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Improper Delegation of Authority Could Cost a Plan its Deferential Standard of Review

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The Employee Retirement Income Security Act (ERISA) gives participants and beneficiaries the right to have plan benefit denials reviewed in federal court. The court reviews a plan claims administrator's benefit denial decision as "de novo" (looking at the facts anew and reaching its own decision, with no deference to the plan's determination) ***or*** it may apply a more deferential standard of review, typically referred to as an "arbitrary and capricious" standard of review (generally deferring to the decision-maker's determination unless the court determines the decision was made based on unreasonable grounds or without consideration of the relevant circumstances). The standard of review applied by a court is critical — it can mean the difference between the plan winning or losing a case. Recent cases have highlighted the importance of the plan documents *clearly* conferring on the decision-maker the discretionary authority to determine benefits. Below is a discussion of those cases.

Background

The ERISA statute does not dictate the standard of review that courts must apply, rather the standard is based on a U.S. Supreme Court ruling (*Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989)) which established the principle that the amount of deference to be paid to a decision to deny benefits depends on how much discretion the plan terms confer on the decision-maker:

> "[A] denial of benefits challenged under [ERISA] 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."

Generally, if claims administrator follows the ERISA claims and appeals regulations, and the plan has delegated the claims administrator the proper discretionary authority, a court will apply the more deferential standard of review — the "arbitrary and capricious" standard — to the plan's benefit

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denial decision. If those requirements are not met, the *de novo* standard is used: the court will review everything anew and may even accept new evidence that was not submitted as part of the administrative process. This process can be very costly and time-consuming.

The cases below explain some of the missteps made by employers when trying to delegate discretionary authority to a claims administrator.

Miller v. PNC Fin. Servs. Grp., Inc.
(2017 WL 4404469 (S.D. Fla. Oct. 2, 2017))

This case involved an ERISA-covered long-term disability (LTD) plan that was self-insured. PNC, the employer, was the plan sponsor and the ERISA Plan Administrator of the LTD plan. The plan lost the arbitrary and capricious standard of review because the claims administrator, Liberty Life Assurance Company ("Liberty"), was not granted sufficient discretion to determine eligibility for LTD benefits.

The court reviewed two issues: (1) what documents were considered the plan documents, and (2) whether the plan documents clearly delegated final discretionary authority to determine appeals to the claims administrator.

Plan Documents

The court began by analyzing the terms of the plan document in question — in this case, the Summary Plan Description (SPD) stated that it was both the plan document and the SPD. The SPD vested the ERISA Plan Administrator (PNC) with "the exclusive discretionary authority to determine eligibility for benefits under the plan, to construe the terms of the plan and to determine any question which may arise in connection with its operation or administration, except to the extent the plan administrator has authorized the claims administrator to make such determinations." The SPD further explained that the ERISA Plan Administrator could delegate fiduciary responsibilities to other persons (including insurance companies and third-party administrators).

Liberty was named as the claims administrator in the SPD, but the SPD stated that Liberty was granted the right to "determine whether [a claimant's] disability meets" the definition of disabled under the plan. The SPD language did not clearly state whether Liberty's determinations were final, or whether Liberty's authority extended to making final determinations during an administrative appeal.

The court held that the delegation from PNC limited Liberty's review to only one component for eligibility — disability — whereas the SPD contained many other requirements to determine whether a claimant was eligible for LTD benefits. The court concluded that the limited SPD language failed to confer Liberty with the full discretionary authority to determine appeals.

Terms of the ASA

Because the SPD did not contain the necessary delegation language, PNC claimed that the needed language was in the Administrative Services Only Agreement (ASA), in which Liberty was vested with some authority to construe and interpret the terms of the plan, and to evaluate and decide questions of eligibility and/or entitlement to LTD benefits under the plan. The Plaintiff argued that the ASA was not a plan document. PNC did not argue that the ASA was a plan document; rather, PNC argued that there was no such high bar for delegation of discretionary

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authority. The court considered whether delegation of authority to a third party through a contract, which is not referenced in the plan document, can constitute a grant of discretion such that judicial review of the claim administrator's determination would only be for abuse of discretion. The court found that it cannot; such a grant of discretion had to be clearly contained in the plan documents.

Even if the ASA was incorporated by reference into the plan document (which it was not), it did not grant the proper authority to Liberty. For example, the ASA stated that all doubtful claims would be referred to PNC for its determination. The ASA did not give Liberty full discretion to determine whether a claimant was eligible for benefits and hence, did not properly vest Liberty with sufficient discretionary authority such that an abuse of discretion review applied to its decisions. Accordingly, the court concluded that the delegation of authority to the claims administrator was incomplete. The court went through the plaintiff's medical evidence to complete its *de novo* review, ultimately reversing Liberty's denial.

Colvill v. Life Insurance Company of North America
(WL 4078398 (E.D. Wis. 2018))

This recent 2018 case involved a dispute over the denial of benefits under an employer-sponsored LTD plan that was fully insured. The ERISA Plan Administrator was the employer, and the LTD policy was issued by Life Insurance Company of North America (LINA). At issue in the case was whether the ERISA Plan Administrator (the employer) had actually delegated the proper authority to LINA.

Summary Plan Description

The SPD stated that the employer had appointed LINA as the named fiduciary for adjudicating claims for benefits under the plan and for deciding any appeals of denied claims. It also stated that LINA had the authority, in its discretion, to interpret the terms of the plan, to decide questions of eligibility for coverage or benefits under the plan, and to make any related findings of fact. Lastly, the SPD stated that all decisions made by LINA were final and binding. While the SPD explained that LINA had been delegated authority to determine appeals, the court determined that the SPD was not the plan document that actually made that delegation to LINA — it simply disclosed to the participants that such a delegation was made. The court then looked to the plan documents to see if there was a proper delegation to LINA.

The Policy

The insurance policy (the "Policy") was the plan document, and within the four corners of the Policy, it did not delegate discretionary authority to LINA to determine claims and appeals. The delegation to LINA was done through a separate document titled the Appointment of Claim Fiduciary Form (ACF). LINA argued that the ACF should be considered part of the plan document because the Policy incorporated other documents by reference through an integration clause, which stated: "[t]his Policy, including the endorsements, amendments, and any attached papers constitutes the entire contract of insurance."

The court determined that the ACF was a plan document based on numerous facts, such as: (1) the ACF was labelled as a plan document with the caption "Employee Welfare Benefit Plan Appointment of Claim Fiduciary"; (2) the ACF named the applicable plan; and (3) the Policy was

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referenced in the ACF document. Accordingly, the court held that the ACF contained the proper delegation, and the court applied the arbitrary and capricious standard of review to LINA's denial of benefits.

Takeaways

(1) Plans should have a wrap plan document that specifically delegates proper discretionary authority to claims administrators and clearly sets forth all of the documents that are considered to be "plan documents."

(2) Review vendor contracts and plan documents to ensure that claims administrators have the final decision-making authority — and do not include provisions allowing the employer (plan sponsor) to override those determinations.

(3) If a plan intends to delegate authority to a third party through a contract (such as an ASA), that contract should state that it is part of the plan documents. However, remember that once that document is considered a plan document, it must be disclosed to participants upon their request. Confidentiality provisions in an ASA may preclude such disclosure. In that case, the delegation agreement can be separate from the ASA, but still included as part of the plan documents.

(4) If the plan designates a third-party administrator (TPA) as the claims administrator, the plan needs to know if the TPA is making the determination on appeals or if it has hired one of its vendors to determine claims and appeals. If the latter has occurred, ensure that a proper delegation of authority has been documented.

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