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The standard of review in ERISA disability cases

ERISA CASES ARE OFTEN WON OR LOST BASED ON WHICH STANDARD OF REVIEW APPLIES

The Employee Retirement Income Security Act ("ERISA") is a unique subset of insurance litigation. Even though the coverage and policy interpretation issues are nearly identical to those involved in an insurance bad faith case, ERISA insurance cases have a unique procedural process.

The standard of review that the trial courts are to apply in considering whether the claim denial should be reversed has been the subject of much development by the courts. Recent Ninth Circuit cases on the standard of review have created a new conundrum where trial courts may now be applying two different standards of review in the same case.

The basic effects of ERISA

If the insurance coverage is group coverage for life, health, or disability benefits, and the plan is not provided by an employer that is either a governmental entity or a church, ERISA will apply. (*Pilot Life Ins. Co. v. Dedeaux* (1987) 481 U.S. 41.) The effect is that state law claims are preempted, and the claim must be pursued in federal court under ERISA law. Some features of state law may still be applied, however, if they are state laws that regulate the business of insurance, such as the California Insurance Code. (15 U.S.C. § 1011 et seq.; 29 U.S.C. § 1144(b)(2)(A).)

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.

Some of the other repercussions of ERISA preempting state law is that there is no entitlement to a jury trial and because the only relief is that specified within ERISA itself, there is no entitlement to punitive damages, *Mertens v. Hewitt Associates*, (1993) 508 U.S. 248, 255, or emotional distress damages, *Bast v. Prudential Ins. Co. of Am*. (9th Cir. 1998) 150 F.3d 1003, 1009. Attorneys fees and costs, however, are recoverable. (29 U.S.C. § 1132(g)(1).)

While state courts have concurrent jurisdiction to hear ERISA cases, as a practical matter, they will be heard in federal court. This is because ERISA has its own federal venue provisions and because ERISA cases are removable under the "complete preemption" doctrine, which deems ERISA cases to present exclusively federal questions. Hence, lack of diversity of citizenship will not exempt the case from being removable should it initially be filed in state court.

Insurer was wrong – but you still lose

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 something called the "standard of review." There are two principle types of review: "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 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

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wrong in denying the claim. In other words, neither party has an advantage going into the case.

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 statute to prevent insurance companies from using the abuse of direction standard of review. Insurance companies argued that the law did not apply to ERISA plans at all. The Ninth Circuit rejected that argument in *Orzechowski v. The Boeing Company Non-Union Long-Term Disability Plan* (9th Cir. May 11, 2017) 856 F.3d 686. There also remained some question as to whether the state statute applied to "self-funded" plans where the insurance company is merely an administrator, and the employer itself pays the benefits. The Ninth Circuit has now answered that question, leading to further complications in applying the standard of review with respect to disability cases. First, however, some background is needed.

Introduction to 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." (*Id*. at 109.) 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 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 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 963.)

This 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.

(*Ibid*. (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.

A conflict of interest is present when a plan administrator is also the entity that pays the benefits, which affects the standard of review. (*Steuer v. Pool Co*. (9th Cir. 2003) 75 F. App'x 667, 668.) "[P]laintiffs will have the benefit of an abuse of discretion review that always considers the inherent conflict when a plan administrator is also the fiduciary, even in the absence of 'smoking gun' evidence of conflict." (*Abatie v. Alta Health & Life Ins. Co*., 458 F.3d at 969.)

Also, under some factual scenarios (for example, if the insurance company ignored plan language or evidence submitted in favor of the claim), "heightened

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review" will apply and even 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 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.

(Citations omitted).

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 118.)

The failure of a plan to exercise its discretion and render a decision at all on a claim is also not deserving of discretion:

> Deference to an exercise of discretion requires discretion actually to have been exercised. Deemed denials are not exercises of discretion. They are therefore undeserving of deference under *Firestone*, and a de novo standard of review applies.

(*Jebian v. Hewlett-Packard Co. Employee Benefits Org. Income Prot. Plan* (9th Cir. 2003) 349 F.3d 1098, 1106 (citations omitted).)

