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THE CONFLICT OF INTEREST STANDARD IN ERISA CASES: CAN IT BE AVOIDED IN THE DENIAL OF HIGH DOSE CHEMOTHERAPY TREATMENT FOR BREAST CANCER?

Judith C. Brostron

INTRODUCTION

Breast cancer is currently the second leading cause of cancer deaths among American women. One out of every eight women in the United States will develop breast cancer at some time over the course of her lifetime. The overall five-year relative survival for breast cancer is seventy-five percent.

While advances in the treatment of breast cancer have been made over the last twenty years, the long-term prognosis remains dismal for metastatic cancer after treatment with conventional-dose chemotherapy.
Over the past ten years, high-dose chemotherapy followed by an autologous bone marrow transplant (HDC-ABMT) has been used for the treatment of metastatic cancer. Studies have shown that HDC-ABMT results in higher rates of complete remission than generally seen in conventional-dose chemotherapy regimens for patients with metastatic breast cancer. Disease free survival at two to five years is reported in ten to thirty percent of patients. Some reports indicate that autologous bone marrow transplant (ABMT) extends the life of the women with stage IV breast cancer for three to five years in fifty percent of the cases studied.

The purpose of the HDC-ABMT procedure is to administer higher
than normal doses of chemotherapy in an attempt to kill cancer cells. The main side effect of the chemotherapy is that in addition to killing cancer cells, it also destroys the bone marrow which is responsible for making new cells. The procedure consists of removing stem cells from the patient's bone marrow or blood stream and freezing the cells for later use. After the administration of the high-dose chemotherapy the stem cells are given back to the patient in an effort to "rescue" the bone marrow and help to produce cells. The woman is usually kept in isolation until her blood tests indicate that she is producing white blood cells to fight infection.

ABMT costs from about $80,000 to over $150,000 compared with about $15,000 to $40,000 for conventional-dose chemotherapy. Several studies have indicated that conventional-dose chemotherapy is cost effective. In an early study, chemotherapy benefitted all women at a cost of $4,500-$9,000 per quality-adjusted life-year. One study calculated the cost-effectiveness ratio of ABMT at $97,000 per quality adjusted life year which is at least ten times that of standard chemotherapy.

Some insurance companies deny coverage for HDC-ABMT under policy exclusions for experimental or investigational treatment. A study and fight infections, the patient's concentrated stem cells are thawed and infused after chemotherapy. When the transplant is done from the blood rather than the bone marrow, the procedure is often referred to as peripheral blood stem cell transplantation.


See id.

See id.

See id.

See Melody L. Harness, What is "Experimental" Medical Treatment?: A Legislative Definition is Needed, 44 CLEV. ST. L. REV. 67, 72-74 (1996) (discussing off-label drugs; the drugs are not Food and Drug Administration (FDA) approved in the doses given).

See Holland, supra note 8, at 1160. In one study involving ABMT and peripheral blood stem cell rescue (PBSC) the median time to achieve neutrophil recovery was twelve days for both the bone marrow recipients and the PBSC recipients. See id.

See G.A.O. Report, supra note 1, at 3.

See id.

See Smith, supra note 3, at 67. Conventional chemotherapy is about as cost effective as treating hypertension. See id.

See id.

See G.A.O. Report, supra note 1, at 5. See also Michael J. Brandi, The Paradox of Technological Progress in Health Insurance Contracts: "Experimental Treatment Clause" and Breast Cancer, 2 CONN. INS. L. J. 243, 247 (1996) (stating that the majority of insurance policies contain some form of coverage limitation for treatment not considered "standard" or commonly
done in 1996 by the General Accounting Office indicates that some insurers cover HDC-ABMT based on the clinical evidence of effectiveness, fear of litigation and adverse public relations.\textsuperscript{22} Many states require private insurers to cover HDC-ABMT through mandated insurance benefit laws.\textsuperscript{23} Some state medicaid programs cover HDC-ABMT.\textsuperscript{24} The Federal Employees Health Benefits Program also covers HDC-ABMT.\textsuperscript{25}

Many lawsuits have been filed by patients who have been denied HDC-ABMT by their insurance plans.\textsuperscript{26} Since the majority of employed individuals obtain their insurance coverage from their employers, most cases involving the denial of insurance benefits are subject to the Employee Retirement Income Security Act of 1974 (ERISA).\textsuperscript{27}

When an insurance company administers an ERISA plan under a policy it issued, a conflict of interest exists.\textsuperscript{28} The Circuit Courts have applied different standards of review in ERISA denial of benefits cases

\textsuperscript{22}See G.A.O. Report, supra note 1, at 2. The health insurers interviewed for the G.A.O. Report were Aetna Health Plans, Anthem Health Plan of Florida, Blue Cross and Blue Shield of Oregon, C.N.N. Insurance, Harvard Pilgrim Health Care, HealthGuard of Lancaster, HealthPartners, Kaiser Permanente, Mutual of Omaha, Prudential HealthCare Group, United HealthCare (formerly Meta Health), and United HealthCare of Ohio. See id. See also Deborah Shalowitz Cowans, Experimental Treatment Being Covered, MODERN HEALTHCARE, June 17, 1996, at 56 (listing several factors as responsible for the increased willingness of health insurers to pay for experimental treatment including clinical evidence of the treatment’s success, fear of litigation, adverse publicity for denying coverage, and state laws mandating coverage).

