SOUTH DAKOTA STATE MEDICAL HOLDING COMPANY, INC. V. HOFER: A DEFERENTIAL STANDARD OF REVIEW PERMITS ERISA ADMINISTRATORS TO CONTRAVENE THEIR FIDUCIARY OBLIGATIONS

DELIA M. DRULEY†

The federal district court for the Western Division of South Dakota recently allowed an insurance company and ERISA fiduciary to pursue subrogation against an injured beneficiary. The court applied an abuse of discretion standard of review, despite a conceded conflict of interest on the part of the insurance company. The court followed Eighth Circuit precedent without considering the protective purposes of the ERISA statute and the nature of the fiduciary obligations it imposes upon plan administrators. South Dakota State Medical Holding Company v. Hofer *is another in a line of cases that fails to consider the propriety of subrogation in the ERISA context.*

I. INTRODUCTION

In July 2007, the federal district court in the Western Division of South Dakota considered *South Dakota State Medical Holding Co. v. Hofer*,[1] in which an ERISA plan sought to enforce a subrogation provision against a plan beneficiary.[2] The beneficiary, Janet Hofer, survived a terrible motorcycle accident with her husband, Terry Hofer, and suffered serious injuries.[3] Her medical bills, which DakotaCare initially paid, totaled over $400,000.[4] After Mrs. Hofer recovered $250,000 from her husband's motorcycle insurance policy, however, DakotaCare pursued the subrogation rights it had written into the plan documents and ultimately recovered the entire settlement.[5]

The Employee Retirement Income Security Act (ERISA) governs employee benefit plans across the nation, with nearly 50 million employees enrolled in such plans.[6] Congress enacted the statute in 1974, after a decade long study of pension plan abuses.[7] ERISA seeks to protect the interests of workers by imposing "minimum standards . . . assuring the equitable character of such plans and

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† J.D. Candidate, 2010, University of South Dakota School of Law; B.A., 2007, University of South Dakota, Vermillion, South Dakota. The author would like to thank Derek Nelsen and Karen Gourley for their editorial advice and insight, Professor Roger Baron for inspiring her interest in the area, and her family for their unwavering support.

1. Civ. No. 06-5038-KES, 2007 WL 2121276, at *1 (D.S.D. July 24, 2007).
2. *Id.*
3. *Id.*
4. *Id.*
5. *Id.* at *7.
6. JAMES A. WOOTEN, THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974: A POLITICAL HISTORY 2 (2005).
7. *Id.*

their financial soundness."[8]

Recently, reimbursement provisions in ERISA plans have been in the news because of the decision in *Administrative Committee of Wal-Mart v. Shank*.[9] The *Shank* case illustrates the terrible outcomes common in subrogation actions.[10] Deborah Shank was a Wal-Mart employee who survived a car accident that rendered her permanently disabled.[11] Her health insurance policy through Wal-Mart paid nearly $500,000 in medical expenses.[12] Shank eventually recovered $700,000 in a lawsuit against the tortfeasor, though $417,477 was all that remained after paying attorneys' fees and court costs.[13] Wal-Mart asserted its right to recoup the award based on a subrogation provision in the policy and subsequently recovered all the remaining money, leaving Shank destitute.[14] The United States Supreme Court denied the Shanks' petition for certiorari on March 17, 2008.[15] However, due to public outcry, Wal-Mart eventually reversed itself and returned the balance to the Shanks.[16]

Sadly, for the Hofers, there was no public outcry against DakotaCare to

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8. 29 U.S.C. § 1001(a) (2000).
9. 500 F.3d 834 (8th Cir. 2007), *cert. denied*, 128 S. Ct. 1651 (2008).
10. *See id.*
11. *Id.* at 835.
12. *Id.*
13. *Id.*
14. *See* Vanessa Fuhrmans, *Accident Victims Face Grab for Legal Winnings*, WALL ST. J., Nov. 20, 2007, at A1, *available at* http://www.usd.edu/~rbaron/Wall%20Street%20Journal%20Article%20on%20Shank%20Case%20and%20ERISA%20Reimbursement.pdf?sid=5LMGzP00yn0&mbox=INBOX&charset=escaped_unicode&uid=5071&number=4&filename=Wall%20Street%20Journal%20Article%20on%20Shank%20case%20and%20ERISA%20Reimbursement.pdf. The article quoted Jim Shank, Deborah Shank's husband, on the impact of Wal-Mart's decision to pursue subrogation:

> "I don't understand why they need to do this," says Mr. Shank on a recent visit to the nursing home, between shifts as a maintenance worker and running a tanning salon. "This girl needs the money more than they do." Mrs. Shank, who needs help with eating and other basic tasks, spends more time alone since Mr. Shank had to let her private caregiver go. "At some point," he says, "she may have to be moved from a private to a semi-private room in the nursing home where she lives."

Id. See also Wal-Mart's Lawsuit: Legal but Wrong. L.A. TIMES, Nov. 21, 2007, at A24, *available at* http://articles.latimes.com/2007/nov/21/opinion/ed-walmart21, commenting:

> Wal-Mart started out as one of the good guys in this story, paying almost $470,000 of her initial medical bills. But three years after Shank's husband sued and settled with the semi driver's employer, the retail giant changed hats. It demanded every penny back, plus interest and legal fees—more, in fact, than the $417,477 the settlement had placed in a special-needs Medicaid trust fund for Shank's future healthcare expenses.

Id.

15. Admin. Comm. of Wal-Mart, Inc. v. Shank, 500 F.3d 834 (8th Cir. 2007), *cert. denied*, 128 S. Ct. 1651 (2008).

16. *See* Tara Parker Pope, *Injured Woman Wins Wal-Mart Saga*, N.Y. TIMES, Apr. 4, 2008, http://well.blogs.nytimes.com/2008/04/04/injured-woman-wins-wal-mart-saga/?scp=1&sq=Walmart%20Shank&st=cse. "Wal-Mart announced it would drop its effort to collect and would change its policy regarding subrogation to *allow for exceptions*." *Id.* (emphasis added). *See also* Michelle Andrews, *Wal-Mart Rethinks Its Move on Deborah Shank*, U.S. NEWS AND WORLD REPORT, Apr. 3, 2008, http://www.usnews.com/blogs/on-health-and-money/2008/4/3/wal-mart-rethinks-its-move-on-deborah-shank/comments/3.

compel it to abandon its claim for reimbursement.[17] The district court awarded DakotaCare the $250,000 settlement Janet Hofer received after being injured in the motorcycle accident.[18] Relying on Eighth Circuit case law, the district court upheld DakotaCare's right of subrogation without considering the protective purposes of ERISA or the fiduciary duty it imposes.[19] The court reviewed the plan fiduciary's decision to seek subrogation under a deferential abuse of discretion standard.[20]

Because Congress enacted ERISA to protect workers, it is ironic that courts allow the enforcement of subrogation/reimbursement provisions without considering the effects enforcement will have on the plan beneficiary.[21] In these situations, the beneficiary likely believes his insurance premiums were all he owed his insurer, and will be blindsided when he discovers that the settlement he fought for in court, which he invested thousands of dollars to pursue, will go entirely to his insurance company.[22] ERISA's regulatory and protective purposes should be foremost in the reasoning of federal courts.[23]

The United States Supreme Court recently confirmed that the dual roles insurance companies often occupy as ERISA fiduciaries and profit-seeking entities create a conflict of interest, which courts should consider.[24] In *Hofer*, DakotaCare's dual obligations as a fiduciary and a for-profit entity created precisely the same kind of conflict of interest.[25] ERISA requires that a plan administrator act "solely in the interest of plan beneficiaries."[26] When a powerful insurance company, like DakotaCare, attempts to recover huge sums of money from cata-

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17. *See* S.D. State Med. Holding Co. v. Hofer, Civ. No. 06-5038-KES, 2007 WL 2121276, at *1 (D.S.D. July 24, 2007).

18. *Id.*

19. *Id.* at *7.

20. *Id.*

21. *See* Scott M. Aronson, Comment, *ERISA'S Equitable Illusion: The Unjust Justice of Section 502(A)(3)*, 9 EMP. RTS. & EMP. POL'Y J. 247, 252 (2005).

22. *See id.* (citing 23 RICHARD A. LORD, WILLISTON ON CONTRACTS § 6151 (4th ed. 2002)). While the law ascribes to the fiction that individuals read and understand contracts in their entirety before signing them, in practice, the reality is different. *Id.* Furthermore, subrogation rights derive from equity, so they need not be expressly stated in a contract to be enforceable, though generally they are. *Id.*

23. John H. Langbein, *Trust Law as Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials Under ERISA*, 101 N.W. U. L. REV. 1315, 1342 (2007) [hereinafter Langbein, *Trust Law as Regulatory Law*] (criticizing the U.S. Supreme Court's approach to ERISA cases and failure to consider the regulatory and protective purpose of ERISA as a part of its analysis).

24. Metro. Life Ins. Co. v. Glenn, 128 S. Ct. 2343, 2346 (2008). The Court stated:

> Often the entity that administers the plan, such as an employer or an insurance company, both determines whether an employee is eligible for benefits and pays benefits out of its own pocket. We here decided that this dual role creates a conflict of interest; that a reviewing court should consider that conflict as a factor in determining whether the plan administrator has abused its discretion in denying benefits; and that the significance of the factor will depend upon the circumstances of the particular case.

Id.

25. *Hofer*, 2007 WL 2121276, at *4.

26. *See* 29 U.S.C. § 1104 (2000).

strophically injured beneficiaries, the company flouts its fiduciary obligation.[27] This scenario is hardly what Congress intended to endorse by enacting ERISA; indeed, it is the opposite.[28]

This casenote will address the appropriate standard of review for ERISA decisions and examine the district court's analysis in the *Hofer* decision.[29] Relevant background information regarding subrogation and ERISA is provided,[30] as is an overview of important United States Supreme Court and Eighth Circuit Court of Appeals ERISA jurisprudence.[31] This casenote concludes that the abuse of discretion standard does not sufficiently safeguard plan beneficiaries in light of modern developments in ERISA plans and the protective purpose of the ERISA statutory scheme.[32] A review of the ERISA statute and its legislative history demonstrates that the decision to pursue subrogation against a beneficiary who has not been made whole is violative of the fiduciary duty imposed by ERISA upon plan administrators.[33] Moreover, this note advocates for the adoption of a de novo standard of review, predicated upon principles of contract interpretation.[34]

II. FACTS AND PROCEDURE

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(This Section Omitted)

27. *See infra* Part IV.A.1.

28. *See* Alison S. Rozbruch, Comment, *Resolving the Conflict Between Two Visions for a Standard of Review in ERISA Benefit Denial Claims*, 9 J.L. & POL'Y 507, 513 (2001) ("[J]udicial interpretation has made employee benefits less secure by creating a body of common law that controverts ERISA's initial policy objectives."); Nola A. Kohler, Note, *An Overview of the Inconsistency Among the Circuits Concerning the Conflict of Interest Analysis Applied in an ERISA Action with an emphasis on the Eighth Circuit's Adoption of the Sliding Scale Analysis in* Woo v. Deluxe Corporation, 75 N.D. L. REV. 815, 821 (1999) ("Congress expected that courts would interpret the prudent man rule and other fiduciary standards while remaining cognizant of the purposes of ERISA."); Dahlia Schwartz, Note, *Breathing Lessons for the ERISA Vacuum: Toward a Reconciliation of ERISA's Competing Objectives in the Health Benefits Arena*, 79 B.U. L. REV. 631, 659 (1999) ("If courts continue to allow contractual provisions to dictate the standard of review they can apply, then the duties of loyalty and prudence imposed by ERISA will become hollow obligations, and Congress's objective of protecting plan beneficiaries will have fallen by the wayside.").