Failing to adhere to procedural deadlines alone can elevate the scrutiny and can lead to de novo review. (*Rasenack ex rel. Tribolet v. AIG Life Ins. Co*. (10th Cir. 2009) 585 F.3d 1311, 1318.)

These decisions provided significant inroads into the abuse of discretion standard. 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 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. (Ins. Code, § 106(b).) HMO plans are generally regulated by the Department of Managed Care, and are subject to the California Health & Safety Code. (Health & Saf. Code, § 1340 et seq.) Hence, HMO plans are not subject to the California Insurance Code, but health insurance plans regulated by the California Department of Insurance are subject to it. Thus, California Insurance Code section 10110.6 applies to disability plans and health plans that are *not* regulated by the Department of Managed Care

California Insurance Code section 10110.6 invalidates discretionary clauses

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

> (a) If a policy, contract, certificate, or agreement offered, issued, delivered,

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> 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.
> (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." (See *Jahn-Derian v. Metropolitan Life Ins. Co*., 2015 WL 900717, at *3 (C.D. Cal. 2015).)

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 891-92.) Thus, the insurer argued that the statute could not apply. (*Ibid*.) The court 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]." (*Ibid*. (citations omitted).)

Section 10110.6 essentially eliminated the right of insurers of ERISA plans to be protected by the abuse of discretion standard.

Orzechowski: The Ninth Circuit held that section 10110.6 applies to all ERISA plans

The Ninth Circuit 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 Cir. 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 § 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.

(*Id*. at 692.)

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."

(*Id*. at 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.

(*Id*. at 695, citations omitted.)

Williby: The Ninth Circuit rules that self-funded plans are not subject to § 10110.6

For some time, it had been established that for plans in which the benefits are administered *and* paid by the employer, no state regulation of insurance could apply since no insurance or insurance entity was involved. (*FMC Corp. v. Holliday* (1990) 498 U.S. 52.) The open question after *Orzechowski* was whether self-funded plans administered by an insurance company would be treated the same as the self-funded and self-administered plan in *FMC Corp*.

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FMC Corp. was extended to the situation where self-funded plans were administered by an insurance company in *Williby v. Aetna Life Insurance Co*. (2018) 867 F.3d 1129, 1136. In *Williby,* the court held that self-funded plans, whether administered by an insurance company or not, are *not* subject to section 10110.6. Previously, some district courts had ruled that section 10110.6 also applied to plans that were self-funded, i.e., plans that may have been administered by an insurance company but where the benefits were paid by the employer. (See *Williby v. Aetna Life Ins. Co*., 2015 WL 5145499, *5 (C.D. Cal. 2015), *vacated*, 867 F.3d 1129 (9th Cir. 2017); *Thomas v. Aetna Life Ins. Co*., 2016 WL 4368110, at *6 (E.D. Cal.).)

What happens when some disability benefits are self-funded and some are not?

It now is clear in the Ninth Circuit that statutes that ban discretionary clauses in disability policies are valid unless the plan is self-funded. The form of entity that administers the plan is not relevant.

An interesting wrinkle, however, now occurs where the short-term disability ("STD") benefits in an ERISA plan are self-funded, but the long-term disability ("LTD") benefits are insured. STD benefits are frequently the first six months of disability, and the LTD benefits take over until retirement age. (This issue only applies to disability cases because only disability cases have two kinds of benefits based on time: STD and LTD benefits, and STD benefits are often self-funded, and LTD benefits are only sometimes self-funded.) In such a case, the ERISA plan will likely be subject to two different standards of review. Even if a court finds at trial that the plan has not abused its discretion in denying self-funded STD benefits, the inquiry does not end if the plan also includes insured LTD benefits. In other words, a trial court might find that under the abuse of discretion standard a plan did not abuse its discretion in denying self-funded STD benefits, but, when examined de novo, the decision to deny insured LTD benefits was wrong. Since the bulk of benefits generally fall within the LTD period, courts may need to be reminded that even if the court finds against the claimant with respect to STD benefits under abuse of discretion, the claimant can still prevail under the de novo standard with respect to the larger insured LTD benefits.

The open question now is whether courts in these kinds of cases will apply two standards of review effectively in the same case with respect to the same disability with the same factual record.

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