ERISA Plan Administrators Take Heed

In an article appearing in the February 10, 2010 editions of the Los Angeles and San Francisco Daily Journals, I discuss the impact of the Ninth Circuit's *Montour v. Hartford Life & Accident*, 588 F.3d 623 (9th Cir. 2009). Here it is:

The Employee Retirement Income Security Act of 1974 (ERISA) is certainly one of the most significant pieces of federal legislation ever enacted by Congress as it impacts the employee benefit plans and retirement funds of millions of Americans. Recently, the 9th U.S. Circuit Court of Appeals issued one of its most significant ERISA decisions in *Montour v. Hartford Life & Accident*, 588 F.3d 623 (9th Cir. 2009).

Under ERISA, when a plan participant challenges the administrator's decision to terminate or deny benefits, that decision is evaluated under either an abuse of discretion or *de novo* standard of review. ERISA litigation lawyers know well that when they are involved in litigating ERISA cases, the applicable standard of review can be outcome determinative. That is why *Montour* should be at the top of every ERISA lawyer's reading list.

In *Montour,* the 9th Circuit clarified the application of the abuse of discretion standard of review when an insurer has a structural conflict of interest. A structural conflict of interest arises when the entity making the decision whether or not to approve benefits is also the same entity that is ultimately responsible for paying those benefits. In the realm of an insured employee benefit plan, this is a common occurrence as insurers typically act as claims administrators and the funding source of ERISA benefits. Because vast numbers of ERISA plans include a provision granting the plan or claims administrator discretionary authority to interpret the plan's terms and to decide the payment of benefits under the plan, determining when and under what circumstances a conflict of interest will be so significant as to affect the outcome of the case is of course critically important.

Prior to *Montour*, but after the 9th Circuit's *en banc* decision in *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955 (9th Cir. 2006), under an abuse of discretion standard of review, a district court would generally uphold the administrator's decision provided it was grounded on any reasonable basis and made in good faith, weighing any conflict of interest of the administrator as factor in determining whether abuse of discretion existed. *See Sznewajs v. U.S. Bancorp Amended & Restated Supplemental Benefits Plan,* 572 F.3d 727, 734-735 (9th Cir.2009).

In *Abatie*, the widow of an ERISA plan participant challenged the administrator's decision to deny benefits. There, Alta Health & Life Insurance Co. was the claims administrator and also the funding source of the ERISA plan, thereby creating a conflict of interest. After addressing what language was necessary to confer discretionary review on an administrator, the court turned to the issue of how to apply that standard of review when an administrator operates under a conflict of interest. In deciding this issue, the 9th Circuit in *Abatie* overruled its prior decision in *Atwood v. Newmont Gold Co.*, 45 F.3d 1317 (9th Cir.1995). Under the *Atwood* standard, a plan participant was required to present "material, probative evidence, beyond the mere

fact of the apparent conflict, tending to show that the fiduciary's self-interest caused a breach of the administrator's fiduciary obligations to the beneficiary." If the participant did so, the burden then shifted to the administrator to prove that the conflict of interest did not affect its decision to deny benefits. If the plan could not carry that burden, a court would give no deference to the administrator's decision to deny benefits, but would instead review the decision *de novo*. Under *Abatie*, the court considered any potential conflict of interest as a *factor* in its analysis. As a factor, the court would weigh the conflict of interest in light of all the factual circumstances. For instance, the conflict of interest might receive little weight if the record was void of any evidence of malice, self-dealing, or parsimonious claims-granting history. Likewise, if the administer provided inconsistent reasons for the denial or failed to adequately investigate the claim, then the court could weigh the conflict more heavily. Moreover, the court held that the district could look beyond the administrative record to determine whether a conflict of interest existed that affected the appropriate level of judicial scrutiny. The reasoning expressed by the 9th Circuit in *Abatie* was confirmed in the U.S. Supreme Court case of *Glenn v. MetLife*, 2008 DJDAR 5285, holding that the conflict of interest was merely a factor in the analysis.

Three years after *Abatie*, the 9th Circuit returned to the conflict of interest issue in *Montour*. In *Montour*, the claimant was a telecommunications manager for Conexant Systems, Inc., which provided Montour with a group long-term disability plan governed by ERISA. Hartford was both the insurer and claims administrator and the plan granted Hartford discretionary authority to interpret plan terms and to determine eligibility for benefits.

In reversing the district court, the 9th Circuit first explained that when an ERISA plan grants the administrator discretionary authority to determine eligibility for benefits or to construe the terms of the plan, the court reviews the decision for abuse of discretion. The court agreed with the district court that the abuse of discretion standard applied and that Hartford had a conflict of interest. However, the appeals court criticized the district court's application of the "clear error" test, explaining that a reviewing court must also take into account the administrator's conflict of interest as a factor in the abuse of discretion analysis. The appeals court concluded that the district court's decision did not adequately balance the conflict factors. Accordingly, the appeals court proceeded to do so.

The 9th Circuit gave a comprehensive description of the "signs of bias" it found Hartford exhibited throughout the decision-making process. These included overstatement of and excessive reliance upon Montour's activities in the surveillance videos; Hartford's decision to conduct a paper review rather than an "in-person medical evaluation;" Hartford's insistence that Montour produce objective proof of his pain level; and Hartford's failure to deal with and distinguish the Social Security Administration's contrary disability decision. The appeals court also noted Hartford's "failure to present extrinsic evidence of any effort on its part to 'assure accurate claims assessment.'" Continuing beyond the facts in *Montour*, the court described what it believed to be common factors that frequently arise in the ERISA context including, "whether the plan administrator subjected the claimant to an in-person medical evaluation or relied instead on a paper review of the claimant's existing medical records, whether the administrator provided its independent experts "with all

of the relevant evidence[,]" and whether the administrator considered a contrary SSA disability determination, if any." Ultimately, the appeals court concluded that Hartford's bias had infiltrated the entire administrative decision-making process, leading the court to accord significant weight to the conflict of interest. Weighing all of the factors together, the court concluded that Hartford's conflict of interest improperly motivated its decision to terminate Montour's benefits. The court reversed and remanded the matter for entry of judgment in favor of Montour and for reinstatement of long-term disability benefits.

Montour makes it clear that when there is a structural conflict of interest, the district court must give the conflict adequate consideration in its analysis of whether the administrator abused its discretion. This consideration includes weighing the relevant factors in light of the factual circumstances, including the following potential "signs of bias:"

Did the insurer overstate the surveillance findings in its communications to third party medical doctors?

Did the insurer exaggerate the extent to which the claimant's activities while under surveillance where inconsistent with his claimed level of disability?

Did the insurer fail to account for a contrary decision by the Social Security Administrator that the claimant was disabled?

Did the insurer fail to adequately inform the claimant of what further evidence should be submitted to help establish his claim for benefits?

Did the insurer conduct a "pure paper" review as opposed to an independent medical examination?

Expect to see district courts focus their analysis on these and other self-interest factors as they assess how much weight to give to an insurer's conflict of interest. Also expect to see district courts applying the *Montour* analysis to find that administrators have acted in a manner that evidences their self-interest and to award more ERISA participants their benefits under insured benefit plans.

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