RECENT DEVELOPMENT

WOO V. DELUXE CORPORATION: THE EIGHTH CIRCUIT ADOPTS THE "SLIDING SCALE" STANDARD OF REVIEW WHEN A CONFLICTED PLAN ADMINISTRATOR DENIES ERISA-PROTECTED BENEFITS

I. INTRODUCTION

To determine whether an employee is entitled to receive employee benefits, the employee benefit plan administrator must decide whether the employee is covered by the employer's benefit plan. When administrators deny a claim for benefits, the Employment Retirement Income Security Act ("ERISA")[1] gives plan beneficiaries the right to seek judicial review.[2] ERISA, however, does not establish the standard of review in such cases. The United States Supreme Court announced the appropriate standard of review in the seminal case of *Firestone Tire & Rubber Co. v. Bruch*.[3] *Bruch* held that a plan administrator's denial of benefits "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,"[4] in which case the denial is reviewed for abuse of discretion. *Bruch* added, however, that "if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there has been an abuse of discretion.'"[5]

Since *Bruch*, federal appellate courts have disagreed on the appropriate standard of review in cases where a conflicted plan administrator denies benefits. The Fourth, Fifth, Seventh, and Tenth circuits have adopted the "sliding scale" approach. This approach reviews the denial of benefits for an abuse of discretion, with the level of deference given to the administrator's

1. Employee Retirement Income Security Act of 1974 ("ERISA"), Pub. L. No. 93-406, 88 Stat. 829 (1974) (codified as amended at 29 U.S.C. §§ 1001-1461 (1994 & Supp. III 1997) and in scattered sections of the Internal Revenue Code, 26 U.S.C. §§ 1-9722 (1994)).
2. 29 U.S.C. § 1132(a) (1994 & Supp. III 1997).
3. 489 U.S. 101 (1989).
4. *Id.* at 115.
5. *Id.* (citing RESTATEMENT (SECOND) OF TRUSTS § 187, cmt. b (1959)).

decision decreased in proportion to the seriousness of the conflict.[6] The Third, Ninth, and Eleventh circuits apply the "presumptively void" test.[7] Under this approach, there is no deference and the conflicted administrator's denial of benefits is presumed to be arbitrary and capricious unless the administrator can show "that either (1) under de novo review the result reached was correct, or (2) the decision was not made to serve the administrator's conflicting interest."[8]

Initially, the Eighth Circuit Court of Appeals seemed to adopt the "presumptively void" test.[9] However, in a recent decision, *Woo v. Deluxe Corp.*[10] the Eighth Circuit adopted the "sliding scale" approach. This Recent Development analyzes the Eighth Circuit's apparent change of law and discusses whether the Eighth Circuit's position is consistent with the Supreme Court's decision in *Bruch* and the underlying purposes of ERISA.

II. HISTORY

Before ERISA, employee benefits and pension law consisted primarily of state common law.[11] Although employers routinely offered benefits and pensions to attract and retain employees, expectations often went unfulfilled when employers used these benefits for their own purposes.[12] ERISA was enacted in 1974 in response to deepening concerns of widespread fraud and abuse in the areas of private employee benefits and pension programs.[13]

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6. *See* Chambers v. Family Health Plan Corp., 100 F.3d 818, 826 (10th Cir. 1996); Doe v. Group Hospitalization & Med. Servs., 3 F.3d 80, 87 (4th Cir. 1993); Wildbur v. Arco Chem. Co., 974 F.2d 631, 638 (5th Cir. 1992); Van Boxel v. Journal Co. Employee's Pension Trust, 836 F.2d 1048, 1052-53 (7th Cir. 1987).

7. *See* Atwood v. Newmont Gold Co., 45 F.3d 1317, 1323 (9th Cir. 1995); Kotrosits v. GATX Corp. Non-Contributory Pension Plan for Salaried Employees, 970 F.2d 1165, 1173 (3d Cir. 1992); Brown v. Blue Cross and Blue Shield of Ala., Inc., 898 F.2d 1556, 1566-67 (11th Cir. 1990).

8. *See* Armstrong v. Aetna Life Ins. Co., 128 F.3d 1263, 1265 (8th Cir. 1997).

9. *Id.*

10. 144 F.3d 1157, 1161 (8th Cir. 1998).

11. For an overview of pre-ERISA benefits law see Jay Conison, *Suits for Benefits Under Erisa*, 54 U. PITT. L. REV. 1, 35-46 (1992).

12. *See* Conison, *supra* note 11, at 36.