\textsuperscript{23}See Provider Contracting & Capitation: State Benefit Mandates Force Contract Change for Plans, MANAGED CARE WK., Feb. 17, 1997., at 30-31. The article opines that state mandates drive up health insurance coverage. Blue Cross & Blue Shield reports monthly premiums for small groups increasing from 5% in Mississippi to 21% in Virginia as a direct result of mandated benefits in fifteen states. See id.

\textsuperscript{24}See G.A.O. Report, supra note 1, at 2.

\textsuperscript{25}See id.

\textsuperscript{26}See G.A.O. Report, supra note 1, at 2.

\textsuperscript{27}See id.

\textsuperscript{28}See 29 U.S.C. § 1001 (1994). Seventy-five percent of employer provided health insurance plans are subject to the Employee Retirement Income Security Act of 1974. See Barry R. Furrow, Managed Care Organizations and Patient Injury: Rethinking Liability, 31 GA. L. REV. 419, 494 (1997); See also Berkeley Rice, Look Who's on the Malpractice Hot Seat Now; But Don't Think Doctors Are Off the Hook, MED. ECON., Aug. 12, 1996, at 200 (noting that health insurers increasingly pay for ABMT because “they're tired of being sued and there's so much public pressure for this”). Under ERISA suit can be brought for the cost of the benefit denied only. The plaintiff may not sue to recover lost wages, pain and suffering or physical injury. See id. at 192.

\textsuperscript{29}See Brown v. Blue Cross & Blue Shield of Ala., Inc., 898 F.2d 1556, 1561 (11th Cir. 1990).
when there is a conflict of interest. The standards have been inconsistently applied.29 The specific contract language limiting coverage may not be enforced when there is a conflict of interest.30

This article focuses on the denial of benefits for HDC-ABMT in an ERISA plan when there is a conflict of interest. The background information discusses HDC-ABMT as a treatment for breast cancer and other forms of cancer. It also explains the background material for ERISA regarding the denial of benefits when a conflict of interest exists. This section includes a discussion of the Supreme Court case of Firestone Tire & Rubber Co. v. Bruch and the de novo and arbitrary and capricious standard of review. The standards of review section identifies the criteria for determining when a conflict of interest exists and analyzes the case law and the tests utilized by the Circuit Courts for reviewing denial of ERISA benefits cases where there is a conflict of interest. It also hypothesizes that a conflict of interest standard provides the reviewing court with an opportunity to circumvent the coverage specified in the insurance contract. This occurs despite the amount of deference that should be accorded to the fiduciary under the "abuse of discretion" or "arbitrary and capricious" standard of review. Finally, suggested recommendations for insurance companies to avoid the conflict of interest standard, and for limiting coverage for experimental treatment are discussed.

BACKGROUND

High-Dose Chemotherapy With Autologous Bone Marrow Transplantation (HDC-ABMT)

Every year hundreds of thousands of women are diagnosed with breast cancer.31 The treatment for breast cancer depends on the clinical stage of the cancer when it is diagnosed.32 There are four clinical stages of breast

29See id.
30See id.
31See Smith, supra note 3, at 67. Each year, 182,000 women are diagnosed with breast cancer. See id.
32See G.A.O. Report, supra note 1, at 4. The treatments for breast cancer are surgery, chemotherapy, radiation therapy, and hormone therapy. See id.
cancer. Women with stage I breast cancer, in which the cancer is confined to the breast tissue only, have an excellent chance of long term survival. Stage IV breast cancer, in which the cancer has spread or metastasized from the breast tissue to the skin or other organs, is usually fatal even with conventional treatment.

One of the treatments for metastatic breast cancer (stage IV) is HDC-ABMT. HDC-ABMT for the treatment of metastatic breast cancer is controversial. Experts claim that the clinical research has not yet proven that HDC-ABMT is more effective than conventional-dose

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33The four clinical stages of breast cancer, increasing in severity from Stage I to Stage IV (metastatic) breast cancer are as follows:

Stage I:
(a) A tumor which is two centimeters or less in its greatest dimension;
(b) No involvement of axillary lymph nodes; or
(c) No evidence of distant metastases.

