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ERISA's Unspoken Standard: The Fight for Employee Benefits

*Riedl v. General American Life Insurance Co.*¹

I. INTRODUCTION

Employee benefit plans provide a myriad of benefits to millions of workers throughout the United States. Most Americans receive insurance benefits through employer-provided benefit plans. In fact, nearly seventy-five percent of all American workers receive some form of insurance through their workplace.² Health insurance coverage provided as a fringe benefit of employment protects more than 150 million Americans.³ A significant amount of life insurance is obtained through employment.⁴ Furthermore, most disability income insurance coverage is “offered as part of an employee group benefit package.”⁵

Due to the prevalence of such plans, Congress sought to protect the interests of these covered employees and their beneficiaries.⁶ The result of Congress's efforts was the passage of the Employee Retirement Income Security Act (“ERISA”) in 1974.⁷ Although ERISA is a “comprehensive and reticulated

1. 248 F.3d 753 (8th Cir. 2001).

2. HEALTH INS. ASS'N OF AM., BOOK OF HEALTH INSURANCE DATA 1999-2000, at 4, fig. 1.1. In 1997, there were 122.7 million wage and salary earners in the United States. *Id.* Ninety-one million of those workers received insurance through their employers. *Id.*

3. *Id.* at 23. An estimated 152 million Americans are covered by health insurance offered by employee benefit plans. *Id.*

4. In 1999, group life insurance constituted thirty-nine percent of all life insurance policies in force. AM. COUNCIL OF LIFE INSURERS, LIFE INSURANCE FACT BOOK 2000, at 2, tbl. 1.1. The number of group life insurance policies has increased 5.9% annually since 1989. *Id.* “Group life insurance is a contract between an insurance company and some group to insure all members of that group.” *Id.* at 16. Life insurance provided by employee benefit plans, professional associations, and unions represent a significant amount of all group life insurance policies. *See id.*

5. *Id.* at 58. Workers are more readily able to obtain disability insurance through work due to the prohibitive costs of obtaining an individual policy. *Id.* Only 12.3% of all disability income insurance in force is individual policies. *Id.* at 57, tbl. 3.3. The remaining 87.7% of disability income insurance is provided by group plans. *Id.*

6. *See* 29 U.S.C. § 1001 (1994).

7. 29 U.S.C. §§ 1001-1461 (1994).

statute,"⁸ numerous battles over its language have garnered much attention from the court system during the twenty-eight years since its enactment.

One such dispute concerns the appropriate standard of review to employ when adjudicating a denial of benefits under ERISA. In *Riedl v. General American Life Insurance Co.*,⁹ the United States Court of Appeals for the Eighth Circuit limited the use of an abuse of discretion standard in reviews of claim denials based on factual determinations under 29 U.S.C. § 1132(a)(1)(B)¹⁰ to circumstances in which the plan provides that discretionary authority is granted to the plan administrator.¹¹ In its ruling, the Eighth Circuit clearly adopted the majority rule applying a *de novo* standard of review.

After establishing the facts and holding of the instant decision, this Note briefly discusses the history of ERISA and examines the differing rationales regarding whether to apply an abuse of discretion¹² or *de novo*¹³ standard when reviewing a claim denial based on a factual determination. This Note reviews major decisions made by the United States Supreme Court on a similar issue, as well as the majority and minority views on the subject. Ultimately, this Note concludes that the majority approach to apply a *de novo* review in such situations is most appropriate in light of ERISA's goal of protecting beneficiaries of employee benefit plans.

8. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 108 (1989) (quoting *Nachman Corp. v. Pension Benefit Guar. Corp.*, 446 U.S. 359, 361 (1980)).

9. 248 F.3d 753 (8th Cir. 2001).

10. A participant or beneficiary may file suit "to recover benefits due to him under the terms of his 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." 29 U.S.C. § 1132(a)(1)(B) (1994).

11. *Riedl*, 248 F.3d at 756.

12. "[An abuse of discretion] standard means 'that the court has a range of choice, and its decision will not be disturbed as long as it stays within that range[.]' is not influenced by any mistake of law' or fact, or makes a clear error of judgment in balancing relevant factors." *Miscellaneous Docket #1 v. Miscellaneous Docket #2*, 197 F.3d 922, 925 (8th Cir. 1999) (quoting *McKnight v. Johnson Controls, Inc.*, 36 F.3d 1396, 1403 (8th Cir. 1994)).

13. An appeal *de novo* is defined as "[a]n appeal in which the appellate court uses the trial court's record but reviews the evidence and law without deference to the trial court's rulings." *BLACK'S LAW DICTIONARY* 94 (7th ed. 1999). "When we review a district court's decision *de novo*, we take note of it, and study the reasoning on which it is based. However, our review is independent and plenary; as the Latin terms suggests, we look at the matter anew, as though it has come to the courts for the first time." *Zervos v. Verizon N.Y., Inc.*, 252 F.3d 163, 168 (2d Cir. 2001).

II. FACTS AND HOLDING

John D. Riedl ("Riedl") was an employee of Phillips Petroleum Company ("Phillips").¹⁴ As such, Riedl participated in a long-term disability insurance plan issued and administered by General American Life Insurance Company ("General American").¹⁵ On April 19, 1995, Riedl did not report for work due to persistent chest pain.¹⁶ As a result of his medical condition, he did not return to work for several months and underwent an angioplasty in August 1995.¹⁷ One month after the procedure, Riedl was authorized "to return to work without any restrictions."¹⁸ However, he accepted an early retirement package and never returned to his job at Phillips.¹⁹ After retiring, Riedl submitted an application for long-term disability benefits to General American.²⁰ General American denied the claim and refused coverage on the grounds that Riedl was not eligible for benefits according to the terms of his insurance policy.²¹

Consequently, Riedl filed suit pursuant to 29 U.S.C. § 1132(a)(1)(B),²² alleging that he was entitled to disability benefits under the policy.²³ "Both

14. *Riedl*, 248 F.3d at 754.