13. Congressional findings and declaration of policy behind ERISA are expressed in 29 U.S.C. § 1001 (1994):

> (a) Benefit plans as affecting interstate commerce and the Federal taxing power
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> The Congress finds that the growth in size, scope, and numbers of employee benefit plans in recent years has been rapid and substantial; that the operational scope and economic impact of such plans is increasingly interstate; that the continued well-being and security of millions of employees and their dependents are directly affected by these plans; that they are affected with a national public interest; that they have become an important factor affecting the stability of employment and the successful development of industrial relations; that they have become an important factor in commerce because of the interstate character of their activities, and of the

ERISA established duties and standards of performance for administrators and fiduciaries of employee benefit and pension plans in order to ensure the safeguarding of valuable[14] benefit expectations.[15]

Congressional intent to implement meaningful reform is evident in

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activities of their participants, and the employers, employee organizations, and other entities by which they are established or maintained; that a large volume of the activities of such plans are carried on by means of the mails and instrumentalities of interstate commerce; that owing to the lack of employee information and adequate safeguards concerning their operation, it is desirable in the interests of employees and their beneficiaries, and to provide for the general welfare and the free flow of commerce, that disclosure be made and safeguards be provided with respect to the establishment, operation, and administration of such plans; that they substantially affect the revenues of the United States because they are afforded preferential Federal tax treatment; that despite the enormous growth in such plans many employees with long years of employment are losing anticipated retirement benefits owing to the lack of vesting provisions in such plans; that owing to the inadequacy of current minimum standards, the soundness and stability of plans with respect to adequate funds to pay promised benefits may be endangered; that owing to the termination of plans before requisite funds have been accumulated, employees and their beneficiaries have been deprived of anticipated benefits; and that it is therefore desirable in the interests of employees and their beneficiaries, for the protection of the revenue of the United States, and to provide for the free flow of commerce, that minimum standards be provided assuring the equitable character of such plans and their financial soundness.

(b) Protection of interstate commerce and beneficiaries by requiring disclosure and reporting, setting standards of conduct, etc., for fiduciaries

It is hereby declared to be the policy of this chapter to protect interstate commerce and 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 the Federal courts.

(c) Protection of interstate commerce, the Federal taxing power, and beneficiaries by vesting of accrued benefits, setting minimum standards of funding, requiring termination insurance

It is hereby further declared to be the policy of this chapter to protect interstate commerce, the Federal taxing power, and the interests of participants in private pension plans and their beneficiaries by improving the equitable character and the soundness of such plans by requiring them to vest the accrued benefits of employees with significant periods of service, to meet minimum standards of funding, and by requiring plan termination insurance.

Id.

14. *See* Francis X. Lilly, *The Employee Retirement Income Security Act*, 35 LAB. L.J. 603 (1984):

> In 1975, the first full calendar year in which ERISA was on the books, there were approximately 340,000 total retirement plans, covering over 44.5 million participants and beneficiaries. These plans had assets of over $543 billion. By the end of 1983, the number of private pension plans had more than doubled, totaling more than 775,000 and covering almost 67 million participants, and their assets were approximately $900 billion . . . .

Id. at 604; *see also* W. Michael Kaiser, *Labor's New Weapon: Pension Fund Leverage—Can Labor Legally Beat Its Plowshares Into Swords?*, 34 RUTGERS L. REV. 409 (1982). "In 1975, private pension plans subject to . . . (ERISA) had assets of approximately $211.5 billion. Those assets had more than doubled by 1980 to $430.6 billion. This number is expected to double by 1985, double again by 1990, and approach three trillion dollars in 1995!" *Id.* at 409.

15. *See supra* note 13 for text of 29 U.S.C. § 1001(b) (1994).

ERISA's broad civil enforcement provision.[16] In part, § 1132(a) provides that a "civil action may be brought (1) by a participant or beneficiary . . . (B) to recover benefits due to him under the terms of his plan . . . ."[17] However, each ERISA-governed employee benefit plan must establish an internal claim and claim review procedure,[18] and although not expressly required by the statute, courts have held that, with some exceptions, the plan participant must exhaust all administrative remedies available under the plan prior to bringing suit under § 1132(a).[19]

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16. 29 U.S.C. § 1132(a) (1994 & Supp. III 1997) reads:

(a) Persons empowered to bring a civil action

A civil action may be brought—

(1) by a participant or beneficiary—

(A) for the relief provided for in subsection (c) of this section, or

(B) 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;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c) of this title;

(5) except as otherwise provided in subsection (b) of this section, by the Secretary (A) to enjoin any act or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this subchapter;

(6) by the Secretary to collect any civil penalty under paragraph (2), (4), (5), or (6) of subsection (c) of this section or under subsection (i) or (l) of this section;

(7) by a State to enforce compliance with a qualified medical child support order (as defined in section 1169(a)(2)(A) of this title);

