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RESOLVING THE CONFLICT BETWEEN TWO VISIONS FOR A STANDARD OF REVIEW IN ERISA DENIAL OF BENEFIT CLAIMS

*Alison S. Rozbruch**

INTRODUCTION

A majority of Americans receive health care benefits as part of their employment.¹ These benefits are encompassed in private sector “employee welfare benefit plans,” which include pension, health care, accident, disability, death benefit and other employee benefit plans, and are governed by the Employee Retirement Income Security Act (“ERISA”).² “Congress enacted ERISA in 1974 after a decade of work on pension and employee benefit issues.”³ ERISA’s stated purpose is to uniformly protect “the interests of participants in employee benefit plans and their beneficiaries . . . by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to federal courts.”⁴ Although the Act purports to protect participants,

* J.D. Brooklyn Law School, 2001; B.A. Union College 1998. The author would like to dedicate this Note to her parents for their constant love and support. She would also like to thank her brother and friends for their encouragement and suggestions throughout this process.

¹ See RAND E. ROSENBLATT ET AL., LAW AND THE AMERICAN HEALTH CARE SYSTEM 159-72 (1997).

² 29 U.S.C. § 1001-1461 (2000).

³ Jeffrey A. Brauch, *The Federal Common Law of ERISA*, 21 HARV. J.L. & PUB. POL’Y 541, 546 (1998) (noting that Congress was unhappy with the existing regulation of pension plans because many workers were not receiving the pensions they were promised).

⁴ 29 U.S.C. § 1001(b) (2000).

judicial decisions continually interpret ERISA as a shield for employers, insurance companies and plan administrators.⁵

It is clear from the legislative history both what is explicitly stated and from what is absent from the text of the statute that Congress intended the courts to develop a federal common law dealing with participant rights and plan obligations under ERISA.⁶ Pursuant to Section 1132 (a)(1)(B) of the statute, a participant may bring a claim to recover benefits due under the plan.⁷ ERISA, however, is silent on the standard of review under which these claims will be reviewed.⁸ The language contained within a plan is the determining factor for the standard of review the court will employ when reviewing denial of benefit claims under ERISA.⁹ If the court concludes that the plan language does not vest discretion in the plan administrator, then the administrator's decision is closely scrutinized under a *de novo* standard of review.¹⁰ Con-

⁵ See, e.g., *Mertens v. Hewitt Ass'n*, 508 U.S. 248, 262 (1993) (holding that no damages were recoverable under the act and that advisors and consultants who may wrongfully participate in plan activities and/or a fiduciary's breach were immune from suit); *Pilot Life v. Dedeaux*, 481 U.S. 41 (1987) (holding that there are no ERISA remedies available for mental distress, punitive damages or state common law bad faith claims against the insurance company); *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134 (1985) (rejecting claims for compensatory or punitive damages and holding that the remedies provided in section 1132(a)(1)(B) were solely for the benefit of the plan as opposed to the rights of the participants and their beneficiaries).

⁶ 120 CONG. REC. S29942 (daily ed. Aug. 22, 1974). Senator Javits said that "a body of federal substantive law will be developed by the courts to deal with issues involving rights and obligations under private welfare and pension plans." *Id.*

⁷ 29 U.S.C. § 1132(a)(1)(B) ("A civil action may be brought by a participant or beneficiary to recover benefits due to him under the terms of the plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.").

⁸ *Id.* ERISA provides for review of denial of benefit claims by the federal courts, but is silent on the standard of review to be used by the courts in reviewing the claims. *Id.*

⁹ *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989) (stating that the standard of review of a denial of benefit claim "is likely to turn upon the interpretation of the terms in the plan at issue").

¹⁰ See Robert Mason Hogg, *The Evidentiary Scope of De Novo Review in ERISA Benefits Litigation After Firestone Tire and Rubber v. Bruch*, 78 MINN.

versely, if the court concludes that the language in the plan vests discretion with the plan administrator, then the decision is reviewed under a deferential arbitrary and capricious standard.¹¹ This deferential standard is a powerful mechanism used by the federal courts to undermine the rights of participants and "thwart benefit expectations."¹²

This Note examines the specific language in benefit plans and the various standards used by federal courts in determining the appropriate standard of review for denial of benefit claims under ERISA, and the link between the two. Part I of this Note examines the framework of ERISA, including its history, structure and the legislative intent behind its enactment, as well as the inherent tensions that have arisen in light of the absence of statutory language conferring a definite standard for judicial review. Part II focuses on the circuit splits over the types of language and methods of interpretation that result in a deferential abuse of discretion review. This split reflects diverging policy choices by the courts, and has prevented the development of a uniform body of federal common law to govern the administration of ERISA plans when determining the appropriate standard of review.¹³ Part II also

L. REV. 1575, 1583 (1994) (noting that the circuits are also split over both the standard of review for denial of benefit claims, as well as the evidentiary scope of review for ERISA benefits litigation).

¹¹ George Lee Flint, Jr., *ERISA: Reformulating the Federal Common Law for Plan Interpretation*, 32 SAN DIEGO L. REV. 955, 960 (1995) (stating that the arbitrary and capricious standard requires only the use of one of many logical reasons and some minimal documentation to confirm the administrator's decision for the denial of benefits pursuant to an ERISA claim).

¹² Jay Conison, *Suits for Benefits Under ERISA*, 54 U. PITT. L. REV. 1, 33 (1992) (arguing that using a deferential standard of review "pays little attention to ERISA's central purpose of safeguarding benefit expectations and rights" and "often seems perversely designed to thwart benefit expectations").

¹³ ROSENBLATT, *supra* note 1, at 196.

[ERISA] enforcement cases reflect a struggle over two visions of ERISA. One vision seeing ERISA's primary goal as the protection of employees' interests ... A second vision sees ERISA's primary purpose as encouraging employers voluntarily to offer benefit plans by limiting employers' costs and liability, and maximizing their discretion.

ROSENBLATT, *supra* note 1, at 196.

explains how the conflicting approaches used by the courts in determining the appropriate standard of review has effectively undermined the twin aims of ERISA: uniformity in enforcement and the safeguarding of patients' rights.¹⁴ Part III proposes and recommends a statutory modification that imposes a uniform standard for plan language necessary to vest discretion in the plan administrator. This Note concludes that in order for ERISA to comport with its underlying protective policies, the statute must be amended to require that health plans contain explicit discretion-granting language – such as 'discretion' or 'deference to' – in order to effectively confer discretion upon the plan administrator and restrict judicial review to an abuse of discretion standard.

I. EMPLOYEE RETIREMENT AND SECURITY ACT

The Employee Retirement and Security Act¹⁵ was enacted by Congress in 1974 in an effort to facilitate the growth and development of private "employee welfare benefit plan[s]"¹⁶ and to address the problems facing the existing regulation of pension plans.¹⁷ "Congress was unhappy with the existing regulation of pension plans, believing that many workers who had been promised pensions were not receiving them."¹⁸ It also found that plans and

¹⁴ 29 U.S.C. § 1001(b) (2000) (specifying the explicit policy objectives of ERISA).

¹⁵ 29 U.S.C. §§ 1001-1461 (2000).

¹⁶ *Id.* § 1002(1). Employee welfare benefit plans include health, accident, disability, death, unemployment, vacation, job training benefits, day care, legal services or scholarship funds. *Id.*

¹⁷ ROSENBLATT, *supra* note 1, at 159 (noting that "[ERISA] was enacted after a decade of Congressional concern about two kinds of 'market failure' that often compromised pension security"). The two kinds of consequences are first, that deregulation of the market that provided employee pension plans left many plans underfunded because of managements' failure to set aside adequate assets. *Id.* Second, while pre-ERISA state and federal law in theory required pension plans to be administered in trust for the benefit of employees, regulatory and remedial provisions were inadequate. *Id.* at 160.

¹⁸ Brauch, *supra* note 3, at 547 n.19 (citing 120 CONG. REC. S29950 (daily ed. Aug. 22, 1974) (statement of Sen. Bensten) ("[G]overnment statistics indicate

their sponsors faced complex and conflicting state laws and regulations.¹⁹ Congress concluded that the inconsistencies in the laws and regulations resulted in administrative inefficiencies and costs that ultimately hurt plan participants.²⁰ The legislature sought to rectify these issues through the creation of nationally uniform benefit laws²¹ designed to protect employees and their beneficiaries in employee benefit plans.²² As a result, Congress enacted ERISA, establishing standards of conduct, responsibility, and obligation for administrators of employee benefit plans, and providing appropriate remedies, sanctions and ready access to the federal courts.²³

that during 1972 alone more than 15,000 pension plan participants lost retirement benefits because their pension plan terminated with insufficient assets to meet all plan obligations.”)).

¹⁹ Dahlia Schwartz, Note, *Breathing Lessons for the ERISA Vacuum: Toward a Reconciliation of ERISA's Competing Objectives in the Health Benefits Arena*, 79 B.U.L. REV. 631, 635-36 (1999) (stating that “Congress enacted ERISA in response to three related problems that attained national prominence in the early 1970’s. First, in the absence of state and federal regulation for employee benefit plans, many employers underfunded plans. Second, plan administrators were not obliged to act as fiduciaries. Third, corporations that engaged in interstate commerce were faced with up to fifty sets of laws designed to address the previous two concerns.”).

²⁰ See H.R. REP. NO. 93-533, at 12 (1974), *reprinted in* 1974 U.S.C.C.A.N. 4639, 4650.

²¹ See 29 U.S.C. § 1144(a) (2000) (stating that ERISA broadly preempts “any and all State laws insofar as they may now or hereafter relate to any employee benefit plan”).

²² *Id.* § 1001(a) (stating that “the lack of employee information and adequate safeguards concerning [plan] operation, it is desirable in the interests of employees and their beneficiaries . . . [that] safeguards be provided with respect to the establishment, operation and administration of such plans”); *see also* Shaw v. Delta Airlines, Inc., 463 U.S. 85, 90, 100 (1983) (stating that ERISA is a comprehensive statute designed to further the interests of employees and their beneficiaries in employee benefit plans).

²³ See 29 U.S.C. § 1001(b) (highlighting that the express legislative purpose of ERISA was to protect plan participants rights through the creation of uniform federal regulations and standards).

A. ERISA's Regulatory Framework

Although employee benefits traditionally were a matter of state contract law, ERISA brought employee benefit plans under federal regulatory authority in an effort to achieve its purposes of protecting patients' rights and establishing uniform standards and regulations for the field.²⁴ In order to achieve these fundamental policies, Congress engaged in a three step process.²⁵ First, Congress eliminated the state law obstacles with a sweeping ERISA preemption provision, bypassing all state law relating to employee benefit plans.²⁶ Second, with respect to pension plans, ERISA established standards for financial vesting²⁷ and participant vesting.²⁸ For both pension plans and employee welfare benefit plans (including health benefits), ERISA requires that plan administrators meet fiduciary standards,²⁹ disclose information

²⁴ See *Shaw*, 463 U.S. at 98-99; 120 CONG. REC. S29933 (daily ed. Aug. 22, 1974) (statement of Sen. Williams); 120 CONG. REC. H29197 (daily ed. Aug. 20, 1974) (statement of Rep. Dent).

²⁵ Flint, *supra* note 11, at 960 (tracing the evolution of ERISA and its federal common law plan of interpretation calling for the reformulation of a standard for federal common law plan of interpretation consistent with the protection of participants' reasonable expectations).

²⁶ 29 U.S.C. § 1144(a) (stating the provisions of this chapter "shall supercede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan"). Other provisions exempt certain laws from the application of this general preemption provision. Section 1144(b)(2)(A), exempts some state laws regulating insurance, banking, or securities. *Id.* § 114(b)(2)(A). Section 1144(b)(4), exempts generally applicable criminal laws, and Section 1144(b)(7), exempts qualified domestic-relations orders. *Id.* § 114(b)(4)(7).

²⁷ See 29 U.S.C. § 1081-1086 (setting minimum funding standards ensuring that plans have sufficient assets to pay promised benefits).

²⁸ See *id.* § 1053 (setting minimum vesting standards ensuring that promised benefits become non-forfeitable within a reasonably short period).

²⁹ See *id.* § 1002(21)(A)(iii) (indicating that a plan administrator is a fiduciary if she "has any discretionary authority or discretionary responsibility in [plan] administration"). A plan fiduciary must act "solely in the interest of the participants and their beneficiaries" and perform her duties "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." *Id.* §

fully,³⁰ and provide fair benefit claim procedures.³¹ Lastly, Congress made federal causes of action and remedies available to participants in federal court.³² Section 1132 (a)(1)(B) of ERISA supplies participants and beneficiaries with a direct means for their benefit expectations to be fulfilled.³³ This provision allows a suit to be brought to recover “benefits due under the terms of the plan”³⁴ and is regarded by some commentators to be ERISA’s “bottom line.”³⁵ ERISA does not regulate the substantive content of plans that provide health care coverage.³⁶ The amount and types of benefits are left to be negotiated between employers and insurers.³⁷

The framework of the statute is composed of standards designed to ensure that benefit expectations are honored and that entities administering benefits are subject to uniform standards.³⁸ Despite its comprehensive nature, ERISA has many gaps and is silent on many issues.³⁹ The accepted understanding is that

1104(a)(1)(A)-(B).

³⁰ See *id.* §§ 1022, 1023, 1025 (establishing standards of conduct, responsibility and obligations for fiduciaries under employment benefit plans including standards for information disclosure and reporting, while also requiring that plan administrators must report detailed financial information to federal regulators and disclose information to individual plan participants and beneficiaries).

³¹ See *id.* § 1133(1).

³² See *id.* § 1132(a),(e). A participant or beneficiary may sue “to recover benefits due to him under the terms of the plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.” *Id.* § (a)(1)(B).

³³ *Id.* § 1132(a)(1)(B).

³⁴ *Id.*

³⁵ See Conison, *supra* note 12, at 3.

³⁶ See *McGann v. H&H Music Co.*, 946 F.2d 401, 406 (5th Cir. 1991) (citing *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 91 (1983) (noting that ERISA does not require employers to offer any particular benefits)).

³⁷ *Id.*

³⁸ 29 U.S.C. § 1144(a) (stating that ERISA supersedes “any and all State laws insofar as they may now or hereafter relate to any employee benefit plan”).

³⁹ *Id.* § 1132(a)(1)(B) (providing for review of denial of benefit claims by the federal courts without enunciating the standard of review to be used by the courts in reviewing the claims). Also, legislative history suggests that Congress intended courts to develop “appropriate equitable relief” for ERISA’s remedial

Congress intended the federal courts to create common-law rights and obligations consistent with ERISA's purposes.⁴⁰ Unfortunately, judicial interpretation has made employee benefits less secure by creating a body of common law that controverts ERISA's initial policy objectives.⁴¹

B. Legislative Purpose - The Twin Aims of ERISA

Although information regarding the legislative history and intent of ERISA is sparse, statements discussing the "twin aims of ERISA" – uniformity and participant protection – can be ascertained from the legislative history and policy declarations surrounding the enactment of the statute. The record reflects that Congress intended ERISA to "preempt the field for federal regulations, in order to eliminate the threat of conflicting or inconsistent state and local regulation of employee benefit plans."⁴² ERISA broadly preempts any and all state laws that "relate to"⁴³ employee welfare benefits, and grants federal courts exclusive jurisdiction for nearly all disputes involving employee benefit plans.⁴⁴ This sweeping preemption provision indicates Congress' intent to provide employers and beneficiaries with a uniform and predictable

provisions contained in Section 1132 (a)(3). *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134 (1985) (Brennan, J., concurring) (quoting 29 U.S.C. § 1132(a)). In addition, ERISA provides a broad grant of preemption with respect to state laws and remedies, the specifics of which have been left to federal common law. 29 U.S.C. § 1144(a).