15. *Id.*

16. *Id.* Riedl had a history of chronic chest pain and suffered a heart attack in 1993. *Id.*

17. *Id.*

18. *Id.* at 755.

19. *Id.*

20. *Id.* Riedl's physician stated that Riedl "was unable to work at any job because of his chronic chest pain." *Id.* Also, the Social Security Administration considered Riedl "permanently and totally disabled" in determining his eligibility for Social Security benefits. *Id.*

21. *Id.* The insurance plan provided that an employee must be "unable to work at his regular job or at a reasonable occupation which is available with the Employer" due to "injury, sickness, or pregnancy." *Id.* at 757-58 (quoting the insurance policy provision). The doctor who filed an Attending Physician's Statement of Disability Form concluded that Riedl could not continue employment with Phillips in his original capacity but was able to perform other work. *Id.* at 755. General American based its denial of Riedl's claim on five grounds: 1) Riedl's cardiologist released him without any work restrictions; 2) Riedl informed General American that he was able to continue working; 3) Riedl's decision to cease employment at Phillips was not attributed to his chest pain but was a result of his acceptance of the early-retirement package offered by General American; 4) none of Riedl's doctors stated that he was unable to continue employment at Phillips in any capacity during the qualifying period; and 5) Riedl's claims of chronic chest pain cannot be supported by any objective evidence. *Id.* at 757.

22. For the relevant text of 29 U.S.C. § 1132(a)(1)(B) (1994), see *supra* note 10.

23. *Riedl*, 248 F.3d at 755.

parties filed motions for summary judgment.”²⁴ The United States District Court for the Western District of Missouri reviewed *de novo* General American’s decision to deny Riedl’s claim for benefits.²⁵ The court granted Riedl’s motion for summary judgment, holding that he clearly established that he was unable to continue working at Phillips.²⁶

General American appealed, claiming that the district court failed to apply the correct standard of review.²⁷ General American argued that the district court should have applied an “abuse of discretion” standard, rather than review the decision *de novo*.²⁸ On appeal, the United States Court of Appeals for the Eighth Circuit held that the district court applied the appropriate standard of review;²⁹ however, the Eighth Circuit reversed the grant of summary judgment, holding that a genuine issue of material fact still existed as to whether Riedl was “totally disabled” according to the terms of the plan.³⁰ The Eighth Circuit held that whenever a policy governed by ERISA lacks any provision granting the administrator discretionary authority to determine eligibility for benefits or to construe the terms of the policy, the administrator’s factual determinations should be reviewed *de novo*.³¹

III. LEGAL BACKGROUND

A. Introduction to ERISA

In 1974, Congress enacted ERISA to address the significant “growth in [the] size, scope, and numbers of employee benefit plans.”³² Congress noted that “the continued well-being and security of millions of employees and their dependants are directly affected by these plans.”³³ ERISA subjected any plan providing fringe benefits to employees to federal regulation.³⁴ Among the various fringe benefits provided by employee benefit plans regulated by ERISA are insurance policies purchased on behalf of employees to provide “medical,

24. *Id.*

25. *Id.*

26. *Id.*

27. *Id.* at 755-56.

28. *Id.* at 756.

29. *Id.*

30. *Id.* at 759-60.

31. *Id.* at 755-56.

32. 29 U.S.C. § 1001(a) (1994).

33. 29 U.S.C. § 1001(a) (1994). Congress also noted that “many employees with long years of employment are losing anticipated retirement benefits.” 29 U.S.C. § 1001(a) (1994).

34. See generally 29 U.S.C. § 1002 (1994).

surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment.”³⁵

Through federal regulation, Congress sought to protect participants in employee benefit plans and their beneficiaries.³⁶ Section 1001(b) explicitly states that the underlying policy behind ERISA is “to 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 appropriate remedies, sanctions, and ready access to courts.”³⁷

When the administrator of an employee benefit plan wrongfully denies benefits, a plan participant or beneficiary may file an action to challenge the administrator’s decision.³⁸ Section 1132 permits a plaintiff in such an action “to recover benefits due to him under the terms of his 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.”³⁹ ERISA, however, does not expressly provide the standard of review applicable to such actions.⁴⁰

B. Application of De Novo Review to Plan Term Interpretations

In *Firestone Tire & Rubber Co. v. Bruch*,⁴¹ the United States Supreme Court held that a *de novo* standard should apply when reviewing an administrator’s decision to deny a plan participant’s claim for benefits in the absence of a provision granting discretionary authority to the administrator.⁴² In

35. 29 U.S.C. § 1002(1)(A) (1994).

36. *See* 29 U.S.C. § 1001(b) (1994).

37. 29 U.S.C. § 1001(b) (1994).

38. 29 U.S.C. § 1132(a) (1994).

39. 29 U.S.C. § 1132(a)(1)(B) (1994).

40. *See, e.g., Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 109 (1989) (“ERISA does not set out the appropriate standard of review for actions under § 1132(a)(1)(B) challenging benefit eligibility determinations.”); *Luby v. Teamsters Health, Welfare, & Pension Trust Funds*, 944 F.2d 1176, 1179 (3d Cir. 1991) (“ERISA is silent on the proper standard by which the district court should review fact findings made by plan administrators”); *Pierre v. Conn. Gen. Life Ins. Co./Life Ins. Co. of N. Am.*, 932 F.2d 1552, 1555 (5th Cir. 1991), *cert. denied*, 502 U.S. 973 (1991) (“ERISA does not set out the appropriate standard of review for evaluating benefit determinations of plan administrators . . . in actions challenging those determinations under § 1132(a)(1)(B).”); *Petrilli v. Drechsel*, 910 F.2d 1441, 1445 (7th Cir. 1990) (“ERISA does not specify a standard of review to be used by the district courts in evaluating benefit denials by plan administrators.”).

41. 489 U.S. 101 (1989).