(8) by the Secretary, or by an employer or other person referred to in section 1021(f)(1) of this title, (A) to enjoin any act or practice which violates subsection (f) of section 1021 of this title, or (B) to obtain appropriate equitable relief (i) to redress such violation or (ii) to enforce such subsection; or

(9) in the event that the purchase of an insurance contract or insurance annuity in connection with termination of an individual's status as a participant covered under a pension plan with respect to all or any portion of the participant's pension benefit under such plan constitutes a violation of part 4 of this title or the terms of the plan, by the Secretary, by any individual who was a participant or beneficiary at the time of the alleged violation, or by a fiduciary, to obtain appropriate relief, including the posting of security if necessary, to assure receipt by the participant or beneficiary of the amounts provided or to be provided by such insurance contract or annuity, plus reasonable prejudgment interest on such amounts.

Id. (citation omitted).

17. 29 U.S.C. § 1132(a)(1)(B) (1994).

18. *See* 29 U.S.C. § 1133 (1994).

19. *See* Charles P. Efflandt, *An Overview of Civil Litigation Under ERISA*, 59 No. 6, J.K.B.A. 24 (1990). "ERISA does not expressly require participants and beneficiaries to exhaust th[e] internal remedies [required by 29 U.S.C. § 1133 (1985)] before initiating civil litigation." *Id.* at 26. *See also*

The central question that has puzzled courts is what standard of review is appropriate in § 1132(a)(1)(B) cases. The spectrum of review[20] ranges from a stringent standard in the form of de novo review, to a deferential standard in which the court will uphold the administrator's denial unless arbitrary or capricious.[21] De novo review of the administrator's denial of a benefits claim provides greater protection for the plan participant, giving her a second chance to obtain denied benefits because the reviewing court will give less deference to the administrator's decision.[22] However, de novo review also means higher costs for employers, placing upon them the burden of multiple, redundant proceedings. Employers, therefore, consistently argue that courts should give deference to an administrator's denial of benefits claims.[23] However, the "arbitrary and capricious" standard of review supported by employers puts the employee, who already lost in the "administrative" proceeding, at an obvious disadvantage because the reviewing court will not conduct an independent review of the denial, but will instead defer to the administrator's decision. The determination of which standard of review to apply in a § 1132(a)(1)(B) action ultimately depends on a careful balancing of ERISA's central purpose of safeguarding benefits on the one hand and the broad public policy that encourages employers to offer ERISA-governed employee benefit plans on the other.

A further complication in this field arises when an administrator has a conflict of interest and that conflict plays a part in the administrator's decision to deny the benefits claim. A typical conflict of interest occurs when the plan administrator is subject to the employer's control and must decide whether to fulfill its fiduciary duty to the plan participant by paying the benefits claim, or to conserve the employer's funds by denying the benefits.[24]

Skrobacz v. Int'l Harvester, 582 F. Supp. 1192, 1195 (N.D. Ill. 1984) (stating that "plaintiffs must pursue . . . [p]lan remedies before they can maintain an action for benefits . . . under section 1132(a)(1)(B)."); Lucas v. Warner & Swasey Co., 475 F. Supp. 1071, 1074 (E.D. Pa. 1979) (exhaustion of administrative remedies is generally required prior to suit under ERISA, except when such attempts would result in irreparable harm or would be futile); Morgan v. Laborers Pension Trust Fund for N. California, 433 F. Supp. 518, 528 (N.D. Cal. 1977) (same).

20. The term "spectrum of review" is meant to describe the general group of all possible standards of review arranged from the most stringent on one end to the most deferential on the other.

21. *See infra* notes 22-39 and accompanying text.

22. *See* Pratt v. Petroleum Prod. Mgmt. Employee Sav. Plan, 920 F.2d 651 (10th Cir. 1990). "Under a *de novo* standard, we would ask not whether the fiduciaries' interpretation of the contract was arbitrary and capricious, but only whether it was correct." *Id.* at 658 (emphasis in original).

23. *See* Winters v. Costco Wholesale Corp., 49 F.3d 550, 553 (9th Cir. 1995); Merideth v. Allsteel, Inc., 11 F.3d 1354, 1357 (7th Cir. 1993).

24. For a discussion of typical conflicts of interest in this area see Noel Christian Capps, Note, *Firestone Tire & Rubber Co. v. Bruch: Are Lower Courts Following The United States Supreme Court Decision in Erisa Benefit Determinations?*, 31 WASHBURN L.J. 280, 289. (1992).

Prior to 1989, courts had developed two alternative views on the proper standard of review in cases where a conflicted plan administrator denied a benefits claim.

