The Practical Impact of Ariana M. v. Humana Health Plan of Tex., Inc. on ERISA Denials of Benefits

By Patrick Ouellette, Esq.

The abuse of discretion standard has long been a proverbial ace in the hole for self-funded employee benefit plan administrators in making factual determinations that, while perhaps not popular with the participant, they believed were consistent with the terms of the plan document.

While the recent *Ariana M. v. Humana Health Plan of Tex., Inc.* is noteworthy for many reasons, the most immediate effect will be on the Fifth Circuit's allowance of plan administrator discretion in making factual determinations.

The Fifth Circuit finally joined the fraternity of all other circuit courts that has held decisions made by plan administrators under ERISA Section 1132(a)(1)(B), whether legal or factual, are to be reviewed using a default de novo standard. In addition to introducing consistency across the circuit courts regarding standard of review, the en banc holding in *Ariana M. v. Humana Health Plan of Tex.*, Inc. greatly reduced the amount of inherent deference granted to plan administrators for factual determinations.

Self-funded employee benefit plans should be aware of the repercussions of no longer having the abuse of discretion standard available in the Fifth Circuit if there is an appeal regarding its factual determinations relating to, for instance, a denial of benefits.

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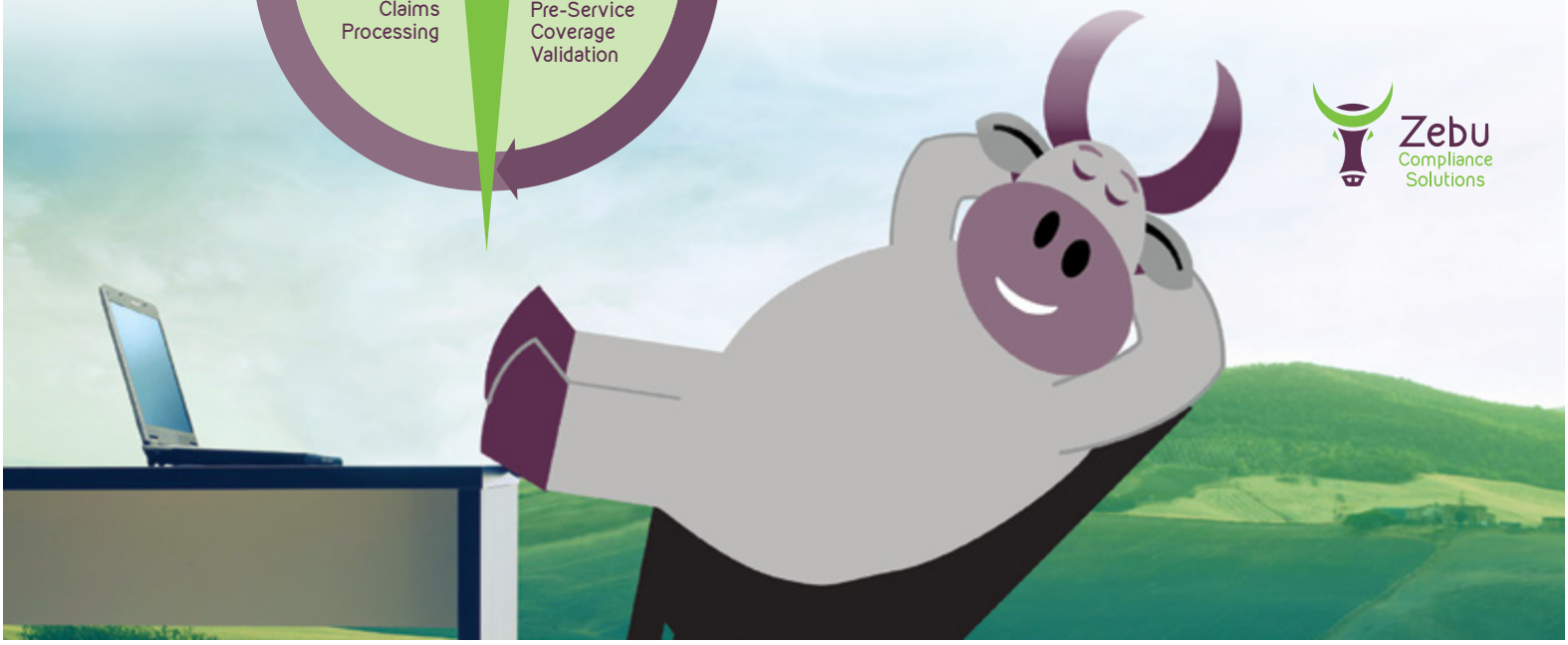


