior, similar interpretations; and (3) the fair and reasonableness of the present interpretation in light of the plan's goals and ERISA's requirements. Such factors may serve ERISA's goals of adequately disclosing to participants their rights under plans and protecting such rights; however, use of such factors by the courts does not amount to a highly deferential standard of review. On the contrary, the author contends that the approach used by these three circuits in their application of the arbitrary and capricious standard is hardly a deferential standard of review. Even if the plan administrator's interpretation was affirmed and not deemed an abuse of discretion, the administrator is certainly put on notice as to the legally correct interpretation of the ambiguous plan provisions, making future reviews of subsequent interpretations of the same provisions more and more suspect. As such, these circuits remain in the minority in their approach.

331. See *infra* note 397.

332. See *Wildbur v. ARCO Chem. Co.*, 974 F.2d 631, 637-38 (5th Cir. 1992) (affirming that if the administrator's interpretation was incorrect, it may nevertheless be affirmed considering the factor of internal consistency of plan interpretation by the plan administrator).

C. Standard of Review in Conflict of Interest Cases

1. Introduction

As a result of Justice O'Connor's admonishment in *Firestone*³³³ to consider conflict of interest as a factor in the application of a more deferential trust law type of standard of review, all the circuits have attempted to adjust or modify ERISA's deferential standard of review in conflict of interest contexts.³³⁴ Such direction, unfortunately and confusingly, has resulted in a proliferation of judicial ink as the courts attempt to resolve such adjustment with their continued use of the arbitrary and capricious standard of review. Subsequent to *Firestone*, there continues to be a disparity between the circuits as to the correct application of an ERISA standard of review in conflict of interest contexts.³³⁵

As discussed earlier, there was a disparity between the circuits at the time of the *Firestone* decision that the courts had hoped the Supreme Court would resolve by granting *certiorari* in *Firestone*.³³⁶ The facts of *Firestone* involved a self-funded and self-administered welfare plan in which the employer interpreted the terms of the plan and denied benefits to the plaintiff.³³⁷ The Supreme Court utilized trust law for the applicable judicial standard of review, thereby rejecting a different approach for funded versus unfunded plans, for pension versus welfare plans, or for insured versus uninsured plans.³³⁸ Today those are the very differences the circuits courts are wrestling with in determining how the ERISA deferential standard of review should be

333. See *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 103 (1989) (noting that if the administrator or fiduciary is operating under a conflict of interest, and the plan gives them discretion then "the conflict must be weighed as a factor in determining whether there is an abuse of discretion.").

334. See *Doyle v. Paul Revere Life Ins. Co.*, 144 F.3d 181, 183-84 (1st Cir. 1998); *Mers v. Marriott Int'l Group Accidental Death & Dismemberment Plan*, 144 F.3d 1014, 1019-20 (7th Cir. 1997); *Sullivan v. LTV Aerospace & Def. Co.*, 82 F.3d 1251 (2d Cir. 1996); *Sweatman v. Commercial Union Ins. Co.*, 39 F.3d 594, 597 (5th Cir. 1994); *Pitman v. Blue Cross & Blue Shield*, 24 F.3d 118, 121 (10th Cir. 1994); *Doe v. Group Hospitalization & Med. Servs.*, 3 F.3d 80, 85 (4th Cir. 1993); *Bernards v. United of Omaha Life Ins. Co.*, 987 F.2d 486, 488 (8th Cir. 1993); *Taft v. Equitable Life Assurance Soc'y*, 9 F.3d 1469, 1471-72 (9th Cir. 1993); *Kotrosits v. GATX Corp. Non-Contributory Pension Plan For Salaried Employees*, 970 F.2d 1165, 1173 (3d Cir. 1992); *Miller v. Metro. Life Ins. Co.*, 925 F.2d 979, 983 (6th Cir. 1991); *Brown v. Blue Cross & Blue Shield of Ala., Inc.*, 898 F.2d 1556, 1561 (11th Cir. 1990); *Wilson v. Group Hospitalization & Med. Servs., Inc.*, 791 F. Supp. 309, 312 (D.D.C. 1992).

335. See *supra* note 334 (listing several cases in which the courts have applied different variations of the standard of review).

336. See *supra* note 150.

337. See *Firestone*, 489 U.S. at 114.

338. See *id.* at 115 ("[A]s to both funded and unfunded plans, the threat of litigation is not sufficient to outweigh the reasons for a *de novo* standard . . .").

adjusted in the conflict of interest context.

In utilizing trust law, the Supreme Court in *Firestone* noted ERISA's adoption of various trust law concepts.³³⁹ The court acknowledged ERISA's use of trust law characteristics; however, ERISA does not mirror trust law in all respects.³⁴⁰ It is in those contexts where trust law appears to be inadequate that the circuit courts grope in their application of a purely trust law standard of judicial review.³⁴¹ Trust law generally requires that property be set aside for the benefit of certain beneficiaries and such property be managed by a trustee.³⁴² However, ERISA does not require the prefunding of *all* employee benefit plans and the resulting setting aside of certain assets for benefit purposes; only pension plans require prefunding and thus trust assets to be managed by a trustee.³⁴³ Thus, such trust law rules appear to have little relevance in the welfare plan context where benefits are not prefunded. Even within the required funding rules of ERISA for pension plans, ERISA does not adopt a wholesale approach to trust law—it permits the employer to be both settlor of the plan and trustee of the assets to the plan.³⁴⁴

Hence, employee benefits that need not be prefunded under ERISA but are funded on a pay-as-you-go basis by the employer may result in an inherent conflict of interest if the employer (or its employees or related subsidiaries) is also the plan administrator.³⁴⁵ In

339. See *id.* at 110 (“ERISA abounds with the language and terminology of trust law.”).

340. See *id.* (noting the legislative history confirms that the Act codifies certain principles “developed in the evolution of the law of trusts.”).

341. See *supra* note 334. See also *Sullivan*, 82 F.3d at 1254-55 (using both *de novo* standard and arbitrary and capricious standard of review).

342. RESTATEMENT (SECOND) OF TRUSTS § 17 (1959) (listing the possible methods of trust creation, including a transfer by the owner of property, or the holder of a power of appointment over the property, by deed or will, to another to hold in trust for a third person).

343. See 29 U.S.C. § 1802 (1994 & Supp. V 1999). From an accounting viewpoint, prefunding by an employer may envision either moving assets to an external trust or setting aside a liability on its balance sheet; however, ERISA section 302 requires the former, whereby assets must be set aside for the benefit of eligible participants and beneficiaries for pension/profit sharing type plans. See *id.* Such distinction is relevant with respect to retiree health coverage as the Financial Standards Accounting Principles (FASB) may require prefunding for accounting purposes which does not coincide with any ERISA requirements for prefunding of such benefits. See FASB No. 106 for Post-retirement Benefits Other Than Pensions; see also Notice on Annual Reporting Enforcement Policy, 63 Fed. Reg. 65506 (Nov. 25, 1998) (requiring multi-employer plans to comply with the Statement of Position 92-6 of the American Institute of Certified Public Accountants, and thus, account for post-retirement obligations and other liabilities).

344. See 29 U.S.C. § 1103 (1994 & Supp. V 1999) (outlining the rules for establishment of the trust).

345. See 29 U.S.C. § 1002(31) (1994 & Supp. V 1999) (prohibiting pay-as-you-go cost methods under ERISA).

deciding eligibility and interpreting the provisions of the plan, the plan administrator's decision will always directly impact the cost to the employer. Any denial of benefit obviously reduces the cost of benefits under the plan.

Similarly, welfare benefits that need not be prefunded under ERISA may well be insured with an insurer as a means for the employer to manage its liability for benefits. If the insurer of the benefits is also the plan administrator, the result may invariably result in a conflict of interest as any decision will always directly impact the cost to the insurer. Such is the usual situation for small- and medium-size employers who cannot self-insure welfare benefits promised under its ERISA plans. Large-size employers may be able to self-insure a portion of the promised welfare benefits, relying on insurance companies as reinsurers for catastrophic risks. In any event, the welfare benefits are not required to be pre-funded nor insured, setting the employer sponsor for an inherent conflict of interest.

Funded ERISA plans may use either a trust or insurance policy as funding medium; however ERISA's trust rules do not compel the trustee or insurer to be a disinterested stakeholder.³⁴⁶ In fact, the rules envision that the employer or insurer may wear both hats with respect to plan administration and funding for plan costs.³⁴⁷ In the administration of the plan, all fiduciaries are required to act for the exclusive benefit of the participants and beneficiaries and to act in a reasonable fashion; whereas in settlor functions, the plan sponsor or designated entity is not bound to such fiduciary duties.³⁴⁸ Thus, the dilemma facing the courts after *Firestone* is how to fashion a judicial standard of review that applies in all benefit denial situations, those involving trusts and those that do not; collectively bargained

346. See 29 U.S.C. §§ 1081-1082 (1994 & Supp. V 1999) (outlining coverage and minimum funding standards).

347. See *Local Union 2134, UMW of Am. v. Powhatan Fuel, Inc.*, 828 F.2d 710, 713-14 (11th Cir. 1987) (holding that the employer's decision to pay corporate obligations in lieu of funding the medical plan was not a breach of fiduciary duty to the participants, as the employer's business decisions are not made in the capacity of a fiduciary even if the decision has a direct impact on the plan).

348. See *Lockheed Corp. v. Spink*, 517 U.S. 882, 892 (1996) (affirming that fiduciary duties do not extend to actions such as the plan's formation, amendment or modification); *Anderson v. Resolution Trust Corp.*, 66 F.3d 956, 960 (8th Cir. 1995) (determining that the plan sponsor's decision to amend and terminate the pension plan was a business decision, not a fiduciary act); *Haberern v. Kaupp Vascular Surgeons Ltd. Defined Benefit Pension Plan*, 24 F.3d 1491, 1499 (3d Cir. 1994) (holding the decision to split compensation into two components where benefits were determined according to compensation was not a fiduciary act); *Belade v. IIT Corp.*, 909 F.2d 736, 737-38 (2d Cir. 1990) (finding that the decision to exclude a given group of employees was a non-fiduciary act).

situations and non-collectively bargained situations; insured and self-insured situations, and funded and unfunded plans.³⁴⁹

2. *Existence of a conflict of interest*

Before analyzing how the circuits adjust the appropriate judicial standard of review in a conflict of interest context, the first issue is how and when the courts determine a conflict of interest exists, thereby raising the issue of an alternative or modified standard of review. In *Pinto v. Reliance Standard Life Insurance Company*, the Third Circuit characterized three different relationships as presenting a conflict of interest: the employer of a self-funded and self-administered plan; an internal benefits committee as plan administrator; and the insurer as both funding agent and plan administrator.³⁵⁰ The Sixth Circuit also noted that designating partners of the law firm, or a committee appointed by the plan sponsor's Board of Directors, as plan administrator constituted a conflict of interest.³⁵¹ Most of the conflict of interest cases involve either the insurance company as plan administrator and insurer of the benefits under the plan, or the employer as plan administrator of a self-funded plan.³⁵²

All the circuits, except for the First, Second and Seventh, are willing to presume that certain relationships inherently pose a conflict of interest.³⁵³ In the context of the insurance company as

349. See Kevin Walker Beatt, *A Decade of Confusion: The Standard of Review for ERISA Benefit Claims as Established by Firestone*, 51 ALA. L. REV. 733 (2000) (discussing, generally, the case law dealing with standards of review in ERISA cases).

350. *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 383-84 (3d Cir. 2000).

351. See *Borda v. Hardy, Lewis, Pollard & Page, P.C.*, 138 F.3d 1062, 1069 (6th Cir. 1998) (recognizing that the trustees were acting under a conflict of interest where there were plan participants and thus, were members of the class to whom the funds would be distributed if not distributed to the plaintiff); *Univ. Hosps. of Cleveland v. Emerson Elec. Co.*, 202 F.3d 839, 846 (6th Cir. 2000). *But cf. Kimber v. Thiokol Corp.*, 196 F.3d 1092, 1098 (10th Cir. 1999) (declining to presume a *per se* conflict if one of the employer's employees was the plan administrator). In such case, the court directed the lower courts to consider a variety of factors, including whether:

(1) the plan is self-funded; (2) the company funding the plan appointed and compensated the plan administrator; (3) the plan administrator's performance reviews or levels of compensation were linked to the denial of the benefits; and (4) the provision of benefits had a significant economic impact on the company administering the plan.