29. *See infra* Part IV.

30. *See infra* Parts III.A, III.B.

31. *See infra* Parts III.C, III.D.

32. *See infra* Part V. The abuse of discretion standard was articulated by the U.S. Supreme Court in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), clarified by *Metro. Life Ins. Co. v. Glenn*, 128 S. Ct. 2343 (2008) and applied by the district court in *Hofer*.

33. *See infra* Part IV.A.1.

34. *See infra* Part V.B.

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III. BACKGROUND

The *Hofer* decision raises several issues regarding subrogation in the ERISA context.[90] Because Congress enacted ERISA to protect employees, the appropriateness of allowing plans to pursue subrogation against plan beneficiaries is questionable.[91] The U.S. Supreme Court has yet to address the issue directly and has confined its analysis to questions of statutory construction.[92] Another issue raised by the *Hofer* decision is the appropriate standard of review for a plan administrator's decision to seek reimbursement.[93] Before delving into particular decisions interpreting ERISA and subrogation, it is helpful to have a basic understanding of both. While this note will not address ERISA in its entirety, an overview of the statute and the circumstances of its enactment are crucial to understanding subrogation in the ERISA context.[94]

A. SUBROGATION GENERALLY

Subrogation is "the substitution of another person in place of the creditor to whose rights he or she succeeds in relation to the debt, and gives the substitute all the rights, priorities, remedies, liens, and securities of the person for whom he

87. *Id.* at *6. Hofer argued that the anti-subrogation rule was not preempted by ERISA because the statute is silent on the issue of subrogation. Defendant's Mem. in Support, *supra* note 56, at 8 (citing Strong v. Omaha Constr. Indus. Pension Plan, 701 N.W.2d 320, 329 (2005) (a court may apply the federal common law to decide an issue where ERISA is silent on the question)). Thus, the anti-subrogation rule, as a part of the federal common law, is applicable to the action. *Id.*

88. *Hofer*, 2007 WL 2121276, at *6.

89. *Id.* Hofer also asserted a counterclaim for bad faith against DakotaCare and sought an award of attorneys' fees. *Id.* at *7. The court in concluding that ERISA preempted Hofer's bad faith claim, cited the U.S. Supreme Court's decision in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987). *Id.* Finally, the court declined Hofer's petition for attorneys' fees, because the plan language provided that DakotaCare would not be responsible for attorneys' fees to members in actions against DakotaCare, unless explicitly stipulated to in writing. *Id.* The court also noted that since DakotaCare did not abuse its discretion in determining it had a right to subrogation, an award of attorneys' fees was not warranted. *Id.*

90. *See generally Hofer*, 2007 WL 2121276.

91. *See* Roger M. Baron, *Public Policy Considerations Warranting Denial of Reimbursement to ERISA Plans: It's Time to Recognize the Elephant in the Courtroom*, 55 MERCER L. REV. 595 (2004) [hereinafter Baron, *Policy Considerations*].

92. *Id.* at 596 (criticizing the U.S. Supreme Court's failure to analyze policy considerations supporting denial of reimbursement).

93. *See supra* notes 69-78 and accompanying text.

94. For a more detailed history, see WOOTEN, *supra* note 6, at 2-116.

or she is substituted."[95] In other words, subrogation allows an insurer to stand in the shoes of the insured in his claim against a third party, generally a tortfeasor.[96] Through subrogation, the insurer acquires the same rights the insured had against a tortfeasor.[97] Essentially, if an insurer indemnifies an insured for injuries or damages he received through the fault of a third party, the insurer may recover from the third party what he has paid to the insured.[98]

Various public policy considerations underlie the doctrine of subrogation, including principles of indemnity.[99] Although the insurance policy gives the insured rights to indemnity, the insured is only entitled to be made whole, not more than whole.[100] Subrogation prevents an insured from recovering twice, once from the insurer pursuant to its obligations under the policy and a second time from the tortfeasor.[101]

The primary use and acceptance of subrogation practices has been in the area of property insurance.[102] However, in the last two decades, insurance companies have pursued the creation of new subrogation rights for payments on personal injury claims.[103] Although at common law, subrogation of personal injury claims was proscribed by both a prohibition against splitting a cause of action and the public policy against assigning personal injury claims, subrogation provisions began to appear in insurance contracts in the 1960s.[104] In order to circumvent these obstacles, insurance companies disguised subrogation provisions by terming the provisions "reimbursement rights" which allowed the insurance company to be reimbursed for any payments it made to the insured if there were any recovery from a tortfeasor.[105]

B. THE EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)

Though "ERISA itself neither permits nor endorses the concept of reimbursement," ERISA plans have consistently pursued subrogation in order to re-

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95. 16 COUCH ON INSURANCE § 222:5 (Lee R. Russ & Thomas F. Segalia eds., 3d ed. 2000).

96. Roger M. Baron, *Subrogation: A Pandora's Box Awaiting Closure,* 41 S.D. L. REV. 237, 238 (1996) (discussing the nature and origins of the doctrine of subrogation) [hereinafter Baron, *Subrogation: A Pandora's Box*]

97. *See* COUCH, *supra* note 95, at § 222:5.

98. Elaine M. Rinaldi, *Apportionment of Recovery Between Insured and Insurer in a Subrogation Case*, 29 TORT & INS. L.J. 803 (1994) (discussing whether the insured or the insurer has first priority on a settlement from a third party tortfeasor where the insured has not been fully reimbursed for his losses).

99. *Id.*

100. *Id.*

101. *Id.*

102. Baron, *Subrogation: A Pandora's Box*, *supra* note 96, at 239.

103. *Id.*

104. David M. Kono, Comment, *Unraveling the Lining of ERISA Health Insurer Pockets—A Vote for National Federal Common Law Adoption of the Make Whole Doctrine*, 2000 B.Y.U. L. REV. 427, 430 (2000).

105. *See* Baron, *Subrogation: A Pandora's Box*, *supra* note 96, at 239. The terms "reimbursement" and "subrogation" are used interchangeably throughout this note.

cover benefits paid to plan members.[106] While the ERISA statutory scheme is detailed in some respects, it is devoid of any governmental oversight regarding insurance principles.[107] Plans seek enforcement of reimbursement provisions through section 502(A)(3) of the ERISA statute, which allows a fiduciary to bring a civil action to enforce any provisions of the plan.[108]

ERISA became law on September 2, 1974; it was the first major federal legislation protecting American workers' pension rights.[109] The statute arose out of growing awareness of pension plan abuses in America.[110] An investigation by the Senate Labor Subcommittee revealed the tragedies caused by an "unregulated and abused" pension system, and the call for regulation strengthened.[111] Despite opposition from the Nixon administration, the business and labor communities, and some pension experts, ERISA was eventually enacted by an "overwhelming and nearly unanimous" vote.[112]

ERISA's declaration of policy states in part that:

> [E]mployees and their beneficiaries have been deprived of anticipated benefits; and that it is therefore desirable in the interest of employees and their beneficiaries, for the protection of the revenue of the United States,

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106. *See* Baron, *Policy Considerations*, *supra* note 91, at 597.

107. Roger M. Baron, A Discussion of Strategies for ERISA Beneficiaries for the Kansas Association for Justice: Understanding ERISA Liens (June 13, 2008) (unpublished presentation paper) (on file with author) [hereinafter Baron, Understanding ERISA Liens].

108. 29 U.S.C. § 1132(a)(3) (2000). This section provides: "(a) A civil action may be brought . . . (3) by a participant, beneficiary, or fiduciary . . . 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." *Id.* An ERISA fiduciary is defined as any person who exercises discretionary authority or control respecting the management or administration of a benefit plan or control over the disposition of plant assets. *Id.* § 1002(21)(A). ERISA requires that all assets of employee benefit plans to be held in trust. *Id.* § 1103(a). Furthermore, ERISA requires all aspects of plan administration be governed by trust fiduciary principles of loyalty and prudence. *Id.* § 1104(a)(1)(A)-(B). For a detailed overview of ERISA's civil procedure rules, see Kathryn J. Kennedy, *The Perilous and Ever-Changing Procedural Rules of Pursuing an ERISA Claims Case*, 70 UMKC L.REV. 329 (2001).

109. ERISA: A COMPREHENSIVE GUIDE 1 (Martin Wald & David E. Kenty eds., 1991). Prior to ERISA's enactment, pension plans were regulated by three different statutes. *See* H.R. REP. 93-533, *reprinted in* 1974 U.S.C.C.A.N. 4639, 4649-51. The three statutes were the Welfare and Pension Plans Disclosure Act of 1958, which required disclosure of information concerning the plan in order to protect the interest of plan participants, 29 U.S.C. § 301, *repealed by* Pub. L. No. 93-406, 88 Stat. 851 (1974); the Labor Management Relations Act of 1947, 29 U.S.C. § 141 (2000), which created guidelines for pension plans which were administered jointly by employers and unions; and the Internal Revenue Code of 1954, 26 U.S.C. §§ 401-404, 501-503 (2006), which gave the IRS the power to determine whether a plan had "qualified status" which gave tax deductions to employers for contributions made to the plan. *See* H.R REP. 93-533, *reprinted in* 1974 U.S.C.C.A.N. 4639, 4649-51.

110. ERISA: A COMPREHENSIVE GUIDE, *supra* note 109, at 4-6. The closure of the Studebaker Automobile Company and subsequent discovery that over 4,000 workers lost some or all of their pensions, despite the fact that the plan was well funded, brought the issue to the attention of ordinary Americans. *Id.* Public outcry was so strong that opposition to pension reform became "politically repulsive." *Id.*

111. *Id.* It became clear that three major problems existed with pension plans at the time. RAND E. ROSENBLATT ET. AL, LAW AND THE AMERICAN HEALTH CARE SYSTEM 159-96 (1997). First, many pension plans were severely underfunded. *Id.* at 159. Second, there were few consequences for pension plan administrators who breached their fiduciary obligations. *Id.* Finally, corporations that were engaged in interstate commerce faced a variety of complex, and often conflicting, state regulations aimed at these problems. 120 CONG. REC. 29, 197 (1974) (comments of Rep. Dent).

112. ERISA: A COMPREHENSIVE GUIDE, *supra* note 109, at 4-6.

> 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.[113]

A review of the legislative history of ERISA demonstrates that the major goal of the statute was the protection of workers.[114] Though originally aimed at pension plans, the law has increasingly influenced employee health plans.[115]

Several features of ERISA impact subrogation actions brought under its civil enforcement provisions. First, subject to only a few exceptions, ERISA preempts any state law relating to subrogation rights if the rights are written into an employee benefit plan.[116] Preemption is an incredibly important feature of ERISA, integral in ensuring it fulfills its purpose of uniform regulation of employee benefits.[117] If a plan is deemed to be an employee benefit plan, ERISA preempts any state laws prohibiting subrogation and the plan reimbursement provision will be enforceable.[118]

If a state law regulates insurance, it is "saved" by another section of ERISA and not preempted by the statute.[119] Only state laws that specifically address the insurance industry are considered to regulate insurance; those that merely affect the insurance business are not saved from preemption by this section.[120] Fur-

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113. 29 U.S.C. § 1001(a) (2000).