Stage II:
(a) A tumor two centimeters or less in its greatest dimension with positive axillary nodes and no distant metastases; or
(b) A tumor more than two but less than five centimeters in its greatest dimension with or without axillary lymph node involvement and no distant metastases.

Stage III:
(a) Tumors between two and five centimeters in their greatest dimension with positive axillary nodes fixed to one another or to other structures and no distant metastases; or
(b) Tumors greater than five centimeters in their greatest dimension with or without axillary lymph node involvement and no distant metastases.

Stage IV:
(a) A tumor of any size with direction extension to chest wall or skin;
(b) Any tumor with involvement of homolateral supra-clavicular or infraclavicular lymph nodes; or
(c) Any tumor with distant metastases including skin involvement beyond the breast area.
chemotherapy. While many phase I and phase II clinical trials have been performed to assess the efficacy of HDC-ABMT for breast cancer most experts agree that phase III randomized clinical trials are necessary to establish that high dose chemotherapy is superior to conventional-dose chemotherapy.

Until now, no large randomized clinical trials in the United States have been completed. Most patients do not want to risk being randomized to the arm of low-dose or standard-dose chemotherapy. There are two major reasons for this apprehension. First, there is a fifty percent chance that a patient will not receive the high dose chemotherapy in a randomized trial. Second, few insurance companies cover treatment in a clinical trial.

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38 See G.A.O. Report, supra note 1, at 5.
39 See Holland, supra note 8, at 1156. Phase I and phase II clinical trials are also being performed to assess adjuvant therapy for positive axillary node disease. See id
40 See G.A.O. Report, supra note 1, at 4-5. The G.A.O. Report describes clinical trials as follows:

A clinical trial is a medical experiment in which procedures or drugs are tested on human subjects to assess their safety or effectiveness. Phase I trials are designed to determine the dose that can be given with an acceptable level of toxicity. Phase II trials seek to evaluate the response in specific tumor types. Phase III trials seek to assess a treatment's effectiveness by comparing patients receiving the experimental treatment with patients receiving conventional treatment. In a randomized phase III trial, patients are randomly assigned either to a control group receiving standard treatment or to one or more experimental groups receiving the treatment being tested.

Id. at 5. Phase IV "post marketing" studies are designed to collect additional information about a treatment. See Whitney v. Empire Blue Cross & Blue Shield, 920 F. Supp. 477, 482 n 3 (S.D.N.Y. 1996). See also J. Gregory Lahr, What is the Method to Their "Madness"? Experimental Treatment Exclusions in Health Insurance Policies, 13 J. CONTEMP. H.L. & POL'Y 613, 620-23 (1997) (describing clinical trials, and how experimental procedures become standard).
41 See Elisabeth de Vries, Breast Cancer Studies in the Netherlands, LANCET, Aug 10, 1996, at 407. HDC is so widely available in the U.S. there is difficulty recruiting patients for randomized clinical trials. Patients do not want to be randomized to the low dose chemotherapy. One of the largest studies is taking place in the Netherlands and will have more than 370 patients. The results will not be available until 2000. See id.
42 See Harness, supra note 15, at 71-72 (discussing the obstacles to patient enrollment in clinical trials).
44 See Lawsuits Publicity Driving Transplants, HOSP. & HEALTHNETWORKS, June 20, 1996, at 72. There are four randomized trials in progress by the National Cancer Institute (NCI) but the NCI lamented that few insurers pay for treatment in clinical trials. The NIH is also doing clinical trials and having a difficult time getting patients to participate. Results will not be available for two years. See id.
Currently, there are four randomized clinical trials being conducted by the National Cancer Institute to determine whether ABMT is better than conventional-dose chemotherapy. The trials involve approximately 2,000 women at more than seventy institutions. At least one of these randomized trials appears to confirm the superiority of high dose chemotherapy (HDC) over conventional chemotherapy for metastatic breast cancer. A national randomized clinical trial for patients with ten or more positive axillary lymph nodes is currently ongoing which should help to clarify the role of HDC in the management of high risk breast cancer.

Employee Retirement Income Security Act of 1974
ERISA regulates employee welfare benefit plans. An employee welfare benefit plan is defined in the statute to be a “plan, fund, or program” that provides pension benefits or non-pension benefits (health benefits) or both. Plans providing health benefits are termed “welfare plans” or “welfare benefit plans.” ERISA also establishes procedural standards such as reporting, disclosure, and fiduciary responsibilities, but does not regulate the substantive content of health insurance coverage provided in the employee welfare benefit plan.
The ERISA statute distinguishes between employee welfare benefit plans that are self-insured and plans that involve the purchase of insurance. The distinction between insured and uninsured plans for purposes of state law is that plans that purchase insurance are regulated by the insurance industry. This occurs as a result of ERISA’s broad preemption. The statute provides specifically that it shall “supercede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.” Preemption is substantially qualified by the “insurance savings clause” which provides that nothing in ERISA “shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.” The exception to the savings clause is called the “deemer clause” which states that no employee benefit plan “shall be deemed to be an insurance company . . . ” The “deemer clause” exempts employee welfare benefit plans from insurance regulation. The effect of the statutes is that the only employee welfare benefit plans that are not subject to state laws are the self-funded plans.