Id.

352. See *Pinto*, 214 F.3d at 382 (comparing the respondent insurance company, which both funded and administered the plan, with the employer in *Firestone*, who was also the plan administrator).

353. See *id.* at 386 ("[S]ome degree of conflict inevitably exists where an employer acts as the administrator of its own employee benefits plan") (quoting *Abnathya v. Hoffman-LaRoche, Inc.*, 2 F.3d 40, 45 n.5 (3d Cir. 1993)); *Schatz v. Mut. of Omaha Ins. Co.*, 220 F.3d 944, 947-48 (8th Cir. 2000); *Vega v. Nat'l Life Ins. Serv., Inc.*, 188 F.3d 287, 295-98 (5th Cir. 1999); *Killian v. Healthsource Provident Adm'rs, Inc.*, 152

insurer and administrator of the plan, the majority view among the circuits is that such a relationship is inherently self-interested.³⁵⁴ Such result generally relies on an economic argument for such conclusion, *i.e.*, the fact that the insurer pays the benefits from its own assets rather than a trust putting the insurer in a "perpetual conflict with its profit-making role as a business."³⁵⁵ A similar holding results in the Ninth and Tenth Circuits if the employer is the administrator of a self-funded plan.³⁵⁶ Again the rationale is economic; because the employer has a financial interest in denying the claim, it is placed in an inherent conflict of interest position.³⁵⁷ However, few courts have addressed whether a conflict of interest exists in the context of an internal benefits committee or when an employee of the employer-sponsor serving as plan administrator. Such courts have declined to find a *per se* conflict of interest in such contexts.³⁵⁸ Interestingly, the Eleventh Circuit makes a distinction regarding a conflict of interest if the plan is funded through an insurance policy and administered by the insurance carrier, versus a plan in which the insurer acts solely as the claims administrator but receives full reimbursement from the

F.3d 514, 521 (6th Cir. 1998); *Smith v. Champion Int'l Corp.*, 1997 U.S. App. LEXIS 26407 (4th Cir. Sept. 25, 1997); *Chambers v. Family Health Plan Corp.*, 100 F.3d 818, 824 (10th Cir. 1996); *Bernstein v. Capital Care, Inc.*, 70 F.3d 783 (4th Cir. 1995); *Bogue v. Ampex Corp.*, 976 F.2d 1319 (9th Cir. 1992); *Brown v. Blue Cross & Blue Shield of Ala., Inc.*, 898 F.2d 1556 (11th Cir. 1990); *Wilson v. Group Hospitalization & Med. Servs., Inc.*, 791 F. Supp. 309 (D.D.C. 1992).

354. See *Pinto*, 215 F.3d at 384-85 (listing the various circuits that consider such relationship as an inherent conflict of interest as well as those circuits that do not); *Armstrong v. Aetna Life Ins. Co.*, 128 F.3d 1263, 1265 (8th Cir. 1997); *Pitman v. Blue Cross*, 217 F.3d 1291, 1295-99 (10th Cir. 1994); *Doe v. Group Hospitalization & Med. Servs.*, 3 F.3d 80, 86 (4th Cir. 1993); *Miller v. Metro. Life Ins. Co.*, 925 F.2d 979, 984 (6th Cir. 1991); *Brown v. Blue Cross & Blue Shield of Ala., Inc.*, 898 F.2d 1556, 1561-65 (11th Cir. 1990) (presuming a conflict of interest only if the insurer pays benefits from its assets, and not as plan administrator of the plan assets where a conflict of interest is presumed only if the insurer pays benefits from its assets, and not as plan administrator of the plan assets). *Cf. Doe v. Travelers Ins. Co.*, 167 F.3d 53, 57 (1st Cir. 1999); *Woo v. Deluxe Corp.*, 144 F.3d 1157, 1160 (8th Cir. 1998); *Yeager v. Reliance Standard Life Ins. Co.*, 88 F.3d 376, 381-82 (6th Cir. 1996); *Atwood v. Newmont Gold Co.*, 45 F.3d 1317, 1322-23 (9th Cir. 1995).

355. See *Pinto*, 215 F.3d at 377, 384. *But cf. Pegram v. Herdrich*, 530 U.S. 211 (2000) (retreating from the sole use of economic analysis).

356. See *Friedrich v. Intel*, 181 F.3d 1105, 1109-10 (9th Cir. 1999); *Chambers*, 100 F.3d at 826. Note, the Eighth Circuit, in *Davolt v. O'Reilly Auto.*, 206 F.3d 806 (8th Cir. 2000), decided not to resolve this issue.

357. See *Friedrich*, 181 F.3d at 1109 (following a two-part test to determine "whether to invoke heightened scrutiny of a benefits decision made by fiduciaries with apparent conflicts").

358. See *Jones v. Kodak Med. Assistance Plan*, 169 F.3d 1287, 1291 (10th Cir. 1999); *Zuckerbrod v. Phoenix Mut. Life Ins. Co.*, 78 F.3d 46, 49 (2d Cir. 1996); *Pagan v. NYNEX Pension Plan*, 52 F.3d 438, 442 (2d Cir. 1995); *Chalmers v. Quaker Oats Co.*, 61 F.3d 1340, 1344-45 (7th Cir. 1995); *Champion Int'l Corp.*, 1997 U.S. App. LEXIS 26407; *Local Union 2134, United Mine Workers of Am. v. Powhatan Fuel, Inc.*, 828 F.2d 710, 713 (11th Cir. 1987).

employer.³⁵⁹ As it utilizes trust law, the court sees the insurer in the former situation as a fiduciary paying benefits from its own assets, rather than the assets of the plan's trust; whereas in the latter situation, the insurer is acting as fiduciary to the trust.³⁶⁰ Hence, only the former results in a perpetual conflict of interest situation.

Regardless of the relationship between the entity responsible for the funding of benefits and the plan administrator, the First, Second and Seventh Circuits require that the plaintiff prove the existence of an actual conflict of interest before it is willing to modify the judicial standard of review.³⁶¹ To clear such a hurdle, these three circuits are not in agreement as to how such proof adjusts the resulting judicial standard of review. In the First Circuit, the fact that an insurer is both plan administrator and insurer under the plan remains insufficient to modify the court's standard of review.³⁶² This circuit shifts the burden to the plaintiff to prove improper motives.³⁶³ If such proof is present, the court appears to shift the arbitrary and capricious standard to a standard of reasonableness, which has "more bite" than the deferential standard.³⁶⁴ While the First Circuit does not elaborate on this modified standard, it does quote the Seventh Circuit's decision in *Chojnacki v. Georgia Pacific Corporation*, inferring its approval of that line of cases.³⁶⁵ In the Second Circuit, an inherent

359. *Brown*, 898 F.2d at 1561 ("Congress intended a distinction between insured and uninsured plans such that the former are subject to state regulations. . .").

360. *Id.* The Eleventh Circuit finds a distinction in the application of a judicial standard of review between an insured ERISA plan and a non-insured ERISA plan. However, the Supreme Court in *Firestone* rejected that a different judicial standard would apply in self-funded versus insured plans, noting that the factor of conflict of interest was simply an element to be considered in the use of the same applicable standard. See *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 114 (1989).

361. See *Doyle v. Paul Revere Life Ins. Co.*, 144 F.3d 181, 184 (1st Cir. 1998) ("This deferential standard may not be warranted, however, when a conflict of interest exists, such as when the policy manager has a personal interest contrary to the beneficiary's."); *Pagan*, 52 F.3d at 442 (holding that even after a conflict of interest is proven, it is merely a factor in considering whether to modify the standard); *Chalmers*, 61 F.3d at 1344 (finding that plaintiff had not proven a conflict of interest because ERISA specifically allows employers to "appoint their own officers to administer ERISA plans even if the company is a 'party in interest' regardless of the administrator's financial interests").

362. See *Doyle*, 144 F.3d at 184 (adhering to arbitrary and capricious standard for "to do more would sacrifice the advantages of the offered argument").

363. *Id.* (giving special emphasis to reasonableness while burdening claimant "to show that the decision was improperly motivated").

364. *Id.* ("The Massachusetts district court had prophesied that in the case of conflict our court [the First Circuit] would merely 'giv[e] 'more bite' to the arbitrary and capricious standard." (quoting *Doe v. Travelers Ins. Co.*, 971 F. Supp. 623, 630 (D. Mass. 1997))). In agreeing to do so, the First Circuit stated that its interpretation of "more bite" would be adherence to the arbitrary and capricious standard, "with special emphasis on reasonableness", but shifting the burden on the claimant to show that the decision was improperly motivated. *Id.*

365. See *Doe*, 971 F. Supp. at 630 (predicting that the First Circuit will hold that a

conflict of interest will not be inferred; the existence of a conflict of interest must be proven and shown to have tainted the plan administrator's decision.³⁶⁶ If such proof can be shown, the standard reverts to the *de novo* standard of review.³⁶⁷ And finally, in the Seventh Circuit, the existence of certain relationships does not automatically alter the standard of review; instead, this circuit uses several factors to determine the applicable standard of review, including the impartiality of the plan administrator.³⁶⁸ By adjusting the arbitrary and capricious standard to account for the presence of a conflict of interest, the court affords leeway and grants less deference when the actual presence and effect of a conflict of interest has been established.³⁶⁹

As noted above, the majority of circuits are willing to deem certain relationships as inherently posing a conflict of interest (*e.g.*, insurer as

conflict of interest would lead to giving more bite to the standard as they held in *Chojnacki v. Georgia-Pacific Corp.*, 108 F.3d 810 (7th Cir. 1997)).

366. See *Pagan*, 52 F.3d at 443 (rejecting plaintiff's contention when she fails to explain "how such an alleged conflict affected the reasonableness of the Committee's decision").

367. See *Sullivan v. LTV*, 82 F.3d 1251, 1256 (2d Cir. 1996), where the Second Circuit stated

[F]ollowing the standard of *Firestone* and *Pagan*, we conclude that, in cases where the plan administrator is shown to have a conflict of interest, the test for determining whether the administrator's interpretation of the plan is arbitrary and capricious is as follows: Two inquiries are pertinent. First, whether the determination made by the administrator is reasonable, in light of possible competing interpretations of the plan; second, whether the evidence shows that the administrator was in fact influenced by such conflict. If the court finds that the administrator was in fact influenced by the conflict of interest, the deference otherwise accorded the administrator's decision drops away and the court interprets the plan *de novo*.

368. See *Chalmers v. Quaker Oats Co.*, 61 F.3d 1340, 1344 (7th Cir. 1995) (examining the following factors in its application of the arbitrary and capricious standard: "the impartiality of the decision making body, the complexity of the issues, the process afforded the parties, the extent to which the decision makers utilized the assistance of experts where necessary, and finally, the soundness of the fiduciary's ratiocination"); see also *Chojnacki v. Georgia-Pacific Corp.*, 108 F.3d 810, 815 (7th Cir. 1997) (declining to find a conflict of interest simply because a corporate officer served as plan administrator, in the absence of proof of an arbitrary and capricious decision by the administrator); *Mers v. Marriott Int'l Group Accidental Death & Dismemberment Plan*, 144 F.3d 1014, 1020 (7th Cir. 1997) (declining to find that a denial of benefits is presumptively void where a subsidiary of the insurer was the third-party administrator and denied the participant's claim for benefits). The court went on to say "[w]e presume that a fiduciary is acting neutrally unless a claimant shows by providing specific evidence of actual bias that there is a significant conflict." *Id.*

369. See *Chojnacki*, 108 F.3d at 815 (rejecting the argument that a conflict of interest resulted in the abandonment of the deferential standard of review). Instead, the court noted that a conflict of interest would cause the court "to give the arbitrary and capricious standard more bite." *Id.* The court characterized the arbitrary and capricious standard as a flexible standard, and thus noted that "[t]he more serious the conflict, the less deferential our review becomes." *Id.*

plan administrator; employer of self-funded plan as plan administrator), and thus a factor to be considered in the utilization of the judicial standard of review.³⁷⁰ Such presumptions are a simplified method for the courts to adjust, automatically, the judicial standard of review in certain presumed conflict of interest contexts.