114. *See* H.R. REP. NO. 93-533, *as reprinted in* 1974 U.S.C.C.A.N. 4639, 4647. *See also* Kono, *supra* note 104, at 444 (quoting House Report that congressional concern was "the absolute need that safeguards for plan participants be sufficiently adequate and effective to prevent the numerous inequities to workers under plans which have resulted in tragic hardships for so many").

115. *See* ERISA: A COMPREHENSIVE GUIDE, § 1.01 (Paul J. Schneider & Brian M. Pinheiro eds., 3d. ed. Aspen Publishing Co. 2008).

116. 29 U.S.C. § 1144(a) (2000). According to the statutory language, an employee benefit plan is:

> [A]ny plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment.

Id. § 1002(1). Generally, if there is a dispute regarding whether a plan qualifies as an employee benefit plan, the debate centers around whether a plan was established or maintained; by an employer or employee organization; and whether the plan covers employees. *See* Kono, *supra* note 104, at 432. However, in the Eighth Circuit, the inquiry is different. For a particular plan to qualify as an employee benefit plan under ERISA, "a reasonable person must be able to ascertain the 'intended benefits, a class of beneficiaries, source of financing, and procedures for receiving benefits.'" *See* Nw. Airlines v. Fed. Ins. Co., 32 F.3d 349, 354 (8th Cir. 1994) (citing Donovan v. Dillingham, 688 F.2d 1367, 1373 (11th Cir. 1982)); Harris v. Ark. Book Co., 794 F.2d 358, 360 (8th Cir. 1986) (citing and approving *Donovan* factors)).

117. *See* 120 CONG. REC. 29, 197 (1974) (statement of Rep. Dent, calling preemption the "crowning achievement" of ERISA). "Federal preemption is the keystone that gives ERISA's arch the ability to span the nation with a single, uniform, pension and welfare-benefit law." Bauthaus USA, Inc. v. Copeland, 292 F.3d 439, 445 (5th Cir. 2002) (Wiener, J., dissenting).

118. COUCH, *supra* note 95, § 222:49.

119. 29 U.S.C. § 1144(b)(2)(A) (2000).

120. Kentucky Ass'n of Health Plans, Inc. v. Miller, 538 U.S. 329 (2003). The U.S. Supreme Court articulated a two-pronged test for whether a state law regulates insurance in its decision in *Miller*. *Id.* According to the Court, for a state law to "regulate insurance" under 29 U.S.C. § 1144(b)(2)(A), the law must be "specifically directed towards entities engaged in insurance" and "substantially affect the risk

thermore, a state's common law doctrines, which "regulate insurance," are saved from preemption.[121] ERISA also contains a "deemer" clause, which prevents a court from determining that a company is an insurance company when it actually is not.[122] The U.S. Supreme Court has interpreted the deemer clause to permit states to regulate an insured plan indirectly through regulation of the plan's insurer and insurance contracts, but if a plan is not insured, the state may not regulate it in any way.[123]

An ERISA plan's decision to seek reimbursement can be justified in a variety of ways. Plans have argued that pursuing subrogation in personal injury claims prevents the insured from receiving an unjust double recovery, or windfall.[124] Put another way, subrogation allows the insurer to recover the costs incurred in indemnifying the insured, if the insured receives compensation from another source as well.[125] Another argument in favor of subrogation is the assertion that allowing subrogation protects consumer interests, as insurance companies are able to maintain lower premiums due to subrogation recoveries.[126]

These justifications are not without criticism.[127] Legal scholars have critiqued the double recovery argument, pointing out that the premiums paid by the insured were in exchange for indemnification.[128] A similar criticism of the windfall argument is that it is the insurer, not the insured, who receives a windfall through subrogation, because the insurer is able to recoup its costs through reimbursement, though the insurer received premiums for its promise to indemnify.[129] A review of many subrogation cases demonstrates that often the insured is far from made whole even after receiving a judgment against a tortfeasor, and thus, the insured does not receive a windfall at the expense of the insur-

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pooling arrangement between the insurer and the insured." *Id.* at 342 (breaking from the mode of analysis governed by the McCarran-Ferguson factors in analyzing state laws under ERISA savings clause). The McCarran-Ferguson Act was passed by Congress in 1945 and states that regulation of insurance by the states is in the public interest and that no laws of Congress "shall be construed to invalidate, impair, or supersede any law enacted by any [s]tate for the purpose of regulating the business of insurance." 15 U.S.C. §§ 1011-1014 (2000). The McCarran-Ferguson Act is still good law, despite efforts to repeal the Act during the Clinton years to enable the creation of the Clintons' federal healthcare plan. *See* Baron, Understanding ERISA Liens, *supra* note 107, at 12. However, following the U.S. Supreme Court's decision in *Miller,* the Act is no longer used by the federal courts to analyze preemption. *Id.*

121. Baron, Understanding ERISA Liens, *supra* note 107, at 14.

122. *See* 29 U.S.C. § 1144(b)(2)(B).

123. FMC Corp. v. Holliday, 498 U.S. 52, 64 (1990) (finding Pennsylvania's anti-subrogation statute was preempted by ERISA). This decision, while very important to the federal courts' interpretation of ERISA, is beyond the scope of this casenote. For a thorough discussion of two United States Supreme Court decisions regarding preemption and the deemer clause, see Shawn C. Moore, Casenote, *ERISA Preemption of State Subrogation Laws: Baxter v. Lynn* and *FMC Corp. v. Holliday*, 43 ARK. L. REV. 477 (1990).

124. Kono, *supra* note 104, at 444.

125. Keith E. Edeus, Jr., Comment, *Subrogation of Personal Injury Claims: Toward Ending an Inequitable Practice*, 17 N. ILL. U. L. REV. 509, 514 (1997).

126. Kono, *supra* note 104, at 446. *Cf.* Baron, *Policy Considerations*, *supra* note 91, at 627.

127. *See* Baron, *Policy Considerations*, *supra* note 91, at 623-25.

128. Lee v. State Farm Mut. Auto. Ins. Co., 129 Cal. Rptr. 271, 278 (Cal Ct. App. 1976) (Friedman, J., concurring).

129. Baron, *Policy Considerations*, *supra* note 91, at 623.

ance company.[130] Scholars have similarly controverted the second justification for subrogation—lowered insurance premiums.[131] Various legal commentators point out that actuarial estimates do not include subrogation recoveries, so premium rates do account for any savings from subrogation.[132] The final criticism addresses the propriety of subrogation in the ERISA context, with some commentators arguing congressional intent did not include allowing ERISA fiduciaries to pursue subrogation against plan beneficiaries.[133]

C. ERISA AND THE U.S. SUPREME COURT: SELECTED CASES

When ERISA was enacted in 1974, the preemptive nature of the statute ensured that any litigation over its protections would occur in federal court.[134] However, Congress left much of the development of the complicated law and the application of trust principles to the courts.[135] This note provides an overview of three significant decisions of the United States Supreme Court relating to ERISA.[136] These cases address the standard of review to be applied by courts in reviewing the decisions of ERISA fiduciaries, further explain ERISA's fiduciary duty requirements, and discuss the scope of ERISA's civil enforcement provisions.[137] The U.S. Supreme Court has decided two cases specifically related to ERISA and subrogation: *Great-West Life & Annuity Insurance Co. v. Knudson*[138] and *Sereboff v. Mid Atlantic Medical Services, Inc.*[139] The two cases, while important ERISA decisions, do not relate to the analysis portion of this note and are therefore not discussed.[140]

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130. *Id.*

131. *See* Edeus, *supra* note 125, at 515.

132. *See id.* As Mr. Edeus noted:

> Insurance companies, based upon actuarial statistics, essentially distribute the losses incurred by a few persons evenly to a large number of persons who face similar risks. . . . These premiums themselves are calculated based upon the losses actually incurred, adjusted, of course, to allow the company to pay its costs and make a profit. What is important to note is that **premiums are based upon losses alone, and do not take subrogation recoveries into account.**

Id. (emphasis added).

133. *See* Baron, *Policy Considerations*, *supra* note 91, at 616-19. This argument will be more fully discussed in the analysis portion of this note. *See infra* Part IV.A.1.

134. *See supra* notes 116-23 and accompanying text.

135. *See* 129 CONGR. REC. 29942 (1974). For example, Senator Javits, one of the major proponents of pension reform and a sponsor of ERISA, stated, "[A] body of Federal substantive law will be developed by the courts to deal with issues involving rights and obligations under private welfare and pension plans." *Id.* (remarks of Sen. Javits).

136. *See infra* Part III.C.

137. *Id.*

138. 534 U.S. 204 (2002).

139. 547 U.S. 356 (2006).

140. *Knudson,* 534 U.S. 204. In *Knudson,* the Court considered whether an ERISA plan's attempt to enforce a reimbursement provision found in plan documents under section 502(a)(3) was "appropriate equitable relief." *Id.* at 208. The Court denied the plan relief. *Id.* at 210. In order for restitution to qualify as equitable, the Court noted that the action should be an attempt to "restore particular funds or property in the defendant's possession" to the plaintiff. *Id.* at 213.

In 2006, the Court again considered subrogation in the ERISA context with its decision in *Se-*

The U.S. Supreme Court addressed the appropriate standard of review for denials of plan benefits under ERISA in *Firestone Tire and Rubber Co. v. Bruch.*[141] In 1980, Firestone sold its plastics division to Occidental Petroleum Company, which retained most of the division's employees.[142] Firestone had maintained several different "employee welfare benefit plans" under ERISA.[143] Six employees rehired by Occidental sought severance benefits under the termination pay plan and information regarding their benefit plans from Firestone.[144] Firestone denied severance benefits and refused to provide the requested information[145]

The employees then brought a class action pursuant to one of ERISA's civil enforcement provisions, 29 U.S.C. § 1132(a)(1), alleging they were entitled to severance benefits.[146] The district court granted Firestone's motion for summary judgment, holding that the company had satisfied its fiduciary duty under ERISA because its decision was "not arbitrary or capricious."[147] The Third Circuit Court of Appeals reversed.[148] The appeals court acknowledged that most federal courts reviewed denial of benefits by ERISA fiduciaries under the arbitrary and capricious standard, but noted the standard had been softened where administrators had some bias, and held that a de novo standard of review was appropriate where an employer "is itself the fiduciary and administrator of an unfunded benefit plan."[149]

The U.S. Supreme Court granted certiorari to determine the appropriate

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reboff. 547 U.S. at 359. The plan fiduciary, Mid Atlantic, brought suit against the Sereboffs under ERISA section 502(a)(3), to enforce the plan's reimbursement provision. *Id.* at 360. Distinguishing the case from *Knudson*, the Court noted that Mid Atlantic sought the imposition of a constructive trust on "particular funds" in the Sereboffs' possession, whereas in *Knudson*, the funds had been placed in a special needs trust. *Id.* at 362. Thus, the type of relief sought was equitable. *Id.* The Court rejected the Sereboffs' petition to apply the make whole doctrine to the action. *Id.* at 368.

