Fifth Circuit Standard of Review
Reconsidered for Benefit Denial Cases

The U.S. Court of Appeals for the Fifth Circuit grants the plaintiff health care plan beneficiary’s request to reconsider the 1991 court decision in Pierre v. Connecticut General Life Insurance Company, 932 F.2d 1552 (5th Cir. 1991), which created a circuit split and established a bifurcated standard of review for challenges to the denial of benefits under the Employee Retirement Income Security Act of 1974 (ERISA). The court now agrees with all other circuit courts and finds that the standard of review does not depend on whether the denial is deemed to be based on legal or factual grounds but rather whether the relevant plan has delegated discretion. The court instructs the district court to reconsider the plaintiff claims regarding a denial of benefits by the defendant insurance company using the de novo standard of review.

In this case, the plaintiff is a dependent covered by an insured group health plan sponsored by the employer of the plaintiff’s parent. The defendant insures and makes benefits determinations for the plan. When the plaintiff was admitted for partial hospitalization to treat an eating disorder, the defendant authorized 49 days of coverage and found that partial hospitalization after that time was no longer medically necessary. The plaintiff’s appeal was denied, and the district court found that because the plan included a clause granting the defendant full and exclusive discretionary authority to interpret the plan, the abuse of discretion standard was appropriate. Using this standard, the district court found that the defendant did not abuse its discretion and granted its motion for summary judgment. Although the plan contained a discretionary clause, Texas state law prohibits discretionary clauses and makes them unenforceable. But Texas law does not prescribe the applicable standard of review for federal courts deciding ERISA cases. A panel of this court affirmed and relied on Pierre to find that abuse of discretion was the appropriate standard of review when reviewing an administrator’s factual determination, regardless of whether the ERISA plan contains a discretionary clause. Despite the deference to Pierre, the entire panel joined a concurring opinion questioning the Pierre decision because every other circuit considering the standard of review issue has decided otherwise. This court now grants the plaintiff’s request for full court reconsideration of Pierre.

In Firestone Tire & Rubber Co. et al. v. Bruch et al., 489 U.S. 101 (1989), the Supreme Court held that when an ERISA plan lawfully delegates discretionary authority to a plan administrator, a court reviewing the denial is limited to assessing whether the administrator abused that discretion. For plans that do not have a valid delegation clause, the Supreme Court held that a denial of benefits is to be reviewed under a de novo standard. In Pierre, this court interpreted that holding to apply only to a denial of benefits based on an interpretation of plan language. It held that “for factual determinations under ERISA plans, the abuse of discretion standard of review is the appropriate standard; that is, federal courts owe due deference to an administrator’s factual conclusions that reflect a reasonable and impartial judgment.” Since that holding in 1991, all other courts of appeals

continued on page 58
have taken the view that the standard of review does not depend on whether the denial is deemed to be based on legal or factual grounds.

All but one of the other courts of appeals have had the opportunity to consider Pierre and have rejected its reasoning due to a disagreement with its reading of Firestone. In Firestone, the Supreme Court stated that “a denial of benefits challenged under ERISA Section 502(a)(1)(B) is to be reviewed under a de novo standard unless the plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or construe the terms of the plan.” The first part of the Supreme Court position referring to a denial of benefits does not distinguish denials that rest on contractual interpretation from those based on a factual assessment of eligibility—Any denial is to be reviewed under a de novo standard. The second part makes a distinction in excepting denials when a plan delegates discretionary authority, and the other courts have questioned why a discretionary clause would be needed to escape de novo review if eligibility determinations were not subject to that standard as a default. In addition, Firestone states that the court expressed no view as to the appropriate standard of review for actions under other remedial provisions of ERISA, which suggests that it was articulating a general default standard of review for ERISA Section 502(a)(1)(B) actions rather than making the fine distinction that Pierre saw between the review of factual determinations and legal determinations. Pierre also predicted that de novo review of factual determinations would result in a vast number of trials that would burden courts and reduce the funds available to pay legitimate claims. However, since this time, there has been no indication that ERISA trials have depleted plan funds or overrun courts in the circuits using the de novo standard of review.

Based on several arguments outlined above, this court concludes that the critiques of other circuits warrant changing course and adopting the majority approach. The court is also influenced by the strong interest in uniformity in ERISA, since being the only court on this side of a split means that ERISA denials in Texas, Louisiana and Mississippi are reviewed with more deference than they are in the rest of the country. Employees working for the same company with the same health or retirement plan may suffer different fates in court depending on the circuit where they reside. Changing the standard of review does not require the court to alter its precedent concerning the scope of the record in ERISA cases. In a 1999 decision by this court, it established an interest in encouraging parties to resolve their dispute at the administrative stage by limiting district courts to reviewing only the administrative record, with few limited exceptions. This decision, along with overruling Pierre, serves the twin ERISA goals of allowing for efficient yet meaningful judicial review.

Due to the delegation clause being unenforceable, the appropriate standard of review here is de novo instead of abuse of discretion. Because a different standard of review may or may not lead to a different outcome, the court now vacates the judgment of the district court and remands for further proceedings consistent with this opinion.

Ariana M. v. Humana Health Plan of Texas, Inc., No. 16-20174 (5th Cir. March 1, 2018).