3. *Adjustments to the de novo standard*

In summarizing the adjusted standards of review, the Third Circuit recently recognized there were “three methods of dealing with a conflict: burden shifting, *de novo* review, and the sliding scale.”³⁷¹ The Second Circuit has been cited as promoting the *de novo* standard of review as the default standard once a given conflict of interest has been shown to taint the decision-making process.³⁷² This conclusion evolved after a series of cases in the Second Circuit.

370. See *Borda v. Hardy, Lewis, Pollard, & Page, P.C.*, 138 F.3d 1062 (6th Cir. 1998) (explaining that the Sixth Circuit recognizes that the application of the abuse of discretion, or the arbitrary and capricious standard applies, but it is shaped by the inherent conflict of interest (*quoting* *Miller v. Metro. Life Ins. Co.* 925 F.2d 979, 984 (6th Cir. 1991))); see also *Univ. Hosp. Of Cleveland v. Emerson Elec. Co.*, 202 F.3d 839, 846 (6th Cir. 2000) (noting that the inherent conflict of interest should be considered as a factor to determine whether the plan administrator's decision was arbitrary and capricious). *But see* *Kimber v. Thiokol Corp.*, 196 F.3d 1092, 1098 (10th Cir. 1999) (refusing to recognize a *per se* conflict of interest in instances when the plan administrator is a company employee and holding instead, that courts should consider various factors, including whether “(1) the plan is self-funded; (2) the company funding the plan appointed and compensated the plan administrator; (3) the plan administrator's performance reviews or level of compensation were linked to the denial of benefits; and (4) the provision of benefits had a significant economic impact on the company administering the plan.”).

371. *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 390-92 (3d Cir. 2000) (explaining the dilemma of incorporating a conflict of interest into the framework of the arbitrary and capricious standard of review). The court notes that if a conflict existed in its decision in *Kotrosits v. GATX Corp. Non-contributory Pension Plan for Salaried Employees*, 970 F.2d 1165, 1173 (3d Cir. 1992), then *Firestone* counsels in favor of withholding deference, thereby suggesting *de novo* review. *Id.* Later, in *Abnathya v. Hoffman-LaRoche, Inc.*, 2 F.3d 40, 45 n.5 (3d Cir. 1993), the Third Circuit grappled with the problem of using an arbitrary and capricious standard to uphold an administrator's decisions unless it was “without reason, unsupported by substantial evidence or erroneous as a matter of law” and applying the factor of a conflict of interest. See *id.* at 45 (finding that the plan administrator was reasonable and supported by substantive evidence and not without reason and unsupported by substantive evidence or erroneous as a matter of law) (*quoting* *Adamo v. Anchor Hocking Corp.*, 720 F. Supp. 491, 500 (W.D. Pa 1989)). Once the conflict becomes a factor however, it is not clear how the process required by the typical arbitrary and capricious review changes. Does there simply need to be more evidence supporting a decision, regardless of whether that evidence was relied upon? *Id.*

372. See *Pinto*, 214 F.3d at 391 (describing the Second Circuit as “stringent” in its evidentiary requirements in first finding a conflict, but once found, using *de novo* review); see also *Sullivan v. LTV Aerospace & Def. Co.*, 82 F.3d 1251, 1255-56 (2d Cir. 1996) (ruling if the court finds a conflict, the deference normally afforded to a plan administrator's decision is no longer extended and the plan is reviewed *de novo*).

In *Pagan v. NYNEX Pension Plan*,³⁷³ the court refused to alter the arbitrary and capricious standard in a conflict of interest context where the plaintiff failed to prove how the conflict affected the reasonableness of the decision.³⁷⁴ Then, in *Sullivan v. LTV Aerospace & Defense Company*,³⁷⁵ the Second Circuit described how the arbitrary and capricious standard was to be applied in a conflict of interest situation. Once a conflict of interest is alleged, the arbitrary and capricious standard becomes a two-pronged test: first, whether the administrator's decision was reasonable; and second, whether the plaintiff's evidence showed that the administrator was in fact influenced by the conflict of interest.³⁷⁶ If the court determines the administrator's decision was affected by the conflict of interest, the judicial standard reverts to the *de novo* standard.³⁷⁷

As a result of *Sullivan*, the Second Circuit has continued to apply this two-pronged test in conflict of interest cases.³⁷⁸ However, the Second Circuit may be retreating from this position, as it later questioned whether such an approach was consistent with *Firestone*.³⁷⁹ *Firestone* seemed to mandate that a conflict of interest be considered as a factor in the judicial standard of review, not an issue that is dependent upon satisfactory proof upon the plaintiff.

373. 52 F.3d 438, 442 (2d Cir. 1995) (applying an arbitrary and capricious standard of review in affirming the district court's summary judgment against the appellant who brought suit under ERISA claiming a wrongful denial of her disability pension by her employer).

374. See *id.* at 443 ("Nor does Pagan's argument that the presence of a potential conflict of interest warrant a different conclusion. *Pagan* fails to explain how such an alleged conflict affected the reasonableness of the Committee's decision.")

375. 82 F.3d 1251 (2d Cir. 1996) (rejecting the Eleventh Circuit's interpretation of *Firestone* in *Brown v. Blue Cross & Blue Shield of Ala., Inc.*, 898 F.2d 1556 (11th Cir. 1990), which held there is an "inherent conflict" between an insurance company's role as a fiduciary and that as a profit-maker, thus automatically rendering "a highly deferential standard of review inappropriate."). *Id.* at 1562.

376. See *id.* at 1255-56 (following *Firestone* and *Pagan*, when the administrator is shown to have a conflict of interest, two inquiries are pertinent).

377. See *id.* at 1256 ("If the court finds that the administrator was in fact influenced by the conflict of interest, the deference otherwise accorded the administrator's decision drops away and the court interprets the plan *de novo*.")

378. See *Doyle v. Paul Revere Life Ins. Co.*, 144 F.3d 181, 184 (1st Cir. 1998) (holding that, in the presence of a conflict of interest, a deferential standard of review might not be warranted). Interestingly, however, the court notes the conflict may not be as severe as first thought because there is a strong competing motive for an employer to not keep an overly "tight-fisted" insurer: employer reputation. *Id.* See *Whitney v. Empire Blue Cross*, 106 F.3d 475, 476-77 (2d Cir. 1997) (*per curiam*) (reversing the district court's adherence to the highly deferential stance taken by the Eleventh Circuit in *Brown*).

379. See *DeFelice v. Am. Int'l Life Assurance Co.*, 112 F.3d 61, 66 (2d Cir. 1997) (doubting its own ERISA standard of review jurisprudence, as developed through a string of cases including *Whitney*, *Sullivan* and *Pagan*, as reducing *Firestone's* ruling regarding the impact of a conflict of interest).

4. *Adjustments to the sliding scale standard*

Once a conflict of interest is inferred for the majority of circuits or proven for the minority, most courts agree the arbitrary and capricious standard should be reformulated and adjusted as a sliding scale standard of review.³⁸⁰ The sliding scale standard allows the courts to lessen and to adjust the deference afforded to the plan administrator's decision given the presence or proof of a conflict of interest.³⁸¹ These circuits describe the arbitrary and capricious standard as a flexible one, affording less deference to the plan administrator's decision in an effort to neutralize the degree of the conflict.³⁸² However, only a few of these circuits elaborate as to what factors are to be considered in the adjustment to this standard. But,

380. See *Pinto*, 214 F.3d at 391 (describing the sliding scale standard of review as according varying degrees of deference, depending on the seriousness of the conflict).

381. See *Doyle*, 144 F.3d at 184 (adopting the Seventh Circuit's language from *Chojnacki v. Georgia-Pacific Corp.*, 108 F.3d 810, 814 (7th Cir. 1997) that the arbitrary and capricious standard is to be applied with "more bite"); *Sullivan*, 82 F.3d at 1255-56 (holding that once a conflict is identified, the plan is reviewed *de novo*); *Pinto*, 214 F.3d at 382 (adopting the sliding scale standard of review); *Vega v. Nat'l Life Ins. Servs.*, 188 F.3d 287, 296 (5th Cir. 1999) (ruling that when a fiduciary acts in a conflict, the court will not act as deferentially as it would otherwise); *Borda v. Hardy, Lewis, Pollard & Page, P.C.*, 138 F.3d 1062, 1069 (6th Cir. 1998) (recognizing that the court could not reverse the trustee's decision under the existing arbitrary and capricious standard of review, which is shaped by the inherent conflict of interest); *Chojnacki*, 108 F.3d at 814 (noting that if a conflict of interest existed, the plan administrator's decision would not be upset, unless it was found to be arbitrary and capricious); *Woo v. Deluxe Corp.*, 144 F.3d 1157, 1160-61 (8th Cir. 1998) (holding that for the plaintiff to obtain a deferential standard of review, the plaintiff must show a conflict of interest that caused a breach in the administrator's fiduciary duty); *Snow v. Standard Ins. Co.*, 87 F.3d 327, 331 (9th Cir. 1996), *overruled on other grounds by Kearney v. Standard Ins. Co.*, 175 F.3d 1084 (9th Cir. 1999); *McGraw v. Prudential Ins. Co. of Am.*, 137 F.3d 1253, 1258 (10th Cir. 1998) (stating that when the plan gives discretion to a conflicted administrator, a less deferential standard of review is used); *Brown v. Blue Cross & Blue Shield of Ala., Inc.*, 898 F.2d 1556, 1562 (11th Cir. 1990) (determining that the inherent conflict between the plan administrator as a profit-maker and as a fiduciary renders a highly deferential standard of review inappropriate).

382. See *Pinto*, 214 F.3d at 377 (holding that the deference accorded the fiduciary will be lessened by the degree necessary to neutralize influence resulting from conflict (quoting *Ellis v. Metro. Life Ins. Co.*, 126 F.3d 228, 233 (4th Cir. 1997))); *Vega*, 188 F.3d at 296 (explaining that the conflict of interest factor is applied on a case by case basis to reduce the deference normally given only to the extent needed to counteract undue resulting influence); *Borda*, 138 F.3d at 1062 (concluding that the fiduciary will be entitled to some deference, but the deference will be subtracted to the degree needed to neutralize any undue influence); *Mers v. Marriott Int'l Group Accidental Death & Dismemberment Plan*, 144 F.3d 1014, 1020 n.1 (7th Cir. 1997) (recognizing the arbitrary and capricious standard is not an "all or nothing" choice between no deference and complete deference); *Woo*, 144 F.3d at 1161 (describing the sliding scale as extremely flexible in that courts may adjust for the circumstances); *McGraw*, 137 F.3d at 1253 (recognizing the arbitrary and capricious standard as inherently flexible in that the degree of deference will be decreased on a sliding scale in proportion to the extent of the conflict present).

because the standard is one for the courts to determine and adjust, litigation will necessarily increase as plaintiffs have been afforded a second chance to challenge the bias in a plan administrator's decision.

Citing the fashionable phrase from the Seventh Circuit that ERISA's arbitrary and capricious standard is simply "a range, not a point,"³⁸³ the majority of circuits feel at liberty to adjust the standard dependent upon the degree of the actual conflict of interest.³⁸⁴ While some circuits note that this adjustment to the standard should be in direct proportion to the degree of the conflict,³⁸⁵ it is not clear whether the judicial standard can be so finely tuned. How much adjustment actually to be made is unclear. Should more evidence be needed to justify the plan administrator's decision?³⁸⁶ Should the plan administrator be required to show that the decision was not tainted by the conflict of interest?³⁸⁷ Should the process used by the plan administrator be examined?³⁸⁸ Such formulations give little guidance to participants/beneficiaries or employer sponsors as to the courts' determinations of ambiguous plan language.

The Eighth Circuit also acknowledges that it uses the sliding scale concept in conflict of interest contexts.³⁸⁹ However, in order to adjust

383. See *Van Boxel v. Journal Co. Employee's Pension Trust*, 836 F.2d 1048, 1052-53 (7th Cir. 1988) (noting that the arbitrary and capricious standard, as a range, "may be in effect a sliding scale . . . more penetrating the greater is the suspicion of partiality, less penetrating the smaller that suspicion is.").