⁴⁰ 120 CONG. REC. S29942 (daily ed. Aug. 22, 1974) (statement of Senator Javits). Sen. Javits's full statement was: "It is also intended that a body of federal substantive law will be developed by the courts to deal with issues involving rights and obligations under private welfare and pension plans." *Id.*

⁴¹ See, e.g., *O'Bryhim v. Reliance Standard Life Ins. Co.*, No. 98-1472, 1999 U.S. App. LEXIS 19232, at *1 (4th Cir. Aug. 16, 1999); *Perez v. Aetna Life Ins.*, 150 F.3d 550, 557 (6th Cir. 1998); *Donato v. Metro Life Ins. Co.*, 19 F.3d 375, 379 (7th Cir. 1994).

⁴² *Pilot Life v. Dedeaux*, 481 U.S. 41, 46 (1987) (quoting 120 CONG. REC. S29933 (daily ed. Aug. 22, 1974) (statement of Senator Williams)).

⁴³ 29 U.S.C. § 1144(a).

⁴⁴ *Id.*

regulatory scheme within which benefit plans may be structured and enforced.⁴⁵

The legislative history suggests that one of the goals of preemption was uniformity.⁴⁶ The purpose of having a uniform body of federal law is to provide employers with a predictable regulatory scheme in which they can structure and promote benefit plans.⁴⁷ Congress sought to preempt state law in order to facilitate the growth of employee welfare benefit plans and “minimize the administrative and financial burden of complying with conflicting directives among states or between states and the federal government . . . [and to prevent] the potential conflict of substantive law . . . requiring the tailoring of plans and employer conduct to the law of each jurisdiction.”⁴⁸ The result is that ERISA has been interpreted as preempting virtually all of the vast body of state insurance, contract, tort, and other law applicable to health plans.⁴⁹

Congress further declared the policy of ERISA is:

[T]o protect . . . the interests of participants in employee benefit plans and their beneficiaries, by requiring the

⁴⁵ See 120 CONG. REC. H29197 (daily ed. Aug 20, 1974) (statement of Rep. Dent) (noting that many considered “the crowning achievement of [ERISA as] the reservation to federal authority [of] the sole power to regulate the field of employee benefit plans . . . eliminating the threat of conflicting and inconsistent state and local regulation”).

⁴⁶ *Id.*

⁴⁷ Schwartz, *supra* note 19, at 650.

⁴⁸ See *Ingersoll-Rand v. Mclendon*, 498 U.S. 133, 142 (1990). *Mclendon* involved a state common law claim for damages on the grounds that an employee was wrongfully discharged in order to prevent his attainment of benefits under an ERISA pension plan. *Id.* The court held that such an action was preempted under ERISA because of its failure to “relate to” an employee benefit plan, and because allowing states to develop different substantive standards for wrongful discharge would create the lack of uniformity that the preemption clause of ERISA was designed to prevent. *Id.*

⁴⁹ ROSENBLATT, *supra* note 1, at 161. The impact of the preemption clause on participants is beyond the scope of this Note. For a detailed discussion on the impact of preemption and the implications of federal common law developments in this area. See Schwartz, *supra* note 19, at 631; Jayne Elizabeth Zanglein, *Closing the Gap: Safeguarding Participants' Rights by Expanding the Federal Common Law of ERISA*, 72 WASH. U. L.Q. 671 (1994).

disclosure and reporting to participants and beneficiaries of financial information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing appropriate remedies, sanctions and ready access to courts.⁵⁰

ERISA imposes these procedural and administrative requirements in an effort to safeguard the rights of participants and beneficiaries in employee benefit plans.⁵¹ In addition, the access and remedies provisions contained in ERISA serve to provide participants with a mechanism to assure that their benefit expectations will be fulfilled.⁵²

ERISA contains four general sets of provisions to accomplish these goals with respect to employer sponsored health benefit plans. The first set of provisions impose informational requirements on employers in an effort to provide participants with notice and reward their benefit expectations.⁵³ These provisions contain detailed reporting and disclosure requirements designed to give plan participants full information regarding their rights.⁵⁴ For example, ERISA requires a plan administrator to provide a summary plan description ("SPD") to participants and beneficiaries.⁵⁵ The SPD is considered to be the "key document in disputes

⁵⁰ 29 U.S.C. § 1001(b) (2000).

⁵¹ See *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 113-114 (1989). ERISA was enacted "to promote the interests of employees and their beneficiaries in employee benefit plans." *Id.* (quoting *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 90 (1983)).

⁵² See 29 U.S.C. §§ 1021-1031(a); see also Conison, *supra* note 12, at 2 (stating that the "central policy of [ERISA] is that employees should receive the pensions and other benefits they were led to believe they would get. The statute consists of preventative rules and standards, designed to ensure that benefit expectations are well grounded and lessen the risk of disappointment"). See generally Jay Conison, *Foundations of the Common Law of Plans*, 41 DEPAUL L. REV. 575 (1992).

⁵³ See 29 U.S.C. §§ 1021-1031(a) (mandating the disclosure and regular reporting of specific financial and benefit information to plan participants and beneficiaries).

⁵⁴ *Id.*

⁵⁵ *Id.* § 1022(a)(1).

over benefits entitlement.”⁵⁶ Accordingly, the SPD must contain certain information about the plan⁵⁷ and must “[b]e written in a manner calculated to be understood by the average plan participant, and shall be accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan.”⁵⁸ In addition, the SPD must provide the participants with notice of their rights with respect to the plan's eligibility requirements, benefits, and any circumstances that may result in disqualification, ineligibility, or denial, loss, forfeiture, or suspension of benefits.⁵⁹ The overall purpose of the SPD is to provide

⁵⁶ Edward B. Miller & Marc A. Dorenfeld, *ERISA: Adequate Summary Plan Descriptions*, 14 HOUS. L. REV. 835 (1977).

⁵⁷ See 29 U.S.C. § 1022(b).

ERISA provides that the SPD shall contain, among other information: the name and type of administration of the plan; the name and address of the person designated as agent for the service of legal process, if such person is not the administrator; the name and address of the administrator; names, titles, and addresses of any trustee or trustees (if they are different from the administrator); a description of the relevant provisions of any applicable collective bargaining agreement; the plan's requirements respecting eligibility for participation and benefits; a description of the provisions providing for nonforfeitable pension benefits; the source of financing of the plan and the identity of any organization through which benefits are provided; the date of the end of the plan year and whether the records of the plan are kept on a calendar, policy, or fiscal year basis; the procedures to be followed in presenting claims for benefits under the plan and the remedies available under the plan for the redress of claims which are denied in whole or in part (including procedures required under section 503 of this Act).

Id.

⁵⁸ 29 U.S.C. § 1022(a)(1) (2000). The SPD must be clear: It “does no good unless an employee can read and digest it.” As stated in *Stahl v. Tony's Bldg. Materials, Inc.*, 875 F.2d 1404, 1409 (9th Cir. 1989):

[T]he regulations specify a large number of topics that a plan summary description must cover, . . . [they] say little about what it must explain in discussing each topic . . . These regulations reflect the reasonable interpretation that descriptions must describe all aspects of the plan, but must remain concise so that employees will read them.

Id.

⁵⁹ See 29 U.S.C. § 1022(b).

participants with adequate notice of the terms and conditions of the plan in an attempt to meet the benefit expectations of the participants.⁶⁰

Second, ERISA contains standards governing plan fiduciaries who exercise discretionary authority over the plan's management or assets.⁶¹ A fiduciary or plan administrator has the "authority to control and manage the operation and administration of the plan."⁶² Central to a fiduciary's duty is that they must provide a full and fair review of denied claims.⁶³ ERISA establishes standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans vis-a-vis a number of substantive provisions.⁶⁴ Pursuant to these requirements, ERISA states that fiduciaries are obligated to discharge their duties with respect to the plan solely in the interests of the participants and their beneficiaries⁶⁵ and are held to a "prudent man standard of care" in plan administration.⁶⁶ With respect to the fiduciary's duty to review claims, ERISA contains a proscription against arbitrary and capricious benefit decisions by requiring that the "appropriate named fiduciary

⁶⁰ Zanglein, *supra* note 49, at 680-81. Given the SPD's important role under the ERISA framework, the SPD must be written comprehensibly in a manner a reasonable participant would understand in order to be controlling. The terms of the SPD take precedence over the incomprehensible, technical, terms of the insurance policy itself. Reliance by participants creates a strong incentive to write the SPD carefully and clearly and it gives beneficiaries an understandable document on which they can rely. Zanglein, *supra* note 49, at 681.

⁶¹ See 29 U.S.C. § 1104(a)(1)(A)-(B) (setting forth the basic administrative and functional duties of a plan fiduciary). The terms "fiduciary" and "plan administrator" are used synonymously. A plan administrator is a fiduciary if she "has any discretionary authority or discretionary responsibility in the administration of such plan." *Id.* § 1002 (21)(A)(iii).

⁶² *Id.* § 1102(a)(1). Section 1102(a)(1) provides that "every employee benefit plan shall be established and maintained pursuant to a written instrument. Such instrument shall provide for one or more named fiduciaries who jointly or severally shall have the authority to control and manage the operation and administration of the plan." *Id.*

⁶³ See *id.* § 1133(2).

⁶⁴ See *id.* §§ 1002(a)(1), 1109, 1104.

⁶⁵ *Id.* § 1109(a).

⁶⁶ See *id.* § 1104(a)(1).

provide a full and fair review of denied claims.”⁶⁷ A plan administrator must provide claimants with a written notice of the reasons for the denial of the claim and provide review procedures by which a claimant may appeal a denial of benefits.⁶⁸

Third, ERISA creates uniform remedial provisions for beneficiaries⁶⁹ and provides for sanctions to be levied against non-compliant plans.⁷⁰ ERISA's civil enforcement provisions limit a participant's recovery to equitable relief.⁷¹ With respect to the plan

⁶⁷ *Id.* § 1133(2); *see also* *Grossmuller v. Int'l Union*, 715 F.3d 853 (3d Cir. 1983).

To afford a plan participant whose claim has been denied a reasonable opportunity for full and fair review, the plan's fiduciary must consider any and all pertinent information reasonably available to him. The decision must be supported by substantial evidence. The fiduciary must notify the participant promptly, in writing and in language likely to be understood by laymen, that the claim has been denied with the specific reasons therefor. The fiduciary must also inform the participant of what evidence he relied upon and provide him with an opportunity to examine that evidence and to submit written comments or rebuttal documentary evidence. If the fiduciary allows third parties to appear personally, the same privilege must be extended to the participant.

Grossmuller, 715 F.3d at 857-58.

⁶⁸ *See* 29 U.S.C. § 1133(1) (indicating that the written notice must provide “specific reasons” for denial and be “written in a manner calculated to be understood by the participant”); *Id.* § 1133(2) (explaining that a plan must provide claimants with a “reasonable opportunity . . . for a full and fair hearing by the appropriate named fiduciary of a decision denying the claim”).

⁶⁹ *See id.* § 1132(a) (indicating remedies provided by the civil enforcement provision of ERISA are limited to equitable relief).

⁷⁰ *See id.* § 1132(l)-(m) (imposing “civil penalties on violations by fiduciaries” and penalties for improper plan distributions).

⁷¹ *See, e.g.,* *Pilot Life v. Dedeaux*, 481 U.S. 41 (1987) (rejecting any ERISA remedies for mental distress, punitive damages or state common law bad faith claims against the insurance company, holding that ERISA's remedies preempt state law and are limited to equitable relief); *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134 (1985) (rejecting claims for compensatory or punitive damages and holding that the remedies provided in Section 1132 (a)(1)(B) were solely for the benefit of the plan as opposed to the rights of beneficiaries); *Mertens v. Hewitt Assocs.*, 508 U.S. 248 (1993) (holding that no damages were recoverable under the Act and that advisors and consultants who may wrongfully participate in plan activities, and/or a fiduciary's breach, were immune from suit).

administrators, ERISA sets forth criminal penalties for anyone who willfully violates any of ERISA's reporting and disclosure requirements.⁷²

Last, ERISA provides beneficiaries with private rights of action and ready access to the federal court system in an effort to recover benefits and reward participants with reasonable expectations of coverage.⁷³ Section 1132 (a)(1)(B) sets forth one of the basic remedies provided by Congress by providing participants and beneficiaries with the right to recover benefits owed under an employee benefit plan.⁷⁴

The purpose of the substantive provisions, as evidenced by the text and legislative history, is to safeguard the rights of participants and beneficiaries in employee welfare benefit plans. However, judicial interpretation of these substantive provisions as well as the federal common law developed by the courts has narrowed the scope of protection by favoring a deferential abuse of discretion standard of review and by limiting the scope of available remedies.⁷⁵ As a result, ERISA's dual purposes of participant protection

⁷² 29 U.S.C. § 1131.

⁷³ *Id.* § 1132(a)(1)(B). Section 1132 (a) of ERISA in pertinent part provides: "A civil action may be brought (1) by a participant or beneficiary (b) to recover benefits due to him under the terms of the plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." *Id.*

⁷⁴ *Id.* § 1132.

⁷⁵ *See Pilot Life*, 481 U.S. at 54.

The detailed provisions of [ERISA's] civil enforcement scheme represent a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA.

Id. The weaknesses and limitations of ERISA's remedial provisions are beyond the scope of this Note. For detailed discussions of the remedial inhibitions of ERISA and the failure of the federal common law to protect participants rights. *See Randall Gingliss, The ERISA Foxtrot: Current Jurisprudence Takes One Step Forward and One Step Back in Protecting Participants' Rights*, 18 VA. TAX REV. 417 (1998); Zanglein, *supra* note 49, at 671.

and consistency in plan interpretation and administration are subverted.

C. The Evolution of a Standard of Review Under ERISA

A participant whose claim has been wrongfully denied can bring a suit under ERISA Section 1132 (a)(1)(B) to attempt to recover a benefit that is due under the plan.⁷⁶ ERISA provides that "a civil action may be brought by a participant or beneficiary to recover benefits due to him under the terms of the plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan."⁷⁷ Although the statutory text explicitly provides for judicial review of denial of benefit claims, ERISA is silent about which standard of review federal courts should use when reviewing denial of plan benefits.⁷⁸ Legislative history shows that Congress intended courts to fill the gaps and interpret the silences of ERISA by developing "a federal common law of rights and obligations under ERISA regulated plans."⁷⁹

In early ERISA cases, courts borrowed the arbitrary and capricious standard of review from cases reviewing decisions by administrators of pension plans set up under the Labor Management Relations Act ("LMRA").⁸⁰ Federal courts justified this

⁷⁶ See 29 U.S.C. § 1132(a)(1)(B); see also Brauch, *supra* note 3, at 573 (reviewing federal common law decisions that have held that before filing a Section 1132 (a)(1)(B) suit for the recovery of denied benefits, a participant or beneficiary must first seek benefits directly from the plan trustee under the internal claim procedures set forth in the plan. Only if the trustee denies the claim may the participant or beneficiary seek judicial review by the federal courts).

