Christian J. Garris
LAW OFFICES OF CHRISTIAN GARRIS

Journal of Consumer Attorneys Associations for Southern California
ADVOCATE
September 2017 Issue

ERISA: The current state of the standard of review

WHERE ERISA APPLIES IN INSURANCE CASES AND HOW COURTS REVIEW CLAIMS DECISIONS MADE BY ERISA PLANS

ERISA cases are a subset of insurance cases, although there is no bad faith or punitive damage claims; those are state-law remedies, and ERISA cases permit the remedies included within ERISA, a federal law. You also do not get a jury, and you are usually required to litigate in federal court. One of the other features of ERISA litigation is that even if you can convince the judge that the insurance company was wrong, you still might lose. This unfortunate feature of ERISA litigation is all caused by the "standard of review" that courts apply when they review the claims decisions made by ERISA plans.

There are two standards of review under ERISA: "de novo" and "abuse of discretion." Traditionally, most cases have been subject to an abuse-of-discretion standard of review, where the judge must not only be convinced that the insurance company was wrong to deny the claim, but also that the insurance company's decision was so outrageous that it abused its discretion in denying the claim. Under de novo review, the judge merely decides if the insurance company was right or wrong in denying the claim. In other words, neither party has an advantage going into the case under the latter standard.

In the last couple of years, the ability of insurance companies to hide behind the abuse-of-discretion standard of review has begun to erode. California, like many other states, enacted a law preventing insurance companies from using the abuse-of-discretion standard of review. There remained some question as to whether this law applies to "self-funded" plans where the insurance company is merely an administrator, and the employer itself pays the benefits. Fortunately, the Ninth Circuit seems to have just answered that question.

See Garris, Next Page

Journal of Consumer Attorneys Associations for Southern California
ADVOCATE
September 2017 Issue

Does ERISA apply?

The first question is: when does ERISA apply in insurance cases?

Based on a consensus in the 1970's that there was a crisis regarding the state of pension plans, Congress took up the problem and drafted a new act to protect employees from pension fraud and abuse: the Employee Retirement and Income Security Act ("ERISA") of 1974, 29 U.S.C. § 1001. ERISA applies to all group life, health, and disability benefits unless the plan is for church or government employees. Initially, however, it was not clear that state bad-faith laws were preempted by ERISA. In *Pilot Life Insurance Co. v. Dedeaux* (1987) 481 U.S. 41, the Supreme Court answered that question, holding that ERISA preempted state law on the subject. Plaintiffs could no longer sue for bad faith arising from the denial of their group life, health, or disability benefits. After that decision, the landscape of insurance law changed forever. Group claims were almost entirely removed from the state court system, and a new set of laws applied.

An ERISA "plan" itself is not an insurance policy. An ERISA plan, named by ERISA in full as an "employee welfare benefit plan," is a program designed by an employer to provide benefits to its employees as a group. An ERISA plan is usually, though not always, administered by an insurance company. The actual benefits are usually paid by the same insurance company, but sometimes the plan is self-funded, whereby the employer itself pays any claims that the administrator deems to be covered and payable.

The standard of review

ERISA cases are often won or lost based on which standard of review applies. Thus, it is critical to determine which standard of review applies. Under the abuse-of-discretion standard, it can be very difficult for a claimant to prevail. If de novo review applies, "The court simply proceeds to evaluate whether the plan administrator correctly or incorrectly denied benefits." (*Abatie v. Alta Health & Life Ins. Co.* (9th Cir. 2006) 458 F.3d 955, 983.)

The origins of the standard of review

ERISA itself does not address the issue of how the district courts are to evaluate ERISA cases. Does a preponderance of the evidence standard apply? Since ERISA's statutes rely heavily on trust law, should those standards apply?

Eventually, the issue reached the United States Supreme Court in *Firestone Tire & Rubber Co. v. Bruch* (1989) 489 U.S. 101. In that case, the Court observed that although ERISA's statutory scheme was "comprehensive," "ERISA does not set out the appropriate standard of review for actions . . . challenging benefit eligibility determinations. The Court observed that courts had mostly adopted the "arbitrary and capricious" standard from the Labor Management Relations Act. The Court also noted that trust law requires courts, somewhat counterintuitively, to be deferential to a decision of a trustee "when a trustee exercises discretionary powers." (*Id.* at p. 111.)

The Court noted how ERISA was enacted to protect plan participants and ultimately held that de novo review should be the default standard in ERISA cases:

> As this case aptly demonstrates, the validity of a claim to benefits under an ERISA plan is likely to turn on the interpretation of terms in the plan at issue. Consistent with established principles of trust law, we hold that a denial of benefits challenged under § 1132(a)(1)(B) is to be reviewed under a de novo standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan. (*Id.* at p. 115.)