384. See *Chambers v. Family Health Plan Corp.*, 100 F.3d 818 (10th Cir. 1996); *Donato v. Metro. Life Ins. Co.*, 19 F.3d 375, 380 n.3 (7th Cir. 1994); *Doe v. Group Hosp. & Med. Servs.*, 3 F.3d 80, 87 (4th Cir. 1993); *Wildbur v. ARCO Chem Co.*, 974 F.2d 631 (5th Cir. 1992); *Ellis*, 126 F.3d at 233; *Miller v. Metro. Life Ins. Co.*, 925 F.2d 979, 984-85 (6th Cir. 1991).

385. See *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 379 (3d Cir. 2000) (adjusting the sliding scale to "intensify[] the degree of scrutiny to match the degree of the conflict"); *Fox v. Fox*, 167 F.3d 880 (4th Cir. 1999) (finding that the deference afforded to the plan administrator would "be lessened to the degree necessary to neutralize any untoward influence resulting from the conflict"); *Pitman v. Blue Cross*, 217 F.3d 1291 (10th Cir. 2000) (holding that the existence of conflict would decrease the level of deference in proportion to the severity of the conflict).

386. See *Pinto*, 214 F.3d at 392-93 (attempting to answer the question of how to insert "conflict of interest" as a factor into the typical, seemingly inconsistent, legal equation of "arbitrary and capricious" and suggesting it might be done by simply requiring more evidence supporting a decision).

387. See *Palmer v. Univ. Med. Group*, 973 F. Supp. 1179, 1189 (D. Or. 1997) (adhering to the Ninth Circuit's holding in *Brown*, calling for a shift in the burden of showing whether a decision was or was not tainted by self-interest from the plan beneficiary to the fiduciary, once a conflict of interest is established).

388. See *Pinto*, 214 F.3d at 392-93 (asking "[d]oes there simply need to be more evidence supporting a decision, regardless of whether that evidence was relied upon?").

389. See *Schatz v. Mut. of Omaha Ins. Co.*, 220 F.3d 944, 947 (8th Cir. 2000) (applying a "sliding scale" approach for determining the degree of deference afforded to the plan administrators by the court).

the abuse of discretion standard, the Eighth Circuit requires that the plaintiff meet a test, which it has named the “two-part gateway requirement.”³⁹⁰ Under this test, the plaintiff must first present “material, probative evidence” demonstrating that the plan administrator had a financial conflict of interest in making its decision, and then, show that the fiduciary’s bias affected its decision.³⁹¹

The first part of this test requires more than a mere assertion of a conflict of interest; evidence must prove the existence of bias.³⁹² However, the Eighth Circuit acknowledges that certain situations (e.g., for-profit insurer as plan administrator) result in a rebuttable presumption of a palpable conflict of interest, requiring the plan administrator to provide mitigating circumstances to disprove any bias.³⁹³

The second part of the test requires a showing that the conflict had

390. See *Woo v. Deluxe Corp.*, 144 F.3d 1157, 1161 (8th Cir. 1998) (referring to its task as turning on whether the plan beneficiary has presented sufficient evidence to satisfy the “two-part gateway requirement” and finding that the beneficiary had); see also *Schatz*, 220 F.3d at 947 (reasoning that the sliding scale approach for determining the appropriate degree of deference to be afforded by the court to the plan administrators’ decision to deny benefits will only be undertaken when the claimant satisfies the preliminary “two-part gateway” requirement).

391. See *Buttram v. Cent. States, S.E. & S.W. Areas Health & Welfare Fund*, 76 F.3d 896, 900 (8th Cir. 1996) (articulating a two-part test that the beneficiary must pass in order to trigger a more stringent review: “(1) that a serious procedural irregularity existed, which (2) caused a serious breach of the plan trustee’s fiduciary duty to the plan beneficiary.” The court continued, “[h]owever, absent material, probative evidence, beyond the mere fact of the apparent irregularity, tending to show that the administrator breached his fiduciary obligation . . . we will apply the traditional abuse of discretion analysis to discretionary trustee decisions.”); see also *Woo*, 144 F.3d at 1160 (echoing and building upon its earlier decision in *Buttram* in holding that for a claimant to trigger a less deferential standard of review, he or she must present “material, probative evidence demonstrating that (1) a palpable conflict of interest or a serious procedural irregularity existed, which (2) caused a serious breach of the plan administrator’s fiduciary duty to her.”).

392. See *Farley v. Arkansas Blue Cross & Blue Shield*, 147 F.3d 774, 777 (8th Cir. 1998) (rejecting the assertion that the nonprofit health insurer’s desire to maintain competitive rates did not provide a conflict of interest, as the insurer has long-term business concerns in retaining customers and attracting new business); see also *Davolt v. Executive Comm. of O’Reilly Auto.*, 206 F.3d 806, 809 (8th Cir. 2000) (declining to create a “blanket rule” recognizing an automatic conflict of interest, which would dictate *de novo* review, in all cases where the insurer acted as plan administrator). But see *Woo*, 144 F.3d at 1161 (holding that the insurer as plan administrator had a conflict of interest because it would receive a direct financial benefit as insurer if it denied the claim; *Schatz*, 220 F.3d at 947-48 (recognizing “something akin to a rebuttable presumption of a palpable conflict of interest” where the insurer is the plan administrator).

393. See *Schatz*, 220 F.3d at 947-48 (noting that it had rejected this holding in its prior decision in *Davolt*, 206 F.3d at 809-10). However, the court reserved the question of whether a palpable conflict of interest existed if the insurer and plan administrator were corporate relatives. See *Schatz*, 220 F.3d at 948.

“a connection to the ‘substantive decision reached.’”³⁹⁴ The Eighth Circuit characterizes this part of the test as presenting a “considerable hurdle for plaintiffs.”³⁹⁵ The evidence must demonstrate that the plan administrator’s decision was arbitrary or a product of whim.³⁹⁶

5. *Adjustment under the presumptively void standard*

In contrast, the Ninth and Eleventh Circuits take a third approach in the context of a conflict of interest. These two circuits invoke a “presumptively void” (or burden shifting) standard in the conflict of interest context.³⁹⁷ Immediately after the *Firestone* decision, the Eleventh Circuit, in *Brown v. Blue Cross & Blue Shield of Alabama, Inc.*,³⁹⁸ reviewed a district court’s granting of summary judgment in

394. See *Barnhart v. UNUM Life Ins. Co. of Am.*, 179 F.3d 583, 589 (8th Cir.), *reh’g denied*, (8th Cir. 1999), *citing Woo*, 144 F.3d at 1161; *see also Layes v. Mead Corp.*, 132 F.3d 1246, 1250 (8th Cir. 1998) (ruling that the evidence must demonstrate “serious doubts as to whether the result reached was the product of an arbitrary decision or the plan administrator’s whim.”).

395. Compare *Barnhart*, 179 F.3d at 588 n.9 (concluding that simply because the plan administrator reached a contrary decision than the claimant’s independent medical evaluators, does not in itself indicate an arbitrary and capricious decision), and *Schatz*, 220 F.3d at 948 (finding that the plaintiff did not satisfy the second prong of the *Woo* gateway requirement where the insurer considered outside medical reviewers and based its decision on substantial evidence), with *Woo*, 144 F.3d at 1161 (holding that the second prong was met, thus triggering a less deferential review, where the plaintiff simply showed that the plan administrator used only an in-house medical review and did not thoroughly investigate the claim before making its determination).

396. See *Buttram*, 76 F.3d at 900 (“We note first that Buttram could have satisfied this burden by providing material, probative circumstantial evidence that left the court with serious doubts as to whether the result reached was the product of an arbitrary decision or the plan administrator’s whim.”); *see also Layes*, 132 F.3d at 1250 (repeating *Buttram* in deciding that evidence showing a conflict of interest must demonstrate that it caused a serious breach of the plan administrator’s duty to pay benefits as due); *Schatz*, 220 F.3d at 948 (reiterating the court’s reasoning in *Buttram* and *Layes* in holding that the claimant must present evidence creating serious doubts of whether the conclusion was the result of an arbitrary decision or whim of the plan administrator).

397. See *Atwood v. Newmont Gold Co.*, 45 F.3d 1317, 1323 (9th Cir. 1995); *see also Brown v. Blue Cross & Blue Shield of Ala., Inc.*, 898 F.2d 1556, 1566-67 (11th Cir. 1990).

398. *Brown*, 898 F.2d at 1556. The majority of other circuits, however, reject the *Brown* presumptively void theory. See *Doyle v. Paul Revere Life Ins. Co.*, 144 F.3d 181, 184 (1st Cir. 1999) (declining to follow *Brown*, thus adhering to the arbitrary and capricious standard in conflict of interest cases unless the conflict affected the choice of a reasonable interpretation); *see also Sullivan v. LTV Aerospace & Def. Co.*, 82 F.3d 1251, 1255 (2d Cir. 1996) (adopting the sliding scale standard of review after examining the cases of the various split circuits); *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 391 (3d Cir. 2000); *Vega v. Nat’l Life Ins. Servs., Inc.*, 188 F.3d 287, 297 (5th Cir. 1999) (affirming and clarifying that the Fifth Circuit embraces the sliding scale standard of review); *Mers v. Marriott Int’l Group Accidental Death & Dismemberment Plan*, 144 F.3d 1014, 1019-20 (7th Cir. 1997) (refusing to follow *Brown* and the presumptively valid standard); *Chambers v. Family Health Plan Corp.*, 100 F.3d 818, 826 (10th Cir. 1996).

favor of a plan fiduciary in a benefits denial claim where the fiduciary appeared to have the appropriate discretion to review and interpret the plan, but was operating under a potential conflict of interest.³⁹⁹ Subsequent to the denial of the claim, the parties agreed to use the arbitrary and capricious standard, which the district court applied.⁴⁰⁰ However, after, and in light of, the Supreme Court's decision in *Firestone*, the plaintiff in *Brown* appealed the verdict, arguing that such a deferential standard of review was inappropriate in conflict of interest contexts.⁴⁰¹

The Eleventh Circuit affirmed the use of the abuse of discretion standard, but altered its application in the context of a conflict of interest.⁴⁰² While the court affirmed the Seventh Circuit's statement that "the arbitrary and capricious standard may be a range, not a point," the court went on to analyze common law and trust law principles, fashioning a third judicial standard applicable when the plaintiff proves a substantial conflict of interest or if there is an inherent conflict of interest.⁴⁰³

Under this new standard, once the conflict of interest is shown or presumed, the burden shifts to the plan administrator to prove that it did not act in its own self interest or, as the court described, that "its interpretation . . . was not tainted by self-interest."⁴⁰⁴ If the plan

399. See *Brown*, 898 F.2d at 1556.

400. See *id.* at 1559 (citing Contracts Plan, § IX(K) ("As a condition precedent to coverage, it is agreed that whenever [Blue Cross] makes reasonable determinations which are not arbitrary and capricious in the administration of the [plan] (including, without limitation, determinations whether services, care, treatment or supplies are Medically Necessary . . .), such determinations shall be final and conclusive.") (alterations in original).

401. See *id.* at 1564 (noting *Firestone* now directs the courts to common law trust principles and, specifically the RESTATEMENT (SECOND) OF TRUSTS, in applying the abuse of discretion standard). In determining whether a trustee has abused its discretion, the Restatement lists six guiding factors:

- (1) the extent of the discretion conferred upon the trustee by the terms of the trust;
- (2) the purposes of the trust;
- (3) the nature of the power;
- (4) the existence or non-existence, the definiteness or indefiniteness, of an external standard by which the reasonableness of the trustee's conduct can be judged;
- (5) the motives of the trustee in exercising the power;
- (6) the existence or nonexistence of an interest in the trustee conflicting with that of the beneficiaries.

RESTATEMENT (SECOND) OF TRUSTS § 187 cmt. d (1959).

402. See *Brown*, 898 F.2d at 1563 (holding that the "abuse of discretion, or arbitrary and capricious, standard applies to cases such as this one, but the application of the standard is shaped by the circumstances of the inherent conflict of interest").