One view was articulated by the Third Circuit Court of Appeals in *Bruch v. Firestone Tire & Rubber Co.*[25] The plaintiffs in *Bruch* were employed in Firestone's plastics division.[26] They argued that they were entitled to benefits under Firestone's severance plan after Firestone sold its plastics division to Occidental Petroleum Company.[27] Firestone, acting as both the plan administrator and the fiduciary, denied the benefits claim.[28] The district court granted Firestone's motion for summary judgment on the ground that Firestone's denial of benefits was not arbitrary and capricious.[29] The Third Circuit reversed, rejecting the district court's use of the arbitrary and capricious standard, and held that when an employer acts both as a plan administrator and a fiduciary, there exists a conflict of interest, and the decision to deny benefits is subject to the more stringent de novo review.[30]

The Seventh Circuit Court of Appeals adopted a different position several months later in *Van Boxel v. The Journal Co. Employees' Pension Trust.*[31] The plaintiff in *Van Boxel* took a twenty-five year leave of absence from his job at the Journal Company to head the local printers' union.[32] Although plaintiff's leave was without pay, his name repeatedly appeared on the company's list of employees who were guaranteed their jobs until they reached the age of 65.[33] When plaintiff asked the company for his pension, claiming that his extended leave of absence counted towards the pension plan's required twenty years of service, the company refused his request.[34]

Judge Posner, writing for the *Van Boxel* court, concluded that "the arbitrary and capricious standard of review may be inapt,"[35] but unlike the Third Circuit in *Bruch*, refused to abandon it altogether. Judge Posner characterized the arbitrary and capricious standard as a "sliding scale of judicial review"[36] that "may be a range, not a point."[37] Under this view, a

25. 828 F.2d 134 (3d Cir. 1987).
26. *See id.* at 136.
27. *See id.* at 136-37.
28. *See id.* at 136.
29. *See* Bruch v. Firestone Tire & Rubber Co., 640 F. Supp. 519 (E.D. Pa. 1986).
30. *See* Bruch v. Firestone Tire & Rubber Co., 828 F.2d 134, 137-45 (3d Cir. 1987).
31. 836 F.2d 1048 (7th Cir. 1987).
32. *See id.* at 1049.
33. *See id.*
34. *See id.*
35. *Id.* at 1052. Posner stated that even though he considered the standard improper, it does not do "serious harm" due to its "vagueness and elasticity." *Id.*
36. *Id.*
37. 836 F.2d at 1052.

court that is asked to review a denial of benefits by an administrator with a conflict of interest should adjust the amount of deference given to the administrator's decision, with the degree of adjustment dependent upon the seriousness of the conflict. The review becomes "more penetrating the greater is the suspicion of partiality, less penetrating the smaller that suspicion is."[38] Thus, when there are no allegations of a conflict of interest, or when the allegations cannot be proven, the proper standard of review is the highly deferential "arbitrary or capricious" standard. In cases where the decision maker has "a serious conflict of interest, however, the proper deference to give their decisions may be slight, even zero. . . ."[39] In such cases, the standard of review essentially becomes de novo.

A. The Supreme Court Defines the Proper Standard of Review in Firestone Tire & Rubber Co. v. Bruch

Presented with the alternative standards of review adopted by the Third and the Seventh Circuits, the United States Supreme Court granted certiorari in *Firestone Tire & Rubber Co. v. Bruch*,[40] "to resolve the conflicts among the Courts of Appeals as to the appropriate standard of review in actions under § 1132(a)(1)(B). . . ."[41]

On its face, the Supreme Court's decision adopted neither the Third Circuit's nor the Seventh Circuit's approaches. Instead, recognizing that ERISA codified many principles of the common law of trusts,[42] the Court relied on common law trust principles to announce that the appropriate standard of review in § 1132(a)(1)(B) actions depends not on the plan administrator's partiality, but on whether the particular plan document "gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan."[43] The Court held that de novo review must be applied when the plan documents grant no such authority.[44] When a plan explicitly grants discretion to the administrator, however, courts may reverse the plan administrator's denial only when that discretion has been abused.[45]

The Supreme Court also added that "if a benefit plan gives discretion to

38. *Id.* at 1052-53.
39. *Id.* at 1052.
40. The grant of certiorari can be found at 485 U.S. 986 (1988).
41. Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 108 (1989).
42. *See id.* at 110.
43. *Id.* at 115.
44. *See id.*
45. *See id.*

an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'"[46]

B. Eighth Circuit's Standard of Review Before and After Bruch

Prior to the Supreme Court's decision in *Bruch*, the Eighth Circuit treated plan administrators' benefit claim denials with a high level of deference.[47] After *Bruch*, however, the Eighth Circuit adjusted the standard in light of the Supreme Court's broad holding.[48] The Eighth Circuit subsequently has held that in cases where the plan documents failed to grant authority or discretion to the plan administrator, the administrator's denial should be reviewed de novo.[49] However, in cases where the plan explicitly confers authority or discretion on the administrator, the Eighth Circuit has held that the reviewing court should be highly deferential and reverse the administrator's denial of benefits only when there has been an abuse of discretion.[50]

Until recently, however, the Eighth Circuit had not had an occasion to decide on the appropriate standard of review in cases where a conflicted plan

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46. *Id.* (quoting RESTATEMENT (SECOND) OF TRUSTS § 187, cmt. d (1959)).