The Court appeared to believe that it was helping claimants by reaching such a decision, but the "unless" part of this rule essentially eliminates the rule altogether. The insurance company can easily and unilaterally give itself discretion in the plan documents. If it does so, it obtains abuse-of-discretion review.

It should come as no surprise that nearly every ERISA plan uses discretionary language in order to be entitled to the abuse-of-discretion standard of review.

Discretionary clauses

With a few exceptions where inexplicably the insurance company failed to clearly state that it had discretion, and therefore de novo review applied, after *Firestone*, almost every case was an abuse-of-discretion case. An example of a discretion clause is: "The responsibility for full and final determinations of eligibility for benefits; interpretation of terms; determinations of claims; and appeals of claims denied in whole or in part under the HFLAC Group policy rests exclusively with HFLAC." (*Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d at p. 963.)

> The Ninth Circuit has held that there are no "magic" words needed: There are no "magic" words that conjure up discretion on the part of the plan administrator. The Supreme Court has suggested that a plan grants discretion if the administrator has the "power to construe disputed or doubtful terms" in the plan. Moreover, we have repeatedly held that similar plan wording – granting the power to interpret plan terms and to make final benefits determinations – confers discretion on the plan administrator.

(*Id.,* citations omitted.)

Certainly, nearly every plan now includes language adequate to confer discretion. (See *Fontaine v. Metropolitan Life Ins. Co.* (7th Cir. 2015) 800 F.3d 883, 885.) What insurance company would not want the deferential abuse-of-discretion standard?

Heightened review

Even though there are only two standards of review, the courts have developed a "heightened review" line of cases that permit a court to look more closely at a denial if certain factual circumstances are present. Under some factual scenarios (for example, if the insurance company ignored plan language or evidence submitted in favor of the claim), "heightened review" will apply and even

See Garris, Next Page

Journal of Consumer Attorneys Associations for Southern California
ADVOCATE
September 2017 Issue

under abuse of discretion of review, the court will look more closely at the insurance company's decision. If the insurance company blatantly ignores its own policy language and is operating under a conflict of interest (that is, it has a financial incentive not to pay claims because the money comes out of its own pocket), the standard can actually fully shift from abuse of discretion to de novo review. This line of cases developed gradually, presumably in response to the overwhelming number of cases where the abuse-of-discretion standard applied.

The Ninth Circuit held in *Abatie v. Alta Health & Life Insurance Co*., 458 F.3d at pp. 971-72, that if an insurance company disregards procedural rules (such as the deadline to respond to a claim), the standard of review should be so heightened as to actually shift all the way to de novo review:

> When an administrator engages in wholesale and flagrant violations of the procedural requirements of ERISA, and thus acts in utter disregard of the underlying purpose of the plan as well, we review de novo the administrator's decision to deny benefits. We do so because, under *Firestone*, a plan administrator's decision is entitled to deference only when the administrator exercises discretion that the plan grants as a matter of contract. *Firestone* directs, consistent with trust law principles, that "a deferential standard of review is appropriate when a trustee exercises discretionary powers." Because an administrator cannot contract around the procedural requirements of ERISA, decisions taken in wholesale violation of ERISA procedures do not fall within an administrator's discretionary authority.

In *Metropolitan Life Insurance Co. v. Glenn* (2008) 554 U.S. 105, the Supreme Court addressed the heightened review issue and whether the standard of review could actually shift from abuse of discretion to de novo review despite discretionary language in the plan. The Court agreed that a conflict of interest and questionable conduct was sufficient to switch the standard of review:

> And the court furthermore observed that MetLife had emphasized a certain medical report that favored a denial of benefits, had deemphasized certain other reports that suggested a contrary conclusion, and had failed to provide its independent vocational and medical experts with all of the relevant evidence. All these serious concerns, taken together with some degree of conflicting interests on MetLife's part, led the court to set aside MetLife's discretionary decision. We can find nothing improper in the way in which the court conducted its review. (*Id.* at p. 118.)

These decisions provided significant inroads into the abuse-of-discretion standard. If the insurance company was provided with discretion in the plan but ignored evidence of disability for example, the standard could actually shift from abuse of discretion to de novo. The court would then presumably look favorably upon the claim for benefits.

The Supreme Court in *Glenn* might just as easily have held that the cited conduct was sufficient to conclude that the insurance company abused its discretion, but the Court went further by approving of a complete shift of the entire standard of review that would apply in such a case – essentially invalidating the discretion clause in the plan. This development seems to have inspired the next one.