141. 489 U.S. 101 (1989). At the time of the *Firestone* decision, courts reviewed benefit denials under ERISA under an arbitrary and capricious standard. Petition for Writ of Certiorari, Firestone Rubber & Tire Co. v. Bruch, 489 U.S. 101 (1989) (No. 87-1054), 1987 WL 955337. The Third Circuit abandoned that standard, imposing a de novo review because it found Firestone had a conflict of interest, which under trust law would mandate a less deferential standard of review. *Id.* at *2. The question of how the term "participant" was to be interpreted in ERISA section 502(c), 29 U.S.C. § 1132(c), was subject to differing treatment in different circuits. *Id.* at *18 (citing Jackson v. Sears, Roebuck & Co., 648 F.2d 225, 228 (5th Cir. 1981) (holding only current employees included); Nugent v. Jesuit High School, 625 F.2d 1285, 1287 (5th Cir. 1980) (former employees are participants within the meaning of ERISA only if their benefits have vested); Kuntz v. Reese, 785 F.2d 1410, 1411 (9th Cir. 1986) *cert. denied*, 107 S. Ct. 318 (1987) (former employee is a participant if he has a reasonable expectation of returning to covered employment or a colorable claim to vested benefits); Saladino v. L.L.G.W.U. Nat'l Retirement Fund, 754 F.2d 473 (2d Cir. 1985) (same), Stanton v. Gulf Oil Corp., 792 F.2d 432 (4th Cir. 1986) (refusing to adopt a broad reading of the term "participant")).

142. *Firestone,* 489 U.S. at 105.

143. *Id.*

144. *Id.*

145. *Id.* at 106.

146. *Id.*

147. *Id.* at 106-07.

148. *Id.* at 107.

149. *Id.*

standard of review for actions brought under 29 U.S.C. § 1132.[150] The Court held that the appropriate standard of review for a denial of benefits claim is de novo, unless the benefit plan gives the administrator or fiduciary "discretionary authority to determine eligibility for benefits or to construe the terms of the plan."[151] Furthermore, the Court noted that the de novo standard applies regardless of whether the fiduciary is operating under a possible or actual conflict of interest, although "that conflict must be weighed 'as a facto[r] in determining whether there is an abuse of discretion.'"[152]

The breadth of ERISA section 502(a)(3), one of the civil enforcement provisions of the statute, was addressed by the U.S. Supreme Court in *Varity Corp. v. Howe.*[153] In *Varity,* a class of employees worked for Massey-Ferguson, a subsidiary of Varity Corporation; the company's employee welfare benefit plan provided insurance coverage to the class.[154] Out of concern that some of Massey-Ferguson's divisions were losing money, Varity transferred the poorly performing divisions to a new subsidiary, Massey Combines.[155] Varity hoped Massey Combines' failure would eliminate the benefit plan's promise to pay medical and other benefits to employees of the money-losing divisions.[156] Varity convinced the employees that their benefits would remain secure if they transferred.[157] Unfortunately, Massey Combines was in receivership two years later and the employees lost their non-pension benefits.[158]

Many of the affected employees brought suit, seeking the benefits they would have been owed under their former plan if they had not transferred.[159] The District Court found that Varity had harmed the beneficiaries through deliberate deception, thus violating the administrators' fiduciary duty to act "solely

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150. *Id.* at 108. The Court also granted certiorari to determine the proper interpretation of the term participant in 29 U.S.C. § 1002(7). *Id.*

151. *Id.* at 115. De novo standard of review is rarely applied however, because, since *Firestone*, plan drafters have uniformly added provisions giving the plan administrator discretion, and thus procuring a more deferential standard of review for the plan, in the event a decision is challenged in court. *See* Langbein, *Trust Law as Regulatory Law*, *supra* note 23, at 1324.

152. *Firestone*, 489 U.S. at 115 (citing RESTATEMENT (SECOND) OF TRUSTS § 187, cmt. d (1959)).

153. 516 U.S. 489 (1995). Petitioners appealed on two grounds. Brief for the Petitioners at *15, Varity Corporation v. Howe, 516 U.S. 489 (1995) (No. 94-1471), 1995 WL 375801. First, that the United State Supreme Court's decision in *Mass. Mut. Ins. Co. v. Russell*, 473 U.S. 134 (1985) and the text of ERISA itself prevented the plaintiffs from suing for breach of fiduciary duty on behalf of themselves rather than the plan. *Id.* Second, that the Eighth Circuit's ruling "vastly expanded the scope of fiduciary obligations on employers beyond those imposed by statute." *Id.* at *16.

154. *Varity Corp.*, 516 U.S. at 493.

155. *Id.*

156. *Id.* By persuading the employees of the failing subsidiaries to switch employers and release the old subsidiary from paying benefits, Varity would avoid the fall out. *Id.*

157. *Id.* at 494.

158. *Id.* Receivership is the process of appointment by a court or a receiver to take custody of the property of a party to a lawsuit pending a final decision on disbursement or an agreement that a receiver control the financial receipts of a person who is deeply in debt (insolvent) for the benefit of creditors. BLACK'S LAW DICTIONARY 1052 (8th ed. 2004).

159. *Varity Corp.*, 516 U.S. at 494.

in the interests of the participants and beneficiaries" of the plan.[160] Noting that ERISA section 502(a)(3) gave the former employees a right to "appropriate equitable relief," the court ordered Massey-Ferguson to reinstate its former employees into its own plan and to pay monetary damages.[161] The Eighth Circuit Court of Appeals affirmed.[162]

The U.S. Supreme Court granted certiorari to determine whether ERISA section 502(a)(3), afforded relief to individuals or only to the plan as a whole when used as a basis for claims of breach of fiduciary obligation.[163] The Court determined that Varity breached its fiduciary duty to employees when it deceived them about the security of their benefits.[164] The Court noted that ERISA "requires a fiduciary to discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries."[165] Thus, knowingly and materially deceiving plan beneficiaries in order to save the company money is not an act solely in the beneficiaries' interests.[166] Finally, the Court found ERISA section 502(a)(3) provided a remedy to an individual beneficiary for a breach of fiduciary obligation for "appropriate equitable relief."[167] Subsection three's words, "appropriate equitable relief" to "redress any act or practice which violates any provision of this title" were sufficiently expansive to provide for an individual cause of action for breach of fiduciary obligation.[168] ERISA's stated purpose, to protect the interests of employee beneficiaries, also favored a reading of the section to provide the plaintiffs with a remedy.[169]

In early 2008, the U.S. Supreme Court considered the remedies authorized

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160. *Id.* (citing ERISA § 404(a) (codified as amended at 29 U.S.C. § 1104 (2000)).
161. *Id.* at 495. The district court's award of monetary damages was undisputed. *Id.*
162. *Id.*
163. *Id.*
164. *Id.* at 506.
165. *Id.*
166. *Id.*
167. *Id.* at 509.
168. *Id.* at 510.
169. *Id.* at 513. Justice Thomas dissented, joined by Justices O'Connor, and Scalia, disagreeing with the majority's conclusion that section 502(a)(3) provided an individual remedy for breach of fiduciary duty on the basis of the court's reasoning in *Russell* and their interpretation of the text. *Varity Corp.*, 516 U.S. at 516. (Thomas, J., dissenting) (citing Massachusetts Mut. Life Ins. Co. v. Russell, 473 U.S. 134 (1985)). The dissenters asserted that congressional intent permitted suit for breach of fiduciary duty under sections 409 and 502(a)(2) exclusively and to make such relief available only for the benefit of the plan. *Id.* at 525. The dissent also concluded that Varity did not act as a fiduciary when it misled beneficiaries. *Id.* at 526. In support of this assertion, the dissenters cited the "artificial definition of fiduciary" provided for in ERISA, which defines fiduciary status in "functional terms of control and authority over the plan" rather than in terms of formal trusteeship. *Id.* at 527-28 (citing Mertens v. Hewitt, 508 U.S. 248, 262 (1993)). The dissenting justices also noted that ERISA does not require ordinary business decisions to be subject to fiduciary standards, only those decisions regarding administering the plan. *Id.* at 529-30. Decisions regarding the management or supervision of the plan are also subject to fiduciary standards. *Id.* The dissenters concluded that representations about expected financial condition of the corporation were made in Varity's role as plan sponsor, which is not subject to fiduciary standards. *Id.* at 531. Finally, the dissent disagreed with the majority's categorization of Varity's statements to employees, finding the message conveyed was that "the security of jobs and benefits would be contingent upon the success of the new company." *Id.* at 537.

by ERISA section 502(a)(2) that it previously addressed in *Massachusetts Mutual Life Insurance Co. v. Russell*,[170] with its decision in *LaRue v. DeWolff, Boberg & Associates, Inc.*[171] Larue filed suit against his employer and the administrator of its ERISA-controlled 401(k) plan for breach of fiduciary duty.[172] The basis for this claim was that DeWolff failed to make particular changes to investments in his personal account as LaRue had directed, and that this failure reduced LaRue's account value by approximately $150,000.[173] The complaint sought "to be 'made-whole' or other equitable relief as allowed by [section 502(a)(3)]."[174] The District Court granted DeWolff's motion for a judgment on the pleadings on the basis that LaRue sought damages rather than equitable relief available under section 502(a)(3).[175]

On appeal, LaRue argued he had claims for relief under sections 502(a)(2) and 502(a)(3) of ERISA, but the Fourth Circuit Court of Appeals rejected his argument.[176] Citing the U.S. Supreme Court's opinion in *Russell*, the court noted that those particular provisions of ERISA protected the entire plan rather than the individual beneficiary, and determined that LaRue sought "personal relief" which was unavailable under those sections.[177]

The U.S. Supreme Court granted certiorari to determine whether LaRue was entitled to individual relief under ERISA section 502(a)(2).[178] The Court distinguished LaRue's factual situation from the one at hand in *Russell*, noting, "*Russell's* emphasis on protecting the 'entire plan' from fiduciary misconduct reflects the former landscape of employee benefit plans. That landscape has changed."[179] Since fiduciary misconduct in defined contribution plans does not necessarily have to threaten the financial health of the entire plan to reduce individual benefits below the amount participants would otherwise receive, the Court

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170. 473 U.S. 134 (1985). In *Russell*, the Court addressed the question of whether an ERISA fiduciary could be held personally liable to a plan participant for extra-contractual compensatory or punitive damages caused by improper or untimely processing of benefit claims. *Id.* at 136. In dicta, Justice Stevens, the author of the majority opinion, observed, "the emphasis upon the relationship between the beneficiary and the plan as an entity is apparent" and further stated that Congress had been primarily concerned with protecting the plan as a whole, rather than individual beneficiaries. *Id.* at 140. Expressing reluctance to interfere with "an enforcement scheme crafted with such evident care as the one in ERISA," the majority concluded that ERISA's six civil enforcement provisions were intended to be exclusive, and that section 409, which allows an action to be brought for breach of fiduciary duty under section 502(a), did not allow suits by an individual beneficiary for extra-contractual damages. *Id.* at 147.

171. 128 S. Ct. 1020 (2008). Petitioners noted that the "sheer number of Americans and amount of money" affected by the resolution of questions regarding the scope of ERISA section 502(a)(2) and the changing nature of employee benefit plans rendered the case significant. Petition for Writ of Certiorari at *7, LaRue v. DeWolff, Boberg & Assoc., Inc., 128 S. Ct. 1020 (2008) (No. 06-856), 2006 WL 3761777.

172. *LaRue*, 128 S. Ct. at 1023.

173. *Id.* The plan permitted participants to direct the investment of their contributions, subject to various procedures and requirements. *Id.* at 1022.

174. *Id.* at 1023.

175. *Id.*

176. *Id.*

177. *Id.*

178. *Id.* at 1024.