42. *Id.* at 115. Prior to the Court’s decision, federal courts applied an “arbitrary and capricious” standard when reviewing a denial of benefits under § 1132(a)(1)(B). *Id.* Published by University of Missouri School of Law Scholarship Repository, 2002

reaching its decision, the Court relied heavily on principles of trust law.⁴³ The Court noted that “a deferential standard of review [is] appropriate when a trustee exercises discretionary powers.”⁴⁴ As a result, a reviewing court normally should not interfere with the judgment of a trustee.⁴⁵ In order to apply a deferential standard, a court must be satisfied that the document governing the plan provides the trustee with such discretionary authority.⁴⁶ Therefore, the lack of a provision granting such discretion would require a court to apply a *de novo* standard of review.⁴⁷

Additionally, the Court recognized that ERISA’s goal is “to promote the interests of employees and their beneficiaries.”⁴⁸ Prior to the enactment of ERISA, courts applied principles of contract law in reviewing a denial of benefits.⁴⁹ Applying a deferential standard of review, even in the absence of language within the plan granting discretionary authority, “would afford less protection to employees and their beneficiaries than they enjoyed before ERISA was enacted.”⁵⁰ Therefore, “a denial of benefits challenged under § 1132(a)(1)(B) is to be reviewed under a *de novo* standard unless the benefit plan expressly gives the administrator . . . discretionary authority to determine eligibility for benefits or to construe the terms of the plan.”⁵¹

at 109-10.

43. *Id.* at 110-13, 115. “In determining the appropriate standard of review for actions under § 1132(a)(1)(B), we are guided by principles of trust law.” *Id.* at 111. The Court noted that the Employee Retirement Income Security Act (“ERISA”) contains numerous references to terminology often used in trust law. *Id.* Furthermore, the Court reviewed legislative history that confirmed ERISA applied certain principles of trust law. *Id.* at 110; see H.R. REP. NO. 93-533, at 11 (1973), reprinted in 1974 U.S.C.A.N. 4639, 4649.

44. *Bruch*, 489 U.S. at 111.

45. *Id.* “[A] court of equity will not interfere to control [the trustee] in the exercise of a discretion vested in [him or her] by the instrument under which [the trustee] act[s].” *Id.* (quoting *Nicholas v. Eaton*, 91 U.S. 716, 724-25 (1875)) (emphasis in original); see RESTATEMENT (SECOND) OF TRUSTS § 187 (1959) (“Where discretion is conferred upon the trustee with respect to the exercise of a power, its exercise is not subject to control by the court, except to prevent an abuse by the trustee of his discretion.”).

46. See *Bruch*, 489 U.S. at 111-12.

47. *Id.* at 111-12, 115.

48. *Id.* at 113 (quoting *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 90 (1983)).

49. *Id.* at 112-13. “The trust law *de novo* standard of review is consistent with the judicial interpretation of employee benefit plans prior to the enactment of ERISA.” *Id.* at 112.

50. *Id.* at 114.

51. *Id.* at 115.

The Supreme Court, however, arguably limited its holding to plan term interpretations,⁵² stating that "[t]he discussion . . . is limited to the appropriate standard of review in § 1132(a)(1)(B) actions challenging denials of benefits based on plan interpretations. We express no view as to the appropriate standard of review for actions under other remedial provisions of ERISA."⁵³ This statement has created controversy regarding whether a *de novo* standard is appropriate in all ERISA reviews or merely in reviews concerning interpretations of plan term limitations.⁵⁴ Consequently, the circuit courts are divided regarding which standard of review is appropriate for factual determinations made by plan administrators.⁵⁵

52. See *id.* at 108; see also *Pierre v. Conn. Gen. Life Ins. Co./Life Ins. Co. of N. Am.*, 932 F.2d 1552, 1556 (5th Cir. 1991), *cert denied*, 502 U.S. 973 (1991) ("[A] point of tension is created by *Bruch*'s express limitation . . . and . . . the absence of the express limitation in the latter part of the opinion."). Prior to the Supreme Court granting certiorari, the Third Circuit, in its *Bruch* decision, limited its holding to plan interpretations. *Bruch v. Firestone Tire & Rubber Co.*, 828 F.2d 134, 144 n.9 (3d Cir. 1987), *aff'd in part and rev'd in part by Bruch*, 489 U.S. 101 (1989). "It should be noted that we also do not deal here with a determination of fact by a plan administrator. We leave for another day the definition of the context . . . in which courts should defer to such a determinations [sic]." *Id.*

53. *Bruch*, 489 U.S. at 108.

54. See *Luby v. Teamsters Health, Welfare, & Pension Trust Funds*, 944 F.2d 1176, 1182 (3d Cir. 1991) ("The split among federal courts on this question results from divergent readings of the scope of *Firestone*'s holding."); *Pierre*, 932 F.2d at 1556 ("[A] point of tension is created by *Bruch*'s express limitation . . . and . . . the absence of the express limitation in the latter part of the opinion.").

55. See, e.g., *Riedl v. Gen. Am. Life Ins. Co.*, 248 F.3d 753, 756 n.2 (8th Cir. 2001) ("We note disagreement among our sister circuits."); *Kinstler v. First Reliable Standard Life Ins. Co.*, 181 F.3d 243, 249 (2d Cir. 1999) ("The four circuits that have explicitly considered this issue are divided."); *Rowan v. Unum Life Ins. Co. of Am.*, 119 F.3d 433, 435 (6th Cir. 1997) ("We thus join every other circuit . . . in rejecting *Pierre*."); *Ramsey v. Hercules Inc.*, 77 F.3d 199, 202 (7th Cir. 1996) ("[T]he courts have disagreed about whether *Firestone* requires *de novo* review only of benefit denials based upon an interpretation of a plan or also of benefit denials based upon factual determinations."); see also 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 USCS § 1132(a)(1)(B))—Post-Firestone Cases*, 128 A.L.R.FED. 1, 19 (1995).

