1st Circuit: ERISA case subject to de novo review

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has surfaced in … later cases [from other circuits]," Judge Kermit V. Lipez wrote for the 1st Circuit panel. "Here, where we do not have procedural default and we do have out-of-circuit precedent rejecting the adequacy of 'satisfactory to us,' our acceptance of the language in *Brigham* is not binding."

In order to secure discretionary review, Lipez continued, an insurer "must offer more than subtle inferences drawn from such unrevealing language [as used in the Sun Life policy]. To conclude otherwise would negate our requirement of a clear grant of discretion."

The 61-page decision is *Gross v. Sun Life Assurance Company of Canada*, Lawyers Weekly No. 01-215-13. The full text of the ruling can be found at masslawyersweekly.com.

CASE: *Gross v. Sun Life Assurance Company of Canada*, Lawyers Weekly No. 01-215-13

COURT: 1st U.S. Circuit Court of Appeals

ISSUE: Should a trial judge have reviewed an insurer's denial of long-term disability benefits under an ERISA plan using a de novo standard rather than the more deferential "discretionary" standard?

DECISION: Yes

Effectively overruled

Jonathan M. Feigenbaum of Boston, who along with Michael D. Grabhorn of Louisville, Ky., represented the claimant, said the 1st Circuit effectively overruled *Brigham*, "which was considered one of the most unfair ERISA benefits decisions ever."

According to Feigenbaum, discretion in an ERISA benefits plan essentially insulates a profit-making fiduciary's decision from meaningful review.

"Few decisions are overturned," Feigenbaum said. "This isn't because undeserving individuals are seeking benefits. Discretionary review elevates legal procedure over the underlying facts. In long-term disability litigation, deference to the fiduciary's decision is more important than the reality of a person's condition."

Meanwhile, Feigenbaum predicted, plaintiffs will continue to have a hard time winning ERISA benefits disputes.

"This decision will, however, provide plaintiffs with a slightly better opportunity," he said. "But only when insurance regulators ban 'discretionary clauses' in all 50 states will the monumental advantage to insurance fiduciaries be tempered."

Stephen Rosenberg, a Boston ERISA lawyer who typically represents insurers and employers, described the case as a "natural culmination of years of judicial approach" in this circuit.

"Whether or not it's shown up in decisions, there's been a certain level of skepticism on how best to apply standards of review to medical evidence in these circumstances," said Rosenberg, who practices with the McCormack Firm and was not involved in the case. "It was only a matter of time before they deviated from *Brigham* and established a higher bar for obtaining discretionary review. The court makes clear — as do other circuits — that they really want to see a clear statement that 'we retain discretion' to decide the issues."

He also said the ruling extends beyond long-term disability insurance plans. In many contexts, the employer itself, rather than an insurer, provides an ERISA plan and wants to maintain discretion to determine benefits eligibility, Rosenberg explained.

"These plans are often written by an in-house benefits person or an in-house attorney who has no ERISA expertise," Rosenberg said. "Years later, when a dispute arises, the company will always want to claim discretionary review, and I think they'll have to learn from this decision that they need to use the proper language in these types of plans as well."

Marcia S. Wagner, an ERISA lawyer in Boston, said most ERISA plans already have the precise language required to obtain protection of the discretionary standard of review.

"Those employers or insurers that relied on 'satisfactory to us' language … will be required to redraft their claims provisions," Wagner said.

That will not be a difficult task, Wagner added, "and perhaps Sun Life should have known better. Once these revisions have been implemented, the standard of review issue raised by the new decision should become a historical footnote."

Insurer's counsel Joshua Bachrach of Wilson, Elser, Moskowitz, Edelman & Dicker in Philadelphia declined to comment.

Benefits denial

Plaintiff Diahann Gross, an optician and office manager for Pinnacle Eye Care in Lexington, Ky., went on disability leave in August 2006 for severe pain, weakness, numbness and recurring headaches.

Her doctor — who apparently confirmed that she was unable to work — attributed her symptoms to a variety of conditions, including reflex sympathetic dystrophy, fibromyalgia, migraines and chronic fatigue.

The plaintiff and other Pinnacle employees were covered by a long-term disability policy issued by the defendant, Sun Life.

Shortly after leaving her job, the plaintiff filed a claim for long-term disability benefits under the policy. She provided medical evidence to support her application, and Sun Life solicited more evidence to aid in its evaluation.

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>
> — Stephen Rosenberg, Boston

The insurer also hired an investigator to conduct a background check and video surveillance of the plaintiff.

In April 2007, Sun Life denied the claim, citing "insufficient objective evidence" to substantiate her disability. The defendant relied on video surveillance and opinions of consulting physicians who never actually examined the plaintiff.

Sun Life rejected her administrative appeal in January 2008.

The plaintiff ultimately sued Sun Life in Superior Court, challenging the denial on state-law grounds. The defendant removed the case to federal District Court and moved to dismiss based on ERISA preemption.

The court granted Sun Life's motion, and the plaintiff amended her complaint to challenge the denial under ERISA. She also asked the U.S. District Court to apply de novo review in evaluating her claims.

Judge Rya W. Zobel denied her request and dismissed the suit, finding that Sun Life's decision to deny benefits was not arbitrary and capricious.

The plaintiff appealed.

De novo review

On appeal, the 1st Circuit rejected Sun Life's contention that, under *Brigham*, the policy language at issue was clear enough to grant discretionary authority to determine benefits eligibility as a matter of law.

Brigham hinged on two critical factors missing from *Gross*, Lipez said.

First, the plaintiff in *Brigham* never advocated for de novo review until the appeal, having instead assumed throughout the trial court proceedings that the discretionary standard applied.

"We saw no injustice in rejecting *Brigham*'s belated argument based on our well established raise or waive rule, and without 'undertak[ing] a thorough exploration of the issue,' in light of the 'widespread acceptance' by courts at that time that the phrase 'satisfactory to us' triggers discretionary review," Lipez said.

Additionally, the legal landscape has changed in the decade since *Brigham*, with three different federal circuits finding that "satisfactory to us" policy language is not enough by itself to confer discretion, Lipez said.

"The procedural backdrop of *Brigham* and the intervening circuit court decisions mean that the standard of review issue in this case cannot be resolved, as Sun Life cursorily asserts, on the ground that it is governed by *Brigham*," the judge said.

Accordingly, Lipez said, "the time is now appropriate for the 'thorough exploration of the issue' that we put off in *Brigham*."

Having fully considered the issue, "we agree with those courts holding that the 'satisfactory to us' wording, without more, will ordinarily fail to meet the 'requisite if minimum clarity' necessary to shift from de novo to deferential review," Lipez said, quoting the 7th U.S. Circuit Court of Appeals' 2000 decision in *Herzberger v. Standard Ins. Co.*

The 1st Circuit was persuaded particularly by the ambiguity of the phrase, which could be construed to state the insurer's right to insist on certain forms of proof as opposed to conferring upon itself the discretion to determine benefits eligibility.

"Indeed, in the present context, the language more naturally supports the former reading," Lipez said, reiterating that while no specific words are required for an insurer to retain discretion, a policy must contain more than subtle inferences drawn from general, unrevealing language.

Accordingly, the 1st Circuit vacated Zobel's judgment and remanded the case to the District Court for further development of the record to enable a de novo review. MLW