179. *Id.* at 1025.

held individual relief for breach of fiduciary duty is appropriate under ERISA section 502(a)(2).[180]

In a recent decision, *Metropolitan Life Insurance Co. v. Glenn*,[181] the U.S. Supreme Court clarified the appropriate standard of review under ERISA when a conflict of interest is present.[182] Wanda Glenn worked for Sears, Roebuck & Co. when she was diagnosed with a serious heart condition.[183] She applied for plan disability benefits with Metropolitan Life Insurance, the administrator and insurer of Sears' plan, and qualified for twenty-four months of benefits.[184] Met Life also instructed her to apply for Social Security disability benefits, which she received after an administrative law judge concluded she was unable to perform her own job or "any other jobs [for which she could qualify] existing in significant numbers in the economy."[185] In order to continue receiving benefits after

180. *Id.* at 1025-26. Chief Justice Roberts and Justice Kennedy concurred. *Id.* at 1026 (Roberts, C.J., concurring in part and concurring in judgment). Justices Thomas and Scalia also concurred. *Id.* at 1028 (Thomas, J., concurring in judgment). Chief Justice Roberts' and Justice Kennedy expressed the view that the relief LaRue sought would be more appropriately addressed under ERISA section 502(a)(1)(B). *Id.* at 1026 (Roberts, C.J., concurring in part and concurring in judgment). This section of ERISA allows a participant to bring a civil action to "recover benefits due 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) (2000). Justices Thomas and Scalia agreed with the majority's conclusion that section 502(a)(2) provided the relief sought, but reached that conclusion on the basis of ERISA's text, not "the kind of harms that concerned [ERISA's] draftsmen." *LaRue,* 128 S. Ct. at 1028. (Thomas, J., concurring in judgment). Justices Thomas and Scalia found the text of sections 409 and 502(a)(2) permitted recovery of plan losses resulting from a breach of fiduciary duty. *Id.* at 1029. Because the assets allocated to the petitioner's individual account were plan assets, Justices Thomas and Scalia concluded the losses in LaRue's account were losses "to the plan" and that the plan in the aggregate suffered as well. *Id.*

181. 128 S. Ct. 2343 (2008).

182. Petition for Writ of Certiorari, Metro. Life Ins. Co. v. Glenn, 128 S. Ct. 2343 (2008) (No. 06-923), 2007 WL 43603. Subsequent to the United States Supreme Court's decision in *Firestone*, a split developed among the circuits regarding how to account for a fiduciary's conflict of interest in the standard of review applied. *See* Jill V. Cartwright, Note, *Why Fight Fought?: A Missed ERISA Opportunity in the Ninth Circuit*, 37 GOLDEN GATE U. L. REV. 563 (2007) (discussing the split in the circuits with an emphasis upon the Ninth Circuit's approach to the question of conflicted fiduciaries). Prior to the *Glenn* decision, a majority of circuits followed the "sliding scale" model, which decreases the level of deference given to the administrator's decision with regard to the seriousness of the conflict of interest. *See* Pinto v. Reliance Standard Life Ins. Co., 214 F.3d 377, 392 (3d Cir. 2000); Ellis v. Metro. Life Ins. Co., 126 F.3d 228, 233 (4th Cir. 1997) (citing Bedrick v. Travelers Ins. Co., 93 F.3d 149, 152 (4th Cir. 1996)); Vega v. Nat'l Life Ins. Servs., Inc. 188 F.3d 287, 297 (5th Cir. 1999); Miller v. Metro. Life Ins. Co., 925 F.2d 979, 984 (6th Cir. 1991); Woo v. Deluxe Corp., 144 F.3d 1157, 1160-61 (8th Cir. 1998); Abatie v. Alta Health & Life Ins. Co., 458 F.3d 955, 969 (9th Cir. 2006) (en banc). The Tenth Circuit followed a "modified sliding scale" approach that places a slight burden on the plaintiff to prove there was a conflict of interest, while simultaneously providing more guidance to the district court regarding how much weight the conflict of interest merits. *See* Fought v. UNUM Life. Ins. Co. of Am., 379 F.3d 997, 1004-08 (10th Cir. 2004). The Second Circuit examined the reasonableness of the administrator's interpretation. *See* Sullivan v. LTV Aerospace & Defense Co., 82 F.3d 1251, 1255 (2nd Cir. 1996). The First and the Seventh Circuits applied a "market forces" analysis, which posited that the realities of the insurance or benefit plan market would remedy any inherent conflict of interest. *See* Wright v. R.R. Donnelly & Sons Co. Group Benefits Plan, 402 F.3d 67, 75 (1st Cir. 2005); Mers v. Marriot Int'l Group Accidental Death & Dismemberment Plan, 144 F.3d 1014, 1020-21 (7th Cir. 1998).

183. *Glenn,* 128 S. Ct. at 2346.

184. *Id.*

185. *Id.*

the twenty-four months elapsed, Glenn had to prove she was incapable of performing "the material duties of any gainful occupation for which she was reasonably qualified."[186] However, MetLife denied the benefits, finding she was capable of sedentary work.[187]

Glenn then filed suit in federal court, seeking review of MetLife's denial of benefits.[188] The district court upheld MetLife's decision and Glenn appealed to the Sixth Circuit.[189] The Sixth Circuit Court of Appeals reversed, using a less deferential standard that recognized the conflict of interest inherent in MetLife's dual role in determining benefit eligibility and paying benefits.[190] MetLife then sought certiorari on the question of whether this dual role constituted a conflict of interest in decisions to determine benefits.[191]

The Court determined there was an implicit conflict of interest in these dual roles, even where the plan administrator was an insurance company and not the employer, in which case the administrator would presumably have an incentive to offer impartial claims processing.[192] The Court then turned to the question of how the courts should treat such a conflict.[193] "We believe that *Firestone* means what the word 'factor' implies, namely, that when judges review the lawfulness of benefit denials, they will often take account of several different considerations of which a conflict of interest is one."[194]

D. ERISA AND THE EIGHTH CIRCUIT

The Eighth Circuit's approach to ERISA has not differed greatly from that

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186. *Id.* at 2347. This standard is similar to the Social Security standard. *Id.*

187. *Id.*

188. *Id.* The opinion also noted that Ms. Glenn had exhausted the administrative remedies available to her. *Id.*

189. *Id.*

190. *Id.*

191. *Id.*

192. *Id.* at 2348.

193. *Id.* at 2349.

194. *Id.* at 2350. Chief Justice Roberts joined all of the majority's opinion, except the portion delineating how courts are to weigh the presence of a conflict of interest. *Id.* at 2352 (Roberts, C.J., concurring). The Chief Justice asserted that the conflict of interest should be considered by courts "only where there is evidence that the benefit denial was motivated or affected by the administrator's conflict." *Id.* at 2353.

Justice Kennedy, concurring and dissenting in part, agreed with the majority's approach to the standard of review, but would have remanded the case to the Court of Appeals, asking them to apply the new standard. *Id.* at 2355. (Kennedy, J., concurring).

Justices Scalia and Thomas dissented noting that they would limit the finding of an automatic conflict of interest to an insurance company administrator of an ERISA plan, rather than extending it to employers before that specific issue had been argued to the Court. *Id.* at 2357 (Scalia, J., dissenting). The dissenters also differed from the majority's adoption of a totality of the circumstances test, with the presence of a conflict of interest weighed as a relevant factor. *Id.* at 2358. The dissenting justices would adopt the Restatement of Trusts' "clear guidelines for judicial review." *Id.* at 2359. The Restatement approach directs courts to apply a de novo standard of review only if the court found the trustee did not have discretionary authority in making the decision or that the trustee had abused its discretion. *Id.* (citing RESTATEMENT (SECOND) OF TRUSTS § 187 (1957)).

of the United States Supreme Court. Because *South Dakota State Medical Holding Co. v. Hofer* was predicated upon the established law of the Eighth Circuit, a review of three important Eighth Circuit decisions is necessary to understand the development of this body of law.

In *Brewer v. Lincoln National Life Insurance Co.*,[195] the Eighth Circuit Court of Appeals considered whether ERISA preempted a state law of construction which provided that terms in an insurance policy were to be construed "*contra* insurer."[196] The case came before the court after Robert Brewer appealed the district court's conclusion that his son received "psychiatric care" which was subject to coverage limitations under his insurance policy with Lincoln National Life Insurance Company.[197] Due to the policy limitations, the insurance company did not pay nearly $56,000 of Brewer's son's medical bills.[198] The district court upheld Lincoln National's denial of coverage as proper under the policy.[199] The court applied Missouri's rule of construction that provided that all ambiguities in insurance contracts would be resolved in favor of the insured.[200]

The Eighth Circuit Court of Appeals concluded that the Missouri law was a general principle of contract construction which did not "regulate insurance" within the meaning of ERISA's saving clause, 29 U.S.C. § 1144(b)(2)(A).[201] In deciding how the policy terms should be defined, the Eighth Circuit looked to ERISA's requirement that plans be "written in a manner calculated to be understood by the average plan participant."[202] The court noted that this requirement obliges the court to accord the term its ordinary meaning to a layperson, not a specialized one set forth by an expert.[203]

In *Waller v. Hormel Foods Corp.*,[204] the Eighth Circuit Court of Appeals rejected a beneficiary's argument that an ERISA plan should not be allowed subrogation rights unless the beneficiary is made whole by the settlement.[205] After sustaining injuries in a head-on automobile collision, the Wallers received over $157,000 in medical benefits from the Hormel Foods Corporation Medical Plan.[206] They settled for $200,000, which was the amount of the tortfeasor's policy limits.[207] However, the insurance company required a release from the plan, which demanded full reimbursement of the benefits it had paid.[208] The

195. 921 F.2d 150, 153 (8th Cir. 1990).
196. *Id.*
197. *Id.* at 152.
198. *Id.*
199. *Id.* at 153.
200. *Id.*
201. *Id.* at 154. *See* 29 U.S.C. § 1144(b)(2)(A) (2000).
202. *Id.* (citing 29 U.S.C. § 1022(a)(1) (2000)).
203. *Id.*
204. 120 F.3d 138 (8th Cir. 1997).
205. *Id.* at 140.
206. *Id.* at 139.
207. *Id.*
208. *Id.*

Wallers sought a declaratory judgment that the plan's subrogation rights were enforceable only if the Wallers were fully compensated for their damages.[209] Hormel counterclaimed for a declaration that its reimbursement rights were "prior to the plaintiffs' rights."[210] The district court ruled for Hormel.[211]

The Eighth Circuit Court of Appeals noted that since ERISA preempts all state law anti-subrogation statutes, the proper interpretation of the plan's subrogation provision was determinative of whether to forbid subrogation unless the beneficiary is made whole.[212] The Wallers urged the Court to construe the word "subrogated" in the provision as including the made-whole doctrine, as had been done in some insurance contracts.[213] The court rejected this argument, noting "[t]here is a good reason not to read ERISA plans like insurance policies."[214]

In *Woo v. Deluxe Corp.*, the court stated the appropriate standard of review under ERISA where a plan administrator had a financial conflict in a benefits denial claim is abuse of discretion.[215] Beverly Woo, an employee of Deluxe, discovered after resigning from employment that she had been effectively disabled by scleroderma prior to leaving her job.[216] She then applied for and received Social Security benefits and applied for benefits under the Deluxe Group Long-Term Disability plan.[217] Deluxe denied her claim, stating Woo was not disabled at the time she resigned.[218]