⁷⁷ 29 U.S.C. § 1132(a)(1)(B).

⁷⁸ See *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 109 (1989); *Quesinberry v. Life Ins. Co. of North America*, 987 F.2d 1017, 1021 (4th Cir. 1993) (en banc).

⁷⁹ *Firestone*, 489 U.S. at 110 (quoting *Pilot Life*, 481 U.S. at 56 (1987)). "A body of federal substantive law will be developed by the courts to deal with issues involving rights and obligations under private welfare and pension plans." 120 CONG. REC. 29, 942 (daily ed. Aug. 22, 1974) (statement of Sen. Javits).

⁸⁰ 29 U.S.C. § 186 (2000); see also *Firestone*, 489 U.S. at 109.

approach on the grounds that "because Congress intentionally drafted ERISA's fiduciary duty provisions to be similar to the fiduciary provisions set forth in the earlier LMRA, the 'arbitrary and capricious' or abuse of discretion standard used there was appropriate for reviewing benefit denials by ERISA fiduciaries."⁸¹ The application of this standard by the federal courts led to the adoption of a number of substantive legal rules regulating ERISA that served to undermine Congress' intent to safeguard patients' rights.⁸²

Under an abuse of discretion standard, the court's review is confined to the information or "record" at the time the decision was made and the issue under examination is whether the decision was "unreasonable" or "clearly erroneous" in light of the evidence presented.⁸³ Judicial deference to the decision of a plan administrator sharply increases a claimant's disadvantage because a plan administrator's decision will be "upheld if it was within [its] authority, reasoned and supported by substantial evidence in the record."⁸⁴

This approach was followed by all twelve circuits until 1989,

⁸¹ *Bayles v. Central States, Southeast and Southwest Areas Pension Fund*, 602 F.2d 97, 99-100 n.3 (5th Cir. 1979). *But see* Paul O'Neil, *Protecting ERISA Health Care Claimants: Practical Assessment of a Neglected Issue in Health Care Reform*, 55 OHIO ST. L.J. 723, 747 (1994) (suggesting that the adoption of the LMRA standard to ERISA plans failed to account for a significant difference between the two types of plans). LMRA plans are joint employer-employee plans, in which the impartiality of the administrator has been assured, and judicial deference makes sense. In ERISA plans, by contrast, because the impartiality of the administrator is not assured, there is no basis for deference to the administrator's decision. *Id.*

⁸² *See Buenman v. Central States, Southeast & Southwest Areas Pension Fund*, 572 F.2d 1208, 1209 (8th Cir. 1978) (holding that the "arbitrary and capricious" standard of review is applicable to cases arising under ERISA); *see also* Flint, *supra* note 11, at 961 (suggesting that the misapplication of labor law principles to ERISA led federal courts to adopt and follow substantive rules that thwart recovery by many-perhaps deserving participants).

⁸³ ROSENBLATT, *supra* note 1, at 160.

⁸⁴ ROSENBLATT, *supra* note 1, at 216 (stating that the arbitrary and capricious standard is a standard that only requires the use of one of many logical reasons and some minimal documentation to confirm the administrator's decision).

when the Supreme Court explicitly disapproved of the use of the LMRA approach in ERISA cases.⁸⁵ In the landmark case, *Firestone Tire & Rubber Company v. Bruch*,⁸⁶ the Supreme Court set forth a new standard of judicial review based on principles of trust law.⁸⁷ Recognizing that “trust principles make a deferential standard of review appropriate when a trustee exercises discretionary powers,”⁸⁸ the Court held that a “denial of benefits challenged under section 1132 (a)(1)(B) is to be reviewed *de novo* unless the benefit plan gives the administrator or fiduciary the discretionary authority to determine the eligibility of benefits or to construe the terms of the plan.”⁸⁹ The Court determined that the decision to grant deference to an administrator's decision depends solely on whether the plan instrument contains language that reserves discretionary authority to the administrator.⁹⁰ The Court reasoned that a *de novo* standard of review was appropriate in ERISA denial of benefit cases since the *de novo* standard has been applied in judicial benefit determinations prior to ERISA,⁹¹ and any lesser standard of review “would afford less protection to employees and their beneficiaries than they enjoyed before ERISA was enacted.”⁹² The Court concluded by noting that such a result would be inconsistent with the clear purposes of ERISA.⁹³

By relying on the language contained in the plan as the basis

⁸⁵ *Firestone*, 489 U.S. at 109 (concluding that the importation of arbitrary and capricious standard developed under the LMRA into ERISA was unwarranted).

⁸⁶ *Id.*

⁸⁷ *Id.*

⁸⁸ *Id.* at 111; see RESTATEMENT (SECOND) OF TRUSTS § 187 (1959) (“[W]here discretion is conferred upon the trustee with respect to the exercise of power, its exercise is not subject to control by the court except to prevent an abuse by the trustee of his discretion.”).

⁸⁹ *Firestone*, 489 U.S. at 115.

⁹⁰ *Id.* (determining that a plan confers discretion on the administrator to review claims based not on principles of trust law such as a fiduciary's conflict of interest or the lack of impartiality, but simply on whether the language in the plan gave the administrator discretionary authority).

⁹¹ *Id.* at 112-14.

⁹² *Id.* at 112.

⁹³ *Id.* at 114.

for determining the standard of review, the Supreme Court in *Firestone* set the stage for the problems that exist today.⁹⁴ *Firestone* requires that there be a grant of discretion to the administrator before such decision will be given the deference of the arbitrary and capricious standard of review.⁹⁵ However, lower courts have struggled with the issue of the particular language that is necessary to trigger a *de novo* review.⁹⁶ In construing the appropriate standard of review for denial of benefit cases, a number of federal circuit courts have interpreted the type of language necessary to vest discretion in benefit plans in ways that have effectively undermined both of ERISA's twin aims.⁹⁷

ERISA was enacted to provide a uniform system of rules and regulations and to "promote the interests of employees and their beneficiaries in employee benefit plans."⁹⁸ However, the tendency of federal courts to imply discretion from ambiguous language contained in the plan serves to promote a standard of review that affords less protection to plan participants and more protection to employers.⁹⁹ Under this approach, employers and plans can use

⁹⁴ See O'Neil, *supra* note 81, at 749.

By holding that a deferential review of ERISA benefit decisions turns on the particular language of a plan rather than questions of conflict of interest, bias, and lack of impartiality on the part of the plan administrator, [*Firestone*] seriously undermined the purpose of ERISA even as the Court affirmed that ERISA was intended to "promote the interests of employees and their beneficiaries in employee benefit plans."

O'Neil, *supra* note 81, at 749; see also *Firestone*, 489 U.S. at 113.

⁹⁵ *Firestone*, 489 U.S. at 115.

⁹⁶ See *Gust v. Coleman*, 936 F.2d 583 (10th Cir. 1991) (noting that decisions throughout the circuits are far from uniform regarding the particular language that is necessary to confer discretion in the plan).

⁹⁷ See *infra* Part II (discussing the split among the circuits).

⁹⁸ *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 90, 100 (1983) (stating that ERISA is a comprehensive statute designed to further the interests of employees and their beneficiaries in employee benefit plans).

⁹⁹ See, e.g., *O'Bryhim v. Reliance Standard Life Ins. Co.*, No. 98-1472, 1999 U.S. App. LEXIS 19232, at *1 (4th Cir. Aug. 16, 1999) (per curiam) (holding that the plain meaning of the plan language conferred discretion upon the plan administrators to make all determinations about benefit eligibility); *Perez v. Aetna Life Ins. Co.*, 150 F.3d 550, 557 (6th Cir. 1998) (holding that the plan language -[Aetna] shall have the "right to require as part of the proof of the

vague language to insulate themselves from a more rigorous standard of review.¹⁰⁰ As a result, employees who are denied promised benefits also lose the benefit of judicial review because their employer reserved discretionary power to itself without making that reservation clear.¹⁰¹ Such an interpretation of ambiguous plan language fails to reward the participants' expectations, leading to a result contrary to congressional intent. Moreover, the circuit split over the type of language that suffices to vest discretion in the plan demonstrates a lack of national uniformity and consistency.¹⁰² "Frequent lawmaking by the various circuit courts and district courts poses a threat to ERISA's goal of uniformity. The prospect of disuniformity remains especially disquieting for businesses with national plans and multi-state operations that can expect to be sued in many different federal forums."¹⁰³ As a result of the disunity among the federal courts, plan administrators and participants are faced with different laws and regulations depending on the jurisdiction.

The federal common law standard of review for denial of benefit cases is *de novo*, unless the plan explicitly confers authority

claim satisfactory evidence"- requires an arbitrary and capricious standard of review); *Donato v. Metro Life Ins. Co.*, 19 F.3d 375, 379 (7th Cir. 1994) (holding that the language "all proof must be satisfactory to us" was sufficient to warrant a deferential arbitrary and capricious review of the administrator's denial).

¹⁰⁰ *Bogue v. Ampex Corp.*, 976 F.2d 1319, 1325 (9th Cir. 1992) (holding that where a plan unambiguously granted discretion to the plan administrator to make factual determinations, beneficiaries had sufficient notice that the plan administrator had discretion to determine eligibility of benefits).

¹⁰¹ *Id.*

¹⁰² *Kinstler v. First Reliance Standard Life Ins. Co.*, 181 F.3d 243, 251 (2d Cir. 1999) (noting that appellate judges are divided on the issue of what language suffices to convey plan administrators the discretionary authority that warrants the more deferential arbitrary and capricious standard of review).

¹⁰³ *Singer v. Black & Decker Corp.*, 964 F.2d 1449, 1453 (4th Cir. 1992) (Wilkinson, J., concurring) (noting that ERISA's preemption provision was designed to avoid conflicting employer obligations and variable standards of recovery under various state laws and prevent disunity among the circuits, in part because of the significant problem that varying standards present to companies with a national presence across many jurisdictions).

upon the plan administrator to review denial of benefit claims.¹⁰⁴ However, judicial resolution of the type of language necessary to confer discretionary authority upon the plan administrator is counterproductive to ERISA's underlying protective policies of protecting participants' rights and promoting uniformity. By using a *de novo* standard as the default standard and implying discretion in vague and ambiguous language, courts afford less protection to beneficiaries and more protection to employers and plan administrators.¹⁰⁵

II. THE CIRCUIT SPLIT

The Supreme Court, in *Firestone Tire & Rubber Company v. Bruch*, held 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."¹⁰⁶ Pursuant to *Firestone*, a court's choice of the standard of review is itself a question of contract interpretation.¹⁰⁷ As a result, a determination of the appropriate standard of review in ERISA denial of benefit claims rests upon particular language contained in a plan, and upon federal common law methods of contract interpretation such as "plain meaning"¹⁰⁸ and "*contra proferentem*."¹⁰⁹ One issue that courts have struggled

¹⁰⁴ *Firestone*, 489 U.S. at 115.

¹⁰⁵ See, e.g., *Perez v. Aetna Life Ins. Co.*, 150 F.3d 558, 561 (6th Cir. 1998) (Boggs, J., dissenting).

¹⁰⁶ 489 U.S. 101, 115 (1989) (holding that a *de novo* standard of review will not be applied under current ERISA jurisprudence unless a plan fails to give an administrator discretion to make benefit determinations).

¹⁰⁷ See *Heasley v. Belden & Blake Corp.*, 2 F.3d 1249, 1254 (1993) (citing *Firestone*, 489 U.S. at 111).

¹⁰⁸ See, e.g., *Perez*, 150 F.3d at 557 (relying on general principles of contract interpretation to interpret the plans provisions according to their plain meaning, in an ordinary and popular sense); *Pitcher v. Principal Mut. Life Ins. Co.*, 93 F.3d 407, 411 (7th Cir. 1996) (interpreting ERISA plans "in an ordinary and popular sense as would a person of average intelligence and experience") (quoting *Meredith v. Allsteel Inc.*, 11 F.3d 1354, 1358 (7th Cir. 1993)).

¹⁰⁹ *Contra proferentem* means "against the party who proffers or puts

with in cases after *Firestone* concerns uncertainty as to the kind of plan language that is sufficient to grant plan administrators the discretionary authority to warrant a more deferential review.¹¹⁰ This split among the circuits over the appropriate standard of review in denial of benefit cases frustrates ERISA's dual purpose of protecting participants rights and providing a uniform body of law to govern employee welfare benefit plans.

A reviewing court determines, *de novo*, whether the ERISA plan confers discretionary authority on the administrator, and if so, whether the administrator abused that discretion.¹¹¹ The burden is on the administrator to show that the plan gives them discretionary authority.¹¹² If the administrator meets this burden, then the court will defer to the administrator's decision.¹¹³ The circuits are split over the specific language that is necessary to invoke a deferential standard of review. Although the plan language in most denial of benefit cases appears to be linguistically similar, the split between the circuits requiring express discretion-granting language versus those that are willing to imply discretion despite the presence of ambiguous plan language, is reflective of divergent policy choices made by the courts.¹¹⁴ The main problem underlying the circuit split is that different circuits have conflicting views

forward a thing." BLACK'S LAW DICTIONARY 327 (6th ed. 1990); See *Kinstler v. First Reliance Standard Life Ins. Co.*, 181 F.3d 243, 251 (2d Cir. 1999) (holding that ambiguities in plan language will be resolved against the plan and the employer because the power to draft clear language rests with them); *Kearney v. Standard Ins. Co.*, 175 F.3d 1084, 1091 (9th Cir. 1999) (en banc) (holding that three reasonable interpretations of the plan term "satisfactory . . . proof" were reasonable and resolved ambiguity against the plan); *Heasley*, 2 F.3d at 1257 (utilizing the principle of *contra proferentem*: "if after applying the normal principles of contractual construction, [an] insurance contract is fairly susceptible of two different interpretations . . . the interpretation that is most favorable to the insured will be adopted.") (quoting *Kunin v. Benefit Trust Life Ins. Co.*, 910 F.2d 534, 539 (1994)).

¹¹⁰ See *supra* notes 107-108 and accompanying text.

¹¹¹ *Heasley*, 2 F.3d at 1258.

¹¹² *Kearney*, 175 F.3d at 1088.

¹¹³ *Id.*

¹¹⁴ ROSENBLATT, *supra* note 1, at 196 (discussing judicial interpretation of enforcement of benefit and preemption cases reflect a struggle over two visions of ERISA).

as to the primary purpose of ERISA.¹¹⁵ One approach views the primary goal of ERISA as improving the protection of employees' interests and accordingly reads the statute as authorizing the courts to incorporate and expand state doctrines regarding trusts and insurance contracts as part of the federal common law of ERISA.¹¹⁶ The other approach views ERISA's primary purpose as encouraging employers to voluntarily offer benefit plans by limiting employers' liability, and maximizing their discretion.¹¹⁷ Although both views have merit, the latter fails to comport with ERISA's twin aims of safeguarding participants' rights and promoting uniformity throughout the system.¹¹⁸

A. Framework for Analysis

As a result of the conflicting rationales underlying ERISA's purpose, the circuits are split over the tenets of contract interpretation they apply in order to determine the type of language that triggers the deferential abuse of discretion review. Although *Firestone* establishes that a clear grant of discretion to determine eligibility of benefits or to construe terms of the plan is necessary before a plan administrator's decision will be given the deference of an arbitrary and capricious review,¹¹⁹ lower courts have

¹¹⁵ ROSENBLATT, *supra* note 1, at 196; *see* Brauch, *supra* note 3, at 548 n.25 (noting that the legislative history of ERISA reflects an attempt by Congress to balance the competing interests of protecting individual plan participants and minimizing administrative burdens) (citing S. Rep. No. 93-127 at 12 (1974), reprinted in 1974 U.S.C.C.A.N. 4838, 4844).