The other difference between self-funded ERISA plans and insured plans is that the insurer’s assets are not included in the ERISA plan or held in trust. Trust law governs the administration of the plan. The

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56 See Brown v. Blue Cross & Blue Shield of Ala., 898 F.2d 1556, 1559 (11th Cir 1990) (citing Metropolitan Life Ins. Co., v. Massachusetts Travelers Ins. Co, 471 U.S. 724, 738-47 (1985)) (“Congress intended a distinction between insured and uninsured plans such that the former are subject to state regulations, for example, mandated-benefit laws, that have the effect of transferring or spreading a policyholder’s risk, that are an integral part of the policy relationship between the insurer and the insured, and that are limited to entities within the insurance industry.”)
62 Regarding the trust nature of ERISA the Eleventh Circuit stated:

The statute provides, with enumerated exceptions, “all assets of an employee benefit plan shall be held in trust by one or more trustees.” 29 U.S.C. §1103(a) (1994). Insurance policy plans fall within the exceptions. The policy is an asset of the plan, but the insurer’s assets are not thereby included in the plan. [T]he insurance policy, is not an asset held in trust for the beneficiaries of the plan because the trust requirements of section 1103(a) do not apply “to assets of a plan which consist of insurance contracts of policies issued by an insurance company
deferential standard of review was developed because of the trust nature of ERISA. When a conflict of interest exists between the fiduciary role and the profit-making objective of an insurance company a highly deferential standard of review may not be appropriate.

The ERISA fiduciary is the administrator of the plan who makes benefit determinations. The duties and responsibilities of the fiduciary are defined by the ERISA statute. The fiduciary must act in the best interest of the beneficiaries.

Pursuant to ERISA, a participant or beneficiary may "bring a civil action to recover benefits due under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." Under ERISA, plan beneficiaries improperly denied benefits can recover the monetary value of the benefit but cannot sue for lost wages, pain and suffering, or wrongful death.

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See Brown, 898 F.2d at 1561 (quoting Moon v. America Home Assurance Co., 888 F.2d 86, 89 (11th Cir. 1989)) (stating that since "the basis for the deferential standard of review in the first place was the trust nature of most ERISA plans," the most important reason for deferential review is lacking).

See id. at 1562. "Because an insurance company pays out to beneficiaries from its own assets rather than the assets of a trust, its fiduciary role lies in perpetual conflict with its profit-making role as a business. That is, when an insurance company serves as ERISA fiduciary to a plan composed solely of a policy or contract issued by that company, it is exercising discretion over a situation for which it incurs 'direct, immediate expense as a result of benefit determinations favorable to plan [p]articipants.' Id. (quoting De Nobel v. Vitro Corp., 885 F.2d 1180, 1191 (4th Cir. 1989)).

The statute provides as follows:

(1[A] fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and

(A) for the exclusive purpose of:

(1) providing benefits to participants and beneficiaries; and

(2) defraying reasonable expenses of administering the plan;

(B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aim;


There is concurrent jurisdiction\textsuperscript{70} in state and federal court but a jury trial is not available under ERISA.\textsuperscript{71} Remedies under ERISA are equitable in nature and consist of obtaining the monetary amount of benefits due, injunction, or declaratory judgment.\textsuperscript{72}

The judicial review of the denial of coverage case under an ERISA plan has been inconsistent.\textsuperscript{73} Typically the insurance company denies coverage because it determines that the HDC-ABMT is "experimental" or "investigational" pursuant to the insurance contract.\textsuperscript{74} Depending upon whether the term "experimental" is defined or not, the courts have found that the definition or lack of definition is either ambiguous and construe the ambiguity against the insurer or not ambiguous and uphold the contract interpretation.\textsuperscript{75} Earlier cases were ambiguous because experimental was not defined.\textsuperscript{76} As a result of decisions against insurers on the basis of ambiguity, contracts have been changed\textsuperscript{77} and many now explicitly deny coverage for HDC-ABMT.\textsuperscript{78}

\textit{Firestone Tire \& Rubber Co. v. Bruch}

The Supreme Court in \textit{Firestone Tire \& Rubber Co. v. Bruch} established \textit{de novo} judicial review for cases involving denial of ERISA benefits

\textsuperscript{70}See 29 U.S.C. § 1132(e)(1) (1994) (stating that "state courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under paragraph (1)(B) and (7) of subsection (a) of this section.")