C. *The Circuit Split*1. The Majority View: *De Novo* Review for Factual Determinations

The majority of circuits that have addressed the issue directly have ruled that the Supreme Court's holding in *Bruch* should apply to factual determinations without any distinction from plan term interpretations.⁵⁶ In *Petrilli v. Drechsel*,⁵⁷ the Seventh Circuit became the first circuit to address whether a *de novo* review is applicable to plan term interpretations and factual determinations without any distinction.⁵⁸ The court examined the district court's rationale for distinguishing plan term interpretations and factual determinations.⁵⁹ It noted that "[t]he Third Circuit in *Bruch* explicitly reserved comment on the proper standard of review for factual determinations."⁶⁰ Arguably, the matter on appeal to the Supreme Court would be limited to plan term limitations, not factual determinations.⁶¹ The Supreme Court's actual holding, however, contained no limitation.⁶² The Seventh Circuit construed the lack of any limiting statement in the holding to mean that the Supreme Court had no intention of distinguishing plan term interpretations from factual determinations.⁶³

[T]he holding strongly suggests that the Court intended *de novo* review to be mandatory where administrators were not granted

56. *Walker v. Am. Home Shield Long Term Disability Plan*, 180 F.3d 1065, 1069 (9th Cir. 1999). "The majority of federal appellate courts that have considered the issue concluded . . . that *Firestone* did not leave open the issue of whether factual determinations should be reviewed under a different standard than plan interpretations." *Id.*; see, e.g., *Kinstler*, 181 F.3d at 249-51; *Rowan*, 119 F.3d at 435-36; *Ramsey*, 77 F.3d at 202-05; *Luby*, 944 F.2d at 1179-80, 1181-84; *Reinking v. Philadelphia Am. Life Ins. Co.*, 910 F.2d 1210, 1213-14 (4th Cir. 1990).

57. 910 F.2d 1441 (7th Cir. 1990).

58. *Id.* at 1446. "We have found no circuit court case that has explicitly addressed this issue" *Id.*

59. *Id.*

60. *Id.* "It should be noted that we also do not deal here with a determination of fact by a plan administrator. We leave for another day the definition of the context . . . in which courts should defer to such a determination." *Id.* (quoting *Bruch v. Firestone Tire & Rubber Co.*, 828 F.2d 134, 144 n.9 (3d Cir. 1987), *aff'd in part and rev'd in part* by *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989)).

61. *Id.*

62. *Id.*; see *Bruch*, 489 U.S. at 115. "[A] denial of benefits . . . is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator . . . discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Bruch*, 489 U.S. at 115.

63. *Petrilli*, 910 F.2d at 1446.

discretion, regardless of whether the denials under review were based on plan interpretations. If this were not the intent, the Court could have omitted the words "to determine eligibility for benefits," from the above-quoted holding and confined the "unless" clause to "unless the benefit plan gives the administrator or fiduciary discretionary authority to construe the terms of the plan."⁶⁴

The Seventh Circuit, however, held that the case involved a plan interpretation.⁶⁵ Therefore, its discussion about the correct standard of review to apply to factual determinations was dictum.⁶⁶

In *Ramsey v. Hercules Inc.*,⁶⁷ the Seventh Circuit officially adopted the position it had postulated several years earlier in *Petrilli*.⁶⁸ Furthermore, the *Ramsey* court noted that, under trust law, "courts do not alter the standard under which they review a trustee's decision based on the characterization of that decision as interpretive or factual."⁶⁹ Consequently, the court held that there is "no meaningful distinction between factual determinations and legal interpretations of plan administrators."⁷⁰ Because there is no meaningful distinction between the two types of decisions, the court held that both plan interpretations and factual determinations should be subject to *de novo* review when a plan does not grant discretionary authority to the administrator.⁷¹

The Third Circuit also addressed the issue in *Luby v. Teamsters Health, Welfare, & Pension Trust Funds*.⁷² Similar to the dictum in *Petrilli*, the Third Circuit addressed the significance of the Supreme Court's limiting statement in *Bruch*.⁷³ The court recognized that the courts holding that a deferential standard of review is appropriate for factual determinations partially have based their

64. *Id.*

65. *Id.* "Since we conclude that the denial of Petrilli's benefits was based on a plan interpretation, we need not choose between these competing interpretations . . ." *Id.*

66. *Id.* at 1446-47. Several years later, the Seventh Circuit had an opportunity to rule on the issue and held that a *de novo* review should be applied to factual determinations. See *Ramsey v. Hercules Inc.*, 77 F.3d 199, 202-05 (7th Cir. 1996).

67. 77 F.3d 199 (7th Cir. 1996).

68. *Id.* at 202-05. The Seventh Circuit in *Ramsey* reviewed the dicta portion of the *Petrilli* opinion in supporting its decision to apply a *de novo* review to factual determinations and plan interpretations. *Id.* at 202-03.

69. *Id.* at 203.

70. *Id.* at 204.

71. *Id.*

72. 944 F.2d 1176 (3d Cir. 1991). "The question . . . is whether . . . [a] *de novo* review of benefit denials based upon administrator interpretations of ERISA plan terminology extends to . . . factfinding." *Id.* at 1182.

73. *Id.* at 1182-83.

holdings upon the rationale that the Supreme Court's holding must be examined in light of the limiting statement.⁷⁴ However, the Third Circuit minimized the importance of the limiting statement by emphasizing the lack of any limitation actually contained in the Supreme Court's holding.⁷⁵ Instead, the court stated that the Supreme Court's limiting statement was intended to "distinguish between remedial actions challenging claim denials brought under 29 U.S.C. § 1132(a)(1)(B) and remedial actions based on or brought under *other* ERISA provisions."⁷⁶

Another argument the Third Circuit advanced in *Luby* was that a deferential review is afforded to governmental agencies due to their expertise.⁷⁷ Such expertise is not presumed with plan administrators, who are often "laypersons appointed . . . sometimes without any legal, accounting, or other training preparing them for their responsible position . . . [and with] little knowledge of the rules of evidence or legal procedures to assist them in factfinding."⁷⁸ As a result, the argument in *Pierre v. Connecticut General Life Insurance Co./Life Insurance Co. of North America*⁷⁹ that a fact-finding body is normally granted discretion in its fact-finding capacity does not apply to situations involving layperson plan administrators.⁸⁰ Therefore, the expertise of the fact-finding body, often cited as a reason to apply a deferential standard of review, is not present in such situations as in other review procedures.⁸¹ Consequently, a *de*

74. *Id.*

75. *Id.* The court supported its holding by citing the rationale used by the Seventh Circuit in *Petrilli*. *Id.* at 1183. For a discussion of the *Petrilli* rationale, see *supra* notes 57-66 and accompanying text.

