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STANDARD OF REVIEW IN COVERAGE DISPUTES OVER POLICIES GOVERNED BY ERISA MAY BE HEADED TO SUPREME COURT

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Earlier this month, the 3rd Circuit took the minority side on an issue affecting life and health insurers that appears headed for the Supreme Court. In *Viera v. Life Insurance Company of North America* (June 10, 2011), the court held that an insurance company did not adequately communicate to policyholders that it retained broad-ranging authority to assess compliance under a group accidental death and dismemberment policy governed by ERISA. The court reached this holding even though the relevant policy made clear that the insurance company required proof of loss "satisfactory to Us," language commonly found in such policies.

Not surprisingly, the parties to the dispute submitted conflicting expert testimony regarding the cause of the policyholder's death. The policyholder was in a motorcycle accident and taken to a local hospital, where he died shortly thereafter. The insurance company refused to accept the policyholder's estate's claim for proceeds under the accidental death policy based on an expert report that his death was hastened by anti-clotting medication in his bloodstream.

Judge Eduardo Robreno of the Eastern District of Pennsylvania viewed the dispute very favorably for the insurance company, noting that the company advised policyholders that claims of loss would need to be "satisfactory to Us," *i.e.*, satisfactory to the company. Because the company retained discretion to assess compliance with the policy, the district court held that the appropriate standard of review was whether the insurance company abused its discretion in denying coverage.

This holding aligned with Supreme Court precedent and the holdings of six courts of appeals to consider this question (1st, 4th, 6th, 8th, 10th, and 11th Circuits). The Supreme Court has held that "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." *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101, 115 (1989) (emphasis added). If a plan gives the administrator or fiduciary discretionary authority to make eligibility determinations, courts will review its decisions under an abuse-of-discretion (or arbitrary and capricious) standard. Obviously, the latter standard is more favorable to insurance companies. On abuse-of-discretion review, a claim decision will be reversed only if it is "without reason, unsupported by substantial evidence or erroneous as a matter of law."

The difference in the two standards of review could mean the difference in millions of dollars each year to life and health insurance companies. Certainly under the *de novo* standard, summary judgment will be much more difficult to obtain in all cases (thereby allowing plaintiffs to impose costs on insurance companies and/or extract larger settlements).

This is a dispute that the Supreme Court should resolve. Six circuits have interpreted the same policy language to require abuse-of-discretion review, while the 3rd Circuit joins the 2nd, 7th, and 9th Circuits in reaching the opposite conclusion. Further percolation of the conflict in the lower courts will only sow confusion and unfairness. Moreover, this threshold issue is one that figures prominently in almost *every* denial-of-coverage lawsuit. It is time for the Court to settle the question.

To discuss any questions you may have regarding the opinion discussed in this Alert, or how it may apply to your particular circumstances, please contact Stephen A. Miller at samiller@cozen.com or 215.665.4736.