¹¹⁶ ROSENBLATT, *supra* note 1, at 196.

¹¹⁷ ROSENBLATT, *supra* note 1, at 196; *see also* H.R. REP. NO. 93-533, at 9 (1973) (revealing that according to legislative history, ERISA is not completely one-sided, as Congress sought to balance the need to protect employee benefits with "the interests of employers and labor organizations in maintaining flexibility in the design and operation of their pension programs"); *Jung v. FMC Corp.*, 755 F.2d 708, 714 (9th Cir. 1985) (noting that "one of the goals of ERISA was to keep plans within reasonable costs" and suggesting that if conditions became too difficult or expensive under ERISA, employers would be discouraged from creating plans).

¹¹⁸ *See supra* Part I.B (discussing the legislative history and the underlying purposes of ERISA).

¹¹⁹ *Firestone*, 489 U.S. at 114-15.

interpreted "clear" to mean much less than the word suggests.¹²⁰ The circuit courts have ruled that the language necessary to vest discretion in a plan administrator to determine benefit eligibility, or to construe the terms of the plan, may be embodied in a variety of forms.¹²¹ The variations among plan language and the approaches to plan interpretation reflect the courts' differing approaches to the underlying purposes of ERISA.¹²²

The first category of cases requires language that explicitly vests discretion in the plan administrator to make benefit determinations or construe the terms of the plan.¹²³ Although, the courts that have adopted this standard require explicit language, they still do not require the use of "magic words" such as "discretion" or "deference to" to vest authority in the plan administrator.¹²⁴ However, these courts require an explicit grant of discretion or its functional equivalent in order to invoke an arbitrary and capricious standard of review.¹²⁵ In addition, these courts have implemented the use of the common law doctrine of *contra proferentem* when construing ambiguous plan language in an attempt to comport with ERISA's protective policy of safeguarding participants' rights.¹²⁶

¹²⁰ See, e.g., *Perez*, 150 F.3d at 557.

¹²¹ Michael A. de Freitas, *Annotation, Judicial Review of Denial of Health Care Benefits Under Employee Benefit Plan Governed by Employee Retirement Income Security Act (ERISA)(29 U.S.C.A. 1132 (a)(1)(B))-Post-Firestone Cases*, 128 A.L.R. FED. 1, 2a (1999).

¹²² ROSENBLATT, *supra* note 1, at 196.

¹²³ There is no basis for distinguishing between questions of benefit determinations and plan interpretation when determining the proper standard of review. *Govindarajan v. FMC Corp.*, 932 F.2d 634, 637 (7th Cir. 1991) (Manion, J., concurring) (noting that the rationale underlying *Firestone* was based "on whether the written terms of the plan confer discretion on the administrator, and not on the type of decision—factual or interpretive—that the administrator is rendering.") (quoting *Petrilli v. Dreschler*, 910 F.2d 1441, 1446 (7th Cir. 1990).

¹²⁴ See, e.g., *Kinstler v. First Reliance Standard Life Ins. Co.*, 181 F.3d 243, 251 (2d Cir. 1999); *Kearney v. Standard Ins. Co.*, 175 F.3d 1084, 1089 (9th Cir. 1999).

¹²⁵ See, e.g., *Kinstler*, 181 F.3d at 251; *Kearney*, 175 F.3d at 1089; *Bounds v. Bell Atlantic*, 32 F.3d 337, 339 (8th Cir. 1994) (stating that the proper way to secure deferential language is through express-discretion-granting language).

¹²⁶ See, e.g., *Heasley v. Belden & Blake Corp.*, 2 F.3d 1249, 1257 (3d Cir. 1993) (finding the terms at issue were ambiguous and could be read in two

The other category of cases demonstrates the willingness of some courts to imply a grant of discretion despite the presence of ambiguous plan language in order to incentivize employers to provide such benefits.¹²⁷ These courts utilize the plain meaning rule of contract interpretation and fail to comport with the legislative intent of Congress.¹²⁸

1. *Pro-Participant Circuits*

The circuits in this category require that benefit plans contain express discretion-granting language or its functional equivalent in order to vest discretion with the plan administrator to determine benefits and interpret the terms of the plan. These circuits have the highest standards for the language necessary to confer discretion to the plan and comport most with the underlying purpose of ERISA.¹²⁹ These courts do not however require that a plan contain “magic words” such as “discretion” and “deference to” a plan administrator in order to invoke a *de novo* review.¹³⁰ Al-

different ways, the court utilized the federal common law of contract interpretation *contra proferentem* to resolve the ambiguity in favor of the insured).

¹²⁷ See, e.g., *Perez v. Aetna Life Ins. Co.*, 150 F.3d 550, 557 (6th Cir. 1998); *Donato v. Metro. Life Ins. Co.*, 19 F.3d 375, 379 (7th Cir. 1994).

¹²⁸ See *Donato*, 19 F.3d at 382.

¹²⁹ See *Bounds*, 32 F.3d at 339 (stating that the proper way to secure deferential language is through express-discretion-granting language, such as “as determined” and “all proof must be satisfactory to us”); *Ganton Techs. Inc. v. Nat’l Indus. Group Pension Plan*, 76 F.3d 462, 466 (2d Cir. 1996) (holding a plan administrator’s interpretation of a plan’s terms was accorded an arbitrary and capricious review because the plan explicitly stated that the trustees had the authority to “resolve disputes and ambiguities relating to the interpretation of the plan”). But see *Perez v. Aetna Life Ins. Co.*, 150 F.3d 550, 558 (6th Cir. 1998) (holding that the less rigorous phrase “satisfactory proof of total disability” was sufficient to preclude *de novo* review); *Patterson v. Caterpillar Inc.*, 70 F.3d 503 (7th Cir. 1995) (stating the phrase “such due proof as shall be required” sufficient to vest discretion in the plan).

¹³⁰ *Kinstler*, 181 F.3d at 251-52 (holding that the administrator’s burden to demonstrate insulation from *de novo* review requires either language stating that the award of benefits is within the discretion of the plan administrator or language that is plainly the functional equivalent of such wording) (citing *Jordan v. Retirement Comm. of Rensselaer Polytechnic Inst.*, 46 F.3d 1264, 1271 (2d

though explicit discretion-granting language is preferred, the functional equivalent of such language is sufficient to reserve interpretive discretion to the plan.¹³¹ In addition to having a high standard for the language necessary to reserve discretion in the plan, these circuits resolve ambiguities in plan language *contra proferentem* in favor of the plan participant. The courts adopting these stringent standards are the Second,¹³² Third,¹³³ Eighth¹³⁴ and Ninth¹³⁵ Circuits. The overall approach taken by these courts comports with ERISA's underlying policy of protecting participants' rights and expectations by providing them with adequate notice of their benefits.

a. Explicit Grant of Discretion or Functional Equivalent

The requirement of express discretion-granting language was announced by the Eighth Circuit in *Bounds v. Bell Atlantic*.¹³⁶ *Bounds* considered whether the language contained in the plan's proof-of-loss provision stating that "claims will be paid 'after the [insurance company] receives adequate proof of loss'" was sufficient to trigger a deferential standard of review.¹³⁷ The court

Cir. 1995)).

¹³¹ *Id.*

¹³² *Id.* at 251 (holding that ambiguities in plan language will not be sufficient to vest discretionary authority to the plan administrator, and such ambiguities will be resolved against the plan and the employer because the power to draft clear language rests with them).

¹³³ *See, e.g.,* Heasley v. Belden & Blake Corp., 2 F.3d 1249, 1257 (3d Cir. 1993) (finding the terms at issue were ambiguous and could be read in two different ways, the court utilized the federal common law of contract interpretation *contra proferentem* to resolve the ambiguity in favor of the insured).

¹³⁴ *See, e.g.,* Delk v. Durham Life Ins. Co., 959 F.2d 104, 105-06 (8th Cir. 1992) (upholding the application of *contra proferentem* in an ERISA case where the language remains ambiguous after interpreting the language as would an average plan participant).

¹³⁵ *See, e.g.,* Kearney v. Standard Ins. Co., 175 F.3d 1084, 1090 (9th Cir. 1999) (holding that where the language reserving discretion to the plan was not explicit and three reasonable interpretations of the plan term "satisfactory . . . proof" were plausible, the court resolved the ambiguity against the plan).

¹³⁶ 32 F.3d 337 (8th Cir. 1994).

¹³⁷ *Id.* at 339 (emphasis added).

held that the terms contained in the insurance company's proof of loss provision "read like a typical insurance policy" and "[did] not trigger the deferential ERISA standard review"¹³⁸ because the provision did not contain explicit discretion-granting language reserving the right of the plan administrator to make benefit eligibility determinations or to construe the terms of the plan.¹³⁹ The court cited language – including "as determined by us"¹⁴⁰ or "all proof must be satisfactory to us"¹⁴¹ – as language it considered to be explicit discretion-granting language warranting a deference to a plan administrator's decisions.¹⁴² The courts' interpretation in this case evidences that express discretion-granting language is the proper way to secure a deferential review of an ERISA plan administrator's claim in the Eighth Circuit.¹⁴³

The Second Circuit, in *Kinstler v. First Reliance Standard Life Insurance*¹⁴⁴ articulated a standard for the type of language required to preclude a *de novo* review. The court stated that:

[N]o one word or phrase must always be used to confer discretionary authority, the administrator's burden to demonstrate insulation from *de novo* review requires either language stating that the award of benefits is within the discretion of the plan administrator or language that is plainly the *functional equivalent* of such wording.¹⁴⁵

In articulating this standard the court recognized that "magic words

¹³⁸ *Brown v. Seitz Foods Inc.*, 140 F.3d 1198, 1200 (8th Cir. 1998) (quoting *Ravenscraft v. Hy-Vee Employee Benefit Plan & Trust* 85 F.3d 398, 402 n.2 (8th Cir. 1996)).

¹³⁹ *Id.*

¹⁴⁰ *Finley v. Special Agents Mut. Benefit Ass'n*, 957 F.2d 617, 620-621 (8th Cir. 1992) (holding that the language "as determined by us" contained in a benefit eligibility clause was the functional equivalent of express discretion-granting language).

¹⁴¹ *Donato v. Metro. Life Ins. Co.*, 19 F.3d 375, 377 (7th Cir. 1994) (stating that the language in the plan stating that disability benefits would be paid when Met Life received proof of a claim, and that "[a]ll proof must be satisfactory to us" was sufficient to preclude *de novo* review).

¹⁴² *Bounds v. Bell Atlantic*, 32 F.3d 337, 339 (8th Cir. 1994).

¹⁴³ *Id.*

¹⁴⁴ *Kinstler*, 181 F.3d at 243.

¹⁴⁵ *Id.* at 252 (emphasis added).

such as 'discretion' and 'deference' may not be 'absolutely necessary' to avoid a *de novo* standard of review."¹⁴⁶ The Second Circuit deems the arbitrary and capricious standard applicable in cases where the language reserving discretion was the functional equivalent of express discretion-granting language.¹⁴⁷ For example, in *Ganton Technologies Inc. v. National Industrial Group Pension Plan*,¹⁴⁸ the court reasoned that since the plan explicitly provided that the trustees had the authority to "resolve all disputes and ambiguities relating to the interpretation of the plan," the deferential arbitrary and capricious standard was appropriate.¹⁴⁹ Similarly, in *Zuckerbrod v. Phoenix Mutual Life*,¹⁵⁰ the use of the phrase "in our judgment" to modify a clause relating to the determination of benefits was also found sufficient to preclude a *de novo* review.¹⁵¹ The Second Circuit interpreted these unambiguous phrases to be the functional equivalent of express discretion-granting language, thus making the arbitrary and capricious standard applicable to the plan administrator's decision.¹⁵²

The requirement of express discretion-granting language or its functional equivalent utilized by the circuits in this category should serve as a model for statutory reform, for these criteria comport most with ERISA's purpose of safeguarding participants' rights by requiring plans to provide express notice of its authority.¹⁵³ In addition, this approach is consistent with *Firestone's* requirement "that there be a grant of discretion to the administrator before [a plan administrator's] decision will be given the deference of an

¹⁴⁶ *Id.* at 251 (citing *Jordan v. Retirement Comm. of Rensselaer Polytechnic Inst.*, 46 F.3d 1264, 1271 (2d Cir. 1995)).

¹⁴⁷ *Id.*

¹⁴⁸ 76 F.3d 462 (2d Cir. 1996).

¹⁴⁹ *Id.* at 466 (holding that a trustee's interpretation of an employee welfare benefit plan's "transfer of asset" provision was accorded deference because the plan explicitly provided that the trustees had the authority to "resolve all disputes and ambiguities relating to the interpretation of the plan").

¹⁵⁰ 78 F.3d 46 (2d Cir. 1996).

¹⁵¹ *Id.* at 48 (determining that where a policy used the language "in our judgment" to modify a determination of benefits, a plan administrator's decision will only be overturned if the decision is arbitrary and capricious).

¹⁵² *Id.*

¹⁵³ See *supra* Part I.B (discussing ERISA's notice provisions).

'arbitrary and capricious' standard of review."¹⁵⁴ Therefore, the requirement of express discretion-granting language or its functional equivalent should serve as the basis for any legislative action toward resolving a standard of review for ERISA denial of benefit claims.

b. Contra Proferentem: Resolving Ambiguities in Favor of Plan Participants

In addition to the high standards set for the type of language that is necessary to preclude a *de novo* review, the courts in this category frequently use the contract maxim of *contra proferentem* to resolve ambiguities in a plan's discretion-granting language in favor of the participants.¹⁵⁵ A resolution of the ambiguous terms in favor of the participants results in a *de novo* review of the administrator's record.¹⁵⁶ The principle of *contra proferentem* is derived from the recognition that:

Insurance policies are almost always drafted by specialists employed by the insurer. In light of the drafters' expertise and experience, the insurer should be expected to set forth any limitations on its liability enough for a common layperson to understand; if it fails to do this, it should not be allowed to take advantage of the very ambiguities that it could have prevented with greater diligence. Moreover, once the policy language has been drafted, it is usually not subject to amendment by the insured, even if he sees an ambiguity; an insurers' practice of forcing the insured to guess and hope regarding the scope of coverage requires

¹⁵⁴ *Perez v. Aetna Life Ins. Co.* 150 F.3d 559 (6th Cir. 1998) (Boggs, J. dissenting) (citing *Firestone Tire & Rubber v. Bruch*, 489 U.S. 101, 115 (1989)).