Prior to this decision, every other circuit court except the Fifth Circuit had applied a de novo review when an ERISA plan document does not expressly grant discretion to plan administrators.

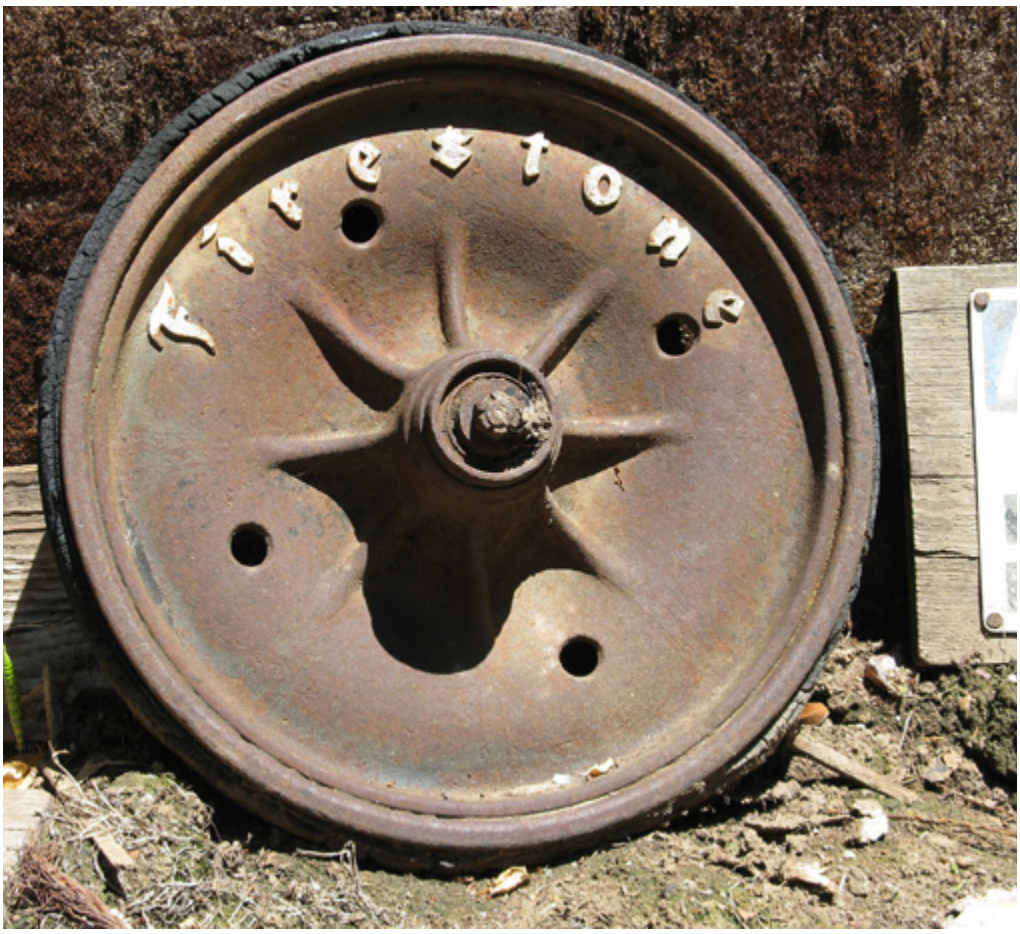
These courts based their rationale on the fact that the famed *Firestone Tire & Rubber Co. v. Bruch* case does not make a distinction between a trustee's legal interpretations versus their factual decisions regarding the requirement for de novo review.