47. *See* Hickman v. Tosco Corp., 840 F.2d 564, 566 (8th Cir. 1988); Redmond v. Burlington N. R.R. Co. Pension Plan, 821 F.2d 461, 465 (8th Cir. 1987); Lawrence v. Westerhaus, 780 F.2d 1321, 1322 (8th Cir. 1985); Central Hardware Co. v. Central States, Southeast and Southwest Areas Pension Fund, 770 F.2d 106, 109 (8th Cir. 1985); Short v. Central States, Southeast & Southwest Areas Pension Fund, 729 F.2d 567, 571 (8th Cir. 1984); Quinn v. Burlington N. Inc. Pension Plan, 664 F.2d 675, 678 (8th Cir. 1981); Morgan v. Mullins, 643 F.2d 1320, 1321 (8th Cir. 1981); Bueneman v. Central States, Southeast & Southwest Areas Pension Fund, 572 F.2d 1208, 1209 (8th Cir. 1978).

48. *See supra* notes 41-46 and accompanying text.

49. *See* Brown v. Seitz Foods, Inc. Disability Benefit Plan, 140 F.3d 1198, 1200 (8th Cir. 1998); Wilson v. Prudential Ins. Co. of Am., 97 F.3d 1010, 1013 (8th Cir. 1996); National Auto. Dealers and Assocs. Retirement Trust v. Arbeitman, 89 F.3d 496, 498 (8th Cir. 1996); Ravenscraft v. Hy-Vee Employee Benefit Plan and Trust, 85 F.3d 398, 402 (8th Cir. 1996); Equitable Life Assur. Soc'y of the U.S. v. Chrysler, 66 F.3d 944, 949 (8th Cir. 1995); Welsh v. Burlington N., Inc., Employee Benefits Plan, 54 F.3d 1331, 1335 (8th Cir. 1995); Bounds v. Bell Atl. Enters. Flexible Long-Term Disability Plan, 32 F.3d 337, 339 (8th Cir. 1994); Stock v. SHARE, 18 F.3d 1419, 1422 (8th Cir. 1994); Donatelli v. Home Ins. Co., 992 F.2d 763, 765 (8th Cir. 1993); Maxa v. John Alden Life Ins. Co., 972 F.2d 980, 983 (8th Cir. 1992); Dvorak v. Metropolitan Life Ins. Co., 965 F.2d 606, 609 (8th Cir. 1992); Baxter v. Lynn, 886 F.2d 182, 187 (8th Cir. 1989); Wallace v. Firestone Tire & Rubber Co., 882 F.2d 1327, 1329-30 (8th Cir. 1989).

50. *See* Hawkeye Nat'l Life Ins. Co. v. AVIS Indus. Corp., 122 F.3d 490, 496-97 (8th Cir. 1997); Hutchins v. Champion Int'l Corp., 110 F.3d 1341, 1344 (8th Cir. 1997); Cash v. Wal-Mart Group Health Plan, 107 F.3d 637, 640-41 (8th Cir. 1997); Fink v. Union Cent. Life Ins. Co., 94 F.3d 489, 491 (8th Cir. 1996); Wald v. Southwestern Bell Corp. Customcare Med. Plan, 83 F.3d 1002, 1006 (8th Cir. 1996); Donaho v. FMC Corp., 74 F.3d 894, 898 (8th Cir. 1996); Kennedy v. Georgia-Pacific Corp., 31 F.3d 606, 609 (8th Cir. 1994); Lutheran Med. Ctr. of Omaha, Neb. v. Contractors, Laborers, Teamsters & Eng'rs Health and Welfare Plan, 25 F.3d 616, 620 (8th Cir. 1994); Brumm v. Bert Bell NFL Retirement Plan, 995 F.2d 1433, 1437 (8th Cir. 1993); Oldenburger v. Central States Southeast & Southwest Areas Teamster Pension Fund, 934 F.2d 171, 173 (8th Cir. 1991).