76. *Luby*, 944 F.2d at 1183 (emphasis in original). "We express no view as to the appropriate standard of review for actions under other remedial provisions of ERISA." *Id.* (quoting *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 108 (1989)). This statement, read in conjunction with the limiting statement immediately preceding it, appears to distinguish § 1132(a)(1)(B) actions from remedies provided by other ERISA provisions. *Id.* The Ninth Circuit agreed with the Third Circuit on this point, stating that the limiting statement "must be read in tandem with the sentence that follows." *Walker v. Am. Home Shield Long Term Disability Plan*, 180 F.3d 1065, 1070 (9th Cir. 1999). "[T]he limiting language logically means that *Firestone* was intended to address the standard of review only under . . . § 1132(a)(1)(B), not under other remedial provisions." *Id.*

77. *Luby*, 944 F.2d at 1183. "[G]overnmental agencies . . . are frequently granted deferential review because of their acknowledged expertise." *Id.*

78. *Id.*

79. 932 F.2d 1552 (5th Cir. 1991).

80. *Luby*, 944 F.2d at 1183. For a discussion of the arguments made in *Pierre*, see *infra* notes 94-115 and accompanying text.

81. *Luby*, 944 F.2d at 1183.

novo standard is appropriate whenever reviewing a plan administrator's decision to deny benefits based upon plan limitations or factual determinations.⁸²

The Sixth Circuit also joined the majority of circuits in rejecting the ruling reached in *Pierre*, holding that "factual determinations of plan administrators in actions brought under 29 U.S.C. § 1132(a)(1)(B) are subject to *de novo* review."⁸³ The court addressed the rationale behind the Fifth Circuit's holding and refuted each contention.⁸⁴ First, the Sixth Circuit stated that the *Pierre* court erroneously applied principles of trust law in reaching its decision.⁸⁵ The court noted that the Fifth Circuit relied on the *Restatement (Second) of Trusts* in ruling that a factual determination should be reviewed for an abuse of discretion, rather than applying a *de novo* standard.⁸⁶ However, the Sixth Circuit concluded that the *Pierre* court misapplied the *Restatement* because the language relied upon "does not provide any basis for distinguishing between court review of factual determinations and review of interpretations of claim language."⁸⁷

The court also refuted the Fifth Circuit's rationale that fact-finding bodies are normally granted deference as a reason to apply an abuse of discretion standard in this situation.⁸⁸ The court noted a distinction between fact finding by administrative bodies and courts and fact finding by employee benefit plan administrators.⁸⁹ The Sixth Circuit stated that "[t]he reason for treating the two situations differently is . . . that one party to a contract has an incentive to find facts not in a neutral fashion"⁹⁰

The Sixth Circuit also rejected the policy argument that application of a *de novo* standard would increase litigation over denial of benefits.⁹¹ The court

82. *Id.* at 1178, 1183.

83. *Rowan v. Unum Life Ins. Co. of Am.*, 119 F.3d 433, 435 (6th Cir. 1997).

84. *Id.* at 436.

85. *Id.*

86. *Id.* "The *Pierre* court based its holding primarily on sections 186(b) and 187 of the *Restatement (Second) of Trusts* (1959)." *Id.*

87. *Id.*

88. *Id.*

89. *Id.* Deference "under these circumstances is very different than deferring to a plan administrator." *Id.* (quoting *Perez v. Aetna Life Ins. Co.*, 96 F.3d 813, 824 (6th Cir. 1996)). The Ninth Circuit also supported the majority position, stating that courts, unlike plan administrators, are "subject to a panoply of constitutional, statutory and procedural strictures." *Walker v. Am. Home Shield Long Term Disability Plan*, 180 F.3d 1065, 1070 (9th Cir. 1999).

90. *Rowan*, 119 F.3d at 436 (quoting *Perez*, 96 F.3d at 824).

91. *Id.* "The *Pierre* court's policy argument that failure to defer to plan administrators' factual findings will lead to a flood of litigation is also unpersuasive." *Id.* The Ninth Circuit stated that the application of two different standards for factual determinations and plan interpretations would lead to increased litigation. *Walker*, 180 F.3d at 1070. Factual determinations and plan interpretations are interrelated. *Id.* "If

emphasized that a *de novo* standard only applies in situations where the plan fails to grant discretionary authority to the administrator.⁹² To avoid a *de novo* review of claim denials, one need only draft a provision granting such discretion to the administrator.⁹³

2. The Minority View: The Fifth Circuit's Application of an Abuse of Discretion Standard

Although it was among the first courts to address the issue, the Fifth Circuit's opinion in *Pierre*, which made a distinction between plan term interpretations and factual determinations when deciding the appropriate standard to be applied by a reviewing court, has become the minority view.⁹⁴ The court acknowledged that an administrator must make two separate determinations before deciding to award or to deny benefits.⁹⁵ The administrator first must make a factual determination;⁹⁶ the administrator then must "determine whether those facts constitute a claim to be honored under the *terms* of the plan."⁹⁷ The Fifth Circuit stated that the holding in *Bruch* applied to plan term interpretations, not to factual determinations.⁹⁸ Furthermore, the court held that "it is completely consistent with the principles of trust law to apply a different standard of review to each of these categories of decision."⁹⁹

review were bifurcated[.] . . . we predict an unnecessary cascade of litigation over whether an administrator's action was a plan interpretation or a factual determination." *Id.*

