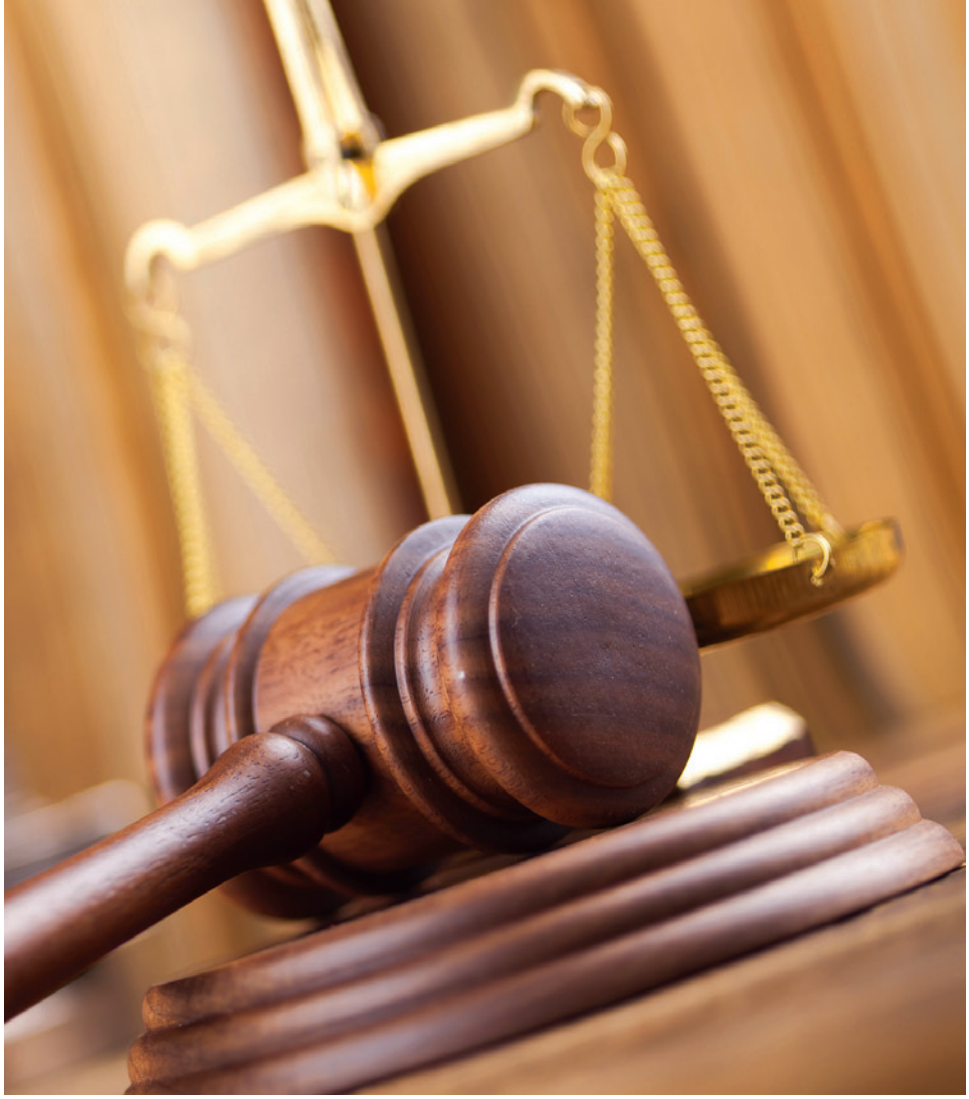

No Standard Standard of Review

It's far from a novel concept that Plan Administrators of self-funded health plans governed solely by ERISA are subject to a fiduciary duty to prudently manage plan assets and act in the best interest of plan participants. ERISA indicates that "a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and... in accordance with the documents and instruments governing the plan,"[1] and that Plan Administrators must discharge duties "with the care, skill, prudence and diligence... that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character... ."[2] Codified in 1974, ERISA's protections are designed for the protection of plan beneficiaries; while ERISA's provisions impose certain limitations and obligations upon fiduciaries, ERISA has not been crafted for their protection.

ERISA applies to a broad spectrum of employee benefits, among them health benefit plans, pension plans and even benefits such as severance pay plans. The vast majority of the law interpreting ERISA's provisions is concerned with pension plans; though pension plans serve different purposes than health benefit plans, ERISA sets identical standards for the administration of each, with few exceptions.

Perhaps the most important and basic requirements of ERISA are those laid out within 29 USC § 1104 – the requirements to both prudently manage Plan assets and administer the Plan strictly in accordance with the governing plan documents.