Ariana M. v. Humana Health Plan of Tex., Inc. is legally significant because Fifth Circuit had long held that, under ERISA, a plan administrator was entitled to an abuse of discretion standard of review with respect to its factual determinations.

In short, the court to this point had given plans the benefit of the doubt for factual determinations unless the plan had made an unreasonable decision. Now these administrators will be held to the de novo standard, without deference to its factual findings.

This shift the court considering an issue for the first time without this deference will likely affect how and under what circumstances plan decisions are made.

Thus, it is critical to also consider the practical impact that the holding will have on plan administrators that have relied for years upon Fifth Circuit providing them with this high degree of discretion in making factual determinations even when a plan has not expressly granted them that discretion.



Fifth Circuit Standard of Review Background

Employers, and the plan administrators, traditionally have broad discretion to determine how plan terms will be used, as well as to decide which entities will have the authority to make benefits determinations, factual determinations, appeals determinations, and language interpretations.

The Supreme Court in *Firestone* held that only if a plan explicitly delegated authority to a plan administrator, the decision would be reviewed under a heightened "abuse of discretion" standard. The Court famously stated a "denial of benefits challenged under § 1132(a)(1)(B) 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."

If there was no express delegation, however, the Court held that courts would need to review a denial of benefits challenged under ERISA using a de novo standard. The holding did not directly clarify whether it was referring to both legal interpretations and factual determinations for the de novo standard.

In *Ariana M. v. Humana Health Plan of Tex., Inc.*, the Humana Health Plan of Texas argued that it had a discretionary clause granting to Humana "full and exclusive discretionary authority to: [i]nterpret plan provisions; [m]ake decisions regarding eligibility for coverage and benefits; and [r]esolve factual questions relating to coverage and benefits."

Due to a Texas antidelegation statute making discretionary clauses unenforceable, Humana agreed not to use the argument that the plan document gave it direct authority. Notably, the court remained silent on whether ERISA preemption came into play because Humana did not raise the argument.

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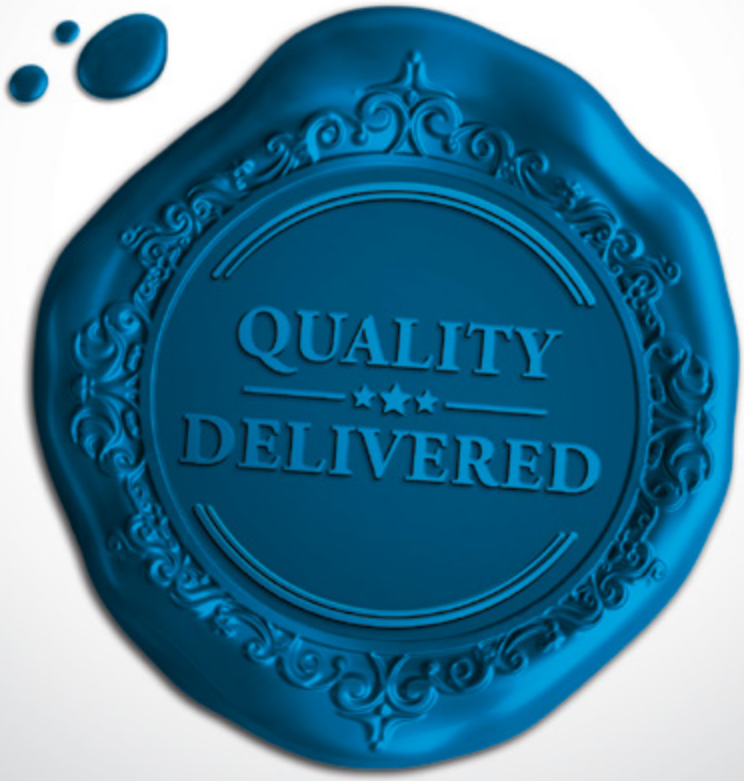

