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BENEFITS REPORT

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

GISUE MEHDI AND MARY E. POWELL

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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

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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 the 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 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 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 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.

2019 Pension Plan Limitation Highlights

SHANNON OLIVER

DECEMBER, 2018

On November 1, 2018, the Internal Revenue Service issued Notice 2018-83, containing the cost-of-living adjustments related to retirement plan limitations under the Internal Revenue Code (the "Code"). These changes will take effect on January 1, 2019. Below are some of the highlights.

Limitations That Have Increased

- The limitation on the annual benefit under a defined benefit is increased from $220,000 to $225,000 (Code section 415(b)(1)(A)).
- The annual contribution limitation for defined contribution plans is increased from $55,000 to $56,000 (Code section 415(c)(1)(A)).
- The annual compensation limit is increased from $275,000 to $280,000 (Code sections 401(a)(17), 404(l),408(k)(3)(C), and 408(k)(6)(D)(ii)).
- The dollar limitation regarding the definition of "key employee" in a top-heavy plan increased from $175,000 to $180,000 (Code section 416(i)(1)(A)(i)).
- The dollar amount for determining the maximum account balance in an employee stock ownership plan subject to a 5-year distribution period is increased from $1,105,000 to $1,130,000, while the dollar amount used to determine the lengthening of the 5-year distribution period is increased to $225,000 up from $220,000 in 2018 (Code section 409(o)(1)(C)(ii)).
- The limitation used in the definition of "highly compensated employee" is increased from $120,000 to $125,000 (Code section 414(q)(1)(B)).
- The adjusted gross income limitation under Code section 25B(b)(1)(A) for determining the retirement savings contribution credit for taxpayers filing as head of household is increased from $28,500 to $28,875; the limitation under Section 25B(b)(1)(B) is increased from $30,750 to $31,125; and the limitation under Code sections 25B(b)(1)(C) and 25B(b)(1)(D) is increased from $47,250 to $48,000.
- The adjusted gross income limitation under Code section 25B(b)(1)(A) for determining the retirement savings contributions credit for all other taxpayers is increased from $19,000 to $19,250; the limitation under Code section 25B(b)(1)(B) is increased from $20,500 to $20,750; and the limitation under Sections 25B(b)(1)(C) and 25B(b)(1)(D) is increased from $31,500 to $32,000.
- The limitation under Code section 408(p)(2)(E) regarding SIMPLE retirement accounts is increased from $12,500 to $13,000
- The deductible amount for an individual making qualified retirement contributions is increased from $5,500 to $6,000. (Code section 219(b)(5)(A)).
- The limitation on deferrals under Code section 457(e)(15) concerning deferred compensation plans of state and local governments and tax-exempt organizations is increased from $18,500 to $19,000.
- The compensation amount for the definition of "control employee" for fringe benefit valuation purposes increased from $220,000 to $225,000. (Code section 1.61-21(f)(5)(iii)).

- The $1,000,000,000 threshold the Code utilizes to determine whether a multiemployer plan is a systematically important plan is adjusted using the cost-of-living adjustment. After taking the applicable rounding rule into account, the threshold used to determine whether a multiemployer plan is systemically important is increased from $1,087,000,000 to $1,097,000,000. (Code sections 432(e)(9)(H)(v)(lll)(aa) and 432(e)(9)(H)(lll)(bb)).
- The compensation amount under Code section 1.61-21(f)(5)(iii) is increased from $220,000 to $225,000.