¹⁵⁵ *See, e.g., Kearney v. Standard Ins. Co.*, 175 F.3d 1084, 1089 (9th Cir. 1999); *Kinstler*, 181 F.3d at 251; *Heasley*, 2 F.3d at 1254-55; *Delk v. Durham Life Ins. Co.*, 959 F.2d 104, 105 (8th Cir. 1992).

¹⁵⁶ *See Heasley*, 2 F.3d at 1257 (finding the term at issue was ambiguous and could be read in two different ways). As a result, the court utilized the federal common law rule of contract interpretation, *contra proferentem* to resolve the ambiguity in favor of the insured, thereby making a *de novo* review appropriate. *Id.* at 1254-1255.

that any doubts be resolved in favor of the party who has been placed in such a predicament.¹⁵⁷

Many courts have upheld the use of the common law contract rule of *contra proferentem* in ERISA cases.¹⁵⁸ *Contra proferentem* has been used in cases where “if, after applying the normal principles of contractual construction, ‘[an] insurance contract is fairly susceptible to two different interpretations, the interpretation that is most favorable to the insured will be adopted.’”¹⁵⁹ Furthermore, courts have upheld the application of *contra proferentem* in ERISA cases where language remains ambiguous after interpreting the language as an “average plan participant” would.¹⁶⁰ The rules’ central rationale is that “un-negotiated contract terms and unequal bargaining power between parties demands that the law tip interpretation against the more sophisticated insurer, and in favor of the insured.”¹⁶¹ The courts that use this method of interpreta-

¹⁵⁷ *Kunin v. Benefit Trust Life Ins. Co.*, 910 F.2d 534, 539 (9th Cir. 1990). Finding the term “mental illness” to be ambiguous on a plain reading of the policy, the court applied the rule of *contra proferentem* against the insurance company, Benefit Trust. *Id.* at 540.

¹⁵⁸ See *supra* note 109 (discussing the application of the federal common law doctrine of *contra proferentem*). In addition, courts have held that the “adoption of *contra proferentem* does not violate ERISA’s pre-emption clause.” *Heasley*, 2 F.3d at 1258; see also Mark Traynor, *Kunin v. Benefit Trust Life Insurance Co.: Protecting Employees Under ERISA by Construing Ambiguous Plan Terms Against the Insurer*, 77 MINN. L. REV. 1219, 1237 (1993) (suggesting that the *Kunin* court properly held that the *contra proferentem* rule was not preempted by ERISA). The proper focus of preemption is on whether Congress intended preemption. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 45 (1987). The *Kunin* court was correct in implying that Congress did not intend to provide less protection to an insured than he enjoyed under state common law prior to the passage of ERISA. *Kunin*, 910 F.2d at 540.

¹⁵⁹ *Kunin*, 910 F.2d at 539 (quoting A. WINDT, *INSURANCE CLAIMS AND DISPUTES* § 6.02, 281-82 (2d ed. 1988)).

¹⁶⁰ See *Delk*, 959 F.2d at 105.

¹⁶¹ Traynor, *supra* note 158, at 1220 (1993) (stating that un-negotiated contract terms and unequal bargaining power between parties requires that the contract be construed against the party that drafted the contract) (citing Stephen M. Hoke, *Contract Interpretation in Commercial Insurance Disputes: The Status of the Sophisticated Insured Exception and Alternatives to the Ambiguity Rule*, 40 FED’N INS. & CORP. COUNS. Q. 259, 261 (1990)).

tion comport most with ERISA's legislative intent of safeguarding participants' rights and rewarding benefit expectations.

The Ninth Circuit took a similar approach in deciding these questions in *Kearney v. Standard Insurance Company*.¹⁶² Consistent with the other circuits in this category, the Ninth Circuit requires that discretion to determine eligibility of benefits or to construe the terms of the plan must be "unambiguously retained" in the plan instrument.¹⁶³ In the event that the terms are ambiguous about whether discretion is conferred to the administrator, the court resolves ambiguities in favor of the insured by precluding an arbitrary and capricious review.¹⁶⁴ In *Kearney*, the Ninth Circuit sitting *en banc* was called upon to review a plan administrator's decision to terminate disability benefits of a plan participant in a group disability insurance policy.¹⁶⁵ The policy stated that Standard Insurance would pay disability benefits "upon satisfactory written proof that you have become disabled."¹⁶⁶ The court examined the plan language to determine whether it conferred discretion upon Standard Insurance to decide whether a claimant is disabled.¹⁶⁷ The majority of the court reasoned that the language the plan administrator claimed granted him discretion was ambiguous because at least three interpretations of the plan language were reasonable.¹⁶⁸ The court engaged in an explanation of each of these interpretations in order to illustrate that each was reasonable, and to ultimately prove that the language was ambiguous as to

¹⁶² 175 F.3d 1084 (9th Cir. 1999) (*en banc*).

¹⁶³ See *Bogue v. Ampex Corp.*, 976 F.2d 1319, 1325 (9th Cir. 1992) (holding that where the plan grants the administrator the authority to evaluate and determine facts, this is sufficient evidence of a grant of discretionary authority). In *Bogue*, the language in the plan was unambiguous and provided beneficiaries with notice that the plan administrator had such discretion over the determining eligibility of benefits in light of the terms of the plan. *Id.* at 1325.

¹⁶⁴ *Kearney v. Standard Ins. Co.*, 175 F.3d 1084, 1086, 1090 (9th Cir. 1999) (affirming the lower courts decision that "the review should be *de novo* because the policy was ambiguous about whether discretion was conferred to the administrator").

¹⁶⁵ *Id.* at 1086.

¹⁶⁶ *Id.* at 1087.

¹⁶⁷ *Id.* at 1086-87.

¹⁶⁸ *Id.* at 1089-90.

whether discretion was conferred to the administrator.¹⁶⁹ The court reasoned that since there were three reasonable interpretations for the phrase “satisfactory written proof,” the policy was ambiguous about whether discretion was conferred to the administrator.¹⁷⁰ The court held that since discretion was not “unambiguously retained,”¹⁷¹ as required by the standard in the circuit, “ambiguities are construed *contra proferentem*, and . . . ambiguities are construed in favor of the insured.”¹⁷² As a result, the plan administrator's decision was to be reviewed under a *de novo* standard.¹⁷³

The Second Circuit applied similar reasoning in *Kinstler v. First Reliance Standard Life Insurance Company*,¹⁷⁴ to arrive at the determination that plan language requiring a claimant to “submit[] satisfactory proof . . . to us” was insufficient to preclude

¹⁶⁹ *Id.* The court explained that one interpretation of the phrase “satisfactory written proof” is a variation of an old insurance phrase that traditionally conferred discretion on the insurance company to determine whether the proof was sufficient. The word “satisfactory” was traditionally limited to an objective standard. Thus, the insurance company could not reject proof that was satisfactory to a reasonable person. *Id.* at 1089. The court found a second plausible interpretation of “satisfactory written proof” by using fundamental rules of contract interpretation. *Id.* at 1089. “[W]here a contract contains a condition that the obligor be ‘satisfied,’ an interpretation is preferred under which the condition occurs if . . . a reasonable person in the position of the obligor would be satisfied.” *Id.* (citing RESTATEMENT (SECOND) OF CONTRACTS, § 228 (1981)). The court recognized that such an analysis would result in the plan administrator being limited to an objective standard, much like the first interpretation. *Id.* at 1090. A third reasonable construction is one that suggests a subjective standard for the phrase “satisfactory written proof.” *Id.* This interpretation suggests that the plan administrator must be satisfied by the proof of the disability, thus limiting the plan administrator's decision only by his fiduciary duties of good faith and fair dealing. *Id.*

¹⁷⁰ *Kearney*, 175 F.3d at 1089-90.

¹⁷¹ *See Bogue*, 976 F.2d at 1325 (holding that an administrator has discretion to determine benefits only where discretion was “unambiguously retained.” In addition, the court upheld the use of *contra proferentem* where the plan language was ambiguous).

¹⁷² *Kearney*, 175 F.3d at 1090 (citing *Mongeluzo v. Baxter Traveno Disability Benefit Plan*, 46 F.3d 938, 942 (9th Cir. 1995)).

¹⁷³ *Id.*

¹⁷⁴ 181 F.3d 243 (2d Cir. 1999).

de novo review.¹⁷⁵ The court affirmed the district court's holding that the *de novo* standard of review applies to all aspects of a denial of an ERISA benefit claim in the absence of a clear reservation of discretion to the plan administrator.¹⁷⁶ The key issue was the denial of disability benefits based on a failure to submit "satisfactory proof of 'Total Disability.'" ¹⁷⁷ The policy provided monthly disability benefits if the claimant "submit[ed] satisfactory proof" of total disability to First Reliance.¹⁷⁸ The court held that an arbitrary and capricious review of the plan administrator's decision was not warranted because the language in the policy was subject to more than one reasonable interpretation.¹⁷⁹ The court stated that it was "unclear whether the key language, requiring claimant to 'submit satisfactory proof to us' meant that the claimant was required to submit proof to First Reliance that is satisfactory, or that the claimant must submit proof that is satisfactory to First Reliance."¹⁸⁰ The court stated that since both interpretations were reasonable, and since a plan administrator bears the burden of proving that the plan vests discretion with her, any ambiguities must be resolved in favor of the insured.¹⁸¹ Relying on the opinion in *Kearney*,¹⁸² the Second Circuit resolved the ambiguity in the plan language using the

¹⁷⁵ *Id.* at 251-52.

¹⁷⁶ *Id.* at 245.

¹⁷⁷ *Id.*

¹⁷⁸ *Id.* "The policy provides monthly disability benefits if the insured is (1) Totally Disabled as the result of a Sickness or Injury covered by this Policy; (2) is under the regular care of a Physician; (3) has completed the Elimination Period; and (4) submits satisfactory proof of Total Disability to [First Reliance]." *Id.* at 246. The plan states that "'Totally Disabled' and 'Total Disability' mean that as a result of an Injury or Sickness . . . an Insured cannot perform the material duties of his/her regular occupation." *Id.* at 245-46.

¹⁷⁹ *Id.* at 251. The Second Circuit required that the language conferring discretion to determine benefit eligibility and construe the terms of the plan must be explicit or language that is the 'functional equivalent' of an explicit grant of discretion. *Id.* at 252.

¹⁸⁰ *Id.*

¹⁸¹ *Id.* at 251-52.

¹⁸² *Kearney*, 175 F.3d at 1086 (affirming the lower court's decision that the "review should be *de novo* because the policy was ambiguous about whether discretion was conferred to the administrator").

maxim of *contra proferentem* against First Reliance.¹⁸³

The court in *Kinstler* also addressed the issue of notice and rewarding participants' expectations of benefits.¹⁸⁴ In dicta, the court stated that the word "satisfactory" was insufficient to convey notice that the plan administrator has discretion to determine matters of benefit eligibility and plan interpretation. Judge Newman opined that "every plan that is administered requires submission of proof that [will] 'satisfy' the administrator."¹⁸⁵ "Thus, saying that proof must be 'satisfactory to the administrator' merely states the obvious point that the administrator is the decision-maker."¹⁸⁶ The court further stated that unless a plan explicitly states that the proof must be satisfactory to the plan administrator, "satisfactory proof" should be construed objectively, as would a reasonable plan participant, and not subjectively to the satisfaction of the administrator, thereby meeting the insured's reasonable expectations of coverage.¹⁸⁷

The court concluded that, although "magic words' such as 'discretion' and 'deference to' may not be 'absolutely necessary' to avoid a *de novo* standard of review," the administrator had the burden of establishing that the plan vested discretion with the plan administrator.¹⁸⁸ However, the administrator's burden to demonstrate insulation must be met with clear, explicit language or the "functional equivalent" of such wording reserving authority to the

¹⁸³ *Kinstler*, 181 F.3d at 252.

¹⁸⁴ *Id.*

¹⁸⁵ *Id.*

¹⁸⁶ *Id.* at 252.

¹⁸⁷ *Id.* (stating that the word "satisfactory" is an inadequate way to convey the idea that the plan administrator has discretion). *But see* O'Bryhim v. Reliance Standard Life Ins. Co., No. 98-1472, 1999 U.S. App. LEXIS 19232, at *1, *13, *14 (4th Cir. Aug. 16, 1999) (holding that plan language "submits satisfactory proof . . . to us" conferred discretion to the plan to determine eligibility for benefits); *Perez*, 150 F.3d at 554 (stating that the plan language, "satisfactory evidence," was sufficient to warrant an arbitrary and capricious review despite the fact that the plan did not specify to whom the satisfactory evidence must be submitted).

¹⁸⁸ *Kinstler*, 181 F.3d at 251 (citing *Jordan v. Retirement Comm. of Rensselaer Polytechnic Inst.*, 46 F.3d 1264, 1271 (2d Cir. 1995)).

plan administrator.¹⁸⁹ Finally, willingness of some courts to apply the principle of *contra proferentem* to ambiguous discretion-granting language comes from the recognition that the insurance company drafts the plan, and is thus capable of including in its policy "clear language" to assure a deferential review.¹⁹⁰

The circuits in this category come closest to upholding the "protective policies" underlying ERISA, by setting high standards for the type of language necessary to preclude *de novo* review and by resolving in favor of the participant.¹⁹¹ The application of *contra proferentem* to ambiguous terms functions to ensure that claims will be reviewed *de novo*.¹⁹² The application of *contra proferentem* to ERISA denial of benefit cases is consistent with the congressional purposes of promoting the interests of employees and beneficiaries and protecting all contractually defined benefits.¹⁹³ The Second and Ninth Circuits also hold that notice is an essential ERISA safeguard since ERISA requires that the SPD must be written in such a way that participants understand their rights and benefits.¹⁹⁴ The very fact that there is a vigorous debate about the

¹⁸⁹ *Id.* at 252.

¹⁹⁰ *Id.*

¹⁹¹ See, e.g., *Kinstler*, 181 F.3d at 251 (holding that ambiguities in plan language will not be sufficient to vest discretionary authority to the plan administrator, and such ambiguities will be resolved against the plan and the employer because the power to draft clear language rests with them); *Kearney v. Standard Ins. Co.*, 175 F.3d 1084, 1091 (9th Cir. 1999) (holding that where the language reserving discretion to the plan was not explicit and three reasonable interpretations of the plan term "satisfactory. . . proof" were plausible, the court resolved the ambiguity against the plan); *Heasley v. Belden & Blake Corp.*, 2 F.3d 1249, 1257 (3d Cir. 1993) (finding the terms at issue were ambiguous and could be read in two different ways, the court utilized the federal common law of contract interpretation *contra proferentem* to resolve the ambiguity in favor of the insured).

¹⁹² *Kinstler*, 181 F.3d 243 (holding that in the absence of a clear reservation of discretion the *de novo* standard of review applies to all aspects of a denial of benefits claim under ERISA). The other aspects of denial of claim benefits under ERISA are beyond the scope of this Note.

¹⁹³ *Masella v. Blue Cross & Blue Shield of Conn. Inc.*, 936 F.2d 98, 107 (2d Cir. 1991) (quoting *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 113-114 (1989)).