The district court granted summary judgment to Deluxe on Woo's ERISA claim and her claim for breach of fiduciary duty.[219] Woo argued that the plan administrator's role as administrator and insurer who paid benefits created a conflict of interest, triggering a less deferential standard of review.[220] The court noted that to obtain a less deferential standard of review, Woo had to satisfy a two-part test, presenting probative evidence that: "(1) a palpable conflict of interest or serious procedural irregularity existed, which (2) caused a serious breach of the plan administrator's fiduciary duty to her."[221] The Eighth Circuit Court of Appeals determined Woo presented sufficient evidence to trigger a less deferential standard of review.[222] The court also stated a "sliding scale" approach was appropriate, which in turn proportionally decreased the deference af-

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209. *Id.*.
210. *Id.*
211. *Id.*
212. *Id.* at 140.
213. *Id.*
214. *Id.* The Eighth Circuit panel remanded the case for consideration of whether the plan's settlement should be reduced by an amount consistent with "a reasonable attorney's fee based upon value of legal services to the [p]lan." *Id.* at 142.
215. 144 F.3d 1157, 1160 (8th Cir. 1998).
216. *Id.* at 1160.
217. *Id.*
218. *Id.*
219. *Id.*
220. *Id.*
221. *Id.* at 1160-61.
222. *Id.* at 1161.

forded to the administrator according to the seriousness of the conflict of interest.[223]

This section has discussed subrogation, the ERISA statute, important United States Supreme Court decisions, and selected Eighth Circuit case law dealing with ERISA. The U.S. Supreme Court has stated that unless a conflict of interest is present, an ERISA fiduciary's decisions are to be given deferential review where the administrator has discretion. The Court has also allowed individual remedies for breach of fiduciary duty. Furthermore, the Court recently clarified that a conflict of interest exists when the fiduciary holds the dual roles of determining which employees are qualified for benefits and paying those benefits from its own pocket. Finally, the Eighth Circuit applies a sliding scale review where the administrator or fiduciary has a conflict of interest and accords deference to the decision with relation to the seriousness of the conflict of interest. The *Hofer* decision will be analyzed within this framework.

IV. ANALYSIS

A. AN ABUSE OF DISCRETION REVIEW WAS INAPPROPRIATE DUE TO THE CONFLICT OF INTEREST

The district court in *South Dakota State Medical Holding Company v. Hofer* applied an abuse of discretion standard of review pursuant to the U.S. Supreme Court's statement in *Firestone*.[224] In its decision in *Firestone*, the Court noted that where a plan document gives a fiduciary discretion, the court is to accord deference to the administrator's decisions, though ERISA claims would generally be reviewed de novo.[225] Hofer implored the court to apply a heightened standard of review, arguing that DakotaCare's dual responsibilities as plan insurer and ERISA fiduciary created a conflict of interest.[226] The court declined to do so and instead applied the Eighth Circuit test from *Woo v. Deluxe Corp.* to apply a less deferential standard of review.[227] The two-pronged *Woo* test requires that a party present "material, probative evidence" showing that "a palpable conflict of interest or serious procedural irregularity existed" which "caused a serious breach of the plan administrator's fiduciary duty."[228]

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223. *Id.*

224. S.D. State Med. Holding Co. v. Hofer, Civ. No. 06-5038-KES, 2007 WL 2121276, at *4 (D.S.D. July 24, 2007). The *Firestone* Court held that trust law principles mandated a de novo standard of review, unless the plan documents endowed the plan administrator with discretion. However, this holding has been subject to some criticism. *See* Keith Walker Beatty, *A Decade of Confusion: The Standard of Review for ERISA Benefit Denial Claims as Established by Firestone*, 51 ALA. L. REV 733, 739 (2000) ("Because most plans contain such language, the Court has essentially *nullified* applying the standard that it deems most appropriate.") (emphasis added).

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

226. *Hofer,* 2007 WL 2121276, at *4.

227. *Id.*

228. *Id.* The sliding scale standard of review adopted by the *Woo* court is not without criticism. *See* Jay Conison, *Suits for Benefits Under ERISA*, 54 U. PIT. L. REV. 1, 34, 63 (1992) (criticizing the sliding scale standard as aiding employers and plan administrators in frustrating benefit expectations). *But see*

DakotaCare did not dispute the existence of a conflict of interest.[229] Thus, a "palpable" conflict of interest existed, satisfying the first prong of the *Woo* test. According to at least one federal court, a "strong conflict of interest exists when the fiduciary making a discretionary decision is also the insurance company responsible for paying claims."[230] Furthermore, the U.S. Supreme Court recently articulated in *Metropolitan Life Insurance Co. v. Glenn* that a conflict of interest exists when an insurance company is responsible for both ERISA fiduciary duties and payment of claims.[231] This decision solidifies the existence of a conflict of interest for DakotaCare in *Hofer*.[232]

The second prong of the *Woo* test requires that the conflict of interest cause a "serious breach of the plan administrator's fiduciary duty."[233] The district court determined that the plan administrator's decision to seek enforcement of the plan's subrogation provision was not a breach of the fiduciary duty imposed by ERISA.[234] Hofer presented no evidence that the fiduciary breached its duty to "act solely in the interest of the participants and beneficiaries [of the ERISA plan]."[235] Because the court found DakotaCare's urged interpretation of the plan provision to be reasonable, it concluded no breach of fiduciary duty occurred.[236]

1. Subrogation Provisions are Violative of ERISA

Arguably, the decision to seek subrogation itself is a breach of the fiduciary duty imposed by ERISA on plan administrators.[237] While ERISA is silent on the issue of subrogation, the decision to seek reimbursement when the plan beneficiary has not been made whole is in no way in the best interest of the beneficiary.[238] If subrogation is permitted, ERISA's stated goal of protecting workers from plan abuses is frustrated, rather than furthered.[239] This is particularly so

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Kirill Y. Abramov, *Woo v. Deluxe Corp.: The Eighth Circuit Adopts the "Sliding Scale" Standard of Review When A Conflicted Plan Administrator Denies ERISA Protected Benefits*, 77 WASH. U. L.Q. 1369 (1999) (concluding that a sliding scale standard of review furthers Congress's underlying goal in ERISA of encouraging employers and plan administrators to offer and maintain employee benefit plans).

229. *Hofer*, 2007 WL 2121276, at *5.

230. Brown v. Blue Cross & Blue Shield of Ala., Inc., 898 F.2d 1556, 1562 (11th Cir. 1990). The Eighth Circuit Court of Appeals has also recognized that a conflict of interest exists when an insurance company is the fiduciary, as the company has an incentive to make a profit, which is counter to its fiduciary duty to act in the best interests of the beneficiary. Armstrong v. Aetna Life Ins. Co., 128 F.3d 1263 (8th Cir. 1997) (applying a de novo standard of review where the fiduciary's role as insurer gave the company "an obvious interest in minimizing its claim payments" but limiting its decision to the facts of the case).

231. Metro. Life Ins. Co. v. Glenn, 128 S. Ct. 2343, 2349 (2008).

232. *Id.*

233. Woo v. Deluxe Corp., 144 F.3d 1157, 1160 (8th Cir. 1998).

234. *Hofer*, 2007 WL 2121276, at *5.

235. *Id.* (citing 29 U.S.C. § 1104 (2000)).

236. *Id.*

237. Baron, *Policy Considerations*, *supra* note 91, at 618.

238. *Id.* It is also important to note that subrogation was likely not contemplated by Congress, as it did not become common in the personal injury context until after ERISA's enactment. *Id.*

239. *Id.*

where beneficiaries with significant injuries are not fully compensated.[240]

The inclusion of a subrogation provision in an ERISA plan violates the statute's anti-opt-out measure, which compels drafters to ensure that plan documents are "consistent with the provisions [of ERISA]."[241] ERISA's drafters inserted this provision to ensure that plan administrators would not circumvent the fiduciary protections imposed by drafting around them with plan documents.[242] Inserting a provision which undermines a fiduciary's or trustee's duties is unacceptable; "trust documents cannot excuse trustees from their duties under ERISA and trust documents must generally be construed in light of ERISA's policies."[243] Finally, ERISA section 403(c) mandates that "the assets of a plan shall never inure to the benefit of any employer and shall be held for the exclusive purpose of providing benefits to participants in the plan and their beneficiaries and defraying reasonable expenses of administration."[244] This provision, known as ERISA's "anti-innurement provision," is intended to ensure that plan assets are not diverted from the beneficiaries.[245]

Leaving a plan beneficiary uncompensated for catastrophic injuries and susceptible to financial ruin is not consistent with ERISA's mandate to fiduciaries to "discharge [their] duties solely in the interest of the beneficiaries," nor is it consonant with ERISA's goal of protecting workers.[246] While securing the "primacy and integrity of written plans" is also a stated purpose of ERISA, the need to protect workers from unscrupulous plan administrators outweighs it.[247] Congress made trust law principles applicable to ERISA in order to protect workers from the types of abuses that induced its enactment.[248] It is logical that the overarching regulatory purpose of Congress in adopting ERISA should do-

240. *See* Admin. Comm. of Wal-Mart, Inc. v. Shank, 500 F.3d 834 (8th Cir. 2007), *cert. denied*, 128 S. Ct. 1651 (2008) (subrogation allowed against Wal-Mart employee rendered permanently disabled in car accident); Cagle v. Bruner, 112 F.3d 1510 (11th Cir. 1997) (court permitted subrogation where insurer refused to pay medical bills until insured signed form acknowledging insurer's right to pursue subrogation and insured had suffered serious injuries in car accident requiring four month hospital stay and four months of outpatient treatment); Sunbeam-Oster Co. Group Benefits Plan v. Whitehurst, 102 F.3d 1368 (5th Cir. 1996) (subrogation of $500,000 settlement allowed though insured had suffered over $2 million in damages); *In Re* Paris, 44 F. Supp. 2d 747 (1999) (subrogation allowed where defendant suffered permanent brain damage as a result of a motorcycle accident and defendant qualified as disabled, destitute adult).

241. ERISA § 404(a)(1)(D), codified at 29 U.S.C. § 1104(a)(1)(D) (2000).

242. John H. Langbein, *The Supreme Court Flunks Trusts,* 1990 SUP. CT. REV. 207, 210 (1990) [hereinafter Langbein, *Supreme Court Flunks Trusts*].

243. Cent. States, Se. and Sw. Pension Fund v. Cent. Transport Inc., 472 U.S. 559, 568 (1985).

244. 29 U.S.C. § 1103(c)(1) (2000).

245. Baron, Understanding ERISA Liens, *supra* note 107, at 22. Some attorneys have successfully relied on this provision in negotiating with ERISA plan administrators in subrogation actions. *Id.*

246. *See* 29 U.S.C. § 1104. *See also* WOOTEN, *supra* note 6, at 1 (stating that ERISA was meant to ensure that benefit plans actually promoted employee welfare).

247. Health Cost Controls v. Isbell, 139 F.3d 1070, 1072 (6th Cir. 1997). *See also* Gulf Life Insurance Co. v. Arnold, 809 F.2d 1520 (11th Cir. 1987) (stating enforcement of plan terms is the essential purpose of 29 U.S.C. § 1132(a)(3)(B)).