California and many other states outlaw discretionary clauses

California joined many other states by enacting a statute that bans the use of discretionary clauses, effective as of 2012. These statutes initiated "[a] further round in the tug-of-war over employee benefits." (*Fontaine v. Metropolitan Life Ins. Co*., 800 F.3d at p. 885.)

Discretionary clauses are disfavored

The Ninth Circuit has previously discussed how discretionary clauses are disfavored:

> Discretionary clauses are controversial. The National Association of Insurance Commissioners ("NAIC") opposes their use, arguing that a ban on such clauses would mitigate the conflict of interest present when the claims adjudicator also pays the benefit. The use of discretionary clauses, according to NAIC, may result in insurers engaging in inappropriate claim practices and relying on the discretionary clause as a shield.

(*Standard Ins. Co. v. Morrison* (9th Cir. 2009) 584 F.3d 837, 840.)

"Health Insurance" is classified as "Disability Insurance"

Health insurance in California is classified as "disability insurance" and is subject to the California Insurance Code provisions relating to disability insurance. (Cal. Ins. Code § 106, subd. (b).) HMO plans are generally regulated by the Department of Managed Care, and are subject to the Knox-Keene Act, codified at Cal. Health & Saf. Code § 1340 et seq. Hence, HMO plans may not be subject to an Insurance Code statute, but health insurance plans regulated by the California Department of Insurance are actually disability plans and come within the scope of the statute.

California Insurance Code § 10110.6 invalidates discretionary clauses

California Insurance Code section 10110.6 was enacted to outlaw discretionary clauses in life, health, and disability plans as of 2012. Section 10110.6 provides in relevant part:

> (a) If a policy, contract, certificate, or agreement offered, issued, delivered, or renewed, whether or not in California, that provides or funds life insurance or disability insurance coverage for any California resident contains a provision that reserves discretionary authority to the insurer, or an agent of the insurer, to determine eligibility for benefits or coverage, to interpret the terms of the policy, contract, certificate, or agreement, . . . that provision is void and unenforceable.
>
> (b) For purposes of this section, "renewed" means continued in force on or after the policy's anniversary date.

See Garris, Next Page

Journal of Consumer Attorneys Associations for Southern California
ADVOCATE
September 2017 Issue

(c) For purposes of this section, the term "discretionary authority" means a policy provision that has the effect of conferring discretion on an insurer or other claim administrator to determine entitlement to benefits or interpret policy language that, in turn, could lead to a deferential standard of review by any reviewing court.

This language on its face is not limited to insurance policies. If it were so limited, it would just say "policy" and not "policy, contract, certificate, or agreement." (*Jahn-Derian v. Metropolitan Life Ins. Co*. (C.D. Cal. 2015) 2015 WL 900717, at *3.)

In other circuits, insurance companies argued that because a discretionary clause was not in an insurance policy but rather in the plan drafted by the employer, the statute banning discretionary clauses could not apply because it was not "regulating insurance" but rather the employer's ERISA plan. (*Fontaine v. Metropolitan Life Ins. Co*., 800 F.3d at pp. 891-92.) Thus, the insurer argued that the statute could not apply. In *Fontaine*, the Seventh Circuit rejected that argument: "[A]n artificial distinction between 'plan' documents and 'insurance' documents is not tenable. It 'would virtually "read the saving clause out of ERISA."' It would also nullify the evident purpose of [the discretionary ban statute]." (*Id.*, citations omitted.)

Section 10110.6 essentially eliminated the right of insurers of ERISA plans to be protected by the abuse-of-discretion standard. The only open question was whether section 10110.6 also prevented self-funded plans from using that standard.

The Ninth Circuit has held that § 10110.6 applies to all ERISA plans

The Ninth Circuit has resolved the issue of whether section 10110.6 applies to ERISA plans in *Orzechowski v. The Boeing Company Non-Union Long-Term Disability Plan* (9th Circ. 2017) 856 F.3d 686. In *Orzechowski*, the Court held that section 10110.6 applies to any group life, disability, or health plan, even if the plan is otherwise subject to ERISA.

The Court reviewed the history of the two standards of review, noting that the California Legislature, as in many states, amended the California Insurance Code to prohibit discretionary clauses in group life, health, and disability plans. In California, the statute is California Insurance Code section 10110.6:

> Opponents believe such clauses lead to inappropriate claim practices, as insurers may use them as a shield to deny valid claims. Supporters, meanwhile, argue they keep insurance costs manageable. Resolving the merits of discretionary clauses is thankfully not before us; individual states make that policy determination for themselves. In response to a particularly notorious example of an insurer who had used discretionary clauses to boost its profits by intentionally denying valid claims, a number of states acted via statute, regulation, or administrative action to ban or limit discretionary clauses.

(*Orzechowski*, 856 F.3d at p. 692.)