¹⁹⁴ See *Stahl v. Tony's Bldg. Materials, Inc.*, 875 F.2d 1404, 1409 (9th Cir.

syntax and semantics of the plan illustrates the ambiguity and the problem of notice to plan beneficiaries.¹⁹⁵ The high standards required for plan language and the *contra proferentem* method of interpretation is both consistent and complementary to Congress' intent of safeguarding participants' rights and rewarding reasonable benefit expectations, and should therefore serve as a benchmark for legislative reform.

2. *Pro-Employer Circuits*

Contrary to the approach taken by the first category of circuits that require an explicit grant of discretion or a functional equivalent, these circuits have relaxed their standards for language that is sufficient to vest discretion in the plan administrator. This expansive approach followed by the Fourth,¹⁹⁶ Sixth,¹⁹⁷ and Seventh¹⁹⁸ Circuits is at odds with congressional purposes of promoting the interests of employees and beneficiaries.¹⁹⁹ The circuits in this category rely on general principles of contract

1989) (holding the SPD must be clear). It "does no good unless an employee can read and digest it." *Id.* The court in this case upheld the use of *contra proferentem* in an ERISA case where the language was ambiguous after interpreting the language as would an average plan participant. *Id.*

¹⁹⁵ See *Kinstler*, 181 F.3d at 251; *Kearney*, 175 F.3d at 1089-90.

¹⁹⁶ See *O'Bryhim v. Reliance Standard Life Ins. Co.*, No. 98-1472, 1999 U.S. App. LEXIS 19232, at *1 (4th Cir. Aug. 16, 1999).

¹⁹⁷ See *Perez*, 150 F.3d at 556-57 (relying on general principles of contract interpretation to interpret plan provisions according to their plain meaning and in an ordinary and popular sense).

¹⁹⁸ See *Pitcher v. Principal Mut. Life Ins. Co.*, 93 F.3d 407, 411 (7th Cir. 1996) (interpreting ERISA plans "in an ordinary and popular sense as would a person of average intelligence and experience").

¹⁹⁹ 29 U.S.C. § 1001(b) (2000).

ERISA's purpose is "to protect . . . the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to federal courts."

Id.

interpretation to interpret a plan's provisions according to their "plain meaning," in an "ordinary and popular sense."²⁰⁰ Characteristically, a "plain meaning rule" means that the court looks only to the "four corners" of the document to find the meaning of the provisions contained therein, and does not consider extrinsic evidence, such as legislative intent and interpretations offered by the parties.²⁰¹ As applied to employee health plans under ERISA, a "plain meaning" approach fails to consider the legislative intent of Congress in enacting ERISA. This approach has the effect of undermining the twin aims of ERISA,²⁰² in that participants are being afforded less rights and protections and the split amongst the circuits defeats the uniformity objective. Furthermore, the less stringent language requirement coupled with the application of the "plain meaning" rule reflects a utilitarian policy choice by the courts.²⁰³ This approach reflects the courts' attempt to encourage employers to provide health insurance for their employees by according deference to the decisions of plan administrators.²⁰⁴

a. Implied Grant of Discretion Despite Ambiguous Plan Language

The *Firestone* court stated that there must be a grant of discretion to the administrator before such decision will be given the deference of an arbitrary and capricious standard of review.²⁰⁵ The Sixth Circuit requires that a plan contain "a *clear* grant of

²⁰⁰ *Perez*, 150 F.3d at 556-57.

²⁰¹ *Id.*; see also *American Flint Glass Workers Union, AFL-CIO v. Beaumont Glass Co.*, 62 F.3d 574, 581 (3d Cir. 1995) (noting that the four corners of the contract provide the starting point for contract interpretation).

²⁰² See *supra* Part I.B (discussing the legislative history and the underlying purposes of ERISA).

²⁰³ See *supra* Part II (discussing the varying approaches to plan interpretation and the divergent policy choices underlying each approach).

²⁰⁴ See *supra* Part II (noting that there are two conflicting visions for ERISA). The pro-employer interpretation uses deference as an incentive for employers to provide insurance for their employees. ROSENBLATT, *supra* note 1, at 196 (stating that the deferential approach has the effect of reducing the employers risk of liability and keeps payout down).

²⁰⁵ See *Firestone Tire & Rubber v. Bruch*, 489 U.S. 101, 115 (1989).

discretion to determine benefits or interpret the terms of the plan.”²⁰⁶ Recently, however, the court has eased its requirements for the type of language that suffices to convey discretion to a plan administrator.²⁰⁷ For example, in *Perez v. Aetna Life Insurance Company*,²⁰⁸ the court held that language such as, “[claimant] shall furnish *written proof of ‘total disability’* [and] . . . [Aetna] shall have the right to require as part of the proof of the claim *satisfactory evidence*,”²⁰⁹ was sufficient to preclude a *de novo* standard of review despite the fact that the plan failed to specify to whom the proof must be satisfactory.²¹⁰ Although the language is subject to numerous interpretations,²¹¹ the court reasoned that the “plain language in its ordinary and popular sense” suggested that since Aetna requested the evidence and reviewed it, it followed

²⁰⁶ *Perez v. Aetna Life Ins. Co.*, 150 F.3d 550, 555 (6th Cir. 1998) (quoting *Wulf v. Quantum Chem. Corp.*, 26 F.3d 1368, 1373 (6th Cir. 1994)) (emphasis added); *see also* *Yeager v. Reliance Standard Life Ins. Co.*, 88 F.3d 376, 380-81 (6th Cir. 1996) (holding that claimant must “submit ‘satisfactory proof’ of disability to us,” clearly grants discretion to the plan); *Miller v. Metropolitan Life Ins. Co.*, 925 F.2d 979, 983 (6th Cir. 1991) (holding that the language -disability determined “on the basis of medical evidence satisfactory to the committee,”- to be clear enough to warrant an arbitrary and capricious review).

²⁰⁷ *Perez*, 150 F.3d at 557 (holding the language, shall have the “right to require as part of the proof of claim satisfactory evidence,” vests discretion in the plan, and warrants a review under an abuse of discretion standard).

²⁰⁸ *Id.* at 550.

²⁰⁹ *Id.* at 555 (emphasis added). The Aetna plan provided (1) “Written proof of total disability must be furnished to [Aetna] within ninety days after the expiration of the [first twelve months of disability]” and, (2) “[Aetna] shall have the right to require as part of the proof of claim satisfactory evidence. . . that [the claimant] has furnished all required proofs for such benefits” *Id.*

²¹⁰ *See id.* at 556.

²¹¹ *Id.* at 559 (Boggs, J., dissenting) (noting that the failure to specify to whom the proof must be satisfactory makes the language subject to different interpretations). The dissent reasons that since the policy was ambiguous about to whom the proof must be satisfactory (either to the participant or to the plan), that the “default reading should be an objective standard, satisfactory to a neutral arbiter . . . rather than satisfactory to one of the two interested parties.” *Id.* The dissent pointed out that “[r]easonable participants reading the language [in the Aetna plan] would be quite unlikely to be on notice” that the plan will have enormous discretion to make benefit determinations. *Id.*

that they made the benefits determination.²¹² The court implied discretion despite the absence of clear language reserving discretion to the plan, thus making Aetna's decision to terminate benefits reviewable under the arbitrary and capricious standard.²¹³

The Seventh Circuit has also taken an implied approach for conferring discretion in the absence of clear plan language.²¹⁴ In *Patterson v. Caterpillar*, the court held that language such as "benefits will be payable only upon receipt of . . . *such due proof as shall be required*" was adequate to apply an abuse of discretion review.²¹⁵ The court reasoned that a deferential standard of review is appropriate even where the language does not state who must receive the evidence, so long as the plan enunciates what the

²¹² *Id.* at 557. The majority stated that the failure of the plan to provide to whom the evidence must be satisfactory is inconsequential. *Id.* The court reasoned that since Aetna had the right to require as part of the proof of the claim satisfactory evidence, that semantically the evidence must be satisfactory to Aetna, the only named party with the right to request such evidence. *Id.* see also *Yeager*, 88 F.3d at 381 (holding that the word "satisfactory," obviously meant satisfactory to the insurance company and ignored the possibility that "satisfactory," as used by the plan language could warrant an objective interpretation).

²¹³ *Perez*, 150 F.3d at 558.

²¹⁴ See, e.g., *O'Bryhim v. Reliance Standard Life Ins. Co.*, No. 98-1472, 1999 U.S. App. LEXIS 19232, at *13 (4th Cir. Aug. 16, 1999) (stating that the language "submits satisfactory proof of Total Disability to us" grants discretion to the plan administrator); *Wilcox v. Reliance Standard Life Ins. Co.*, No. 98-1036, 1999 U.S. App. LEXIS 5027, at *7 (4th Cir. Mar. 23, 1999) (noting that "satisfactory proof" is sufficient to vest discretion in the plan administrator thereby precluding a *de novo* review); *Patterson v. Caterpillar Inc.*, 70 F.3d 503, 505 (7th Cir. 1995) (upholding that the plan language stating "benefits will be payable only upon receipt by the Insurance Carrier of such notice and such due proof, as shall be from time to time required, of such disability" was sufficient to warrant an arbitrary and capricious review). But see *Kearney v. Standard Ins. Co.*, 175 F.3d 1084, 1089 (9th Cir. 1999) (holding that "satisfactory proof" language has three reasonable interpretations and is insufficient to confer discretion to the plan administrator).

²¹⁵ 70 F.3d 503, 504 (7th Cir. 1995). The Caterpillar plan provides that "benefits will be payable only upon receipt by the Insurance Carrier or Company of such notice and such due proof, as shall be from time to time required, of such disability." *Id.* at 505 (emphasis added).

claimant is required to submit.²¹⁶ This case was a marked departure from a higher standard of language that had governed in the Seventh Circuit prior to this case.²¹⁷ The former benchmark standard in the Seventh Circuit, as reflected by *Donato v. Metropolitan Life Insurance Company*, required the functional equivalent of express discretion-granting language.²¹⁸

The relaxed standards used by the courts in this category for the type of language that is sufficient to confer discretion in the plan undermine ERISA's notice requirements.²¹⁹ As the dissent in *Perez* aptly noted, when the language contained in the plan is vague and ambiguous, "reasonable participants reading the language in the plan would be quite unlikely to be on notice that the plan will have enormous discretion to make benefit determinations."²²⁰ In holding that unclear language suffices to vest discretion in the plan, these courts fail to provide participants' with notice of their rights, and fails to reward expectations of benefits under the plan. This approach to plan interpretation has the dual effect of undercutting participants' rights, and creating a split among the circuits. As a result, legislative action is necessary to set

²¹⁶ *Id.* at 505.

²¹⁷ See *Donato v. Metro. Life Ins. Co.*, 19 F.3d 375, 379 (7th Cir. 1994) (holding that the language "all proof must be satisfactory to us" expressly stated that MetLife had discretionary authority over benefit decisions made pursuant to the plan).

²¹⁸ *Id.* at 379 (noting that the standard in the Seventh Circuit used to be higher, requiring an explicit discretion-granting language or a functional equivalent in order to vest discretion in the plan administrator). Recently, courts in the Seventh Circuit have returned to a *Donato* type standard for the type of discretion-granting language that is required in order accord deference to a plan administrator's decision. See, e.g., *Herzberger v. Standard Life Ins. Co.*, 205 F.3d 327 (7th Cir. 2000) (stating that "proof of loss" language is standard in an insurance contract and is insufficient to invoke discretion with the plan administrator to construe benefits and determine eligibility). *Id.* at 329

²¹⁹ See *supra* Part I (discussing the role of the Summary Plan Description as providing participants and beneficiaries with a document on which they base their expectations of benefits and obtain notice of the terms of the plan, and thus must be written to be understood by a lay person).

²²⁰ *Perez v. Aetna Life Ins. Co.*, 150 F.3d 550, 559 (6th Cir. 1998) (Boggs, J., dissenting) (stating that vague and ambiguous language is not sufficient to provide participants with notice that the plan has discretion).

standards for the language necessary to invoke discretion, and to restore uniformity throughout the federal courts.

b. Plain Meaning Rule – Method of Interpretation

In developing a body of federal common law for plan interpretation, a number of circuits rely on classical contract theories.²²¹ The rationale for applying contract theories to ERISA is based on the simple idea that employee benefit plans are written contracts.²²² As such, federal common law rules of contract interpretation determine the meaning of a policy's terms.²²³ Pursuant to a plain meaning approach, courts examine the specific language of the contract and interpret the terms as a reasonably intelligent person would.²²⁴ A number of circuits apply a plain meaning rule to the interpretation of ERISA plan provisions.²²⁵ Consistent with

²²¹ See, e.g., *Perez*, 150 F.3d at 557 (relying on general principles of contract interpretation to interpret the plan provisions according to their plain meaning, in an ordinary and popular sense); *Pitcher v. Principal Mut. Life Ins. Co.*, 93 F.3d 407, 411 (7th Cir. 1996) (interpreting ERISA plans "in an ordinary and popular sense as would a person of average intelligence and experience") (quoting *Meredith v. Allsteel Inc.*, 11 F.3d 1354, 1358 (7th Cir. 1993)); *Bellino v. Schlumberger Techs. Inc.*, 944 F.2d 26, 29-30 (1st Cir. 1991) (using basic principles of contract interpretation, "natural meaning" and "plain meaning" to interpret terms of an employee welfare benefit plan).

²²² *Bullwinkel v. New England Mut. Life Ins. Co.*, 18 F.3d 429, 430-31 (7th Cir. 1994) (noting that an insurance policy is a written contract that memorializes an agreement or "meeting of the minds" between the insurer and the insured).

²²³ *Id.*

²²⁴ See *id.*; see also RESTATEMENT OF THE LAW OF CONTRACTS § 230 (1932) ("The standard of interpretation . . . except where it produces an ambiguous result . . . is the meaning that would be attached . . . by a reasonably intelligent person acquainted with all operative usages and knowing all the circumstances . . .").

²²⁵ See, e.g., *Perez*, 150 F.3d at 556 (relying on general principles of contract interpretation to interpret the plans provisions according to their plain meaning, in an ordinary and popular sense); *Pitcher*, 93 F.3d at 411 (interpreting ERISA plans in an ordinary and popular sense as would a person of average intelligence and experience)(quoting *Meredith v. Allsteel Inc.*, 11 F.3d 1354, 1358 (7th Cir. 1993)); *Bullwinkel*, 18 F.3d at 431 (stating that "we are restricted by federal common law rules of contract interpretation to view the language of the insurance policy . . . and must give effect to the words which denote the bargain,

this approach, courts start by looking at the four corners of the document.²²⁶ If the terms are clear in light of the other provisions contained in the contract, the court does not allow extrinsic evidence such as legislative intent or the parties' interpretations.²²⁷ The problem with the application of the plain meaning rule is that the courts are reluctant to find the plan's discretion-granting language ambiguous.²²⁸ Consequently, the application of this rule results in an arbitrary and capricious review of the plan administrator's denial, which hinders a participant's recovery.²²⁹ Although the plain meaning approach is consistent with *Firestone*,²³⁰ its misapplication by the federal courts undercuts the

not in light of public policy considerations, but in light of their plain meaning"); *Bartlett v. Martin Marietta Operations Support, Inc. Life Ins. Plan*, 38 F.3d 514, 517 (10th Cir. 1994) (applying a plain meaning analysis to determine the meaning of plan terms); *Hughes v. Boston Mut. Life Ins. Co.*, 26 F.3d 264, 268 (1st Cir. 1994) (giving language in an ERISA regulated insurance policy its "natural meaning"); *Meredith v. Allsteel Inc.*, 11 F.3d 1354, 1358 (7th Cir. 1993) (stating that federal common law rules of contract interpretation require the courts to interpret the insurance contract "in an ordinary and popular sense as would a person of average intelligence and experience"); *Bellino v. Schlumberger Techs. Inc.*, 944 F.2d 26, 29 (1st Cir. 1991) (the court used basic principles of contract interpretation, "natural meaning" and "plain meaning" to interpret terms of an employee welfare benefit plan).