248. *See* Langbein, *Supreme Court Flunks Trusts*, *supra* note 242, at 210.

minate.[249]

2. ERISA's Fiduciary Protections Extend to Individuals as Well as the Plan

While there is support for the position that ERISA's fiduciary duty provisions extend to plan beneficiaries as a class, rather than to individual beneficiaries, the decision to pursue a subrogation action against a particular beneficiary does not create a benefit for the entire class of plan beneficiaries.[250] Insurance companies argue that pursuing subrogation actions allow them to maintain lower premiums; however, that argument does not stand because potential subrogation recoveries are not included in premium calculation.[251] The proceeds from subrogated recoveries do not inure to the beneficiaries, but rather to the insurer, which receives a windfall at the expense of an individual beneficiary whose premium payments did not buy the indemnification advertised.[252] There is no valid reason to allow the plan fiduciary to pursue a course of action that harms an individual beneficiary, particularly if it creates no benefit for the plan beneficiaries collectively.[253]

The U.S. Supreme Court has allowed individual beneficiaries to recover for breach of fiduciary duty under ERISA.[254] The Court found support for this position in the ERISA's legislative history, noting that Congress intended the enforcement to "provide . . . participants and beneficiaries with broad remedies for

249. Langbein, *Trust Law as Regulatory Law*, *supra* note 23, at 1336.

250. Mass. Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 142 (1985) ("A fair contextual reading of the statute makes it abundantly clear that its draftsmen were primarily concerned with the possible misuses of plan assets, and with remedies that would protect the entire plan, rather than with the rights of an individual beneficiary"). However, the concurring opinion opposed this dictum. *Id.* at 152-53 (Brennan, J., concurring). Justice Brennan, emphasizing the duties of loyalty and prudence set forth in the statute, stated the "legislative history demonstrates that Congress intended . . . to incorporate the fiduciary standards of trust law into ERISA, and it is black-letter trust law that fiduciaries owe strict duties running directly to beneficiaries in the administration and payment of trust benefits." *Id. See* John H. Langbein, *What ERISA Means by "Equitable": The Supreme Court's Trail of Error in Russell, Mertens, and Great-West,* 103 COLUM. L. REV. 1317, 1341 (2003) [hereinafter Langbein, *What ERISA Means*] (stating in reference to dicta by Justice Stevens in *Russell*, "The assertion that ERISA was meant to protect plans, not participants is transparently wrong.").

251. *See* Edeus, *supra* note 125, at 514. Insurance premiums are calculated based upon losses actually incurred and adjusted to allow the company to turn a profit. *Id.* Subrogation recoveries are not included in the factors, which influence premium calculation. *Id. See also* Johnny C. Parker, *The Made Whole Doctrine: Unraveling the Enigma Wrapped in the Mystery of Insurance Subrogation,* 70 MO. L.REV. 723, 737 (2005) (collecting cases recognizing that the insurer receives a windfall if allowed both subrogation and retention of the premiums paid by the insured). Furthermore, various courts have recognized that subrogation does not lead to lower premiums. *See* Cooper v. Argonaut Ins. Co., 556 P.2d 525, 527 (Alaska 1976); Allstate Ins. Co. v. Druke, 576 P.2d 489, 492 (Ariz. 1978) (en banc); Travelers Indem. Co. v. Chumbley, 394 S.W.2d 418, 425 (Mo. Ct. App. 1965); DeCespedes v. Prudence Mut. Cas. Co., 193 So.2d 224, 227-28 (Fla. Dist. Ct. App. 1966); Rimes v. State Farm Mut. Auto. Ins. Co., 316 N.W.2d 348, 355 (Wis. 1982).

252. *See supra* notes 129-32 and accompanying text. This may be violative of ERISA's anti-innurement provision. *See supra* note 245 and accompanying text.

253. *See supra* notes 129-32 and accompanying text.

254. *See* Varity Corp. v. Howe, 516 U.S. 489 (1996); LaRue v. DeWolff, Boberg & Assoc., Inc., 128 S. Ct. 1020 (2008).

redressing or preventing violations of ERISA."[255] More recently, in 2008, the Court allowed an individual to recover for breach of fiduciary duty where the plan administrator failed to invest according to the participant's instructions, causing his *individual* pension account to lose value.[256] The *LaRue* majority noted that the reasoning in *Russell* applied to the "former landscape of employee benefit plans" and "[t]hat landscape has changed."[257] This makes evident the Court's recognition that ERISA decisions must reflect the current atmosphere in employee benefits.[258] Thus, the interests of the individual are cognizable under ERISA as well.[259] If the district court had adopted this mode of analysis and examined the consequences of DakotaCare's decision to seek subrogation, it would have concluded that to do so would breach DakotaCare's obligation to act "solely for the benefit of plan participants."[260]

3. *Failure to Apply Sliding Scale Review as Required by* Woo

In addition to the two-pronged test, the district court noted that *Woo* further directs that "a reviewing court will always review for abuse of discretion, but it will decrease the deference given to the administrator in proportion to the seriousness of the conflict of interest."[261] The district court found a conflict of interest, but did not apply the sliding scale approach advocated by both *Woo* and the Supreme Court's decision in *Firestone*.[262] Thus, though the conflict of interest did not amount to the serious breach of fiduciary duty required by the second prong of the *Woo* test, the court was still obliged to decrease the deference it accorded to the plan's decision.[263] Failure to do so was erroneous.[264] As the U.S. Supreme Court noted in *Rush Prudential HMO, Inc. v. Moran*,[265] when reviewing for abuse of discretion, the court should "home in on any conflict of interest on the plan fiduciary's part[,]" stating "[i]t is a fair question just how deferential the review can be when the judicial eye is peeled for conflict of interest."[266] If the court had employed a sliding scale standard of review, it is less likely DakotaCare's strained interpretation of the contract would have been viewed as reasonable.[267]

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255. *Varity Corp.*, 516 U.S. at 512 (citing S. REP. No. 93-127 at 35 (1973), 1 LEG. HIST. 621; H. REP. No. 93-533 at 17 (1973), 2 LEG. HIST. 2364)).

256. *LaRue*, 128 S. Ct. at 1026.

257. *Id.* at 1025.

258. *Cf.* Baron, *Subrogation: A Pandora's Box*, *supra* note 96, at 238-39. Subrogation in the personal injury context is a fairly modern development, unknown in 1974 when ERISA was adopted. *Id.*

259. *See, e.g.*, *LaRue*, 128 S. Ct. at 1025-26.

260. 29 U.S.C. § 1104 (2000).

261. S.D. State Med. Holding Co. v. Hofer, Civ. No. 06-5038-KES, 2007 WL 2121276, at *4 (D.S.D. July 24, 2007) (citing Woo v. Deluxe Corp., 144 F.3d 1157 (1998)).

262. *Hofer*, 2007 WL 2121276, at *4.

263. *Id.*

264. *See* Metro. Life Ins. Co. v. Glenn, 128 S. Ct. 2343 (2008); *Woo*, 144 F.3d 1157.

265. 536 U.S. 355 (2002).

266. *Id.* at 384.

267. *See Woo*, 144 F.3d at 1162 (noting that under sliding scale review, in certain cases, no defe-

4. *DakotaCare's Flawed Interpretation of the Plan Language*

Another issue the district court addressed was whether Terry Hofer, Janet Hofer's husband, could be considered a "third party" under the terms of the plan.[268] This was crucial in order to allow DakotaCare to acquire subrogation rights.[269] The district court applied the test articulated in *Finley v. Special Agents Mutual Benefit Associates, Inc.*, which examines:

> Whether [the administrator's] interpretation is consistent with the goals of the Plan, whether their interpretation renders any language of the Plan meaningless or internally inconsistent, whether their interpretation conflicts with the substantive or procedural requirements of the ERISA statute, whether they have interpreted the words at issue consistently, and whether their interpretation is contrary to the clear language of the Plan.[270]

The district court, relying on the plan language that "all benefits are personal to the member," erroneously held that Terry Hofer was a third party within the meaning of the plan's subrogation clause.[271]

First, under the plain and ordinary meaning of the term third party, Terry Hofer, as a plan member and insured, does not qualify.[272] ERISA requires plan documents to be "written in a manner calculated to be understood by the average plan participant."[273] According to the Eighth Circuit, "This requirement provides a source from which we may fashion a federal common law rule; the terms should be accorded their ordinary, and not specialized, meanings."[274] A third party is defined as "a person who is not a party to a lawsuit, agreement, or other transaction but who is usually somehow implicated in it; someone other than the principal parties."[275]

Janet Hofer acquired her plan rights because of her husband's status as an employee with his law firm.[276] If, the term "third party" is accorded its ordinary meaning as understood by laypeople and not insurance experts, as the Eighth Circuit requires, the district court's adoption of the plan's urged interpretation is incorrect.[277] Court have not written the requirement that plan documents be clear to an ordinary person into the body of rights under ERISA, but it is an integral part of the statute, incorporated into ERISA's detailed reporting and dis-

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rence need be accorded to the ERISA fiduciary's interpretation of the contract).

268. *Hofer*, 2007 WL 2121276, at *5.

269. *Id.*

270. *Id.* at *6 (citing Finley v. Special Agents Mut. Benefit Ass'n., 957 F.2d 617, 621 (8th Cir. 1992)).

271. *Id.*

272. *See infra* note 275.

273. 29 U.S.C § 1022(a)(1) (2000).

274. Brewer v. Lincoln Nat'l Life Ins. Co., 921 F.2d 150, 154 (8th Cir. 1990).

275. BLACK'S LAW DICTIONARY 1239 (8th ed. 2004).

276. *Hofer*, 2007 WL 2121276, at *1.

277. *Id.* at *6 (failing to consider the requirement that plan documents and phrases within those documents be clear to a layperson, set forth at 29 U.S.C. § 1022(a)(1), as part of the ERISA statute).

closure requirements.[278]

Second, though the court concludes the evident goal of the plan is to obtain reimbursement for expenses covered by third parties,[279] it would seem the overarching goal of an employee benefit plan is the protection of the employee.[280] One of the factors articulated in the *Finley* test is whether the plan's interpretation is consistent with the goals of the plan.[281] This interpretation also conflicts with the substantive and procedural requirements of ERISA, another *Finley* factor.[282] ERISA's overarching goal was the protection of workers from pension plan abuses.[283] Allowing DakotaCare to recover the entirety of the Dairyland settlement from Janet Hofer, who had been grievously injured, is inconsistent with this requirement.[284]

The district court's final error, though supported by Eighth Circuit case law, was enforcing the reimbursement provision of the plan merely because it existed; the court concluded it was a manifestation of the parties' intent with regard to subrogation.[285] "Because this action falls within the ambit of ERISA, the explicit intentions of the parties regarding subrogation are controlling."[286] Subrogation provisions are often unilaterally inserted into plan documents; furthermore, plan documents are not subject to any sort of administrative review for reasonableness.[287] ERISA plans are classic examples of contracts of adhesion, offered on a "take or leave it" basis with no room for negotiation over terms and disparate bargaining power between the parties.[288] Thus, it is somewhat disingenuous to enforce a subrogation provision because it is the "explicit intention of the *parties*."[289]

V. CONCLUSION

The district court's decision, while grounded in the case law of the Eighth

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278. 29 U.S.C § 1022(a)(1) provides, in relevant part:

> A summary plan description of any employee benefit plan shall be furnished to participants and beneficiaries as provided in section 1024(b) of this title. The summary plan description shall include the information described in subsection (b) of this section, shall be written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan.

Id.

279. *Hofer*, 2007 WL 2121276, at *6.

280. *See* 29 U.S.C. § 1001 (setting forth Congress's findings and declaration of policy regarding ERISA and employee benefit plans).

281. Finley v. Special Agents Mut. Benefit Ass'n, 957 F.2d 617, 621 (8th Cir. 1992).

282. *Id.*

283. *See* ERISA's declaration of policy, 29 U.S.C. § 1001(a).

284. *Hofer*, 2007 WL 2121276, at *6.