403. See *id.* at 1563-64, citing *Van Boxel v. Journal Co. Employees' Pension Trust*, 836 F.2d 1048, 1052-53 (7th Cir. 1987) (noting that the plaintiff's proof need not show that the fiduciary acted in favor of itself, that it acted in bad faith, that it gained any advantage or that the plaintiff was harmed by the decision).

404. *Id.* at 1566. See also *Atwood v. Newmont Gold Co.*, 45 F.3d 1317, 1323 (9th Cir. 1995) (citing *GEORGE TAYLOR BOGERT, TRUSTS*, § 95, 341-42 (6th ed. rev'd 1987) for the proposition that, "[u]nder the common law of trusts, any action taken by a

administrator was successful in meeting its burden, the court continued to apply the arbitrary and capricious standard of review, which meant the court could still find such decision arbitrary and capricious.⁴⁰⁵

Interestingly, the court characterized the fiduciary's decision in this context as "wrong but apparently reasonable" assuming the decision has to be wrong because of the bias, yet presumed reliable under the arbitrary and capricious standard.⁴⁰⁶ However, if the plan administrator was unsuccessful in meeting this burden, its decision would then be held arbitrary and capricious because it furthered the fiduciary's position and not the beneficiaries under the plan.⁴⁰⁷ While the court professes not to revert to the *de novo* standard of review, the resulting sliding standard of review weighs heavily on the fiduciary to disprove that its benefit denial was not tainted by a conflict of interest. The fiduciary must show that the denial was instead, justified and served the class of all participants and beneficiaries, even though it may have been to the detriment of an individual plaintiff.⁴⁰⁸ This standard is certainly no longer a range for the courts to judge the fiduciary's decision, as the presumption now is that the decision was wrong, arbitrary and capricious.⁴⁰⁹

After *Brown*, the Ninth Circuit also embraced the reasoning of the Eleventh Circuit and adopted the "presumptively void" standard of review in conflict of interest contexts.⁴¹⁰ The court's reasoning was

trustee in violation of a fiduciary obligation is presumptively void."); *Lee v. Blue Cross & Blue Shield of Ala., Inc.*, 10 F.3d 1547, 1552 (11th Cir. 1994) (rejecting the insurer's claim that it does not operate under a conflict of interest because it is a non-profit state-regulated entity).

405. *See Brown*, 898 F.2d at 1567 (recognizing that the decision was based on an extension of federal common law rules developed under labor law and subsequently applied in ERISA contexts).

406. *See id.* at 1566-67 ("It is fundamental that the fiduciary's interpretation first must be 'wrong' from the perspective of *de novo* review before a reviewing court is concerned with the self-interest of the fiduciary.").

407. *See id.* at 1568. Even if the plan administrator meets this burden, its decision may nevertheless be held to be arbitrary and capricious by other means.

408. *See id.* at 1567; *see also Godfrey v. Bellsouth Telecomm., Inc.*, 89 F.3d 755, 758 (11th Cir. 1996) (ruling that the plan administrator's inability to justify its determination "on the ground of its benefit to the class of all participants," was arbitrary and capricious).

409. *See supra* note 402 and accompanying text.

410. *See Atwood v. Newmont Gold Co., Inc.*, 45 F.3d 1317, 1322-23 (9th Cir. 1995) (reviewing its own cases reveals that the Ninth Circuit utilizes an approach comparable to the Eleventh Circuit: "[w]e ultimately apply a traditional abuse of discretion standard to the decisions of apparently conflicted employer- or insurer-fiduciaries unless the affected beneficiary comes forward with further evidence indicating that the conflicting interest caused a breach of the administrator's fiduciary duty to the beneficiary."); *see also Lang v. Long-Term Disability Plan of Sponsor Applied Remote Tech., Inc.*, 125 F.3d 794, 798 (9th Cir. 1997) (holding that when the plaintiff has presented material evidence of the administrator violating the

that under trust law (which was prescribed by *Firestone*), any self-interested action taken by a trustee could trigger a violation of fiduciary obligations, which rendered such action presumptively void.⁴¹¹ Any denial of benefit claims by a self-interested plan administrator must be construed as a breach of fiduciary duty under trust law, and thereby presumed void by the courts.⁴¹² However, the Ninth Circuit is quite forward in its assertion that a *de novo* standard of review is the resulting standard in the context where the defendant cannot sufficiently disprove its bias.⁴¹³ Such result could certainly be inferred from the Eleventh Circuit's approach, but has become explicit in the Ninth Circuit's approach.

Unfortunately, the language in *Firestone* has boxed the circuits into their various corners. By invoking trust law as directed by *Firestone*, the Ninth and Eleventh Circuits try, religiously, to apply trust law standards and to adjust the standard of review depending on the position of the plan administrator.⁴¹⁴ ERISA however does not follow all the dictates of trust law. For example, a fiduciary under ERISA may "wear two hats," one of a trustee or fiduciary and one of a settlor.⁴¹⁵ Such a position may very well place the employer sponsor or the insurance company in a position of a conflict of interest. The other circuits also invoke the language of *Firestone*, interjecting any conflict of interest as merely a factor in the adjustment of the judicial standard of review.⁴¹⁶ However, this adjustment is just as inexact as the trust law standard, thus not affording the plan sponsors or plan administrators advance knowledge of the standard that will be applied to their decisions.

The Eleventh Circuit's justification for its new standard was that it would be "prophylactic" in discouraging arrangements where a

fiduciary obligation, the court will not defer to the administrators decision).

411. See *Lang*, 125 F.3d at 798. However, the court notes that the plan may be able to meet its burden if it can, for example, present evidence to indicate that through its decision the plan on the whole benefited and as a result, the individual plan beneficiaries benefited as well. *Id.*

412. See *Atwood*, 45 F.3d at 1323 (refusing to defer to the administrator's "presumptively void" decision to deny benefits when the affected beneficiary presents material evidence of a fiduciary violation).

413. See *id.* ("If the plan cannot carry that burden, we will review the decision *de novo*, without deference to the administrator's tainted exercise of discretion.").

414. See *supra* notes 407-23 and accompanying text.

415. See *Local Union 2134, United Mine Workers of Am. v. Powhatan Fuel, Inc.*, 828 F.2d 710, 713 (11th Cir. 1987) (confronting the irony of a corporate officer acting both as an employee, with an interest in promoting the corporation, and acting as health plan fiduciary, with an overlapping yet conflicting interest in advancing the best interest of the plan's beneficiaries).

416. See *supra*, note 392 and accompanying text (noting majority of circuits recognize conflict of interest as factor).

conflict of interest could be inferred or shown, which the court presumed to be consistent with ERISA's intent.⁴¹⁷ Such a result has not happened; nor is this result necessarily to the benefit of participants/beneficiaries. ERISA envisions that the plan sponsor may serve in multiple fiduciary contexts: as sponsor, as plan administrator and as trustee, and that the plan's insurer may serve as administrator and insurer to the plan.⁴¹⁸ In fact, for small- and medium-size employers, the use of insurance carriers is one of necessity, as they could not possibly fully assume the risks associated with welfare benefits nor economically undertake the administration of such plans. Thus, the result of this third standard is to open the flood-gate of litigation to any fully insured ERISA plan (administered by its carrier) or to any self-funded and self-administered plan.

If all that is needed is proof of a potential or actual conflict of interest, there is little to lose in challenging a benefits denial case in these contexts. The insurer- or employer-administrator will have the burden to substantiate every one of its decisions to the court and to dispel any theory that it acted for its own best interest. If such a showing is not met, the court will deem the decision arbitrary and capricious. For small- and medium-sized employers, the costs of litigation will increase the administrative costs of the plan, making it even more difficult to sponsor and maintain. This result is obviously in conflict with the initial purpose of ERISA to continue the growth and development of privately-sponsored employee benefit plans.⁴¹⁹

D. Ancillary Issues

There are two important ancillary issues that arise in benefit denial cases that have also split the circuits, and, if afforded weight, may

417. See *Brown v. Blue Cross & Blue Shield of Ala., Inc.*, 898 F.2d 1556, 1565 (11th Cir. 1990) (disclaiming that the rule is intended to deprive the fiduciary of any unjust enrichment or to compensate the beneficiary, rather, its sole purpose and effect is to deter the formation of arrangements where a conflict may arise); see also *Fulton Nat'l Bank v. Tate*, 363 F.2d 562, 572 (5th Cir. 1966) ("Its sole purpose and effect is prophylactic: the fiduciary is punished for allowing himself to be placed in a position of conflicting interests in order to discourage such conduct in the future. Though equity protects the beneficiary with a gentle wand, it polices the fiduciary with a big stick.").

418. See *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995) (acknowledging the right of the employer to serve as fiduciary as well as settlor with respect to the employee benefit plan).

419. See ERISA § 2(a), 29 U.S.C. § 1001(a) (1994) ("The Congress finds that the growth in size, scope and numbers of employee benefit plans in recent years has been rapid and substantial; [and] that the continued well-being and security of millions of employees and their dependents are directly affected by these plans; [and] that they have become an important factor affecting the stability of employment and the successful development of industrial relations . . .").

undoubtedly affect the outcome of the case for the participant. The first concerns the standard of review applicable to the plan administrator's factual findings in the benefits review process and the second is the introduction of evidence outside of the plan administrator's records at the district court level when applying the standard of review.

1. *Factual findings*

An ERISA cause of action grounded on a benefits denial claim may be based on either the plan administrator's interpretation of the plan (*e.g.*, employees terminated other than for cause or voluntary separation are eligible for severance benefits)⁴²⁰ or the plan administrator's findings of fact (*e.g.*, accidental death for a claim for insurance benefits).⁴²¹ From the participant's vantage point, both the interpretation of the plan and the findings of fact are relevant in appealing the plan administrator's denial. However, the courts do not automatically apply the same standard of review in both contexts.

The confusion regarding the applicable standard of review for factual findings began with the *Firestone* decision. In its holding, Justice O'Connor stated "that a denial of benefits challenged under section 1132(a)(1)(B) is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan."⁴²² As the determination of eligibility for benefits may be conditioned upon factual findings, a broad reading of *Firestone* would apply the same standard of review as used in plan interpretations.⁴²³ However, proponents for different standards of review point to other *Firestone* language that states "[t]he

420. *See* *Anstett v. Eagle-Picher Indus. Inc.*, 203 F.3d 501, 503 (7th Cir. 2000) (rebuffing the plan administrator's argument that the proper interpretation of the plan warranted denial of benefits and holding that the evidence indicates, and the administrator cannot refute, that the employees were indeed terminated and as such, were entitled to separation benefits).

421. *See* *Pierre v. Connecticut Gen. Life Ins. Co.*, F.2d 1552, 1554 (5th Cir. 1991) (reversing the district court's ruling, which rejected the plan administrator's conclusion that the participant's death was not accidental and thus not covered under the employer's accidental life insurance plan).

422. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989) (concluding that, regardless of whether the plan is or is not funded and regardless of whether the administrator or fiduciary is acting under a conflict, the *de novo* standard of review applies).

423. *See id.* Immediately, preceding the sentence prescribing *de novo* standard of review, the Court notes, "the validity of a claim to benefits under an ERISA plan is likely to turn on the interpretation of terms in the plan at issue." While the Court stops short of specifically holding that a *de novo* standard of review applies to plan interpretation, this might be a reasonable inference.

discussion which follows is limited to the appropriate standard of review in section 1132(a)(1)(B) actions challenging denials of benefits based on plan interpretations. We express no view as to the appropriate standard of review for actions under other remedial provisions of ERISA.⁴²⁴ Read narrowly, such language appears to restrict the Supreme Court's holding solely to plan interpretation cases.

The Third, Fourth, Sixth and Seventh Circuits, as well as numerous district courts, however, favor a broad reading of *Firestone*, and thus, apply its holding to all benefit denial claims, whether they involve factual determinations or plan interpretations.⁴²⁵ In contrast, the Fifth Circuit has held that a plan administrator's factual findings should always be subject to a deferential standard of review, regardless of specific plan language conferring such powers.⁴²⁶

The Fifth Circuit reasoned that the authority to control and manage the operation and administration of a plan involved an

424. *Id.* at 108 (noting also that section 1132(a)(1)(B) "allows a suit to recover benefits due under the plan, to enforce rights under the terms of the plan, and to obtain declaratory judgment of future entitlement to benefit under the provisions of the plan contract.").