administrator denies benefits. The Eighth Circuit first confronted the issue of the proper standard of review of benefit claim denial by a conflicted administrator in *Armstrong v. Aetna Life Insurance Co.*[51] The plaintiff, Pamela Armstrong, was diagnosed with leukemia in 1993.[52] She underwent chemotherapy treatment and her cancer went into remission.[53] While in remission, Anderson changed jobs and moved from her home in Colorado to Missouri.[54] Her new employer offered her a group health insurance plan provided by Aetna.[55] Under the terms of the plan, Aetna was both the insurer and administrator.[56] The plan gave Aetna "broad discretion to construe the terms of the plan."[57]

In 1995, Armstrong's leukemia returned and she underwent chemotherapy treatment and a bone marrow transplant.[58] When she sought coverage for her treatments from Aetna, the company limited the amount of her claim on the grounds that Armstrong's leukemia was a "pre-existing condition."[59] Armstrong challenged Aetna's denial, and argued that the district court "should review Aetna's decision de novo because Aetna's role as both insurer and administrator of the plan created a conflict of interest."[60] Armstrong produced evidence that Aetna provided "incentives and bonuses to its claim reviewers based on criteria that include[d] a category called 'claims savings.'"[61] Armstrong argued that these incentives and bonuses prevented Aetna's claim reviewers from making an impartial review of her claim.[62] The district court, however, applied the abuse of discretion standard and found that Aetna's denial of Armstrong's claim was supported by substantial evidence.[63]

On appeal to the Eighth Circuit, Armstrong challenged the district court's use of the abuse of discretion standard.[64] The Eighth Circuit discussed both the strict "presumptively void" approach taken by the Ninth and Eleventh Circuits and the deferential "sliding scale" approach taken by the Fourth,

51. 128 F.3d 1263 (8th Cir. 1997).
52. *See id.* at 1264.
53. *See id.*
54. *See id.*
55. *See id.*
56. *See* 128 F.3d at 1264.
57. *Id.* at 1266-67 (Beam, J., concurring and, in part, dissenting).
58. *See id.* at 1264.
59. *Id.*
60. *Id.*
61. 128 F.3d at 1265.
62. *Id.* at 1264-65.
63. *See id.* at 1265.
64. *See id.*

Fifth, Seventh, and Tenth Circuits.[65]

The Eighth Circuit held that the circumstances of *Armstrong* required the Court "to review Aetna's decision to deny benefits de novo."[66] The *Armstrong* court recognized that Aetna's role as insurer gave the company "an obvious interest in minimizing its claim payments."[67] Because this interest was counter to Aetna's interest as plan administrator, Aetna "faces a continuing conflict."[68]

Less than a week after deciding on the proper standard of review in *Armstrong*, the Eighth Circuit faced the same issue in *Woo v. Deluxe Corp.*[69] In 1993, while in the employ of Deluxe, the plaintiff, Beverly Woo, began experiencing "severe fatigue, stiff joints, arthritis-like pain, and a loss of concentration and memory."[70] Late in 1993, Woo resigned from Deluxe.[71] Several months after her resignation, Woo was diagnosed with systemic scleroderma, a slowly progressive disease that results in death.[72] Woo's doctor reviewed her medical record and found that she became disabled while still working for Deluxe.[73] Woo subsequently applied for benefits under the Deluxe Group Long-Term Disability Plan ("LTDP").[74] The Hartford Life Insurance Company, the LTDP administrator, denied Woo's claim and her subsequent appeals.[75] Woo filed a § 1132(a)(1)(B) action, and presented evidence that Hartford had a financial incentive to deny her claim.[76]

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65. *See id.* The "presumptively void" test adopted by the Ninth and Eleventh Circuits requires that "a decision rendered by a plan administrator with such a conflict is presumed to be an abuse of discretion unless the administrator can demonstrate that either (1) under de novo review the result was correct, or (2) the decision was not made to serve the administrator's conflicting interest." *Id.* The "sliding scale" approach adopted by the Fourth, Fifth, Seventh, and Tenth Circuits requires the court to apply an "abuse-of-discretion standard but decreases the amount of discretion given to the administrators in proportion to the seriousness of the conflict." *Id.*

66. 128 F.3d at 1265.

67. *Id.*

68. *Id.*

69. 144 F.3d 1157 (8th Cir. 1998).

70. *Id.* at 1159.

71. *See id.* at 1160.

72. *See id.* The Court noted that "[S]ystemic scleroderma is a 'disorder of the connective tissue characterized by induration and thickening of the skin, by abnormalities . . . and by fibrotic degenerative changes in various body organs, including the heart, lungs, kidneys, and gastrointestinal tract.'" *Id.* at 1159 n.1 (citing Dorland's Illustrated Medical Dictionary 1495 (28th ed. 1994)). "'The condition is usually slowly progressive over many years, and death is usually due to renal or cardiac failure or to sepsis.'" *Id.* at 1159 n.1 (citing Stark v. Weinberger, 497 F.2d 1092, 1094 n.1 (7th Cir. 1974)).