92. *Rowan*, 119 F.3d at 436. "The *de novo* standard of review applies only when the plan does not explicitly vest fact-finding discretion in the plan administrator." *Id.*

93. *Id.* The Seventh Circuit also reasoned that employers concerned with "excessive layers of review, or burdensome litigation, can write . . . their plans to give discretion to their plan administrators." *Ramsey v. Hercules Inc.*, 77 F.3d 199, 205 (7th Cir. 1996). "We are reenforced in our conclusion by recognition of the relative ease with which ERISA plans may be worded explicitly to reserve to plan administrators the discretionary authority that will insulate . . . their decisions from *de novo* review." *Kinstler v. First Reliance Standard Life Ins. Co.*, 181 F.3d 243, 251 (2d Cir. 1999).

94. *Pierre v. Conn. Gen. Life Ins. Co./Life Ins. Co. of N. Am.*, 932 F.2d 1552, 1556-59 (5th Cir. 1991), *cert. denied*, 502 U.S. 973 (1991).

95. *Id.* at 1557.

96. *Id.* "[An administrator] must determine the facts underlying the claim for benefits." *Id.*

97. *Id.*

98. *Id.* "*Bruch* addressed the proper standard of review that is to be given to the plan administrator's [plan term] determination. *Bruch* did not speak to [factual determinations]." *Id.*

99. *Id.*

Citing the *Restatement (Second) of Trusts* Section 187,¹⁰⁰ the Fifth Circuit agreed with the Supreme Court that, when discretion is granted to a trustee, a judicial review only will interfere with the trustee's decision when there is an abuse of discretion.¹⁰¹ Nevertheless, the court stated that "an ERISA trustee . . . is granted some *inherent* discretion."¹⁰² The court further concluded that this discretion includes making factual determinations.¹⁰³ Therefore, a reviewing court only should reverse the administrator's decision as to factual determinations when there is an abuse of discretion.¹⁰⁴

Additionally, the court found that "[f]actual determinations are generally reviewed under some discretionary standard such as . . . abuse of discretion."¹⁰⁵ Therefore, the use of a deferential standard for factual determinations "does not result in the loss of any substantial rights comparable to the loss . . . in applying the arbitrary and capricious standard to term interpretations."¹⁰⁶

Furthermore, the Fifth Circuit noted that most reviewing bodies defer to the fact finder's decisions.¹⁰⁷ This is true of "a district court giving deference to an administrative body, or an appellate court giving deference to the district court."¹⁰⁸ As a result, the court stated that the plan administrator, as a finder of fact, should not be treated differently.¹⁰⁹

Finally, the Fifth Circuit presented a practical reason as to why deference should be afforded to plan administrators in making factual determinations.¹¹⁰ The court noted that the plan administrator must make several determinations before awarding or denying benefits.¹¹¹ By applying a *de novo* review, the

100. "Where discretion is conferred upon the trustee with respect to the exercise of a power, its exercise is not subject to control by the court, except to prevent an abuse by the trustee of this discretion." RESTATEMENT (SECOND) OF TRUSTS § 187 (1959).

101. *Pierre*, 932 F.2d at 1557-58.

102. *Id.* at 1558 (emphasis in original).

103. *Id.* "[T]his . . . discretion includes passing on issues of fact that determine individual eligibility for benefits." *Id.*

104. *Id.*

105. *Id.*

106. *Id.*

107. *Id.* at 1559. The purpose of this deference is to "respect[] the advantage of the fact finder while also protecting against [an] abuse of . . . power." *Id.*

108. *Id.*

109. *Id.* "We see no reason here why the plan administrator, *i.e.*, the trier of fact, should be placed in a different status." *Id.*

110. *Id.*

111. *Id.* The administrator must examine factors such as: length of service by the insured, unused benefits, nature of the injury, location of the injury-causing event, whether the injury occurred as a result of an accident, or whether the injury occurred while the insured was acting within the scope of employment. *Id.*

reviewing court essentially would be substituting itself in place of the administrator.¹¹² Moreover, the court opined that application of such a standard of review would lead to increased litigation, and the expenses of such litigation would be drawn from funds used to pay benefits to claimants.¹¹³

After analyzing arguments made by other courts in favor of applying a *de novo* standard,¹¹⁴ the Fifth Circuit rejected these approaches and held that an abuse of discretion standard is appropriate when reviewing an administrator's factual determinations.¹¹⁵

IV. THE INSTANT DECISION

In *Riedl*,¹¹⁶ the Eighth Circuit initially addressed the standard of review applied by the lower court.¹¹⁷ The court observed that neither party disputed the fact that the employee benefit plan failed to grant the administrator discretionary authority.¹¹⁸ It then addressed General American's contention that the Supreme Court's holding in *Bruch* did not apply to the instant case because the Supreme Court's holding "is limited to plan interpretations and does not extend to fact-based determinations."¹¹⁹ Consequently, General American concluded that, because the instant case involved a factual determination and not a plan interpretation, an abuse of discretion standard was appropriate.¹²⁰

The Court disagreed with General American's argument, holding that such a rule "construes *Bruch* too narrowly and urges upon us a difference that should not be controlling."¹²¹ The court then noted that an administrator must make

112. *Id.*

113. *Id.*

114. *Id.* at 1559-62. The Fifth Circuit examined the rationale behind the Fourth and Seventh Circuits' decisions that seemed to mandate a *de novo* standard when reviewing an administrator's factual determinations. *Id.*

115. *Id.* at 1562.

116. The court also addressed the issue whether *Riedl* was, in fact, disabled. This Note, however, is primarily concerned with the standard of review the court decided to employ, rather than any actual factual findings made by the court. Therefore, this Note will not address the factual findings by the Eighth Circuit in any length.