425. See *Rowan v. First UNUM Life Ins. Co.*, 119 F.3d 433, 435 (6th Cir. 1997) (holding factual determinations of plan administrators in actions brought under section 1132(a)(1)(B) are subject to *de novo* review); *Ramsey v. Hercules, Inc.*, 77 F.3d 199, 203-05 (7th Cir. 1996) (finding *de novo* the appropriate standard of review for factual determinations); *Luby v. Teamsters Health, Welfare, & Pension Trust Funds*, 944 F.2d 1176, 1183 (3d Cir. 1991) (holding that regardless of whether a plan administrator's decision to deny benefits was based on plan interpretations, *Firestone* strongly suggests *de novo* review); *Foster McGaw Hosp. of Loyola Univ. v. Bldg. Material, Chauffeurs, Teamsters & Helpers Welfare Fund Local 786*, 925 F.2d 1023, 1025 (7th Cir. 1991) (ruling that "*Firestone* does not require *de novo* review in every case."); *Reinking v. Philadelphia Am. Life Ins. Co.*, 910 F.2d 1210, 1213-14 (4th Cir. 1990) *overruled in part by* *Quisinberry v. Life Ins. Co. of N. Am.*, 987 F.2d 1017 (4th Cir. 1993) (holding that courts will review both questions *de novo*); *Cleary v. Knapp Shoes, Inc.*, 924 F. Supp. 309, 313 n.5 (D. Mass. 1996) (applying *de novo* review in factual determinations); *Pettit v. Olin Corp.*, 93-0254-CV-W-6, 1994 U.S. Dist. LEXIS 13843, 13844-45 (W.D. Mo. Sept. 26, 1994) (applying *de novo* review to initial eligibility requirements); *Maushardt v. Harris Corp.*, 855 F. Supp. 1240, 1243 (M.D. Fla. 1994); *Dawes v. First UNUM Life Ins. Co.*, 851 F. Supp. 118, 119-20 (S.D.N.Y. 1994); *Donaldson v. Metro. Life Ins. Co.*, 812 F. Supp. 103, 105 n.5 (E.D. Mich. 1993) (noting that *Firestone* suggests *de novo* review for factual determinations); *Guisti v. Gen. Elec. Co.*, 733 F. Supp. 141, 147-48 (N.D.N.Y. 1990) (recognizing the *Firestone* court drew no distinctions between the *de novo* review for plan interpretation and factual findings).

426. See *S. Farm Bureau Life Ins. Co. v. Moore*, 993 F.2d 98, 101 (5th Cir. 1993); *Wildbur v. ARCO Chem. Co.*, 974 F.2d 631, 642 (5th Cir. 1992) (ruling that a plan administrator's factual determinations shall be reviewed with an abuse of discretion standard); *Pierre v. Connecticut Gen. Life Ins. Co.*, 932 F.2d 1552, 1157-58 (5th Cir. 1991) (interpreting *Firestone* in finding it is consistent with the principles of trust law to apply different standards of review). District courts in the First and Ninth Circuits have chosen not to follow the Fifth Circuit's reasoning as well. See, e.g., *Peters v. Life Ins. Co. of N. Am.*, 816 F. Supp. 615, 617 (N.D. Cal. 1993).

inherent grant of power to make factual determinations.⁴²⁷ Thus, under trust law, a plan administrator's factual determinations were entitled to a deferential review and additional language under the plan/trust was not necessary. In contrast, the court acknowledged that the plan administrator's administrative power was not an inherent grant of power to make plan interpretations, thus requiring appropriate plan language to shift from the *de novo* standard.⁴²⁸ In its reasoning, the Fifth Circuit also analogized the plan administrator's determination of facts to those findings of fact made by a district court or an administrative agency, the latter of which are always afforded deference.⁴²⁹ Finally, the court concluded that a deferential standard for factual determination was the most practical result, as an alternative result would encourage unnecessary litigation under ERISA.⁴³⁰

The Sixth and Seventh Circuits have specifically rejected the Fifth Circuit's reasoning in *Pierre v. Connecticut General Life Insurance Company*.⁴³¹ While *Firestone* directed the use of trust law, the Seventh Circuit noted that traditional trust law made a distinction between the discretionary and mandatory powers, not between the trustee's interpretative or factual determinations. Thus, the focus should be solely upon whether the written plan conferred discretion, not the type of decision (factual or interpretative).⁴³²

The Seventh Circuit was also unpersuaded with the other reasons

427. See *Pierre*, 932 F.2d at 1558 (questioning whether the inherent grant of discretion in an ERISA trustee can be interpreted to go beyond mere discretion and be interpreted as authority to make factual interpretations).

428. See *id.* (clarifying that the inherent grant of power does not extend to the interpretation of terms of the plan but does extend to decisions made pursuant to necessary and appropriate functions of daily and routine administration of plans).

429. See *id.* at 1559 (seeing no reason why the plan administrator, as the trier of fact, should be afforded any less deference than that given to an administrative body by a reviewing district court or a district court by a reviewing appellate court).

430. See *id.* (remarking "[c]onsiderations of expediency therefore support deference to factual determinations made in the administration of the plan. Otherwise, federal trials are encouraged in the vast numbers of claims that are filed in the thousands of ERISA plans throughout this country.").

431. See *Wilkins v. Baptist Healthcare Sys., Inc.*, 150 F.3d 609, 613 (6th Cir. 1998) (finding that the *de novo* review standard applies to both factual and legal conclusions); *Rowan*, 119 F.3d at 435 (holding factual determinations are subject to *de novo* review); *Ramsey*, 77 F.3d at 203-05 (ruling that *de novo* review is the appropriate standard in factual determinations). The Seventh Circuit cited GEORGE GLEASON BOGERT & GEORGE TAYLOR BOGERT, *THE LAW OF TRUSTS AND TRUSTEES* § 560, at 181 (2d ed. rev'd 1980) and WILLIAM FRATCHER, *SCOTT ON TRUSTS* § 186.1, at 12-13 (4th ed. 1987), for support that the court will review the actions or inactions of a trustee based on discretionary and mandatory powers. See also *Grady v. Paul Revere Life Ins. Co.*, 10 F. Supp. 2d 100, 104 (D.R.I. 1998).

432. See *Ramsey*, 77 F.3d at 203 (7th Cir. 1996) (interpreting the U.S. Supreme Court's rationale in *Firestone*).

offered for an automatic deferential review, because plan administrators may not necessarily “enjoy the acknowledged expertise” available in agency cases, nor are they “unbiased fact finders like the courts.”⁴³³ Similarly, threats of increased ERISA litigation were unpersuasive as courts acknowledge that plan sponsors may simply amend plans to confer the appropriate level of discretion on their plan administrators.⁴³⁴

2. *Evidentiary evidence*

Another ancillary issue that arises in benefit claims litigation is the question of whether the district court is limited to the evidence that was before the plan administrator during the claims review procedure. Obviously the more evidence the plaintiff can present before the court, either evidence developed after the claims review procedure or evidence that could be used by the district court to assist in its understanding of medical terminology or practices, the greater the chance that the court may consider such evidence. The answer to this question first hinges on the applicable standard of review utilized by the court.

If the court has determined that the discretionary (*i.e.*, arbitrary and capricious) standard is to be utilized, then virtually all the circuits are in agreement that the district court is limited to the evidence contained in the administrative record.⁴³⁵ Such a result is consistent

433. *See id.* at 205. The Seventh Circuit also notes that the Administrative Procedure Act requires the federal courts to review fact and law on a *de novo* basis. *See* 5 U.S.C. § 706(2)(F) (1994).

434. *Id.* *See also* Sarosy v. Metro. Life Ins. Co., 94 Civ. 5431 (SHS), 1996 U.S. Dist. LEXIS 10765, 10766-67 (S.D.N.Y. July 30, 1996) (rejecting the *Pierre* analogy to administrative agency law on three different grounds: first, the analogy of plan administrator’s factual findings to that of governmental agencies’ findings was inappropriate because the latter may be presumed to be acting in the public’s best interest, which is not necessarily the case of a plan administrator, especially one operating under a conflict of interest; second, plan administrators may not have a certain level of expertise that may be assumed at the governmental agency; finally, governmental agencies are subject to extensive procedural protections afforded by the Constitution and federal law, whereas plan administrators are subject only to the procedures imposed by ERISA and the plan).

435. *See* *Heller v. Fortis Benefits Ins. Co.*, 142 F.3d 487, 493 (D.C. Cir. 1998); *Bernstein v. CapitalCare, Inc.*, 70 F.3d 783, 790 (4th Cir. 1995); *Miller v. United Welfare Fund*, 72 F.3d 1066, 1071 (2d Cir. 1995); *Krawczyk v. Harnischfeger Corp.*, 41 F.3d 276, 279 (7th Cir. 1994); *Lee v. Blue Cross & Blue Shield of Ala.*, 10 F.3d 1547, 1550 (11th Cir. 1994); *Abnathya v. Hoffmann-La Roche, Inc.*, 2 F.3d 40, 48 n.8 (3d Cir. 1993); *Taft v. Equitable Life Assurance Soc’y*, 9 F.3d 1469, 1471-72 (9th Cir. 1993); *Sandoval v. Aetna Life & Cas. Ins. Co.*, 967 F.2d 377, 381 (10th Cir. 1992); *Pierre v. Connecticut Gen. Life Ins. Co.*, 932 F.2d 1552, 1563 (5th Cir. 1991); *Oldenburger v. Cent. States SE & SW Areas Teamster Pension Fund*, 934 F.2d 171, 174 (8th Cir. 1991); *Perry v. Simplicity Eng’g*, 900 F.2d 963, 967 (6th Cir. 1990). *But see* *Moon v. Am. Home Assurance Co.*, 888 F.2d 86, 89 (11th Cir. 1989) (permitting additional facts unavailable to the plan administrator to be submitted under the *de*

with the courts' requirement that internal claims procedures be exhausted before proceeding to court.⁴³⁵ The Fifth Circuit provides an exception to this general rule such that the district court may consider evidence outside the administrative record with respect to plan interpretation questions and explanation of certain terms and procedures.⁴³⁷ For example, expert medical evidence may be admissible to assist the district court in understanding the medical terminology or practice related to a claim.⁴³³ However, outside evidence is not permitted to resolve disputed material.⁴³⁷

If the court's standard of review is *de novo*, many courts are willing to give the district court the discretion to consider evidence outside of the administrative record.⁴⁴⁰ In contrast, the Sixth Circuit is

novo standard of review).

436. See *Brown v. Seitz Foods, Inc. Disability Benefit Plan*, 140 F.3d 1198, 1201 (8th Cir. 1998) (affirming that the plaintiff's effort to provide additional evidence outside the administrative record was "nothing more than a last-gasp attempt to quarrel with [the plan administrator's] determination." (quoting *Davidson v. Prudential Ins. Co. of Am.*, 953 F.2d 1093, 1095 (8th Cir. 1992))). While ERISA has no express provision requiring exhaustion of administrative remedies prior to suit, the courts do impose an exhaustion requirement as a prerequisite to filing a suit for ERISA benefits. See, e.g., *Ravencraft v. UNUM Life Ins. Co.*, 212 F.3d 341, 343 (6th Cir. 2000); *Perrino v. S. Bell Tel. & Tel. Co.*, 209 F.3d 1309, 1315 (11th Cir. 2000); *Schlepper v. Purina Benefits Ass'n*, 170 F.3d 1157 (7th Cir. 1999); *Layes v. Mead Corp.*, 132 F.3d 1246, 1252 (8th Cir. 1998); *McGraw v. Prudential Ins. Co. of Am.*, 137 F.3d 1253, 1263-64 (10th Cir. 1998); *Hall v. Nat'l Gypsum Co.*, 105 F.3d 225, 231-32 (5th Cir. 1997); *Doe v. Blue Cross & Blue Shield United of Wisconsin*, 112 F.3d 869, 873 (7th Cir. 1997); *Kinthead v. Southwestern Bell Corp. Sickness & Accident Disability Benefit Plan*, 111 F.3d 67 (8th Cir. 1997); *Sarraf v. Standard Ins. Co.*, 102 F.3d 991, 993 (9th Cir. 1996); *Communications Workers of Am. v. Am. Tel. & Tel. Co.*, 40 F.3d 426, 431 (D.C. Cir. 1994); *Rodriguez-Abreu v. Chase Manhattan Bank, N.A.*, 986 F.2d 580 (1st Cir. 1993); *Kennedy v. Empire Blue Cross & Blue Shield*, 989 F.2d 588 (2d Cir. 1993); *Riggs v. A.J. Ballard Tire & Oil Co., Inc. Pension Plan & Trust*, 979 F.2d 848 (4th Cir. 1992); *Berger v. Edgewater Steel Co.*, 911 F.2d 911, 916 (3d Cir. 1991); *Simmons v. Willcox*, 911 F.2d 1077, 1081 (5th Cir. 1990); *Drinkwater v. Metro. Life Ins. Co.*, 846 F.2d 821, 826 (1st Cir. 1988); *Alfarone v. Bernie Wolff Constr. Corp.*, 788 F.2d 76,79 (2d Cir. 1988).

