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The Tide is Turning Against Discretionary Authority and the Abuse-of-Discretion Standard of Review

Orzechowski v. Boeing Co. Non-Union Long-Term Disability Plan (9th Cir. May 11, 2017) is the latest in a string of court decisions that undermine the abuse-of-discretion standard of review in ERISA disability benefits cases. It may not be the last.

Background

Most employee benefit plans today give the plan administrator discretionary authority to decide claims for benefits. In *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), the Supreme Court determined that such a plan provision vests the plan administrator with special authority to decide benefit claims, and that a deferential standard of judicial review would apply in litigation involving such decisions. That deferential standard is the "arbitrary and capricious" or "abuse of discretion" standard.

For decades, *Firestone* deference has been the touchstone of ERISA jurisprudence. Over the last few years, however, legislators, courts, and regulators have all moved to severely limit the discretion of plan administrators and walk back the deference traditionally afforded their decisions under the deferential, abuse-of-discretion standard of review.

Orzechowski Upholds a California Statutory Ban on Discretionary Clauses

In *Orzechowski*, the Ninth Circuit rejected ERISA preemption arguments and held that California's statutory ban on discretionary clauses, Cal. Ins. Code § 10110.6, was enforceable against an ERISA disability plan that was sponsored by Boeing but administered and insured by a third-party insurer. The court also held that the ban applied to a plan implemented *prior to the enactment of the statute* because the policy insuring the plan had been renewed after the enactment of the statute. By its terms, California's statute applies to any "policy, contract, certificate, or agreement" that is "offered, issued, delivered, or renewed" after the statute's January 1, 2012 effective date.

Because of the *Orzechowski* decision, ERISA plans in California, and maybe elsewhere in the Ninth Circuit, that rely on a "policy, contract, certificate, or agreement" have now lost the benefit of deferential judicial review.

Orzechowski may not be the last word on this issue in the Ninth Circuit. In two District Court cases, the Central District of California (generally, the Los Angeles, Riverside, and Santa Ana areas), the same California statute applied to *self-funded* ERISA disability plans. One of those cases settled. The other, *Williby v. Aetna Life Ins. Co.*, 2015 WL 5145499 (C.D. Cal. Aug. 31, 2015), is currently on appeal before the Ninth Circuit.

Court decisions construing legislative bans on discretionary clauses—like *Orzechoski* and *Williby*—are vitally important. More than 20 states ban discretionary clauses in insurance contracts and other agreements, and arguments that ERISA preempts such bans have failed in other circuits. *See Fontaine v. Metro. Life Ins. Co*., 800 F.3d 883 (7th Cir. 2015); *Standard Ins. Co. v. Morrison*, 584 F.3d 837 (9th Cir. 2009); *Am. Council of Life Insurers v. Ross*, 558 F.3d 600 (6th Cir. 2009).

The Second Circuit Requires Plans to "Strictly Comply" with Claims Rules

The Second Circuit has abandoned the "substantial compliance" doctrine and held that even minor violations of the Department of Labor claim regulations deprive a plan administrator of the abuse-of-discretion standard of review. *Halo v. Yale Health Plan*, 819 F.3d 42 (2d Cir. 2016), is one of the more notable cases in this area. In *Halo*, the Second Circuit considered the consequences of a plan administrator's failure to comply with the 2000 version of the Department of Labor's claim regulations. After examining the stated purpose and intent of the claim regulations, the court held that any violation of the regulations means that a plan administrator is not entitled to deference. The court rejected the argument that substantial compliance (*e.g*., minor violations found among a good faith dialogue and exchange of information with a plan participant) preserved the plan administrator's discretion. According to the Second Circuit, a deviation from the Department of Labor's claim regulations should not be lightly tolerated, and a plan administrator seeking refuge in the abuse-of-discretion standard of review in such cases will have the burden to show that any failure to comply with the regulations was both inadvertent *and* harmless.