\textsuperscript{75}See Wolf, supra note 73, at 2063-72 (discussing the exclusions for experimental medical treatment and whether the experimental exclusions are defined); Hamess, supra note 15, at 79-90; Brandi, supra note 21, at 72-74.

\textsuperscript{76}See Saver, supra note 73, at 1098-1104.

\textsuperscript{77}See Wilson, 791 F. Supp. at 311 (noting that Blue Cross conceded that it acted out of self-interest in changing the policy and excluding coverage).

\textsuperscript{78}See Bailey v. Blue Cross \& Blue Shield of Va., 67 F.3d 53, 57-58 (4th Cir. 1995) (noting that even though the contract explicitly excluded coverage for ABMT or SCR with HDC the court held that since chemotherapy was covered elsewhere the contract was ambiguous). \textit{See also} Mattive v. Healthsource of Savannah, 893 F. Supp. 1559, 1572 (S.D. Ga. 1995) (noting that even though ABMT and PSCR accomplish the same thing since the contract explicitly denied coverage for ABMT the court held that PSCR was covered).
unless "the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan."\textsuperscript{79} \textit{De novo} review is appropriate whether the plan is funded or unfunded and whether or not the administrator or fiduciary is operating under a possible or actual conflict of interest.\textsuperscript{80} However, the \textit{Firestone} Court held that when the administrator has discretionary authority, the applicable standard of review is the arbitrary and capricious standard.\textsuperscript{81} In reaching this holding, the Court looked to the principles of trust law.\textsuperscript{82} Trust law makes a deferential standard of review appropriate when a trustee exercises discretionary powers.\textsuperscript{83}

When a conflict of interest exists because the insurer is also the plan administrator, the claim must be reviewed with a reduced level of deference.\textsuperscript{84} The "conflict must be weighed as a ‘facto[ ]r in determining whether there is an abuse of discretion’" in the denial of benefits.\textsuperscript{85} This standard was also derived from trust law. \textit{Firestone} also specifically states however that if no discretion is reserved to the administrator then the \textit{de novo} standard is applied even if a conflict of interest exists.\textsuperscript{86}

\textbf{De Novo vs Arbitrary and Capricious Standard of Judicial Review: The Grant of Discretionary Authority}

The Court in \textit{Firestone} established that, in cases where the plan specifically grants discretion to the fiduciary to construe the terms of the plan and to determine eligibility for benefits, the standard of review is abuse of discretion.\textsuperscript{87} Under the abuse of discretion or arbitrary and capricious standard of review, the court should defer to the fiduciary’s decision and the denial of coverage should only be overturned if the court determines that the fiduciary abused his or her discretion or that the denial

\textsuperscript{80} See id.
\textsuperscript{81} See id. at 113.
\textsuperscript{82} See id. at 112-13.
\textsuperscript{83} See id. at 111.
\textsuperscript{84} See Firestone, 489 U.S. at 115 (holding that the \textit{de novo} standard applies).
\textsuperscript{85} See id. at 115 (quoting \textit{RESTATEMENT (SECOND) OF TRUSTS} § 187 cmt. d (1959)).
\textsuperscript{86} See id.
\textsuperscript{87} See id.
of coverage was arbitrary and capricious.\textsuperscript{88} The administrator's decision should not be disturbed if reasonable.\textsuperscript{89}

When determining the standard of review, the court initially must review the contract to determine whether discretion is granted to the fiduciary of the plan.\textsuperscript{90} The Firestone Court did not specify the language that must be contained in the plan in order to grant discretion to the fiduciary. Instead, the Court in Firestone only advised that the written instruments should be reviewed as "determined by the provisions of the [plan] as interpreted in light of all the circumstances and such other evidence of the intention of the [plan’s creator] with respect to the [plan] as is not inadmissible."\textsuperscript{91}

Courts have upheld the grant of discretionary authority where the plan is clear and unequivocal.\textsuperscript{92} To determine this, the court looks to the intent of the drafter of the plan.\textsuperscript{93} In Brown v. Blue Cross & Blue Shield of Alabama, the contract language provided that "[a]s a condition precedent to coverage, it is agreed that whenever [Blue Cross] makes reasonable determinations which are not arbitrary and capricious in the administration of the [plan] (including, without limitation, determinations whether services, care, treatment or supplies are medically necessary . . .), such determination shall be final and conclusive."\textsuperscript{94} The Brown court held that the language conferred discretionary authority to construe the terms of the plan and to determine benefits.\textsuperscript{95} In Atwood v. Newmont Gold Co., the specific language in the plan that granted discretion to Newmont to determine severance benefits was "[Newmont] shall be the sole and exclusive judge as to whether or not a termination is qualified for benefits under the terms of this Plan."\textsuperscript{96} Similarly, in Doe v. Group Hospitalization & Medical Services, Inc., the specific language conferring discretionary authority to the defendant stated that the defendant "shall