Preemption

Although ERISA preempts many state laws, it specifically does not preempt laws that regulate the business of insurance. (*Id.*; 29 U.S.C. § 1144(b)(2)(A).) The Court in *Orzechowski* found that section 10110.6 is a law that regulates the business of insurance, even though in that case Boeing argued that it was not in the business of insurance and was instead an aerospace company:

> We, too, conclude that § 10110.6(a) regulates "entities engaged in insurance," even if they are not insurance companies. Section 10110.6 is directed at "insurance, not insurers," because it covers "a policy, contract, certificate, or agreement . . . that provides or funds life insurance or disability insurance coverage.

(*Orzechowski*, 856 F.3d at p. 694, citations omitted.)

Even though Boeing was not an insurance company, its plan is "a policy, contract, certificate, or agreement" of insurance. Again, Boeing argued that the discretionary language was not in an insurance policy but was located in the employer's ERISA plan documents. The Ninth Circuit rejected that this distinction nullified the application of the statute, holding that section 10110.6 applies not just to insurance policies but to contracts as well:

> Boeing argues that § 10110.6(b) must refer only to insurance policies and not other plan documents. Thus, claims Boeing, the discretionary clause in the Master Plan survives and applies to Orzechowski's claim. This is a variation on the prior argument that ERISA's saving clause applies only to insurance companies, and not to insurance provided or funded by other companies. The argument fares no better the second time. By its terms, § 10110.6 covers not only "policies" that provide or fund disability insurance coverage but also "contracts, certificates, or agreements" that "fund" disability insurance coverage. "An ERISA plan is a contract," and thus the Master Plan falls under § 10110.6.

(*Orzechowski*, 856 F.3d at p. 695. citations omitted.)

The Ninth Circuit ruled: "We too conclude that § 10110.6(a) regulates 'entities engaged in insurance,' even if they are not insurance companies. Section 10110.6 is directed at 'insurance, not insurers.'" (*Id.*, at p. 694.) The fact that the plan is self-funded does not change the result: "ERISA plans 'are a form of insurance,' even when issued by a corporation whose principal business is not insurance." (*Orzechowski*, at p. 693.)

Thus, even though the employer may not be an insurance company and the benefits are self-funded, its plan to offer insurance to its employees is a contract that is a "form of insurance" subject to § 10110.6. The discretionary language in such a plan is thus prohibited by § 10110.6.

FMC Corp.

It bears mentioning that the effect of *Orzechowski* might be affected by the Supreme Court in *FMC Corp. v. Holliday* (1990) 498 U.S. 52 ("FMC"). Although

See Garris, Next Page

Journal of Consumer Attorneys Associations for Southern California
ADVOCATE
September 2017 Issue

ERISA generally preempts state law, it includes a "savings clause" that carves out an exception from its preemptive scope for state laws that regulate "the business of insurance." This "savings clause" permits the states to continue to regulate the insurance industry. But ERISA's saving clause is limited by a "deemer clause," which states:

> Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies. (29 U.S.C. § 1144(b)(2)(B).)

The purpose of the deemer clause appears to be to prevent states from "deeming" non-insurance entities to be engaged in the business of insurance, as a means of circumventing ERISA's preemptive scope.

Based on these sections within ERISA, the United States Supreme Court held in *FMC* that a Pennsylvania law that prohibited plans from exercising subrogation rights on tort recoveries could not be applied to a self-funded ERISA plan. It should be noted that the plan in *FMC* did not involve any insurance company. Not only were benefits funded by the employer, the employer also administered the plan. Whether this total absence of any insurance entity was a factor in the outcome of the decision is not clear.

The deemer clause seems to state that an ERISA plan itself cannot be deemed to be an insurance company. As a consequence, self-funded ERISA plans routinely argue that state laws that regulate the business of insurance are not exempt from preemption because the plan itself is not in the business of insurance. Insurance companies that administer but do not fund ERISA plans, however, might still be subject to state regulation. The Supreme Court has not reevaluated this decision with respect to self-funded plans since 1990. It is unclear how the Court would evaluate this issue today.

The Ninth Circuit in *Orzechowski* did not cite *FMC* or discuss the deemer clause. *Orzechowski* states very clearly that ERISA plan are "entities engaged in insurance" even if they are not insurance companies. Whether this part of the ruling would survive a challenge based on the *FMC* decision from 27 years ago is uncertain. Certainly, insured plans and self-funded plans where an insurance company is administering the benefits should be subject to § 10110.6. The open question is whether self-funded plans administered by the employer themselves are subject to § 10110.6 in light of *FMC*.

Christian J. Garris, Los Angeles, litigates insurance bad faith and consumer class-action matters.