²²⁶ *Perez*, 150 F.3d at 556 (noting that the four corners of the contract provide the starting point for contract interpretation) (citing *American Flint Glass Workers Union AFL-CIO v. Beaumont Glass Co.*, 62 F.3d 574, 581 (3d Cir. 1995)).

²²⁷ *Bellino*, 944 F.2d at 32.

²²⁸ See *supra* note 224 (discussing the application of the plain meaning rule to denial of benefit claims under ERISA).

²²⁹ O'Neil, *supra* note 81, at 749 (stating that under an arbitrary and capricious review, the court will give deference to an administrator's decision if it is supported by substantial evidence). The decision will not be reversed even if a preponderance of evidence supports a contrary conclusion. As a result, judicial deference to the decision of a plan administrator sharply increases a claimant's disadvantage and almost always results in negative results for claimants. O'Neil, *supra* note 81, at 749.

²³⁰ *Firestone Tire & Rubber v. Bruch*, 489 U.S. 101, 112 (1989) (directing courts to consider "the provisions of the [plan] as interpreted in light of all the circumstances and such other evidence of the intention of the [plan's creator] with respect to the [plan] as is not inadmissible" and represents a divergence

legislative intent behind ERISA.

An example of such a misapplication can be found in *Perez v. Aetna Life Insurance Company*.²³¹ The plan in *Perez* states “[claimant] shall furnish *written proof of ‘total disability’* . . . [Aetna] shall have the right to require as part of the proof of the claim *satisfactory evidence*.”²³² Although the plan fails to clearly state to whom the proof must be satisfactory, the court held that the language as interpreted in its ordinary and popular sense suggests that the right to require proof of satisfactory evidence means the evidence must be satisfactory to Aetna, for Aetna is the only named party who maintains the right to request evidence.²³³ The majority opined that when read together, the logical conclusion of the phrases mandates that the proof must be satisfactory to Aetna.²³⁴ The dissent asserts that there was no clear grant of discretion as required by *Firestone*.²³⁵ In light of the absence of clear language, the dissent argued that the difference between “satisfactory” and “satisfactory to Aetna” was too great to infer, and thus opted for the term “satisfactory” to be viewed objectively, in favor of the plan participant.²³⁶

between legislative intent and practical enforcement)(quoting RESTATEMENT (SECOND) OF TRUSTS § 4, comment d (1959)).

²³¹ 150 F.3d 550 (6th Cir. 1998).

²³² *Id.* at 555 (emphasis added). The Aetna plan provided (1) “[w]ritten proof of total disability must be furnished to [Aetna] within ninety days after the expiration of the [first twelve months of disability]” (2) [Aetna] shall have the right to require as part of the proof of claim satisfactory evidence . . . that [the claimant] has furnished all required proofs for such benefits.” *Id.*

²³³ *Id.* at 556.

²³⁴ See *supra* note 211 (discussing how the *Perez* majority reasoned that ambiguities in the language were inconsequential, since logically Aetna was the only party that was able to request and review evidence).

²³⁵ See *Perez*, 150 F.3d 558-59 (Boggs, J., dissenting).

²³⁶ *Id.* (stating that unless a policy makes it explicit that the proof must be satisfactory to the decision-maker, the better reading of “satisfactory proof” is that it establishes an objective standard, (proof satisfactory to a reasonable participant) rather than a subjective one (proof satisfactory to the plan administrator)); see also, *Kinstler*, 181 F.3d at 252 (holding that where a plan is read to require “satisfactory proof,” an objective reading is favored); *Kearney*, 175 F.3d at 1086 (holding that “satisfactory written proof” was insufficient to reserve discretion to the plan administrator and invoke a *de novo* review).

The majority misapplied the plain meaning rule when it inferred that the plan contained clear and unambiguous discretion-granting language.²³⁷ The fact that both the majority and the dissent have differing reasonable interpretations of the plan language suggests that the plan's language is ambiguous.²³⁸ Accordingly, a consideration of extrinsic evidence, such as legislative intent, was warranted and should have been applied to reach a contrary result.

The Fourth Circuit applied similar principles, as a matter of common law in *O'Bryhim v. Reliance Standard Life Insurance*.²³⁹ In *O'Bryhim*, the Fourth Circuit held that the plain meaning of the language – “submits satisfactory proof . . . to us” – was sufficient to invoke an abuse of discretion standard for judicial review.²⁴⁰ Based on the plain meaning of the language interpreted in light of the other provisions contained in the policy, the court found no ambiguity in the language, and no occasion to consider legislative intent or the parties' interpretation.²⁴¹ This approach is contrary to the Second Circuit in *Kinstler*,²⁴² where the court determined that the plan language – “submits satisfactory proof . . . to us” – was insufficient to preclude *de novo* review of the administrator's decision.²⁴³ The court held that an arbitrary and capricious review of the plan administrator's decision was not warranted because the language in the policy was subject to more than one reasonable

²³⁷ *Perez*, 150 F.3d at 557.

²³⁸ *Id.* at 556, 559. In addition to the differing interpretations of the plan language by both the majority and the dissent, a third reading by a reasonable person of average intelligence is plausible. This reading suggests that all the plan language requests is “written proof” and “satisfactory evidence that the claimant has furnished such written proof.” *Id.* at 560. Thus, a claimant who furnishes proof via a facsimile transmission and receives confirmation that the transmission went through, could be under the impression that he or she has satisfactory evidence (the confirmation) that written proof had been submitted to the plan.

²³⁹ *O'Bryhim v. Reliance Standard Life Ins. Co.*, No. 98-1472, 1999 U.S. App. LEXIS 19232, at *13 (4th Cir. Aug. 16, 1999).

²⁴⁰ *Id.* at *14.

²⁴¹ *Id.* at *14-15; *see also* *Yeager v. Reliance Standard Life Ins. Co.*, 88 F.3d 376 (6th Cir. 1996); *Donato v. Metro. Life Ins. Co.*, 19 F.3d 375 (7th Cir. 1994).

²⁴² *Kinstler*, 181 F.3d 243.

²⁴³ *See supra* notes 174-193 and accompanying text (discussing how the Second Circuit requires explicit language or a functional equivalent in order to confer discretion to determine benefit eligibility to the plan).

interpretation.²⁴⁴ The court applied *contra proferentem* to resolve the ambiguity in the plan language in favor of the participant.²⁴⁵ *O'Bryhim* and *Kinstler* illustrate how the various circuits interpret the same plan language differently, causing participants who live in the Second Circuit and the Fourth Circuit to be faced with different coverage results despite being governed by the same plan language.

The misapplication of the plain meaning rule to ERISA plan interpretation fails to safeguard participants' rights and creates disunity among the circuits.²⁴⁶ The propensity of some courts to find terms unambiguous based on the plain meaning of the plan's language, precludes consideration of a reasonable participants' point of view. As a result, employers have an incentive to structure plans with vague discretion-granting language. This conflicts with ERISA's central purposes of providing adequate notice and awarding benefit expectations.²⁴⁷

It is clear that Congress intended the courts to develop rules to govern actions for benefits.²⁴⁸ Those rules, however, must be consistent with the purposes of ERISA. The approach taken by the courts in this category view ERISA's primary purpose as encouraging employers voluntarily to offer benefit plans by limiting the

²⁴⁴ See *supra* note 179-180 and accompanying text (discussing the application of *contra proferentem* in instances where the language is subject to two or more reasonable interpretations).

²⁴⁵ *Kinstler*, 181 F.3d at 251.

²⁴⁶ See *supra* notes 230-237 and accompanying text (discussing problems with the application of the plain meaning rule to ambiguous plan language).

²⁴⁷ *Kinstler*, 181 F.3d at 252 n.3 (noting that awarding deference to a plan that contains vague discretion-granting language creates a perverse incentive for employers to use vague language to insulate them from a higher standard of review); see also *Firestone*, 489 U.S. at 118 (noting that Congress' purpose in enacting ERISA disclosure provisions was so that "the individual participant knows exactly where he stands with respect to the plan.") (quoting H.R. REP. NO. 93-533, at 11 (1973)).

²⁴⁸ See 120 CONG. REC. S29942 (daily ed. Aug. 22, 1974) (Statement of Sen. Javits) (stating that "a body of federal substantive law will be developed by the courts to deal with issues involving rights and obligations under private welfare and pension plans").

liability of employers and maximizing their discretion.²⁴⁹ This policy choice favors deference to the plan and the application of the arbitrary and capricious standard of review for denial of benefit claims. This policy would not be objectionable but for the propensity of the courts to find clear discretion-granting language in ambiguous plan terms. The application of this policy to ERISA denial of benefit claims results in a failure to fulfill the legislative intent of safeguarding participants' rights through notice and disclosure and leaves participants with less protection than they would have under state law.²⁵⁰ In addition, this approach serves to defeat uniformity in the administration of employee welfare benefit plans. As a result of this "pro-employer" approach, and the division resulting from the circuit split, Congress must amend ERISA to ensure that the language used by employers to vest discretion in a plan administrator is explicit and provides participants with adequate notice.

III. WHAT HAS HAPPENED TO THE TWIN AIMS OF ERISA?

Congress must amend ERISA in order to fulfill its stated legislative purpose of protecting "the interests of participants in employee benefit plans and their beneficiaries . . . by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to federal courts."²⁵¹ The use by some courts of an implied discretion approach despite unclear plan language has the dual effect of undercutting participant safeguards and promoting disunity across the jurisdictions.

²⁴⁹ See *supra* notes 12, 113-116 and accompanying text (discussing the struggle over two versions of ERISA).

²⁵⁰ ROSENBLATT, *supra* note 1, at 219 (noting that the purpose of ERISA was to provide participants and their beneficiaries with more protection than they had traditionally been afforded under state law). State law contract doctrines aim to honor the reasonable expectations of insureds, contain an implied covenant of good faith and fair dealing, and favor the insureds interests through the application of doctrines such as *contra proferentem*. ROSENBLATT, *supra* note 1, at 146-147.

²⁵¹ 29 U.S.C. § 1001(b) (2000).

Moreover, a finding that ambiguous plan language is sufficient to vest discretion in the plan administrator fails to afford participants notice of their rights, and provides an incentive for employers to negotiate plans with elusive language. In order to fulfill both congressional intent and the Supreme Court's vision for ERISA, the statute must be amended to finally "promote the interests of employees and their beneficiaries in employee benefit plans"²⁵² and "to protect contractually defined benefits."²⁵³

A. Arbitrary & Capricious Standard of Review—Failure to Safeguard Participants Rights

The lenient application of the deferential abuse of discretion standard creates negative results for claimants.²⁵⁴ A finding by the court that a plan administrator has discretionary authority and the subsequent application of an arbitrary and capricious standard to a dispute is the practical equivalent of the cessation of judicial review over that administrator's decision.²⁵⁵ As one commentator has noted, "the rule of deferential review . . . serves no apparent function other than to impede protection of employee benefit rights."²⁵⁶

It must be remembered that ERISA was designed "to promote the interests of employees and their beneficiaries in employee benefit plans."²⁵⁷ "ERISA clearly instructs courts, in developing plan-related law, to treat as paramount the goal of protecting

²⁵² *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 90 (1983).

²⁵³ *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 148 (1985).

²⁵⁴ *See, e.g., Meditrust Financial Services Corporation v. Sterling Chemicals Inc.*, 168 F.3d 211 (5th Cir. 1999) (affirming the plan administrator's denial of claim under an arbitrary and capricious standard); *Sheppard & Enoch Pratt Hosp., Inc. v. Travelers Ins. Co.*, 32 F.3d 120 (4th Cir. 1994); *Pierre v. Connecticut Gen. Life Ins. Co.*, 932 F.2d 1552 (5th Cir. 1991). *See generally* O'Neil, *supra* note 81, at 749 n.156 (stating that "[t]he deferential standard has been applied to countless ERISA cases, almost always with negative results for claimants.").

²⁵⁵ *See supra* notes 75-76 and accompanying text.

²⁵⁶ *See Conison, supra* note 12, at 60.

²⁵⁷ *Firestone*, 489 U.S. at 113 (quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983)).

employee rights and expectations relating to benefits from plans.”²⁵⁸ A court's finding that an arbitrary and capricious standard applies despite the presence of ambiguous language shows little concern for this instruction and allows plan sponsors to “evade the fundamental purpose of ERISA.”²⁵⁹ Critics of this standard argue that it “pays little attention to ERISA's central purpose of safeguarding benefit expectations and rights” and “often seems perversely designed to thwart benefit expectations.”²⁶⁰ When rendering their decisions, courts must give consideration to the purposes of ERISA and the consequences of a finding of deferential review lest they convert ERISA from a shield for employees into a sword for employers and insurance companies. Additionally, the Supreme Court's holding in *Firestone*, and Congress' silence as to the appropriate standard of review for denial of benefit claims, has resulted in divergent interpretations and applications by federal courts. The consequence of the interpretation used by the Fourth, Sixth and Seventh Circuits²⁶¹ is that ERISA's goals of safeguarding patients' rights as well as promoting predictability and uniformity within the system is compromised.²⁶²

²⁵⁸ See Conison, *supra* note 52, at 579 (discussing how the federal common law surrounding Section 1132 (a)(1)(B) is inconsistent with ERISA's purposes of safeguarding participants' rights and awarding benefit expectations because it allows employers to structure a plan using ambiguous language which defeats benefit expectations).

²⁵⁹ Conison, *supra* note 52, at 635-636 (stating that the use of a deferential standard of review is “a doubtful rule” that allows plan sponsors to “evade the fundamental purpose of ERISA”).

²⁶⁰ Conison, *supra* note 12, at 3 (noting that an arbitrary and capricious standard for denial of benefit claims fails to safeguard patients' rights, and seems “perversely designed to thwart [participants'] benefit expectations”).

²⁶¹ See *supra* Part II.A.2. (discussing circuits that imply discretion to the plan administrator despite ambiguous plan language).

²⁶² Jonathan Heyl, *Survey of Developments in North Carolina Law and the Fourth Circuit: Bedrick v. Travelers Insurance Co.: The Fourth Circuit's Continued Attempt to Work with the 'Doctrinal Hash' of the Standard of Review in ERISA Benefit Denial Cases*, 75 N.C.L. REV. 2382, 2426 (1997) (noting that the Court's decision in *Firestone* and Congress' failure to specify a standard of review “sacrifices predictability and threatens to discourage plan formation”).