117. *Riedl v. Gen. Am. Life Ins. Co.*, 248 F.3d 753, 755 (8th Cir. 2001). "As an initial matter, we must address whether the District Court applied the appropriate standard of review." *Id.*

118. *Id.* "It is undisputed that Phillip's long-term disability plan does not give the plan's administrator discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Id.*

119. *Id.* at 756.

120. *Id.*

121. *Id.*

factual determinations in addition to applying those facts to the plan's terms in order to determine whether the claimant is eligible for benefits.¹²² The court stated: "[t]o rule that an administrator's fact-based determinations should be reviewed for an abuse of discretion, even though the plan lacks the appropriate discretionary language, does not give sufficient effect to *Bruch*'s holding."¹²³ Therefore, the Eighth Circuit held that a *de novo* standard of review is appropriate when a court is called upon to review an administrator's decision to deny benefits based upon a factual determination unless the terms of the plan grant the administrator discretionary authority "to determine eligibility for benefits or to construe the terms of the plan."¹²⁴

However, the Eighth Circuit reversed the district court's grant of summary judgment in favor of Riedl.¹²⁵ The court stated that there were genuine issues of material fact that remained to be resolved and remanded the case to the district court for further proceedings.¹²⁶

122. *Id.* "Often an employee's eligibility for benefits under a plan depends both on an administrator's determination of certain facts, and on the application of those facts to the terms of the plan." *Id.*

123. *Id.*

124. *Id.*

125. *Id.* at 759-60.

126. *Id.* The court examined the record and held that there remained a disputed issue concerning whether Riedl was actually disabled. *Id.* at 756-60.

V. COMMENT

A. *The Doctrine of Contra Proferentem*¹²⁷

The doctrine of *contra proferentem* states that ambiguities in a contract are to be strictly construed against the drafter.¹²⁸ The rationale behind the doctrine is that:

[i]nsurance 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 limitation on its liability clearly 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.¹²⁹

Furthermore, the parties to a contract of insurance—the insured and the insurer—are normally in positions of unequal bargaining power with the insurer holding the advantage.¹³⁰ Therefore, the insured has little, if any, opportunity to negotiate the terms of the policy. Because the insured has little control over the

127. In a case originating out of Missouri, the Eighth Circuit held that the doctrine of *contra proferentem* is inapplicable to ERISA provisions. *Brewer v. Lincoln Nat'l Life Ins. Co.*, 921 F.2d 150, 153-54 (8th Cir. 1990), *cert. denied*, 501 U.S. 1238 (1991). However, a subsequent Eighth Circuit decision permitted the application of the pro-insured doctrine in certain circumstances. *Delk v. Durham Life Ins. Co.*, 959 F.2d 104, 105-06 (8th Cir. 1992). "[A] court construing plans governed by ERISA should construe ambiguities against the drafter only if, after applying ordinary principles of construction, giving language its ordinary meaning and admitting extrinsic evidence, ambiguities remain." *Id.* at 106. Additionally, a majority of courts ruling on the issue have held that *contra proferentem* applies to ERISA benefit plans. See LEE R. RUSS & THOMAS F. SEGALLA, *COUCH ON INSURANCE* 3D § 7:12 (3d ed. 1996) [hereinafter *COUCH*].

128. "The rule is based upon the principle . . . that when one party is responsible for the drafting of an instrument . . . any ambiguity will be resolved against the drafter." *Kunin v. Benefits Trust Life Ins. Co.*, 910 F.2d 534, 539 (9th Cir. 1990), *cert. denied*, 498 U.S. 1013 (1990). "The first principle of insurance law is captured by the maxim *contra proferentem*, which directs that ambiguities in a contract be interpreted 'against the drafter,' who is almost always the insurer." Kenneth S. Abraham, *A Theory of Contract Interpretation*, 95 MICH. L. REV. 531, 531 (1996); see also ROGER C. HENDERSON & ROBERT H. JERRY, II, *INSURANCE LAW: CASES & MATERIALS* 237 (3d ed. 2001).

129. *Kunin*, 910 F.2d at 540; see also *COUCH*, *supra* note 127, § 22:18.

130. HENDERSON & JERRY, *supra* note 128, at 237.

terms of the policy, it would be inequitable to allow the insurer's ambiguous terms to take precedent over reasonable expectations.¹³¹

Although not identical to *contra proferentem*, the absence of a provision granting the administrator discretion invokes a similar rationale in determining which standard should apply. As the drafter of the plan, the insurer has the ability to avoid the application of *de novo* review in litigation over a claim denial. The Eighth Circuit's holding requires a reviewing court to apply a *de novo* standard only in the absence of any provision granting discretionary authority to the plan administrator.¹³² Therefore, the insurer effectively can guarantee that a deferential standard will apply to § 1132 actions by inserting a discretion-granting provision into the terms of the plan.

As a means of protecting plan participants, notice of any significant plan details must be provided to participating employees.¹³³ If vague language fails to provide sufficient notice,¹³⁴ then the lack of any language also must constitute a failure to provide notice. This is exactly the situation when there is no provision granting the administrator discretionary authority. Consequently, it would be inequitable to enforce against an employee a provision of which he or she lacked notice. This is especially true when the imposition of a deferential standard not expressly provided for within the terms of the plan would prevent the employee from recovering benefits under the plan.

B. Consequences of the Abuse of Discretion Standard of Review

The application of an abuse of discretion standard would provide the administrator an inherent advantage in the litigation of claim denials.¹³⁵ A denial

131. A rule stating otherwise would provide an incentive to draft an insurance policy with ambiguous language, thus allowing the insurer to deny coverage by pointing to the ambiguous language. Alison S. Rozbruch, Note, *Resolving the Conflict Between Two Visions for a Standard of Review in ERISA Denial of Benefit Plans*, 9 J.L. & POL'Y 507, 556 (2001). A pro-insurer result would "encourage employers to use vague language to insulate themselves from having to pay out benefits owed to participants." *Id.* Furthermore, use of ambiguous language does not provide the employee with clear notice as to what rights the employee possesses in respect to the plan. *Id.* at 555. "Acceptance of evasive language . . . provides employers and plans with an incentive to supply inadequate notice by purposely using vague . . . language." *Id.*

132. *Riedl v. Gen. Am. Life Ins. Co.*, 248 F.3d 753, 755-56 (8th Cir. 2001).