437. See *Wildbur v. ARCO Chem. Co.*, 974 F.2d 631, 639-42 (5th Cir. 1992) (permitting additional evidence when considering issues of plan interpretation); *Schadler v. Anthem Life Ins. Co.*, 147 F.3d 388, 394 (5th Cir. 1998) (citing *Wildbur* for its holding). See also *Alcorn v. Sterling Chems., Inc. Med. Benefits Plan for Hourly Paid Employees*, 991 F. Supp. 609, 614-15 (S.D. Tex. 1998) (citing *Wildbur* in holding the court is to focus on evidence before the administrator in determining plan interpretation, but is not bound by the record).

438. See *Quesinberry v. Life Ins. Co. of N. Am.*, 987 F.2d 1017, 1027 (4th Cir. 1993) (allowing expert medical testimony where administrative procedures lack a mechanism for the taking of such testimony); *Masella v. Blue Cross & Blue Shield of Conn., Inc.*, 936 F.2d 98, 104-05 (2d Cir. 1991) (finding no error in the admission of expert testimony to aid in plan interpretation).

439. See *Schadler*, 147 F.3d at 394 (citing *Wildbur* in limiting the allowance of outside evidence to the determination of whether an abuse of discretion occurred in administration of the plan).

440. Several circuits provide discretion to district courts regarding the consideration of outside evidence. See *Recupero v. New England Tel. & Tel. Co.*, 118 F.3d 820, 834 (1st Cir. 1997) (allowing courts a range of discretion in admitting

unwilling to go beyond the administrative record.⁴⁴¹ The Sixth Circuit rejects the premise that ERISA requires the courts to serve as substitute plan administrators, and thus, responsible for developing an administrative record.⁴⁴² Such a result would not only encourage additional evidence to be offered to the courts, but would also hinder ERISA's goal of expediting the claims process.⁴⁴³ The Fourth Circuit takes a middle-of-the-road approach, affording the district court discretion to go beyond the administrative record if it believes such action is necessary to resolve the benefit claim.⁴⁴⁴

V. AUTHOR'S RECOMMENDATIONS

In the words of Justice Becker of the Third Circuit, "only the Supreme Court can undo the legacy of *Firestone*."⁴⁴⁵ Such a result leaves the circuits with the ongoing task of fashioning a standard of review that is manageable for the district courts and yet consistent with the goals of ERISA.⁴⁴⁶ The author proposes a multi-step approach to the question of judicial review in benefit claims cases, which is

evidence suitable for judicial review); *Masella*, 936 F.2d at 104; *Casey v. Uddeholm Corp.*, 32 F.3d 1094, 1099 (7th Cir. 1994); *Kirwan v. Marriott Corp.*, 10 F.3d 784, 789-90 (11th Cir. 1994); *Donatelli v. Home Ins. Co.*, 992 F.2d 763, 765 (8th Cir. 1993); *Luby v. Teamsters Health, Welfare & Pension Trust Funds*, 944 F.2d 1176, 1184-85 (3d Cir. 1991); *Brown v. Blue Cross & Blue Shield of Ala., Inc.*, 898 F.2d 1556, 1571 (11th Cir. 1990). *But cf.* *Davidson v. Prudential Ins. Co.*, 953 F.2d 1093 (8th Cir. 1992) (holding where evidence was known or should have been known during administrative proceedings, the record may not be re-opened to allow submission of the evidence).

441. *See* *Wulf v. Quantum Chem. Corp.*, 26 F.3d 1368, 1376 (6th Cir. 1994) (noting the Sixth Circuit's variation from other courts in refusing to address evidence outside of the administrative record); *Perry v. Simplicity Eng'g*, 900 F.2d 963, 966 (6th Cir. 1990) (holding within the ERISA context, review is limited to the evidence presented to the administrator).

442. *See* *Perry*, 900 F.2d at 966 (noting the legislative history indicates no Congressional intent for courts to act as administrators).

443. *See id.*

444. *See* *Quesinberry*, 987 F.2d at 1026-27 (finding in the particular instance a need for discretion due to the wide variety of administrative records presented to the court; however, the court noted that in most cases, additional evidence would not be necessary for the court's review and thus it should contain itself to the administrative record). For other courts that sympathize with the Fourth Circuit's opinion, *see* *Bernstein v. CapitalCare, Inc.*, 70 F.3d 783, 790 (4th Cir. 1995) (allowing additional evidence where the administrative record did not contain medical evidence sufficient to find a denial of benefits); *Mongeluzo v. Baxter Travenol Long Term Disability Benefit Plan*, 46 F.3d 938 (9th Cir. 1995) (stating its agreement with the Fourth Circuit allowing for additional evidence "to enable the full exercise of informed and independent judgment"); *Donatelli*, 992 F.2d at 765 (noting that discretion to allow outside evidence should not be exercised without good cause).

445. *See* *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 393 (3d Cir. 2000) (arguing that *Firestone* is not easily reconciled with the basic principles of trust law).

446. *See id.* (adopting in the third Circuit a "sliding scale" approach, requiring the consideration of apparent conflicts when performing review of benefits determinations).

consistent with the legislative intent of ERISA, but provides a more uniform and cohesive approach.⁴⁴⁷

A. *De Novo by Default*

By utilizing trust law, *Firestone* has taught us that the *de novo* standard is the presumed standard of review unless the plan/trust language confers discretionary powers to the fiduciary regarding plan interpretation and determination of benefit eligibility.⁴⁴⁸ Thus, the initial question for the court is whether the plan/trust language is silent or whether sufficient discretionary powers have been granted to afford a much more deferential standard of review. Presumably, the plan/trust language could confer discretionary powers that were subject to an intermediate level of judicial review. The fallacy in using trust law at this juncture of the inquiry is that the plan sponsor, who is in control of the plan/trust language, along with the power to shift from a *de novo* standard to a more deferential standard, has little incentive to voluntarily subject itself to the court's "second guessing." Such a result hardly is in the interests of the plan participants and beneficiaries as the employer is the entity deciding the standard of review.

Accordingly, the option of choice for the employer is to provide the full grant of discretionary powers of plan interpretations and determinations of benefit eligibility to the named plan administrator. The existing case law is clear regarding the appropriate language to insert to confer full discretionary powers of interpretation and eligibility determination; the Seventh Circuit in *Herzberger* provides safe harbor language to insert for those unclear on the matter.⁴⁴⁹ The majority of the circuits are now in agreement that standard "proof of loss" language contained in insurance policies does not amount to discretionary powers of interpretation.⁴⁵⁰

A plan administrator's denial of benefits may be based on either an interpretation of plan provisions, or factual determination, or both.⁴⁵¹ In many situations, the decision regarding benefits is dependent on

447. See *infra* Part V.A-D (outlining the author's multi-step approach).

448. See *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 111-12 (1989) (noting unless otherwise specified, courts do not defer to the interpretation of either party in construing the terms of a trust).

449. See *Herzberger v. Standard Ins. Co.*, 205 F.3d 327, 331 (7th Cir. 2000) ("Benefits under this plan will be paid only if the plan administrator decides in his discretion that the applicant is entitled to them.").

450. See *supra* Part IV.1 (discussing circuit courts' views of language and discretionary interpretation).

451. See *supra* note 425 and accompanying text.

both determinations.⁴⁵² If appropriate discretionary power has been granted to the plan administrator, the author contends that to separate the benefit determination process between the interpretation phase and the factual phase distorts the very process of plan administration, and also undermines the authority of the plan administration. As a result, whatever standard is made applicable to plan interpretation issues should be applicable in factual determinations. Employers wishing to extend discretionary powers to all plan administrator's determinations should expand plan/trust language to afford full discretionary powers to the plan administrator regarding plan interpretations, as well as factual determinations.

B. Reasonableness Standard

ERISA requires that the plan administrator enforce the plan in accordance with its terms.⁴⁵³ Such is the fiduciary's duty for which the administrator may be sued for breaching.⁴⁵⁴ If the terms of the plan in question are exact and unambiguous such that a reasonable person would enforce the terms as written, the author contends the sponsor has no need to grant any discretionary authority to the fiduciary to interpret the plan. The result in a benefit denials claim would be a suit for breach of fiduciary duty, where the courts would be determining as a matter of law whether the fiduciary was acting according to the terms of the plan. Such a review would amount to a *de novo* standard of review.

The Supreme Court in *Firestone* affirmed that the plan sponsor has the power to grant discretionary plan interpretation powers to the plan administrator.⁴⁵⁵ Such powers would necessarily refer to interpreting *ambiguous* plan language or plan language that implicitly will change due to future medical advances (*e.g.*, "medical necessity," or "experimental procedure").⁴⁵⁶ Such grant of discretionary powers

452. See, *e.g.*, *Sweatman v. Commercial Union Ins. Co.*, 39 F.3d 594, 598-600 (5th Cir. 1994) (discussing plan interpretation of the term "totally disabled" and factual determination of the interpretation to the plaintiff).

453. See ERISA § 404(a)(1)(D), 29 U.S.C. § 1104(a)(1)(D) (stating "in accordance with the documents and instruments governing the plan").

454. See ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3) (authorizing civil suits "by a participant, [or] beneficiary . . . (A) to enjoin any act or practice which violates any provision of this subchapter or the 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.")

455. See *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989) (holding that a denial of benefits is to be challenged under a *de novo* standard unless the administrator or fiduciary is given discretionary authority to determine benefits or terms under the plan).

456. See *Hubbard v. Blue Cross & Blue Shield Ass'n*, 42 F.3d 942, 946 (5th Cir.

would remove the benefit denial claim from that of a breach of fiduciary duty cause of action *to* that of a benefits denial cause of action. Thus, instead of judging the fiduciary's actions from a traditional fiduciary (or trust law) context, it should now be judged in the context of a plan administrator rendering decisions under an employee benefit plan over which the administrator has discretionary powers.

In this context, the author contends that ERISA sets forth an external standard of review under section 404⁴⁵⁷ by requiring that the discharge of the plan administrator's duties be judged under a standard of reasonableness, otherwise known as the prudent man standard.⁴⁵⁸ Such a standard of review affirms the intent of ERISA to protect the plan participants and beneficiaries,⁴⁵⁹ as well as affirming the expertise presumed in the naming of such individual or entity as plan administrator.⁴⁶⁰ The burden of proving that the plan administrator's benefit denial was not reasonable should be on the plaintiff. A plan administrator engaging in the normal day-to-day operations of administering the plan should not have to justify and prove every one of its decisions. Such a result would put an unreasonable burden on the system, increasing plan administration costs and the amount of litigation.⁴⁶¹ However, the amount of evidence required for such proof need not be a horrific challenge for the participant or beneficiary.