Written by Jon Jablon

TPAs and self-funded health plans have all heard the argument from medical

providers that "ERISA requires you to pay this claim in full." TPAs and self-funded health plans are similarly aware that this assertion, as a catch-all, is severely misguided. What some have discovered, however, is that the assertion that ERISA requires a health plan to pay a given claim in full can *become* true, by virtue of language within the plan document that makes it true. Of course, the statement that ERISA itself requires any particular level of payment is not technically accurate, but instead ERISA imposes a duty on the Plan Administrator to ensure that it abides by the plan document's terms.

It has been made clear by the courts that Congress' intent in passing ERISA was not, in general, to control the *substance* of agreements between employers and beneficiaries, but rather to ensure that such agreements, if falling within the purview of ERISA's protections, are followed. According to one court, ERISA's fiduciary duty imposition was designed "to prevent fiduciaries from depriving beneficiaries of what they concededly had been promised."[3] In this manner, ERISA acts as a regulating body of statutes, with corresponding common law and regulatory interpretations – with respect to pension plans, health benefit plans and many other types of employee welfare benefit plans.

As we know, the Plan Administrator of a self-funded health plan may be given broad discretion to interpret the plan document's provisions, decide issues of fact related to claims for benefits and otherwise determine the benefits payable by the plan for a given claim. That discretion is not just useful for making determinations; it is also useful when it comes to having the Plan Administrator's determinations reviewed in court. Affording the Plan Administrator discretion gives the Plan Administrator a certain amount of deference by a court – but only in certain cases. A common misconception is that the Plan Administrator is *always* afforded the deferential "arbitrary and capricious" standard of review, but that is not necessarily the case.

A deferential standard of review provides the reviewing court with a much higher threshold that the claimant must meet in order to prevail on the appeal of a denial. When a court finds it proper to employ the "arbitrary and capricious" standard, the court is charged with determining only whether the Plan Administrator's interpretation was reasonable and made in good faith.[4] The inquiry is limited to whether the Plan Administrator's decision was made "(a) as a result of reasoned and principled process (b) consistent with any prior interpretations by the plan administrator (c) reasonable in light of any external standards and (d) consistent with the purposes of the plan."[5]

The first point – (a) – seems to be an iteration of the requirement that the Administrator's determination not be capricious. The second point is codified within the Code of Federal Regulations and requires that the Plan Administrator afford the same interpretations of plan document language in similar circumstances with respect to similarly-situated individuals. The third point is an indication that the governing plan document may not, in fact, be the *only* relevant guidance used by the Plan Administrator, if other extra-plan information is truly necessary to take into account.

A simple example is that "reasonable expectations" of claimants or beneficiaries are sometimes taken into account when determining whether the Plan Administrator has breached its duty – and despite the breadth of the plan document, a beneficiary's "reasonable expectations," strictly speaking, may not be within the plan document. Regarding the fourth point, the purpose of the plan is first and foremost to constitute a contract to provide benefits – and as with any contract, if the parties' actions indicate a deviation from the most basic purpose of the contract, there will likely be a problem.

Interestingly, it is not uncommon to see language within a plan document that affords the Plan Administrator the right to determine issues of law as well as issues of fact related to claims for benefits. Although the Plan Administrator may certainly be given the discretion to interpret the language of the governing plan documents as well as factual issues surrounding claims for benefits, the Plan Administrator does not implicitly have the same right to interpret relevant questions of *law*. One federal appeals court has indicated that "in contrast to the great deference we grant the Committee's interpretations of the Plan, which involve contract interpretation, we accord no deference to the Committee's conclusions as to the controlling law, which involve statutory interpretation. The interpretation of ERISA itself must be made *de novo* by the court."[6]

In other words, while the governing plan documents may give the Plan Administrator extraordinarily broad discretion to interpret the terms of the plan documents themselves and make factual determinations, the determinations of law – that is, those based upon the interpretation of statutes (drafted by a legislature) as opposed to contracts (drafted by the parties) – are not subject to deference on review and will be reviewed *de novo*.

The *de novo* standard of review is a Plan Administrator's worst enemy. It is a non-deferential standard, pursuant to which a court will examine a claim for benefits from start to finish (de novo is in fact a Latin expression meaning "from the beginning"), without

affording any deference to the Plan Administrator's prior determination.

Under current law, the review standard for every determination by every Plan Administrator is *de novo* by default, but can be altered based on plan language. (Notably, this is one primary reason that it is so important for the plan document to give the Plan Administrator discretion.) As with every other facet of the law, however, there are exceptions, exemptions, loopholes and all other manner of niches when it comes to ERISA and review of benefit determinations.