133. Rozbruch, *supra* note 131, at 555. "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." Rozbruch, *supra* note 131, at 555.

134. For discussion of the vagueness issue, see *supra* note 131.

135. Rozbruch, *supra* note 131, at 522. "Judicial deference to the decision of a plan administrator sharply increases a claimant's disadvantage." Rozbruch, *supra* note

of benefits will be overturned under an abuse of discretion standard only if the reviewing court determined the administrator's decision to be unreasonable or clearly erroneous.¹³⁶ An abuse of discretion standard would compel a reviewing court to uphold the administrator's decision even in situations where the insured would suffer an inequitable result.¹³⁷ "[T]he subsequent application of an [abuse of discretion] standard to a dispute is the practical equivalent of the cessation of judicial review over that administrator's decision."¹³⁸

C. Abuse of Discretion: The Default Rule

The purported goal of ERISA is to protect employees and their beneficiaries.¹³⁹ The Eighth Circuit's ruling in *Riedl* has taken one step in the direction of achieving the goal of protecting plan participants and their beneficiaries by choosing not to adopt an abuse of discretion standard as the default rule for factual determinations.¹⁴⁰ Nevertheless, several commentators have argued that ERISA's goals have been compromised to some extent.¹⁴¹

For example, following the Supreme Court's decision in *Bruch*, drafters of employee benefit plans began revising their language to include such provisions and, thus, to avoid *de novo* review in subsequent litigation.¹⁴² Consequently,

131, at 522.

136. Rozbruch, *supra* note 131, at 522.

137. Jay Conison, *Suits for Benefits Under ERISA*, 54 U. PITT. L. REV. 1, 3 (1992). "If the reasons [given for denying a claim] are acceptable, a court may even uphold a denial of benefits that it believes to be wrong." *Id.*

138. Rozbruch, *supra* note 131, at 552.

139. 29 U.S.C. § 1001(b) (1994).

140. *See Riedl v. Gen. Am. Life Ins. Co.*, 248 F.3d 753, 756 (8th Cir. 2001). "We hold that, absent language in the plan granting discretionary authority to the administrator to determine eligibility for benefits or to construe the terms of the plan, fact-based determinations should receive *de novo* review." *Id.*

141. *See, e.g.,* Conison, *supra* note 137, at 3 (arguing that the current law and jurisprudence fail to protect employees participating in ERISA plans); Melissa Grant, *Battling for ERISA Benefits in the Ninth Circuit: Overcoming Abuse of Discretion Review*, 28 SW. U. L. REV. 93, 131-32 (1998) (arguing that the abuse of discretion standard fails to promote an employee's interests); Rozbruch, *supra* note 131, at 561 (arguing that courts have hurt the expectations of employees by granting discretion based on vague language); Craig M. Stephens, Note, *ERISA: The Inevitable but Unexpected Hurdles of the Plaintiff's Welfare Benefit Plan*, 20 AM. J. TRIAL ADVOC. 151, 152 (1996) (arguing that plaintiffs in suits under ERISA face numerous obstacles in recovering benefits).

142. Brian W. Bergland, *Fundamentals of Employee Benefits Law: ERISA Litigation*, SF73 ALI-ABA 463, 470 (2001). "Today, most plans grant the . . . discretionary authority [to plan administrators]." *Id.*
<https://scholarship.law.missouri.edu/mlr/vol67/iss2/9>

most claim denials are reviewed using a deferential standard of review.¹⁴³ Given that an experienced drafter will be able to draft clear language granting discretionary authority to the administrator, the abuse of discretion standard has become the default standard for all practical purposes.¹⁴⁴

Furthermore, several courts will apply an abuse of discretion standard even when there is no express language granting discretion.¹⁴⁵ Although a majority of circuits have held that an abuse of discretion standard for suits involving factual determinations is appropriate only when the plan grants discretionary authority to the administrator,¹⁴⁶ several of those courts also have been willing to imply such language based on vague provisions.¹⁴⁷ In reality, it seems reasonable to assume that *de novo* review actually occurs in a limited number of circumstances. Given the ease with which drafters may circumvent *de novo* review, more may be required from the judicial system to safeguard the rights of employees participating in benefit plans regulated by ERISA adequately.

VI. CONCLUSION

The objective of ERISA, as stated by Congress, is to protect the interests of participants in employee benefit plans and their beneficiaries.¹⁴⁸ The Eighth Circuit has taken a positive step to promote such goals without hindering the interests of insurers and plan administrators.¹⁴⁹ By requiring the application of *de novo* review to both plan interpretations and factual determinations when the plan does not grant discretionary authority to the administrator, the Eighth Circuit has eliminated an obstacle to an employee's subsequent recovery pursuant to § 1132 actions. Given the ease with which drafters may circumvent the ruling by the Eighth Circuit and the other circuits that have adopted the majority position, this step, however, may not be enough to protect plan participants adequately.

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143. *Id.*

144. Grant, *supra* note 141, at 122.

145. Rozbruch, *supra* note 131, at 541-51. The Fourth, Sixth, and Seventh Circuits do not require an express grant of discretionary authority in order to apply an abuse of discretion standard. Rozbruch, *supra* note 131, at 541-51.

146. For a list of cases, see *supra* note 56.

147. See Rozbruch, *supra* note 131, at 530-41. The Fourth, Sixth, and Seventh Circuits "have relaxed their standards for language that is sufficient to vest discretion in the plan administrator." Rozbruch, *supra* note 131, at 541-42.

148. 29 U.S.C. § 1001 (1994).

149. Riedl v. Gen. Am. Life Ins. Co., 248 F.3d 753, 756 (8th Cir. 2001).

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