\textsuperscript{88} See id.
\textsuperscript{89} See Firestone, 489 U.S. at 111.
\textsuperscript{90} See id. at 112.
\textsuperscript{91} Id. (quoting RESTATEMENT (SECOND) OF TRUSTS § 187 cmt. d (1959)).
\textsuperscript{92} See Brown v. Blue Cross & Blue Shield of Ala., 898 F.2d 1556, 1559 (11th Cir. 1990).
\textsuperscript{93} See id.
\textsuperscript{94} See id.
\textsuperscript{95} See id.
\textsuperscript{96} See id.
\textsuperscript{55} Atwood v. Newmont Gold Co., 45 F.3d 1317, 1321 (9th Cir. 1995).
have the full power and discretionary authority to control and manage... the contract..."

The following language has also been held to grant discretionary authority to the plan administrator to determine whether a treatment is exempt from coverage: "[W]e will not cover the treatment... if, in our sole discretion, it is not medically necessary.... We may apply the following five criteria in exercising our discretion and may in our discretion..." apply any or all of them. Therefore, as a threshold issue under Firestone, before the court can determine whether the standard of review is de novo or arbitrary and capricious, the court must make a determination whether the plan grants discretionary authority to the administrator of the plan.

THE STANDARDS OF REVIEW WHEN COURTS FIND A CONFLICT OF INTEREST UNDER ERISA

The Criteria For Determining When a Plan Administrator Has a Conflict of Interest

A conflict of interest exists when an insurance company administers claims under a policy it issued. The Eleventh Circuit referred to this

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97 Doe v. Group Hosp. & Med. Serv. Inc., 3 F.3d 80, 85 (4th Cir. 1993). The complete terms were stated in the Nov. 30, 1990, amendment as follows:

[Blue Cross] shall have the full power and discretionary authority to control and manage the operation and administration of the Contract, subject only to the Participant's rights of review and appeal under the Contract. [Blue Cross] shall have all powers necessary to accomplish these purposes in accordance with the terms of the contract including, but not limited to: determining all questions relating to Employee and Family Member eligibility and coverage; determining the benefits and amounts payable therefor to any Participant or provider of health care services; establishing and administering a claims review and appeal process; and Interpreting, applying, and administering the provisions of the contract.

Id.


99 See Brown v. Blue Cross & Blue Shield of Ala., 898 F.2d 1556, 1561 (11th 1990) ("A final distinction involves the inherent conflict between the roles assumed by an insurance company that administers claims under a policy it issued."). See also Pitman v. Blue Cross & Blue Shield of Okla., 24 F.3d 118, 123 (10th Cir. 1994) (discussing conflicts of interest); Mattive v.
The conflict of interest as an inherent conflict of interest. The reason that an inherent conflict of interest exists is because the insurance company pays out to beneficiaries from its own assets rather than the assets of a trust. This inherent or perpetual conflict occurs because the insurer’s fiduciary role conflicts with its profit-making role as a business. The Brown court also referred to this type of conflict of interest as a strong conflict of interest.

In Brown, the defendant initially refused to cover two successive hospital admissions because defendant concluded there was no pre-admission certification which was required for all admissions except emergency admissions. The defendant later agreed based on review of the medical records to cover the first admission as an emergency admission. Since the medical record should have been a part of a good faith determination at the outset, the court found that the two different conclusions based on the same evidence highlighted the conflict of interest and seriously challenged "the assumptions upon which deference is accorded to Blue Cross’ interpretation of the plan."

The courts use different terminology in identifying conflicts of interest where the plan administrator is also the plan’s insurer. The terminology is also predictive of the outcome. For example, the Fourth Circuit determined that a “substantial” conflict of interest existed in Doe v. Group Hospitalization & Medical Services since the defendant Blue Cross was the plan administrator as well as the plan insurer. The defendant had discretion to avoid claims which would promote its own

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See Brown, 898 F.2d at 1561.

See id.

See id.

See id. A “strong conflict of interest exists when the fiduciary making a discretionary decision is also the insurance company responsible for paying the claims . . . .” Id. at 1561 (quoting Jader v. Principal Mut. Life Ins. Co., 723 F. Supp. 1338, 1343 (D. Minn. 1989)).

See id. at 1569.

See Brown, 898 F.2d at 1569.

Id. at 1569. The Brown court also observed that Blue Cross interpreted the plan to work a forfeiture of benefits by Brown because the admission would have been covered if precertification had been obtained. See id. “As a general principle, employee benefit plans should not be interpreted in such a way as to produce a forfeiture.” Id.

See id.