In *Salisbury v. Prudential*, 2017 WL 780817 (S.D.N.Y. Feb. 28, 2017), the Southern District of New York applied *Halo* and, because it found that the plan administrator violated the claim regulation, the court determined that *de novo* review applied. The plan administrator attempted to extend the 45-day deadline for its decision to obtain medical and vocational reviews. The court noted that the claim regulations permit extensions only in "special circumstances," and it found that medical and vocational reviews could not constitute "special circumstances" because virtually every disability claim will involve physician and vocational review. The court also refused to consider the size of the claimant's file, which contained almost 5,000 pages and several days of surveillance, because the plan administrator did not include this as a justification for the extension in its letter to the claimant. Although there was no apparent prejudice to the plaintiff, the court noted that the plan administrator purposefully sought the extension, and therefore the conduct could not be characterized as inadvertent. Consequently, the conduct could not fall within the *Halo* exception for inadvertent *and* harmless violations of the claim regulations. The plan administrator thus lost its right to a deferential standard of review.

The Fifth Circuit Appears Poised to Revisit its Standard of Review Jurisprudence

In *Ariana M. v. Humana Health Plan* (5th Cir. April 21, 2017), a Fifth Circuit panel recently affirmed a plan administrator's decision under the abuse-of-discretion standard of review. After doing so, the panel took the unusual step of authoring a unanimous, concurring opinion decrying the deference afforded ERISA plan administrators—which, in the court's view, are not neutral adjudicators, and are no better suited than judges to evaluate claims for benefits. This concurring opinion looks like a call to action for the Fifth Circuit to overhaul its standards for deferential review.

The DOL's View is in Accord with These Cases

Halo, *Salisbury*, and *Ariana* exemplify the intent of the Department of Labor's revised disability claim regulations. Effective January 1, 2018, disability plans must comply with a host of new rules, including the requirement that adverse benefit decisions explain any disagreement with a claimant's treating physicians and the Social Security

administration. 29 CFR § 2560.503-1(g)(1)(vii), (j)(6)(i) (eff. 1/1/2018). Prior to issuing a decision on appeal, the plan administrator must provide the claimant with any new or additional evidence considered, and give the claimant a reasonable opportunity to respond to that evidence prior to rendering a final decision. 29 CFR § 2560.503-1(h)(4)(i). If on appeal the plan administrator identifies a new or additional rationale justifying the denial of the claimant's application, the plan administrator must likewise explain this new rationale to the claimant, and give the claimant a reasonable opportunity to respond prior to the final decision. 29 CFR § 2560.503-1(h)(4)(ii).

If a plan administrator fails to ***strictly comply*** with the regulations governing the timing, substance, and manner of benefit determinations, a claimant will be deemed to have exhausted his administrative remedies, and he "shall be entitled to pursue any available remedies under section 502(a)" of ERISA. 29 CFR § 2560.503-1(l)(1). "If a claimant chooses to pursue remedies under section 502(a) of the Act under such circumstances, the claim or appeal is deemed denied on review ***without the exercise of discretion by an appropriate fiduciary***." CFR § 2560.503-1(l)(2)(i) (emphasis added). The Department readily acknowledges that "[t]he legal effect… may be that a court would conclude that ***de novo review is appropriate***" because the regulation "determines as a matter of law that no fiduciary discretion was exercised in denying the claim." 81 FR 92316, 92328 (12/19/2016) (emphasis added).

Conclusion

The developments described above are troubling for plan sponsors and administrators for obvious reasons. Decades ago, the Supreme Court laid down a framework for the review of claims decisions that recognized the expertise of fiduciaries in deciding claims and the importance of minimizing the burdens of litigation. That framework is changing, and plan sponsors and administrators need to adjust their claims practices to comply with the new standards. Plan sponsors and administrators also need to reconsider their litigation strategies to account for the possibility of *de novo* review. Our firm will continue to monitor closely developments in this area.