285. *Id.*

286. *Id.*

287. Baron, *Policy Considerations*, *supra* note 91, at 616-17.

288. Langbein, *Trust Law as Regulatory Law*, *supra* note 23, at 1323.

289. *Hofer*, 2007 WL 2121276, at *6 (emphasis added).

Circuit, did not adequately account for Congress's primary purpose of protecting beneficiaries. While Congress left much of the development of the substantive law surrounding ERISA to the federal courts, Congress certainly intended the protection of workers to be the primary guidepost of the courts in doing so. To allow subrogation where the beneficiary has not been made whole grievously harms that particular beneficiary and does not create any benefit for the plan as a whole. Thus, pursuing subrogation against a beneficiary who has not been made whole constitutes a breach of the fiduciary obligations Congress imposed upon plan administrators. A mode of analysis with ERISA's fiduciary obligations at the forefront would better protect beneficiaries from inequitable results.[290] Furthermore, abuse of discretion review of the decision to seek subrogation fails to protect plan beneficiaries.

A. ELIMINATION OF THE ABUSE OF DISCRETION STANDARD

Various scholars have noted that the abuse of discretion standard set forth by the *Firestone* decision and reiterated by the Court in *Glenn* does not adequately protect the rights of plan beneficiaries.[291] Their suggestions range from prohibiting reimbursement actions as violative of public policy to the creation of specialized ERISA courts to the outright adoption of a de novo standard of review. Regardless of the solution, it seems the scholarly consensus is that the abuse of discretion standard is inadequate to protect beneficiaries.

John H. Langbein, an ERISA expert and professor of law and history at Yale University, believes that it would be appropriate to adopt a de novo standard of review and eliminate the dicta in *Firestone* that provides for deferential review if the plan documents endow the administrator with discretion.[292] Langbein notes that this second portion of the Court's holding relies on general principles of trust law that allow the settlor and the trustee to agree on a more defe-

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290. Because much of this casenote has been devoted to criticizing the federal courts' approach to subrogation in the ERISA context, it would seem to prompt the question of why the issue should remain with the judiciary, rather than be addressed by Congress in an amendment to the ERISA statutory scheme. However, Congress has not amended the statutory scheme in any significant way since its enactment in 1974. This inaction can be explained by several factors. First, the bevy of strong business interests and the insurance lobby support leaving the statute as it is and would likely subvert any legislative attempt to amend the statute in favor of lending more protections to workers. *See* Schwartz, *supra* note 28, at 642. Second, ERISA beneficiaries do not have nearly the same political clout. *Id.* Finally, ERISA's drafters contemplated that the federal courts would develop federal law under ERISA; amending the statute would subvert congressional intent that the development of rights under ERISA would be left to the discretion of the federal courts. *See* H.R. REP. No. 93-533, *reprinted in* U.S.C.C.A.N. 4630 (1974) ("It is also intended that a body of Federal substantive law will be developed by the courts to deal with issues involving rights and obligations under private welfare and pension plans.").

291. *See* Mark D. DeBofsky, *What Process is Due in the Adjudication of ERISA Claims?* 40 J. MARSHALL L. REV. 811 (2007) (discussing lower court's interpretation of *Firestone* as authorizing a quasi-administrative adjudicative process). See also Langbein, *Supreme Court Flunks Trusts*, *supra* note 242 (discussing Court's garbled reasoning in *Firestone*). *See also* Baron, *Policy Considerations*, *supra* note 91, at 631-32 (discussing due process challenges to subrogation actions); Baron, Understanding ERISA Liens, *supra* note 107, at 18 (noting that the limited review mandated by the abuse of discretion standard makes discovery in ERISA proceedings difficult for the plan beneficiary).

292. Langbein, *Trust Law as Regulatory Law*, *supra* note 23, at 1336.

rential standard of review.[293] Congress imported trust law principles into ERISA for regulatory purposes in order to confine employers' authority over employee benefit plans rather than to enhance it.[294] It would appear that a true de novo standard of review, as required by the primary holding of *Firestone*, would more closely conform to congressional intent.

As the U.S. Supreme Court has noted, ERISA provides for an "artificial definition of fiduciary" that defines fiduciary status in "functional terms of control and authority over the plan," rather than in terms of formal trusteeship.[295] In private trusts, there is a presumption that the trustee is disinterested, without a personal stake in the trust. Within the context of ERISA plans, however, fiduciaries are often directly associated with the employer.[296] Generally, the law of trusts defers to the wishes of the transferor, because the creation of a private trust is essentially a gift.[297] In contrast, pension and employee benefit plans come from contractual obligations and are offered by employers for economic reasons to secure a competitive edge in attracting employees.[298]

B. THE ADOPTION OF CONTRACT PRINCIPLES

When the U.S. Supreme Court decided *Firestone*, the United States Solicitor General urged the court to apply principles of contract interpretation to ERISA.[299] The Court declined to do so, preferring to utilize general principles of trust law.[300] Given the conflicted nature of many ERISA fiduciaries' dual roles, a de novo standard of review derived from principles of contract interpretation could potentially afford more protection to ERISA beneficiaries than the defe-

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293. *Id.* at 1335.

294. *Id.* at 1337. *See* Beatty, *supra* note 215, at 751 ("A standard that allows plan administrators to control the level of deference to be afforded their decisions does not appear to comply with the intent of the statute."); Rozbruch, *supra* note 25, at 524-25, stating:

> [E]mployers and plans can use vague language to insulate themselves from a more rigorous standard of review. As a result, employees who are denied promised benefits also lose the benefit of judicial review because their employer reserved discretionary power to itself . . . Such an interpretation of ambiguous plan language fails to reward the participants' expectations, leading to a result contrary to congressional intent.

Id. But see Noel Christian Capps, 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 (1992) (defending the Court's decision in *Firestone* as maintaining a balance between ERISA's purpose of protecting employees and the necessity to provide incentives for employers to maintain an employee benefit plan).

295. Varity Corp. v. Howe, 516 U.S. 489, 528 (1996) (Scalia, J., dissenting) (citing Mertens v. Hewitt Assoc., 508 U.S. 248, 262 (1993)).

296. 29 U.S.C. § 1102(a)(1) (2000). ERISA plans must select a fiduciary to manage the plan. *Id.* The plan sponsor, which is usually the employer, chooses the fiduciaries. *Id.* § 1102(a)(2).

297. Langbein, *Supreme Court Flunks Trusts*, *supra* note 242, at 211.

298. *Id.*

299. Brief for United States as Amicus Curiae Supporting Respondents at 6, Firestone Tire and Rubber Co. v. Bruch, 489 U.S. 101 (1989) (No. 87-1054), 1988 WL 1025997.

300. *Firestone*, 489 U.S. at 111 ("Trust principles make a deferential standard of review appropriate when a trustee exercises discretionary powers.").

rential standard of review that is currently applied.[301]

Contract law affords several advantages. First, contract law presumes that the interests of the parties are adverse to one another, which is increasingly the case in ERISA litigation.[302] Second, contract law has various protective doctrines such as *contra proferentum,*[303] unconscionability, and the requirement that contracts not contravene public policy. The doctrine of unconscionability, which has the goals of preventing oppression and unfair surprise, would be of particular value in ERISA benefit plans due to the two-pronged analysis required by the doctrine.[304] Furthermore, contracts between a fiduciary and a beneficiary are subject to special requirements under contract law; "courts of equity demanded it (contracting) be on fair terms and that the beneficiary's assent be with full knowledge of the facts and a full understanding of the beneficiary's legal rights."[305]

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301. *See* Langbein, *Trust Law as Regulatory Law*, *supra* note 23, at 1321. Following the *Firestone* decision, plan administrators have been quick to write discretionary authority into plan documents. *Id.* In discussing the Unum/Providential scandal, Langbein quoted an internal memo at the notorious insurance company in which an executive extolled the advantages ERISA bestowed upon the company in federal court: "[S]tate law is preempted by federal law, there are no jury trials, there are no compensatory or punitive damages, relief is usually limited to the amount of benefit in question, and claims administrators may *receive a deferential standard of review*." *Id.* (emphasis added). It is ironic that a statute intended for the protection of beneficiaries has been seized upon by unscrupulous companies to take advantage those very same beneficiaries. *Id.*

302. Langbein, *Supreme Court Flunks Trusts*, *supra* note 23, at 223.

303. Kunin v. Benefit Trust Life Ins. Co., 910 F.2d 534, 539 (9th Cir. 1990). The Ninth Circuit has explained the rationale behind *contra proferentum* as such:

> Insurance policies are almost always drafted by specialists employed by the insurer. In light of the drafters' expertise and experience, the insurer should be expected to set forth any limitations on its liability 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. Moreover, once the policy language has been drafted, it is usually not subject to amendment by the insured, even if he sees an ambiguity; an insurer's practice of forcing the insured to guess and hope regarding the scope of coverage requires that any doubts be resolved in favor of the party who has been placed in such a predicament.

Id. (applying *contra proferentum* against an ERISA plan; finding the principle not preempted by ERISA). *See* Mark Trayhnor, Kunin v. Benefit Trust Life Insurance Co.: *Protecting Employees Under ERISA by Construing Ambiguous Plan Terms Against the Insurer*, 77 MINN. L. REV. 1219, 1237 (1993) (agreeing that *contra proferentum* is not preempted by ERISA). Though this particular principle of contract law has been applied against ERISA plans under the current standard of review predicated upon trust law, explicitly setting forth a de novo standard of review predicated upon contract law would encourage more federal courts to apply the doctrine in ERISA cases.

304. *See* RESTATEMENT (SECOND) OF CONTRACTS § 208 (1982). This section of the Restatement provides:

> If a contract or term thereof is unconscionable at the time the contract is made a court may refuse to enforce the contract, or may enforce the remainder of the contract without the unconscionable term, or may so limit the application of any unconscionable term as to avoid any unconscionable result.

Id. See also UNIF. COMMERCIAL CODE § 2-302 (2002). This section of the Uniform Commercial Code provides, in relevant part:

> If the court as a matter of law finds the contract or any clause of the contract to have been unconscionable at the time it was made the court may refuse to enforce the contract, or it may enforce the remainder of the contract without the unconscionable clause, or it may so limit the application of any unconscionable clause as to avoid any unconscionable result.

305. E. ALLEN FARNSWORTH, CONTRACTS § 4.27 at 297 (4th ed. 2004).

This requirement has extended into modern common law courts.[306] Thus, contract law would yield greater protection because it recognizes that the parties are self-interested and it imposes further requirements when contracts are made in the course of a fiduciary relationship.

A true de novo standard of review would further the goals of ERISA's drafters of "protect[ing] interstate commerce and the interests of participants in employee benefit plans."[307] Contract law, with its roots in commerce and various protective doctrines, is more suited to protect plan beneficiaries than the general principles of trust law that the Court has applied in its ERISA decisions. Because it more clearly reflects the true landscape of employee benefit plans today and recognizes the conflicted nature of most ERISA fiduciaries' roles, a de novo standard of review predicated upon contract law is best suited to further ERISA's goals. Applying de novo review to decisions made by ERISA fiduciaries, who often serve two masters, would do more to prevent inequitable outcomes for beneficiaries like Janet Hofer.

306. *Id.* *See* RESTATEMENT (SECOND) OF CONTRACTS § 173 (1982) (rendering the contract voidable if the beneficiary's assent is not made with a full understanding of the facts and circumstances as well as his legal rights under the contract).

307. 29 U.S.C. § 1001(b) (2000).