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This issue addresses two recent U.S. appellate court decisions in ERISA cases that involve the standard of review under ERISA, and one of which involves the definition of “own occupation” in disability cases.

ERISA Issues: Standard of Review and Meaning of “Own Occupation”

ABOUT THE AUTHOR



Cove Geary is a partner with Jones Walker LLP in New Orleans, and is Co-Chair of its Insurance Coverage Litigation Team. Cove has more than thirty years of experience in representing and advising clients in connection with life, health, disability insurance and ERISA disputes and class actions, insurance coverage, energy litigation and aviation litigation, and is recognized by Chambers USA and Best Lawyers in America®. He is an active member of the IADC Insurance and Reinsurance Committee, the Defense Research Institute’s Life, Health and Disability Insurance and ERISA Committee, and the ABA TIPS Section’s Life Insurance Law Committee (former chair) and Health Insurance Law Committee. He can be reached at cgeary@joneswalker.com.

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Bryan D. Bolton
Vice Chair of Newsletters
Funk & Bolton
bbolton@fblaw.com

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In *Rittinger v. Healthy Alliance Life Insurance Company, et al.*, No. 17-20646 (5th Cir. Jan. 31, 2019), the Fifth Circuit Court of Appeals addressed a case involving “a bariatric surgery gone wrong and the ensuing clash over insurance coverage.” *Id.* at 1. The Court’s opinion involving the application of the deferential standard of review under ERISA and the application of choice-of-law principles is instructive.

Rittinger underwent bariatric surgery, but subsequently suffered complications that required follow-up surgery and intensive care. The defendant plan administrator, Anthem, had denied the pre-authorization for both the bariatric surgery and the follow-up surgery. The denial was based on an exclusion in the Certificate that provided that the plan does not cover bariatric surgery, and that “Complications directly related to bariatric surgery that result in an Inpatient Stay or an Extended Inpatient Stay for the bariatric surgery, as determined by Us, are not covered.” *Id.* at 2. The Certificate also contained an exception to the exclusion, providing that the exclusion “does not apply to conditions including but not limited to . . . excessive nausea/vomiting.” *Id.* Anthem found that none of the medical information submitted with the pre-authorization mentioned “excessive nausea or vomiting,” and accordingly relied upon the exclusion and denied coverage. The plaintiff pursued two required internal appeals and, still dissatisfied, brought suit.

In bringing suit, plaintiff relied upon medical records that showed that she suffered from

Gastroesophageal Reflux Disease (“GERD”) and esophagitis, and argued that GERD/esophagitis is linked to nausea and vomiting, and that she underwent surgery to address these problems. The parties did not dispute that the plan properly delegated discretion to Anthem to administer the plan.

At the district court level, summary judgment was granted in favor of the plaintiff, as the Court found that the plaintiff’s evidence linking GERD/esophagitis to nausea/vomiting deserved more weight. On appeal, the Fifth Circuit reversed, found that Anthem did not abuse its discretion, and entered judgment in favor of Anthem.

First, the Fifth Circuit cited the well-established standards for an “abuse of discretion” review:

“If the plan fiduciary’s decision is supported by substantial evidence and is not arbitrary or capricious, it must prevail.” (quoting *Ellis v. Liberty Life Assurance Co. of Boston*, 394 F.3d 262,273 (5th Cir. 2004).” “Substantial evidence is ‘more than a scintilla, less than a preponderance, and is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion.’” *Ellis*, 394 F.3d at 273 (quoting *Deters v. Secretary of Health, Education & Welfare*, 789 F.2d 1181, 1185 (5th Cir. 1986).

Id. at 5. (Internal quotations included). Applying these standards, the Court observed that plaintiff challenged Anthem’s

application of the plan terms, but not its *interpretation* of the plan terms. The district court had reasoned that Anthem's distinction between GERD/esophagitis and nausea/vomiting was "sophistic" and rendered the exception to the exclusion "meaningless." *Id.* at 6. The district court had gone on to find that such "a construction that renders terms superfluous is 'contrary to the provision's plain meaning.'" *Id.* at 6.

The Fifth Circuit approached the standard of review differently. It found, "We ordinarily think of GERD/esophagitis and nausea/vomiting as two different things." *Id.* at 7. The Court observed that GERD/esophagitis and nausea/vomiting might overlap at times or in part, but also that they were separate conditions and could occur separately. The Court applied the "abuse of discretion" standard with strong language:

We are asking whether Anthem's construction **was so egregiously wrong** that it **flouts the plan's plain language** and constitutes an abuse of discretion. We cannot say that Anthem's interpretation of [the exception to the exclusion] **was so off-kilter** as to be an abuse of discretion.

Id. at 7 (emphasis added). By stating that an abuse of discretion is an interpretation that "flouts the plan's plain language," is "egregiously wrong," or is "off-kilter," the Fifth Circuit used dramatic language to demonstrate how broad the range of discretion truly is. The Fifth Circuit further

observed that two of plaintiff's prior medical providers did not mention nausea or vomiting *per se*, but only GERD and esophagitis.