See Doe v. Group Hosp. & Med. Serv., 3 F.3d 80, 86 (4th Cir. 1993) (“Because of the presence of a substantial conflict of interest, we therefore must alter our standard of review.”)
profit. In that case, the plan was insured by payment of a fixed premium and there was no evidence that the insurer would collect from the employer retrospectively for unexpected liabilities.

Similarly, a "substantial" conflict of interest exists when the insurer is at financial risk if the cost of claims exceed the premiums collected. For example, in Whitney v. Empire Blue Cross & Blue Shield, the district court held that the defendant was "particularly conflicted because of the prospect of an unusually expensive benefit in a high-incidence disease." In that case, Empire approved coverage for HDC-ABMT for multiple myeloma, a rare blood cancer, but not for breast cancer. There was testimony that the incidence of breast cancer is between 175,000 and 200,000 new cases per year, whereas the annual incidence of multiple myeloma in the United States is only about 8000 cases.

Additionally, a "total" conflict of interest exists when the insurer is the single beneficiary of a substantial sum of money based on the denial of benefits. Moreover, when the insurer is also the plan administrator and the policy is changed to exclude coverage for HDC-ABMT, a "classic" conflict of interest exists.

Some courts have found that even though a conflict of interest exists the conflict does not play a significant role in the denial of benefits. In Atwood v. Newmont Gold, even though Newmont was both the employer and the plan administrator and had discretion to interpret the plan, the court held that the "apparent" conflict of interest did not interfere with the payment of severance benefits.
The fact that he was denied severance pay was not enough to establish a breach of fiduciary duty.\textsuperscript{119}

In a case where the insurer had to pay only the first $30,000 of expenses incurred plus twenty percent of additional expenses, the court held that only a "limited" or "financial" conflict of interest existed.\textsuperscript{121} Whereas, in a case where the defendant filed an affidavit specifically stating that, no conflict of interest existed since the plaintiff had already exceeded defendant's coverage limit. The court reasoned a conflict of interest was likely to be found and granted a preliminary injunction.\textsuperscript{122}

One court found no conflict of interest in a case where a self-funded plan was administered by the employer with the health benefits claims being administered by an insurer.\textsuperscript{123} Neither did the court find that there was a substantial conflict of interest where the plan was fully funded and any savings inured directly to the beneficiaries and participants of the plan.\textsuperscript{124} Likewise, there was no conflict of interest found where the employer was the administrator of the medical assistance plan with ultimate decision making authority, and an insurance company administered claims and had discretion to make and review the benefit determinations.\textsuperscript{125} However, another court found a conflict of interest in a self-funded plan with stop-loss coverage being provided by the insurer administrator because the cost of the HDC-ABMT was high enough to trigger the stop-loss coverage.\textsuperscript{126}

\textsuperscript{119}See id. at 1323. The plaintiff's counsel represented at oral argument that the plaintiff was not relying on any improper acts of the company or any personal motivations of the company's employees. See id.

\textsuperscript{120}See id. at 1323.

\textsuperscript{121}Healthcare Am. Plans, Inc. v. Bossemeyer, 953 F. Supp. 1176, 1183 (D. Kan. 1996) ("HAPI was operating under a limited conflict of interest. If it had determined that the procedure was covered, HAPI would have been required to pay the first $30,000 of expenses incurred; 50% of the additional expenses would have been covered by a reinsurance policy issued by Allianz Life Insurance Company of North America."")


\textsuperscript{123}See Clark v. K-Mart Corp., 979 F.2d 965, 968 (3d Cir. 1992). K-Mart's Director of Employee Benefits administered the self-funded plan, but had an administrative services contract with Blue Cross & Blue Shield to administer the claims for health benefits. See id

\textsuperscript{124}See De Nobel v. Vitro Corp. 885 F.2d 1180, 1187 (4th Cir. 1989).


\textsuperscript{126}See Glauser-Nagy v. Medical Mut. of Ohio, 987 F. Supp. 1002, 1011 (N.D. Ohio 1997). Plaintiff's employer Seaway Food Town, Inc. self-funded the plan which was administered by defendant Medical Mutual of Ohio. The defendant also provided stop-loss coverage for the plan. See id.
The Standards of Review When Courts Find a Conflict of Interest Under ERISA

The Circuit Courts of Appeal have applied different standards of review to the denial of ERISA benefits cases where the fiduciary has a conflict of interest. There are essentially four standards that are used by the Circuit Courts of Appeal. The "burden-shifting" approach established by the Eleventh Circuit,\(^\text{127}\) shifts the burden to the fiduciary to prove that the denial of benefits was not tainted by self-interest.\(^\text{128}\) The "decreased deference" approach followed by the Fourth\(^\text{129}\) and Tenth Circuits\(^\text{130}\) decreases the deference accorded to the fiduciary's interpretation to neutralize the conflict of interest.\(^\text{131}\) The "heightened review" or "less deferential" approach utilized by the Ninth Circuit\(^\text{132}\) applies the traditional abuse of discretion standard unless the beneficiary shows that the conflict of interest caused a breach of fiduciary duty.\(^\text{133}\) The "two-step" approach followed by the Second Circuit\(^\text{134}\) applies the arbitrary and capricious standard unless the conflict of interest affected the choice of a reasonable interpretation.\(^\text{135}\)