B. Problems With Uniformity

One of the fundamental purposes of ERISA was national uniformity over employees' benefits plans.²⁶³ In fact, national uniformity was one of the stated reasons why ERISA preempted then existing state laws.²⁶⁴ The diverging approaches and results by the various circuit courts defeat ERISA's purpose of national uniformity. A prime example of similarly situated employees being treated differently by the courts is available through analysis of the *O'Bryhim* case in the Fourth Circuit²⁶⁵ and *Kinstler* in the Second Circuit.²⁶⁶ In both cases the plan language governing the employees was identical. If ERISA's goal of national uniformity had been fulfilled, the employees would have been treated similarly.²⁶⁷ They were not. One was accorded *de novo* review over his denial of benefits.²⁶⁸ The other received only arbitrary and capricious review.²⁶⁹ *O'Bryhim* and *Kinstler* illustrate how two employees, subject to the same plan language, but living in different parts of the country, have different rights and receive different treatment under ERISA's presumably nationally uniform policies. It seems unlikely that the courts will resolve this divergence without Congress amending ERISA.

C. Notice and Rewarding Benefit Expectations

The legislative history behind ERISA's disclosure provisions suggests that another purpose behind the passage of ERISA was to ensure that "the individual participant knows exactly where he

²⁶³ See *supra* notes 38-45 and accompanying text.

²⁶⁴ See 120 CONG. REC. H29197 (daily ed. Aug 20, 1974) (statement of Rep. Dent) (noting that many considered "the crowning achievement of [ERISA is] the reservation to federal authority [of] the sole power to regulate the field of employee benefit plans. . .eliminating the threat of conflicting and inconsistent state and local regulation").

²⁶⁵ *O'Bryhim*, 1999 U.S. App. LEXIS 19232, at *1.

²⁶⁶ *Kinstler*, 181 F.3d 243.

²⁶⁷ See *supra* Part II.2.A.

²⁶⁸ *Kinstler*, 181 F.3d at 251.

²⁶⁹ *O'Bryhim*, 1999 U.S. App. LEXIS 19232, at *14.

stands with respect to the plan.”²⁷⁰ The presence of unclear language in the plan's SPD fails to comport with the notice and reporting requirements set forth in ERISA.²⁷¹ When confronted with this issue, the Ninth Circuit, in *Stahl v. Tony Bldg. Materials, Inc.*,²⁷² held that the SPD must be clear for it “does no good unless an employee can read and digest it.”²⁷³ The obvious objection to the use of ambiguous discretion-granting language is that it allows an employee to structure a plan in a way that facilitates the defeat of the participants' benefit expectations.²⁷⁴ As the dissent in *Perez v. Aetna Life Insurance Co.* correctly pointed out, the vague language contained in plans do not provide reasonable participants with notice that the plan administrator has such enormous discretion.²⁷⁵ Since one of the central policies of ERISA is to award benefit expectations, adequate notice of the rights and remedies that a participant has is tantamount in ensuring that benefit expectations are well grounded and to lessen the risk of disappointment.²⁷⁶ Acceptance of evasive language as sufficient to preclude *de novo* review provides employers and plans with an incentive to supply inadequate notice by purposely using vague discretion-granting language.

²⁷⁰ *Firestone*, 489 U.S. at 116 (quoting H.R. REP. NO. 93-533, 11 (1973)).

²⁷¹ See 29 U.S.C. §§ 1022, 1023, 1025 (2000); see also *id.* § 1022(a)(1)(b) (requiring that the SPD must be written in a manner calculated to be understood by the average plan participant and that the SPD contain a description of circumstances which may result in disqualification, ineligibility, or denial or loss of benefits).

²⁷² 875 F.2d 1404 (9th Cir. 1989).

²⁷³ *Id.* at 1409.

²⁷⁴ See Conison, *supra* note 12, at 35 (noting that the competing interests of employers and participants leads to the creation of plans that present a substantial danger of defeating the expectations that the plan creates in the participant).

²⁷⁵ *Perez v. Aetna Life Ins. Co.*, 150 F.3d 550, 559 (6th Cir. 1998).

²⁷⁶ See Conison, *supra* note 12, at 2 (stating that “the central policy of [ERISA] is that employees should receive the pensions and other benefits they were led to believe they would get”).

D. Perverse Incentives for Employers

In addition to the other arguments calling for the use of an explicit grant of discretion or a functional equivalent, it is important to consider the perverse incentives that employers have to deny treatment pursuant to ERISA's preemption provisions.²⁷⁷ Since ERISA's preemption provisions limit any recovery to equitable relief, employers and plans have a perverse incentive to include vague language since they face no likelihood of extra contractual damages.²⁷⁸ Toward that end, the Ninth Circuit cautioned that construing ambiguous language to vest discretion in a plan would encourage employers to use vague language to insulate themselves from having to pay out benefits owed to participants.²⁷⁹ As the late Judge Wisdom observed,

We do not want to encourage an employer to insulate himself from effective appellate review through the abuse of vague phrases that fail to make clear to the employees that the employer will have the final determination of benefit decisions. Employees who lose promised benefits should not lose the additional benefit of judicial review because their employer reserved discretionary power to itself without making that reservation clear.²⁸⁰

A finding that a plan reserves discretion based on elusive plan language has the result of affording participants less protection

²⁷⁷ See 29 U.S.C. § 1144(a) (stating that ERISA preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan"); *Id.* § 1132(a); *Pilot Life Ins. Co., v. Dedeaux* 481 U.S. 41 (1987) (holding that ERISA's civil enforcement provisions under Section 1132(a) are limited exclusively to equitable remedies for violations related to employee benefit plans).

²⁷⁸ ROSENBLATT, *supra* note 1, at 1046 (noting that ERISA preemption has given insurers and plans the perverse incentive to make medically and factually unsupportable coverage decisions because they face no likelihood of damages).

²⁷⁹ See *Bogue v. Ampex Corp.*, 976 F.2d 1319, 1325 (9th Cir. 1992).

²⁸⁰ *Id.* at 1325 (quoting Judge Wisdom, sitting by designation with the Ninth Circuit).

under ERISA than they had previously enjoyed under state law.²⁸¹ The Second Circuit, in *Kinstler v. First Reliance*,²⁸² cautioned against this position and also noted that “since clear language can be readily drafted and included in policies, even in the context of collectively bargained benefit plans when the parties really intend to subject claim denials to judicial review under a deferential standard, courts should require clear language. . . .”²⁸³ A failure to require clear and explicit language reserving discretion to the plan fails to provide participants with notice of their rights, in direct contradiction of the statute.

E. Fiduciary Duty and Conflict of Interest – Modified Deferential Review

Section 1102 (a)(1) of ERISA provides that “[E]very employee benefit plan shall be established and maintained pursuant to a written instrument . . . [and] such instrument shall provide for one or more named fiduciaries who jointly or severally shall have authority to control and manage the operation and administration of the plan.”²⁸⁴ The fiduciary or plan administrator named in the plan is not required to be independent of the plan sponsor, thus leaving the potential for a conflict of interest.²⁸⁵ ERISA was enacted in 1974, a time known as the “blank check era” in the medical community.²⁸⁶ With little focus on cost containment, and

²⁸¹ *Mertens v. Hewitt Ass’n*, 508 U.S. 248, 266-67 (1993) (White, J., dissenting) (stating that reference to “appropriate equitable relief” contained in ERISA’s civil enforcement provision should not be limited exclusively to equitable remedies). “Construing the statute in this manner avoids the anomaly of interpreting ERISA so as to leave those Congress set out to protect - the participants in ERISA governed plans and their beneficiaries with less protection . . . than they enjoyed before ERISA was enacted.” *Id.* (quoting *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989)).

²⁸² *Kinstler v. First Reliance Life Ins. Co.*, 181 F.3d 243 (2d Cir. 1999).

²⁸³ *Id.* at 252.

²⁸⁴ 29 U.S.C. § 1102(a)(1) (2000).

²⁸⁵ *Id.* § 1108(c)(3). For example, a company may serve as an administrator to an employer funded plan, or an insurance company may administer the plan and pay claims out of funds it has received from employer premiums.

²⁸⁶ See JAMES C. ROBINSON, *THE CORPORATE PRACTICE OF MEDICINE* 65

a reliance on the LMRA, courts presumed that they should defer to fiduciary decisions about benefit entitlement and plan interpretation.²⁸⁷ Today, however, in light of managed care principles and an emphasis on cost containment, most plan administrators have a financial interest in curtailing the payment of benefits.²⁸⁸ Consequently, the relationship between a participant in a health plan and the plan administrator is not a neutral relationship.²⁸⁹ Accordingly, granting unfettered deference to a plan administrator who has an economic incentive to keep treatment costs low is inappropriate because of the conflict of interest it presents.²⁹⁰

(1999).

The 'Blank Check Era' of medicine in the U.S. refers to a period of time under which traditional indemnity insurance governed the delivery of health care services in this country. Indemnity insurance refers to a payment structure under which physicians' provided services to patients, and were then subsequently paid by the patient or by the patients' insurer for the services rendered. The indemnity contract or service contract covered clinical services provided by any licensed physician, without differentiation according to cost or quality. Physicians billed services and received reimbursement on a fee for service basis. This era is marked by having very high rates of reimbursement for services, and is charged in part with contributing to the health care cost crisis that brought about initiatives and attempts at health care reform.

Id. at 65.

²⁸⁷ See *supra* notes 78-79 and accompanying text (discussing the wholesale importation of the arbitrary and capricious standard of review from LMRA cases into ERISA).

²⁸⁸ O'Neil, *supra* note 81, at 749 (noting that plan administrators may have financial incentives to deny treatment).

By holding that deferential review of ERISA benefits decisions turns on the particular language of the plan rather than questions of conflict of interest, bias, and lack of impartiality on the part of the plan administrator, [Firestone] seriously undermined the purpose of ERISA even as the Court affirmed that ERISA was intended to 'promote the interests of employees and their beneficiaries in employee benefit plans.'

O'Neil, *supra* note 81, at 749 (citing *Firestone*, 489 U.S. 101 at 113).

²⁸⁹ O'Neil, *supra* note 81, at 749.

²⁹⁰ See *Brown v. Blue Cross & Blue Shield of Ala., Inc.*, 898 F.2d 1556-67 (11th Cir. 1990), *cert denied*, 489 U.S. 1040 (1990) (noting that the fiduciary

The Supreme Court in *Firestone* recognized this potential conflict, and suggested that a plan administrator's conflict of interest "must be weighed as 'a factor in determining whether there is an abuse of discretion.'"²⁹¹ This became known as a modified abuse of discretion standard, which affords less deference to an administrator's review when he or she is operating under a conflict of interest.²⁹² In light of the emphasis on cost containment placed upon plan administrators, it seems inconsistent to allow employers and plans the additional advantage of structuring a policy to defeat participants' expectations.²⁹³ The use of vague discretion-granting language, and the tendency of some courts to accord deference despite such language, simply enlarges the potential for ineffective judicial review.

F. Statutory Reform

Congress should amend ERISA to require that health plans contain explicit or express discretion-granting language, such as "discretion" or "deference to" in order to effectively confer discretion upon the plan administrator and restrict judicial review to an abuse of discretion standard. Congress' intent behind enacting ERISA was to safeguard the rights of participants and beneficiaries

role of an insurance company lies in perpetual conflict with its profit making role as a business).

²⁹¹ *Firestone*, 489 U.S. at 115 (quoting RESTATEMENT (SECOND) OF TRUSTS § 187 (1959)).

²⁹² See *Brown*, 898 F.2d 1556-1567 (stating that when a plan beneficiary demonstrates that there is a substantial conflict of interest on the part of the fiduciary responsible for benefit determinations, the burden shifts to the fiduciary to prove that its interpretation of plan provisions committed to its discretion was not tainted by self interest).

²⁹³ O'Neil, *supra* note 81, at 749.

The relationship between a benefits claimant and a benefits plan administrator is not a neutral relationship. With very few exceptions, the plan administrator – whether the employer itself, a retained administrator of an employer-funded plan, or an insurance company – will have a financial interest in curtailing the payment of benefits, an interest often heightened in the current cost-conscious climate.

O'Neil, *supra* note 81, at 749.

and to promote a predictable and uniform system for the structure and administration of employee welfare benefit plans.²⁹⁴ Although this amendment will not ensure that incorrect decisions are remedied, it will fulfill ERISA's promise of providing participants and their beneficiaries with notice of their rights and establish uniform standards for judicial review of ERISA denial of benefit claims.²⁹⁵

Providing participants with notice will have the dual effect of creating an informed and educated participants, and rewarding the contractually defined benefit expectations promised in the plan.²⁹⁶ Although notice alone will not be able to rectify incorrect decisions, an educated participant will operate as a check on plan administrators, thereby promoting administrative efficiency. Moreover, this amendment leaves room for parties to negotiate alternatives to judicial resolution in the context of the collectively bargained agreement. Parties contracting for health benefits could provide for alternative dispute resolution, such as arbitration and mediation, in an effort to resolve denial of benefit claims without involving the judiciary. Pursuant to this alternative, the parties involved would be able to negotiate a procedure and a standard of review for the resolution of the dispute, thereby conserving costs to participants and eliminating the burden on courts. Although this amendment enables plans to receive an arbitrary and capricious standard of review, it comports with ERISA's purpose of safeguarding participants rights by ensuring that participants' will have explicit notice of their rights, and that their benefit expectations will be rewarded.²⁹⁷ Additionally, setting a standard for the type

²⁹⁴ See generally 29 U.S.C. § 1001 (2000).

²⁹⁵ See *supra* notes 51-58 and accompanying text (discussing the importance of ERISA's information disclosure requirements, the summary plan description and the importance the SPD as the governing document in the administration of benefits).

²⁹⁶ See *Firestone*, 489 U.S. at 112 (noting that ERISA was designed to promote the interest of employees in employee welfare benefit plans and to protect contractually defined benefits); see also *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 90 (1983); *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 148 (1985).

²⁹⁷ See Heyl, *supra* note 262, at 2420 (stating that a *de novo* review would further certain goals, but there are other practical concerns such as increased

of language necessary to invoke an arbitrary and capricious review will serve to promote uniformity and stability in the drafting and structuring of private health plans.

CONCLUSION

It is clear that Congress intended the courts to develop rules to govern actions for benefits.²⁹⁸ Those rules however, must be consistent with the purposes of ERISA. The federal common law approach to standard of review creates a divergence between legislative intent and practical enforcement. Contrary to ERISA's legislative purpose, courts have interpreted plan language in ways that undermine participants' rights, and provide employers and plan administrators with a perverse incentive to structure plans containing vague language. An amendment to ERISA requiring that plans use explicit discretion-granting language, such as "discretion to" or "deference to" in order to effectively confer an arbitrary and capricious standard of review for denial of benefit claims is necessary to comport with ERISA's protective policies of safeguarding benefit expectations through notice, and promoting uniformity throughout the system of benefits administration.

litigation and administrative costs. As a result of a reduction of plan benefits, costs would be passed on to participants through higher premiums); George Lee Flint, Jr., *ERISA: The Arbitrary and Capricious Rule Under Siege*, 39 CATH. U. L. REV. 133, 181 (1989) (noting that plan administrators are concerned that a higher standard of review would increase litigation, costs to the plan, and ultimately participants premiums).

²⁹⁸ See 120 CONG. REC. S29942 (daily ed. Aug. 22, 1974) (Statement by Sen. Javits). Senator Javits said that "a body of federal substantive law will be developed by the courts to deal with issues involving rights and obligations under private welfare and pension plans." *Id.*