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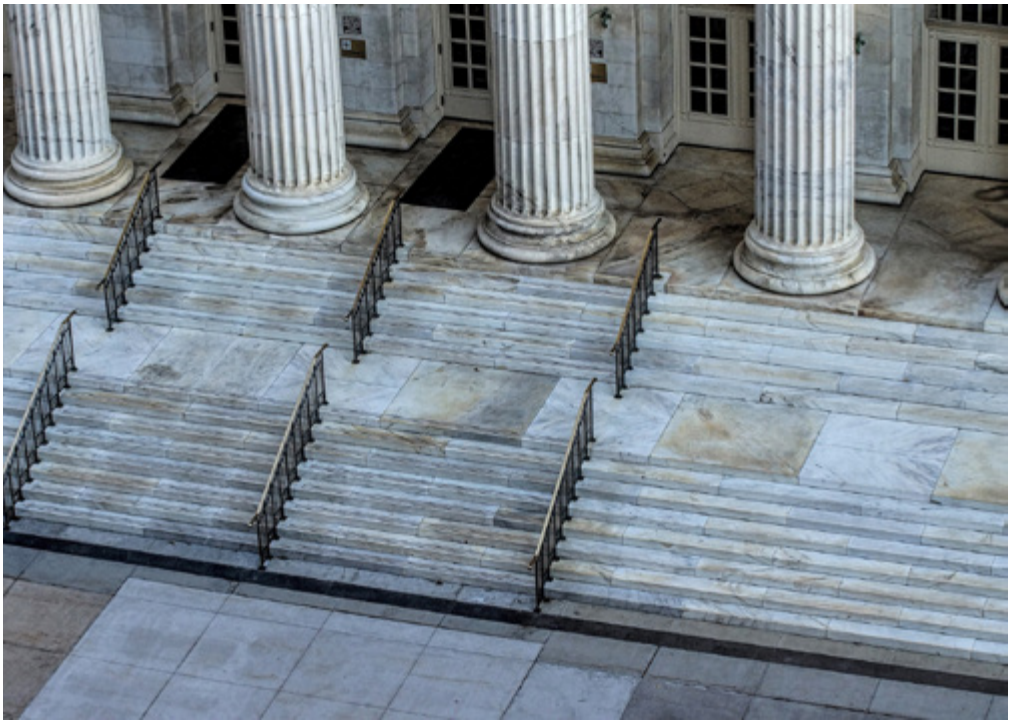
Instead, Humana relied upon the Fifth Circuit's holding in *Pierre v. Conn. Gen. Life Ins. Co.* to argue that for factual determinations under ERISA plans, the abuse of discretion standard of review is the appropriate standard and therefore it had not abused its discretion in making its determination. The Fifth Circuit granted en banc review to reconsider *Pierre* and determine the default standard of review that would apply in these situations.

The Fifth Circuit's decision in *Ariana v. Humana Health Plan of Texas* essentially reversed its own interpretation of *Firestone* in *Pierre*. According to *Pierre,* without delegation of authority to a plan administrator, challenges to a *legal* interpretation of a plan should be considered under a de novo standard of review while factual determinations were to be under an abuse of discretion standard of review. The *Pierre* court based its reasoning on the concept that an administrator's factual determinations are inherently discretionary and the Restatement (Second) of Trusts supports giving deference to an ERISA plan administrator's resolution of factual disputes even when the plan does *not* grant discretion.

