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TOPIC: ERISA Fiduciary Obligations: Application for Life Insurance Coverage

CITES: Silva v. Metropolitan Life Insurance Company, 2014 WL 3896156 (U.S. Ct App, 8th Cir, Aug 7, 2014); *CIGNA Corp. v. Amara*, 131 S.CT. 1866 (2011); 29 U.S.C. §§ 1001 et seq.

SUMMARY: The Eighth Circuit Court of Appeals reversed a grant of summary judgment on the right of a deceased employee's beneficiary to death benefits under a supplemental life insurance plan where the employee had failed to complete the health forms required for coverage but had enrolled on line and premium contributions had been deducted from his pay. While the appellate court acknowledged that the applicable standard of review under ERISA is whether the administrator abused its discretion to interpret and apply the terms of the plan, the court concluded that there were outstanding issues of material fact that could lead to the conclusion that there had been such an abuse of discretion, particularly in light of the conflict of interest of the insurer administrator. The appellate court also overturned the districts court's refusal to allow an amendment to the complaint to seek equitable relief under ERISA based on futility, holding that make-whole monetary damages are available as an equitable remedy under ERISA.

FACTS: Abel Silva (Abel) died on June 27, 2010 and his father (Plaintiff) sought to recover life insurance benefits under a supplemental life insurance plan sponsored by Abel's employer (the Plan). The insurer and plan administrator, Metropolitan Life Insurance Company denied Plaintiff's claim, asserting that Abel did not have coverage because he had not completed the required paperwork regarding evidence of insurability. Abel's father brought suit against MetLife and the employer, Savvis Communications Corporation (together, the Defendants) under ERISA. The district court granted summary judgment to Defendants because it found that Abel did not qualify to receive benefits under the Plan. The district court also denied the Plaintiff the right to amend his compliant to seek equitable relief under ERISA because the only relief available was compensatory rather than equitable.

Abel had originally declined coverage under the Plan but had later applied for coverage online and premium payments had been withheld from his pay. However, he apparently never completed a statement of health that was required for participation in the Plan. After Abel died, MetLife denied him coverage even though premiums had been paid because he had failed to complete the paperwork required for qualification for coverage. It was subsequently found that as many as 200 other employee participants in the Plan had also failed to complete the required health form. The appellate court also noted that the requirement for completion of the health statement was not clear in the Plan document. The Plan document was over 100 pages long and supposedly doubled as the Summary Plan Description, even though the court did not find it to be "a condensed and understandable plan explanation" nor to be written in "plain and simple terms" under the ERISA mandate for summary plan descriptions.

While the appellate court acknowledged that the applicable standard of review when an ERISA plan grants an administrator plenary discretion to interpret and apply the terms of the plan is whether the administrator abused such discretion, the court noted that a higher standard needed to be applied where the administrator had a conflict of interest. In this case, since MetLife was both the administrator *and* the payor, it clearly had a conflict of interest in making the determination regarding coverage.

Keeping in mind MetLife's conflict of interest, the court looked at the following five factors to determine whether MetLife's denial of coverage was an abuse of discretion:

> (1) whether the administrator's decision is contrary to the clear language of the plan;
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> (2) whether the interpretation conflicts with the substantive or procedural requirements of ERISA;
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> (3) whether the interpretation renders any language in the plan meaningless or internally inconsistent;
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> (4) whether the interpretation is consistent with the goals of the plan; and
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> (5) whether the administrator has consistently followed the interpretation.

The appellate court found that additional facts were necessary in order to address these factors such as:

> (a) what had been communicated to Abel regarding the statement of health form requirement through the online prompt or otherwise,
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> (b) what information was included in the statement, and
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> (c) whether Abel's allegedly healthy, daily presence at work could be sufficient to establish insurability.

Because there were outstanding issues of material fact, the court concluded that it was not appropriate for the district court to enter summary judgment on the issue of abuse of discretion.

The appellate court went on to address the refusal of the district court to allow the Plaintiff to amend the complaint to request "other appropriate equitable relief" under ERISA provided in 29 U.S.C. Section 1132(a)(3). While the district court had found that there was "good cause" for such an amendment due to later-discovered facts, the district court denied the request because it concluded that the amendment was futile. The appellate court disagreed. It noted three possible grounds for equitable relief for breach of fiduciary duty. First the court noted the possible basis for equitable remedy based on the failure of the administrator to provide a summary plan description. Second the court noted that Plaintiff may be able to show mutual mistake, or fraud of one party and mistake of the other. Finally the court noted that an equitable estoppel argument might be made based on MetLife's collection of premiums and Abel's reliance on that collection as proof that he had coverage. The appellate court rejected the district court's conclusion that monetary compensation was not available as an equitable remedy citing the Supreme Court's recent discussion in *CIGNA Corp. v. Amara*. The appellate court determined that *Amara* had changed the law as previously interpreted by prior case law and that "make-whole, monetary relief" is available under § 1132(a)(3).

RELEVANCE: This case illustrates the importance of insurance companies and other plan administrators providing covered employees with clear understandable communications, including condensed user-friendly summary plan descriptions (SPDs) and on-line enrollment materials, as well as carefully advising participants regarding the requirements for obtaining coverage and monitoring the status of that coverage.

***WRNewswire* #14.9.02 was written by Marla Aspinwall of Loeb & Loeb, LLP.**

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