73. *See id.* at 1160.

74. *See* 144 F.3d at 1160.

75. *See id.* Hartford Life denied her claim because "she was not disabled when she resigned from Deluxe." *Id.*

76. *See id.* at 1160.

Woo demonstrated that "Deluxe sponsors and funds the LTDP during the first two years of a qualifying disability. After that two-year period, Hartford insures the plan for the remaining period of disability."[77] Woo argued that "when Hartford, as plan administrator, denies benefits, it will receive a direct financial benefit as plan insurer, if the disability extends beyond the two years."[78]

The district court granted Hartford's motion for summary judgment, concluding that Hartford had not abused its discretion in denying Woo's claim.[79]

On appeal, the Eighth Circuit once again noted the different approaches taken by appellate courts in the context of administrator conflicts of interest.[80] In striking contrast to its position in *Armstrong*, however, the *Woo* Court held that "[b]ased on our review of [*Bruch*], we adopt the 'sliding scale' approach."[81]

The Eighth Circuit reaffirmed its adoption of the "sliding scale" approach several months later in *Farley v. Arkansas Blue Cross and Blue Shield*[82] by holding that a "plan beneficiary is not entitled to less deferential review absent material, probative evidence demonstrating that a palpable conflict of interest existed, which caused a serious breach of the administrator's fiduciary duty."[83]

III. ANALYSIS

The *Armstrong* and *Woo* decisions appear to stand in stark contrast to one another. In *Armstrong*, the Eighth Circuit applied the stringent de novo

77. *Id*. at 1161.

78. *Id.*

79. *See id*. at 1160.

80. *See* 144 F.3d at 1161. The Court noted that the Tenth Circuit adopted the "sliding scale" approach, while the Eleventh Circuit prefers the "presumptively void" approach. *Id.*

81. *Id.*

82. 147 F.3d 774 (8th Cir. 1998). Here, Arkansas Blue Cross and Blue Shield was the insurer and administrator of a health insurance plan provided by Farley's spouse's employer, International Paper Company. *See id.* at 775. Blue Cross denied Farley's claim that resulted from medical treatments for an enlarged uterus. Blue Cross argued that Farley's claim was not covered as a preexisting condition because her symptoms first appeared two weeks before she became eligible for the health insurance plan. *See id*.

83. *Id.* at 776 (citing *Woo*, 1998 WL 261176 at *3-4. The court rejected Farley's argument that Blue Cross's "desire to maintain competitive insurance rates [should automatically] be construed as a conflict of interest." *Id.* at 777. The court concluded that "[I]n the long run, an insurer that routinely denies valid claims for benefits would have difficulty retaining current customers and attracting new business, thus providing an incentive to "make these determinations in a fair and consistent manner, thus negating any indicia of bias." *Id.*

standard of review.[84] In *Woo*, however, the Eighth Circuit adopted the more deferential "sliding scale" standard in which the administrator's decision is reviewed for abuse of discretion and the administrator's conflict of interest is simply weighed as a factor in determining whether there is such abuse.[85] The standards applied by the Eighth Circuit in these two cases are at opposite ends of the spectrum of review.[86]

Despite these stark differences, *Armstrong* and *Woo* are reconcilable. It is worthwhile to note that *Armstrong* did not adopt the de novo standard of review in all cases where an administrator labors under a conflict of interest.[87] Instead, the Eighth Circuit's holding in *Armstrong* was limited to the specific circumstances of that case.[88]

In *Armstrong*, the Eighth Circuit recognized that "Aetna ha[d] an obvious interest in minimizing its claim payments."[89] Apparently, the court considered this interest "obvious" because Aetna is a profit driven enterprise. However, this interest alone probably would not have been enough to warrant stringent review. Instead, the fact that seems to have swayed the *Armstrong* court was Aetna's incentive and bonus program that may have encouraged claim reviewers to reject meritorious claims.[90] This fact alone, which the *Armstrong* court believed created a serious conflict of interest,[91] may have been enough for the court to reduce what would otherwise have been deferential abuse of discretion review to the stringent de novo review.

Armstrong may be precisely the type of case that Judge Posner hypothesized in *Van Boxel* when he noted that in cases when administrators "have a serious conflict of interest, the proper deference to give their decisions may be slight, even zero."[92] The zero-deference standard of review in *Armstrong* was the result of the serious conflict of interest created by Aetna's bonus and incentive program.