However, as ERISA's prudent man standard should be relevant, there are a number of other ERISA protections afforded to participants that courts interject in their review of the plan administrator's decisions, *e.g.*, existence of a claims review procedure; a full and fair review process; notification of the rationale for any denial of claims. Such protections are assurances that elements of fairness and due process will be afforded to participants/beneficiaries in the claims process. Thus, all would be elements offered by the

1995); *Heasley v. Belden & Blake Corp.*, 2 F.3d 1249, 1258 (3d Cir. 1993); *Luby v. Teamsters Health, Welfare & Pension Trust Funds*, 944 F.2d 1176, 1180 (3d Cir. 1991).

457. See ERISA § 404, 29 U.S.C. § 1104.

458. See ERISA § 404(a)(1)(B), 29 U.S.C. § 1104(a)(1)(B) (defining as "with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims.").

459. See *supra* note 18 and accompanying text (discussing ERISA's claims review procedure, which enables a participant to perfect an otherwise defective claim).

460. See *supra* note 29 and accompanying text (discussing the Supreme Court's interpretation of ERISA's preemption clause where ERISA is silent).

461. See *Extract of Testimonies by Employers at the DOL Hearings held February 17-19, 1999, on the Proposed Regulations*, 27 TAX MGMT COMP. PLANNING J. 79 (Apr. 2, 1999).

plan administrator in assuring the courts that such protections were in fact afforded, even though the benefit claim was denied.

Utilizing the factors offered by the Fourth Circuit,⁴⁶² the author recommends the following application of the arbitrary and capricious standard in benefit cases. To ascertain whether the plan administrator's interpretation of ambiguous plan language was arbitrary, the following factors should be considered: (1) whether there is evidence that the decision was the result of a reasoned and principled review process; (2) whether the interpretation is consistent with any prior interpretations; (3) whether it is reasonable in light of an external standard; and (4) whether it furthers the purposes of the plan. In the application of these factors, the author does not recommend the courts employ the first of these factors to put "on trial" the plan's claims review procedures.⁴⁶³ Use of such a factor simply requires the plan administrator to document and show that its interpretation was made pursuant to reasoned and principled process. Certainly, the courts should consider examples of the plan administrator's arrogant disregard for the claims review process or its total reliance on internal medical experts for guidance; however, the courts are not the designated agency for review of the plan's claims procedure for compliance.⁴⁶⁴ Similarly, the second factor, "consistency with prior interpretations," affords the courts assurance the plan administrator's decision under the given facts was not arbitrary, but instead consistent with its prior interpretations. Use of such a factor is not an invitation for the courts to ascertain their interpretation of the plan provision in question. The third factor—use of ERISA's reasonableness standard—does call upon the courts to decide what is reasonable, within limits. The author recommends that ERISA's prudent man standard is utilized as a factor, and not the sole test, in the application of the arbitrary and capricious standard. This means that there could be many reasonable interpretations

462. See *supra* Part IV.B.2.a (reviewing the Fourth Circuit's considerations of the arbitrary and capricious standard).

463. According to the Department of Labor in the preamble to its recently finalized regulations on claims procedures, failure to comply with the regulations, even in minor respects, permits a claimant to initiate litigation. See Preamble, 65 Fed. Reg. at 48395. The Department of Labor does not want a claimant to pursue a claims procedure that does not comply with the law and remarked that such a result should not increase benefit claims litigation due to the limited remedies available under ERISA section 502(a). *Id.* What the Department of Labor fails to acknowledge is the advantage of a claimant pursuing litigation in order for the courts to determine the administrative record upon which it will base its opinion.

464. See 29 U.S.C. § 1133 (1994 & Supp. V 1999) (conferring upon the Secretary of Labor by Congress the authority to provide minimum requirements for benefit claims procedures).

ascertainable from the plan language in question; but if the plan administrator's interpretation is reasonable, such a factor has been satisfied. The court is not to substitute its reasonable interpretation for that of the plan administrator's, if the administrator's interpretation is equally reasonable. To permit the court to do so would negate the discretionary powers afforded to the plan administrator. The final factor—consistency with the purposes of the plan—is simply additional evidence for the plan administrator to present that its interpretation furthered the goals of the plan instead of undermining the plan. It is not an invitation for the courts to substitute its opinion for that of the plan administrator's if the latter presents a rationale and reasonable interpretation of the provision in question.

The use of the existing highly deferential arbitrary and capricious standard should be continued in collectively bargained employee benefits plans because nothing in ERISA directs that the labor law standard of review should be altered in such contexts. However, such distinction of standards of review under ERISA makes sense. As collectively bargained plans are negotiated by both management and labor, such plans do reflect the intent of both parties; in fact, both contracting parties agree to an intermediate standard of review. And, as such plans are jointly administered by equal representation from management and employees, the courts are assured of the impartiality in the joint board's benefit determinations. Thus, use of a highly deferential standard of review has appropriate safeguards in the collectively bargained context that are not necessarily available under non-union plans.

C. *Conflict of Interest Contexts*

The existence of a conflict of interest should not alter this standard of reasonableness, as ERISA itself permits an employer or insurer to wear "two hats"—one of administrator and one of funding agent.⁴⁶⁵ The author acknowledges that certain situations in employee benefit plans pose an inherent conflict of interest situation, *e.g.*, an employer administering a self-funded plan or an insurer administering an insured plan. Other situations which do not present an inherent conflict of interest should require the plaintiff to prove the existence of the conflict. Whether a conflict is inferred or proven, ERISA permits such situations, imposing an exclusive benefit rule and a

465. See 29 U.S.C. § 1102(c)(1) (1994 & Supp. V 1999) ("[A]ny person or group of persons may serve in more than one fiduciary capacity with respect to the plan").

reasonableness standard with respect to any fiduciary's actions.⁴⁶⁶ Thus, instead of negating the existence of a conflict of interest context, ERISA assumes the possibility of such conflict and imposes standards to protect participants and beneficiaries.

However, to further protect participants and beneficiaries in such conflict of interest contexts, the author recommends shifting the burden to the fiduciary to justify the reasonableness of its decision. This puts the plan administrator on notice that its decisions will be judged for their reasonableness and provides the courts with a record that must show that the conflict of interest did not taint such decision. Such a result is still consistent with the *Firestone* admonition to consider as a factor any conflict of interest, but provides more direction for the courts in the application of the reasonableness standard.

The author does not recommend use of the presumptively void theory in conflict of interest cases, advocated by the Ninth and Eleventh Circuits.⁴⁶⁷ Given the existence of a conflict of interest, the plan administrator's decision is rendered void, requiring the courts to review such decisions *de novo*.⁴⁶⁸ The author does not believe such a drastic approach is necessary as the plan administrator is aware of its potential for a conflict of interest, it is in the best position to justify its decision for reasonableness and have the courts review such a decision. But to begin the review process anew, as the *de novo* standard does, is equivalent to throwing the baby out with the bath water. It clogs up the courts unnecessarily with additional administrative costs without resulting participant protection.

The author's proposal to retain the reasonableness standard but shift the burden of proof in conflict of interest contexts is consistent with ERISA's approach to the prohibited transaction provisions. ERISA section 406 provides an enumerated list of activities/transactions that are prohibited, simply because they involve transactions between parties where there was a *presumed* conflict of interest.⁴⁶⁹ However, because many such activities and

466. See 29 U.S.C. § 1104(a)(1)(A) and (B) (1994 & Supp. V 1999) (charging the fiduciary with duties to provide for the exclusive provision of benefits to participants and to exercise those duties as would a prudent man).

467. See *supra* Part IV.C.2 (detailing the shifting of the burden to the administrator to demonstrate proper application when a conflict of interest exists).

468. See *Brown v. Blue Cross & Blue Shield of Ala., Inc.*, 898 F.2d 1556, 1566-68 (11th Cir. 1990) (concluding that a highly deferential standard of review is inappropriate in conflict of interest cases).

469. See 29 U.S.C. § 1106 (1994 & Supp. V 1999); see also *Comm'r v. Keystone Consol. Indus., Inc.*, 508 U.S. 152, 160 (1993) ("Congress' goal was to bar categorically a transaction that was likely to injure the pension plan.").

transactions benefit the participants and beneficiaries, ERISA provides exemptions for such activities, so long as certain safeguards are guaranteed.⁴⁷⁰ The effect of the prohibited transaction exemptions is to shift the burden of proof to the fiduciary or party-in-interest to justify the use of an exemption. In this context, ERISA is modifying the use of trust law to accommodate the practicalities and beneficial uses of such activities for employee benefit plans.

The author contends that ERISA's approach to the application of the prohibited transaction activities would be advantageous in the conflict of interest context. The exemptions to the ERISA prohibited transactions presume a conflict of interest, which is why they are prohibited;⁴⁷¹ however, the exemptions are conditioned on appropriate protections for participants/beneficiaries so that legitimate activities and transactions are permitted.⁴⁷² In fact, there is a statutory exemption to the prohibited transaction rules in the context where a fiduciary, acting as a participant or beneficiary is permitted to receive benefits.⁴⁷³ The only safeguard imposed by the exemption is that the computation and payment of the benefit is done on a basis consistent with the terms of the plan, as applied to all other participants and beneficiaries.⁴⁷⁴ There is no requirement that the computation be done by an independent third party, nor by the courts; simply that the computation and payment be done on a consistent basis based on everyone else.⁴⁷⁵ Such is a very low threshold requirement in the context of a conflict of interest case. Yet ERISA recognizes that fiduciaries can serve in multiple roles—that of fiduciary, as well as that of plan or participant/beneficiary.⁴⁷⁶

CONCLUSION

ERISA was passed over twenty five years ago, not to dictate a prescribed set of benefits, but to interject elements of fairness, disclosure, and due process to participants/beneficiaries under plans.

470. See 29 U.S.C. § 1108(b) (1994 & Supp. 1999) (detailing the types of exemptions allowed and the requirements for complying with each).

471. The prohibited transactions rules are not designed to question whether the fiduciary's interest *in fact* affected its decision, but rather, whether such interest could have affected such judgment. See *Pension Benefit Guar. Corp. v. Greene*, 570 F. Supp. 1483, 1494 (W.D. Pa. 1983), *aff'd*, 727 F.2d 1100 (3d Cir.).

472. See *supra* note 469 and accompanying text.

473. See 29 U.S.C. § 1108(c) (1994 & Supp. V 1999) (allowing fiduciaries to act as participants or beneficiaries, so long as benefits are consistent with those received by all other participants or beneficiaries).

474. See *id.*

475. See *id.*

476. See *id.*

For employers willing to deliver employee benefits voluntarily, ERISA prescribes standards to assure that such benefits would be afforded fairly and properly to such participants. ERISA does not dictate a certain level of benefits; in fact, ERISA affirms the power of the settlor or a named fiduciary to prescribe the benefits promised under a given employee benefits plan. Therefore, courts should be cautioned not to rewrite the terms of such employee benefits plans in light of what would be protective of employee's benefits but not within the scope of the employer's prescribed set of benefits. While such a result may have a short-term goal of providing necessary benefits to a needy participant/beneficiary, the long-term goal may be to discontinue coverage for certain benefits due to the prohibitive costs of such coverage. Equally relevant is the development of a system whereby the employer must deliver voluntary benefits that have been promised. Otherwise, we will be faced with earlier judicial precedent that such benefits may be gratuitous in nature, and thus, subject to the whim of the employer.

The author has proposed a dual test for the review of plan administrator's denial of claims, based both on a reasonableness standard and on a conflict of interest between the goal of maximizing the protection of the participants/beneficiaries and the intent of the sponsor to deliver a given set of benefits at a known cost. Employee benefits law is not exempt from the adage that "hard cases make bad law." While it may be desirable to include all employee benefit claims within the coverage of the employee benefits plan, the result is simply uneconomical for any employer. Accordingly, the employer must confront the hard issues, *e.g.*, what is excluded from coverage and which participant group should be favored in lieu of other participant groups. For most employers, the grant of discretionary powers to the plan administrator is the implementation of such decision as to what must further be excluded from coverage, now and in the future. ERISA is engaged in a balancing act between two competing interests. The goal should not be to interject the courts into the process as to what benefits must be provided under the plan. Likewise the employers are expected to definitely and explicitly ascertain promised benefits under employee benefits plans so that participants/beneficiaries are aware of the extent of benefits delivered to them via the employee benefit plan.