The *Ariana* court essentially held that *Pierre's* interpretation is no longer good law, despite some strong dissenting opinions, including from Judge E. Grady Jolly, who authored *Pierre*. The dissent focused its dissatisfaction with the majority's opinion on the discrepancy between legal analysis and credibility determinations and a lack of express authority in *Firestone*.

Factual Determinations That May Now Be Subject to De Novo Review

Now that *Ariana* held that *Firestone's* default de novo standard applies when the denial is based on a factual determination, it is worthwhile to see how this change would play out in the types of factual determinations that plan administrators make on a regular basis.



This is not intended to be an exhaustive list of decisions that will be affected, but instead meant to illustrate the types of complications that *Ariana* could create for plan administrators if they are a party to case that reaches the Fifth Circuit.

First and foremost, Humana Health Plan of Texas in *Ariana* used its discretion to decline to allow partial hospitalization for Ariana beyond June 5th, claiming it was no longer medically necessary. Using *Pierre's* precedent, the district court concluded only that "Humana did not abuse its discretion in finding that Ariana M.'s continued treatment at Avalon Hills was not medically necessary after June 4, 2013."

Plan administrators are often making factual decisions as to whether treatment is "medically necessary" and therefore whether it should provide coverage according to the terms of the plan document. In the Fifth Circuit, these plans were granted broad deference regarding these determinations because of its decision in *Pierre*. Similar to the rest of the circuit courts, medical necessity determinations are now subject to de novo review.

However, *Ariana* is merely the tip of the iceberg in that these types of factual determinations are not limited only to questions of medical necessity.

Another determination in which plan administrator discretion is paramount is the application of plan document exclusions, such as excluding coverage if the treatment or care was the result of illegal or hazardous activity. Each plan document has its own set of exclusions that it can choose whether or not to apply to a given set of facts, but the Fifth Circuit had traditionally separated itself from the rest of the circuit courts up until this point as to the standard by which these exclusion determinations would be judged.

Anyone who works in the self-funded industry knows how controversial and fact-dependent the practice of excluding participant claims can be for a plan administrator. Without an abuse of discretion standard and de novo standard now in place, however, these administrators may potentially be more wary to automatically exclude a plan participant's claims due to an illegal or hazardous activity exclusion if, for example, the facts are unclear.

Next, plan administrators often make plan eligibility decisions that will be affected by the *Ariana* decision in the Fifth Circuit. These determinations will include, for instance, whether spouses are eligible for coverage after they dropped their own plan based on the plan's eligibility language. Previously free from the potential second-guessing involved in with the de novo standard of review, administrators now more than ever will need to be sure to document their coverage decisions based on the plan document language and be able to defend them in court if necessary.

Administrators also make factual determinations regarding administration of high-deductible health plans (HDHPs), health savings accounts (HSAs), flexible spending accounts (FSAs). Some prime examples of these administrative issues would be deciding which items covered under an HSA would be deemed "preventive" or whether the plan had avoided first-dollar coverage under an HDHP. Similar to the above, the Fifth Circuit will now view the process of how these factual decisions were made in a much different light.

Finally, now that these plan administrators are subject to the de novo standard of review instead of abuse of discretion review, they should remember the ERISA requirement that factual determinations must be made consistently in similar scenarios in the future. Though this is not necessarily a novel consideration for plan administrators, it is a worthwhile reminder that decisions made under this "new" standard of review will be used as precedent for its decisions made in the future as well, adding to the weight of these determinations. ■

Patrick Ouellette, Esq. joined the Phia Group in 2017. He earned his B.A. in journalism and writing from the University of Rhode Island and spent time as a sports writer and also as a healthcare technology journalist. He later graduated from the Suffolk University Law School evening program with a health and biomedical concentration with distinction. Patrick has legal experience with healthcare providers and in state government. He was also a published staff member of the Suffolk University Law School Journal of Health and Biomedical Law and later served as Chief Content Editor on the journal's executive board.