Thus, *Armstrong* and *Woo* can both be seen as cases in which the court applies the "sliding scale" standard of review. In *Armstrong* the egregious

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84. *See Armstrong*, 128 F.3d at 1265. *See also supra* notes 64-68 and accompanying text.

85. *See Woo*, 144 F.3d at 1161. *See also supra* notes 80-81 and accompanying text.

86. *See supra* note 20.

87. *But see Armstrong*, 128 F.3d at 1266-67 (Beam, J., concurring and, in part, dissenting) (noting that the majority's adoption of the de novo standard in *Armstrong* is contrary to the Supreme Court's decision in *Bruch*).

88. *See Armstrong*, 128 F.3d at 1265 (holding that the decision to apply the de novo review was based on "the circumstance of this case," thus limiting the holding).

89. *Id.*

90. The court, in determining that Aetna had a conflict of interest, focused on the "incentives and bonuses to its claims reviewers," given by Aetna based on denied claims. *Id.*

91. *See Armstrong*, 128 F.3d at 1265.

92. *See Van Boxel*, 836 F.2d at 1052.

conflict of interest caused the scale to slide to the most stringent side of the spectrum of review: de novo review. In *Woo*, however, Hartford's financial conflict of interest was sufficient to slide the scale away from deferential review, but was not serious enough to allow for de novo review.

The Eighth Circuit's explicit adoption of the "sliding scale" standard of review in *Woo* is in agreement with the Supreme Court's dicta in *Bruch*,[93] that in the case of a plan which gives the administrator discretion, a plan administrator's conflict of interest should be "weighed as a 'facto[r] in determining whether there is an abuse of discretion.'"[94] This language implies that reviewing courts should always start with a deferential, abuse of discretion review, and then scale back that review when a beneficiary presents evidence that the plan administrator had a conflict of interest that may have influenced the denial of benefits.[95]

This is precisely the approach followed by the Eighth Circuit in *Armstrong* and *Woo*. In both cases the court modified the abuse of discretion standard of review, although to different extents, by weighing the administrator's respective conflicts of interest. Because the conflict in *Armstrong* was so serious, the court reviewed Aetna's denial with the least possible deference.[96] In *Woo*, a less serious conflict resulted in more deferential review.[97]

Some legal commentators have criticized the "sliding scale" standard of review as being in conflict with the ERISA's broad purpose to ensure and safeguard benefit expectations for employees.[98] The general complaint about this level of review is that employers and plan administrators are aided by lenient courts in their efforts to thwart benefit expectations.[99]

This criticism, however, ignores the fact that ERISA was designed not only to secure employee benefits, but also to encourage employers to offer and maintain benefit plans for their employees.[100] The "sliding scale" standard of review is in keeping with a congressional "desire not to create a [benefits] system that is so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefits plans

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93. *See Bruch*, 489 U.S. at 115.
94. *Id.*
95. *See Armstrong*, 128 F.3d at 1267 (Beam, J., concurring, and in part, dissenting).
96. *See supra* notes 66-68, 90-92 and accompanying text.
97. *See supra* notes 76, 92 and accompanying text.
98. For a discussion of ERISA's broad purpose, see *supra* notes 11-15 and accompanying text. For a discussion of criticisms of the "sliding scale" approach, see *infra* note 100 and accompanying text.
99. *See generally* Capps, *supra* note 24, at 288-90; *see also* Conison, *supra* note 11, at 34 and 62.
100. *See* Youngberg v. Bekins Co., 930 F. Supp. 1396, 1402 (E.D. Cal. 1996).

in the first place."[101] Although the "sliding scale" standard of review is more lenient on conflicted plan administrators, a more stringent standard, with higher administrative and litigation costs, may force employers and plan administrators to curtail or cancel existing employee benefit plans. This result would be detrimental to employees and contrary to the traditional congressional goals underlying ERISA. The "sliding scale" standard of review strikes the proper balance by allowing employees to seek effective review of denied benefits, and, at the same time, by encouraging employers to offer and maintain employee beneifits plans.

IV. CONCLUSION

The Eighth Circuit's adoption of the "sliding scale" approach in *Woo* was not a radical departure from the approach the Eighth Circuit took in *Armstrong*. In fact, the Eighth Circuit may have adopted the "sliding scale" approach as far back as *Armstrong* and simply adjusted the standard of review in *Armstrong* to reflect what the court considered an egregious conflict of interest in that case.[102]

The "sliding scale" standard of review conforms with traditional congressional goals underlying ERISA by encouraging employers and plan administrators to offer and maintain employee benefit plans.[103]

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101. Varity Corp. v. Howe, 516 U.S. 489, 497 (1996).
102. *See supra* notes 87-92, 97 and accompanying text.
103. *See supra* notes 99-102 and accompanying text.