Limitations That Remain Unchanged

- The limitation under Code section 664(g)(7) concerning the qualified gratuitous transfer of qualified employer securities to an employee stock ownership plan remains at $50,000.
- The dollar limitation on premiums paid with respect to a qualifying longevity annuity contract under Code section 1.401(a)(9)-6, A-17(b)(2)(i) of the Income Tax Regulations remains at $130,000.
- The compensation amount under Code section 408(k)(2)(C) regarding simplified employee pensions (SEPs) remains at $600.
- The maximum amount of catch-up contributions that individuals aged 50 or over may make to 401(k) plans, 403(b) plans, SEPs, and governmental 457(b) plans remains at $6,000 (Code section 414(v)(2)(B)(i)).
- The maximum amount of catch-up contributions that individuals aged 50 or over may make to SIMPLE 401(k) plans or SIMPLE retirement accounts remains at $3,000 (Code section 414(v)(2)(B)(ii)).
- The limitation concerning the qualified gratuitous transfer of qualified employer securities to an employee stock ownership plan remains at $50,000 (Code section 664(g)(7)
- The compensation amount under the Income Tax Regulations concerning the definition of "control employee" for fringe benefit valuation purposes remains at $110,000 (Code section 1.61-21(f)(5)(i)).

	2019	2018	2017	2016
401(k)/403(b)/457 Elective Deferral Limit	$ 19,000	$ 18,500	$ 18,000	$ 18,000
Defined Contribution Plan Annual Limit	$ 56,000	$ 55,000	$ 54,000	$ 53,000
Defined Benefit Plan Annual Limit	$ 225,000	$ 220,000	$ 215,000	$ 210,000
Annual Compensation Limit	$ 280,000	$ 275,000	$ 270,000	$ 265,000
Catch-Up Contribution Limit	$ 6,000	$ 6,000	$ 6,000	$ 6,000
Highly Compensated Employee Compensation Threshold	$ 125,000	$ 120,000	$ 120,000	$ 120,000
Key Employee Compensation Threshold	$ 180,000	$ 175,000	$ 175,000	$ 170,000

FIRM NEWS

Trucker Huss is pleased to announce...

- **Elizabeth (Liz) Loh** will serve on the Board of Directors for Richmond Area Multi-Services (RAMS), Inc., a San Francisco-based private non-profit mental health agency with an emphasis on serving Asian & Pacific Islander Americans.
- **Robert Gower** has been appointed to the Citizens Advisory Committee for the San Francisco County Transportation Authority (SFCTA).

On November 1, **Gisue Mehdi** and **Callan Carter** led a Business and Legal Resources (BLR) webinar titled *Health Savings Accounts: Essential Legislative and Compliance Updates for Complying with ERISA, Contribution Limits, Eligibility, 'Aging Out' and More* — discussing how companies can keep their health savings accounts in compliance with the tax code, ERISA and possible new legislation.

On November 27, **Brad Huss** presented the *Regulation and Litigation Update* at the "Best of PLANSPONSOR National Conference" session in San Francisco, addressing a range of topics related to current ERISA litigation and fiduciary responsibility issues.

On November 27, **Clarissa Kang** participated in a Strafford panel discussion regarding *ERISA Remedies: Key Enforcement Provisions and Scope of Equitable Relief for Benefit Claims*. The panel addressed matters related to ERISA claims (including proven defenses, administrative processes that must precede litigation, how the courts are handling these matters), as well as plan design and best practices.

On January 11, 10–11:30 AM PST, **Mary Powell** and Lauren Vela (Pacific Business Group on Health) will lead a webinar, co-presented by Trucker Huss and PGBH. Please join them for this group discussion on bringing "transparent thinking" to PBM management.

- Join via Zoom using this link: https://pbgh.zoom.us/j/230618300
- Or dial by your location: +1 669 900 6833 US (San Jose), +1 646 558 8656 US (New York)
- Meeting ID: 230 618 300

The Trucker ✦ Huss *Benefits Report* is published monthly to provide our clients and friends with information on recent legal developments and other current issues in employee benefits. Back issues of *Benefits Report* are posted on the Trucker ✦ Huss web site (www.truckerhuss.com).

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In response to new IRS rules of practice, we inform you that any federal tax information contained in this writing cannot be used for the purpose of avoiding tax-related penalties or promoting, marketing or recommending to another party any tax-related matters in this *Benefits Report*.

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