The Fifth Circuit went on to observe that Anthem was not required to supply original evidence or expert witnesses: "It only needed to clear the low, more-than-a-scintilla threshold" of "abuse of discretion." *Id.* at 10. Even though the final appeal panel had not even elaborated on its reasons for the denial of coverage, the court found that the decision was not so "off-kilter" as to constitute an abuse of discretion. The *Rittinger* opinion thus stands as a strong example of the broad range of discretion that a plan administrator has when authority is so delegated under ERISA.

A second takeaway from the *Rittinger* case has to do with the choice of state law. The plaintiff had been treated at a hospital in Texas, and argued that a Texas Insurance Code provision that bans insurers' use of delegation clauses in Texas applied. However, the Court found that the case involved a plan sold in Missouri by a Missouri insurer to a Missouri employer, and that the Certificate stated that the "laws of the state in which the Group Contract was issued [Missouri] will apply." *Id.* at 4. Accordingly, the Texas Insurance Code provision did not apply.

One week after the *Rittinger* decision was issued, the Third Circuit Court of Appeals ruled on a long-term disability insurance case governed by ERISA in *Patterson v. Aetna*

Life Insurance Company, No. 17-3566 (3d. Cir. Feb. 7, 2019). At issue was the application of the term “own occupation” to a claim in which the long-term disability policy defined “disability” as requiring the plan member to be: (1) unable to perform the “material duties” of his or her “own occupation” solely because of disease or injury, and (2) if the plan member earns 80% or less of his or her adjusted pre-disability earnings. “Own occupation” was not defined in the policy.

Aetna found that Patterson was not disabled because “he could fulfill the material duties of his ‘own occupation’ as performed in the ‘national economy,’” *id.* at 2, whereas Patterson argued that “own occupation” must involve a consideration of his “actual duties” as performed in his job before the onset of the disability. *Id.* at 3. The Third Circuit, affirming the district court, agreed with the plaintiff and found that given that the ability to travel and stand in order to give presentations were material duties of his “own occupation,” Aetna had committed error in finding that “in the national economy” he could perform sedentary work and therefore was not disabled. The court also stated in footnotes that its opinion is not precedential because one of the three judges who had heard the case had retired before the filing of the opinion, and therefore the decision had been rendered by a quorum of the panel rather than the full panel. Nonetheless, it is instructive on the definition of “own occupation” and the standard of review.

The policy at issue gave the administrator discretionary authority to determine eligibility for benefits or to construe the terms of the plan. At first blush, it might seem like the Third Circuit in *Patterson* applied a far stricter standard of review than the Fifth Circuit had a week earlier in *Rittinger*, even though both were applying a deferential standard of review.

The difference in the cases is that a precedential decision of the Third Circuit of *Lasser v. Reliance Standard Life Insurance Co.*, 344 F.3d. 381 (3rd Cir. 2003) had previously held that the application of the term “own occupation” must involve consideration of the plan member’s actual duties performed before the onset of the disability. The *Patterson* court held that its “precedent – particularly *Lasser* – indicates that ‘own occupation’ is unambiguous and that Aetna’s ‘national economy’ interpretation of the term ‘cannot stand.’” *Id.* at 5. Thus, a material limitation on the deferential standard of review is that an administrator’s interpretation of its plan language is not “reasonable” if it conflicts with precedent. The Court also observed that the policy did not define “own occupation,” suggesting that if it had defined “own occupation” with a reference to “national economy,” Aetna’s interpretation might have survived scrutiny.

The *Patterson* decision also serves as a warning to disability plans that pay benefits for a number of years but then, after a review, change their position and deny benefits. The Court observed that Aetna had

paid Patterson benefits under the “own occupation” standard from 2007 to 2014, even though in 2009, an independent examination commissioned by Aetna “determined that Patterson could engage in sedentary work, i.e., work commensurate with his occupation in the national economy.” *Id.* at 8, fn. 8. The Court appeared to go out of its way to find that not only had Aetna been inconsistent in its application of the term “own occupation” to Mr. Patterson’s claim, but that the position it was taking in this case was inconsistent with a position it had taken in another case in district court in Connecticut. The *Patterson* court observed that Aetna had argued that the *Lasser* decision was not controlling because the policy in that case used the term “regular occupation,” whereas the *Patterson* policy used the term “own occupation,” suggesting that there is a distinction between those two terms. But the Court observed that in *Peck v. Aetna Life Insurance Co.*, 495 F. Supp. 2d 271 (D. Conn. 2007), Aetna had successfully argued that those terms are interchangeable. *Id.* at 7.

precedent’s interpretation of a plan term must be followed, and the deferential standard of review does not extend so far as to allow a plan administrator to re-interpret that term’s definition.

How would one reconcile the *Rittinger* and *Patterson* decisions in their application of the deferential standard of review under ERISA? The *Rittinger* case emphasizes the broad discretion that is generally accorded, allowing a decision to be upheld if “more than a scintilla” of evidence supports it, or finding an abuse of discretion standard where the interpretation “flouts the plan’s plain language,” is “egregiously wrong,” or is “off-kilter.” But that discretion is limited, as *Patterson* instructs, in that a controlling

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