One primary exception to the deferential standard of review, even when proper plan language exists to support the Plan Administrator's discretion, involves instances of a conflict of interest. When a conflict of interest exists for the Plan Administrator, the court may still apply a deferential standard of review, if appropriate, but the conflict of interest will be weighed as a factor in determining whether the conflict has somehow affected the Plan Administrator's exercise of discretion. In other words, no matter what the Plan Administrator's decision entailed – and no matter how reasonable it may have been – if there is a conflict of interest, that may render an otherwise reasonable decision unreasonable. According to one federal appeals court, an "apparent" conflict of interest (and therefore the presumption of a conflict of interest) exists "whenever a plan administrator is responsible for both funding and paying claims."[7]

In other words – and this may turn some pre-conceived notions upside-down – when the entity that is the Plan Sponsor also serves as the Plan Administrator, a presumption of conflict of interest is created. Granted, the presumption is rebuttable, but it is sometimes difficult to rebut the idea that the entity responsible for *funding* claims has no incentive whatsoever to deny claims. Notably, however, that "apparent" conflict does not necessarily affect the standard of review ultimately used, but instead triggers a court's examination into that dual role as the holder of both the sword and purse-strings.

The burden is on the claimant to demonstrate that there exists some reason to believe that a conflict has affected the Plan Administrator's decision, more than the mere fact of the apparent conflict. The claimant, notably, need not at this stage prove that a conflict has affected the Plan Administrator's decision – but the claimant merely needs to demonstrate that there is some reason to think that it has happened. From there, the burden switches to the Plan Administrator to prove that the conflict did not, in fact, influence its decision.

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Denials of claims for benefits are not the only possible reviews that courts may conduct; the standards of *de novo* and "arbitrary and capricious" apply only to appeals of benefit determinations.[8] For other reviews of fiduciary conduct unrelated to benefit determinations, the standard has commonly been deemed to be that of a "prudent man."

In fact, the "prudent man" standard is laid out in the very terms of ERISA itself; a fiduciary must discharges its duties "with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise with like character and with like aims."[9] When a given case is for redress under ERISA but "does not concern a denial of benefits under 29 U.S.C. § 1132(a)(1)(B) or an interpretation of [the plan document]," the deferential standard of "arbitrary and capricious" becomes inapplicable.[10]

We are left with a number of different standards, used in different situations and under various circumstances and there can easily be confusion with which apply in a given situation. The take-away, though, is primarily two-fold: first, the drafter of the plan document should ensure that the Plan Administrator is afforded the maximum discretion allowed under the law and second, the Plan Administrator should ensure that in every case, it acts within the strict purview of the Plan Document and it does not in any way "try" to find reasons to deny claims.

Every determination made by a Plan Administrator – and, accordingly, determinations on appeal of those determinations – should be strictly neutral, or the Plan Administrator runs the risk of having its deferential standard of review extinguished by the conflict of interested created by both determining whether to pay and footing the bill.

Those two responsibilities can be a dangerous combination when in the wrong hands – so the legal burden rests with the Plan Administrator to ensure that any actions taken in its capacity as a fiduciary of the plan are appropriate, reasonable and neutral – or, in the words of ERISA, *solely in the interest of the participants and beneficiaries.* ■

After being admitted to the bars of New York and Massachusetts, Jon Jablon joined The Phia Group's legal team in 2013. He is well-versed in the ins and outs of ERISA, stop-loss policies, PPO agreements, administrative services agreements and health plans. Jon focuses on providing various consulting services to clients as well as serving as a part of The Phia Group's in-house legal counsel.

References

[1] *29 USC § 1104(a)(1)(D).*

[2] *29 USC § 1104(a)(1)(B).*

[3] *Trans World Airlines, Inc. v. Sinicropi, 887 F. Supp. 595, 608 (S.D.N.Y. 1995) aff'd, 84 F.3d 116 (2d Cir. 1996).*

[4] *Geddes v. United Staffing Alliance Employee Med. Plan, 469 F.3d 919, 929 (10th Cir. 2006).*

[5] *Fought v. Unum Life Ins. Co. of Am., 379 F.3d 997, 1003 (10th Cir. 2004).*

[6] *Penn v. Howe-Baker Engineers, Inc., 898 F.2d 1096, 1100 (5th Cir. 1990).*

[7] *McDaniel v. Chevron Corp., 203 F.3d 1099, 1108 (9th Cir. 2000).*

[8] *Struble v. N.J. Brewery Emp. Welfare Trust Fund, 732 F.2d 325 (3rd Cir.1984).*

[9] *29 USC § 1104(a)(1)(B)*

[10] *In re Unisys Sav. Plan Litig., 173 F.3d 145, 155 (3d Cir. 1999)*