The Burden Shifting Approach of The Eleventh Circuit

The Eleventh Circuit applies a "burden shifting" approach to the review of benefit denials by fiduciaries where there is a conflict of interest.\(^\text{136}\) This test is also referred to as the "heightened arbitrary and capricious" standard\(^\text{137}\) or the "two-step" approach.\(^\text{138}\) This standard is applied when

\(^{127}\) Brown v. Blue Cross & Blue Shield of Ala., 898 F.2d 1556, 1566 (11th Cir. 1990).

\(^{128}\) See id.

\(^{129}\) Doe v. Group Hosp. & Medical Serv., 3 F.3d 80, 87 (4th Cir. 1993).

\(^{130}\) See Pitman v. Blue Cross & Blue Shield of Okla., 24 F.3d 118, 123 (10th Cir. 1994).

\(^{131}\) See id.

\(^{132}\) Atwood v. Newmont Gold Co., 45 F.3d 1317, 1322 (9th Cir. 1995).

\(^{133}\) See id.

\(^{134}\) Whitney v. Empire Blue Cross & Blue Shield Co., 106 F.3d 475, 477 (2d Cir. 1997).

\(^{135}\) See id.

\(^{136}\) Brown v. Blue Cross & Blue Shield of Ala., 898 F.2d 1556, 1566 (11th Cir. 1990).

\(^{137}\) See id.

\(^{138}\) Whitney I, 920 F. Supp. 477, 484 (S.D.N.Y. 1996) (calling both the Eleventh Circuit test in Brown and the Ninth Circuit test in Atwood v. Newmont Gold the "two-step" approach. The main difference between the tests is that in the Brown "burden shifting" test, when the court finds a conflict of interest the burden shifts to the fiduciary to prove that its decision was not the result of self-interest, whereas in the Ninth Circuit test in Atwood, the burden remains on the plaintiff to prove that the conflict caused a breach of fiduciary duty).
there is a substantial conflict of interest. A substantial conflict of interest exists when an insurer is the decision making fiduciary for benefits paid out of its assets. The standard is triggered when a fiduciary acting with discretionary authority interprets a disputed contract term and denies benefits. When the standard is triggered, the court accords less deference than would otherwise be appropriate if no conflict of interest existed.

In Brown v. Blue Cross & Blue Shield of Alabama the Eleventh Circuit held that when a substantial conflict of interest exists, the burden of proof shifts to the fiduciary to prove that its interpretation of the plan is not tainted with self-interest. In Brown, the substantive issue was whether there was a reasonable basis for the fiduciary's decision to deny benefits with the "reasonable basis" being modified by the Firestone case. Since the plan specifically granted discretionary authority to Blue Cross & Blue Shield, the standard of review applied under Firestone was arbitrary and capricious. In applying the arbitrary and capricious standard of review to the Brown case, the Eleventh Circuit proposed the following analysis:

1. Determine the legally correct interpretation of the disputed plan provision.
2. Determine if Brown has proposed a sound interpretation of the plan, one that can rival the fiduciary's interpretation.
3. To evaluate whether the fiduciary was arbitrary and capricious in adopting a different interpretation, the burden of proof is shifted to the fiduciary to prove that its interpretation of the plan is not tainted by self-interest.
4. If the fiduciary's interpretation of the plan is exclusively for the benefit of the plan participants and beneficiaries, it would satisfy the fiduciary's burden to purge the taint of self-interest.

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139 See id.
140 See Brown, 898 F.2d at 1561.
141 See id. at 1564.
142 See id. at 1566.
143 Id. at 1559.
144 See id. Firestone refers to the standard of review in discretionary situations as abuse of discretion. See id. at 1558 (citing Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989)).
145 See Brown, 898 F.2d at 1566-70 (describing the methodology recommended by the Fifth Circuit in Denton v. First National Bank of Waco, 765 F.2d 1295, 1304 (5th Cir. 1985)).
If the fiduciary carries the burden, the plaintiff can still succeed if the fiduciary's action is arbitrary and capricious by other measures.

In determining the appropriate standard of review after Firestone, the Eleventh Circuit looked at pre-Firestone ERISA cases, trust law, and the application of the "arbitrary and capricious" or "abuse of discretion" standard of review. Consistent with the Firestone case, this test is grounded in the common law principles of trusts.

Brown's claim involved two hospitalizations. The plan provided benefits for hospital care for emergency admissions but required written pre-certification for all other admissions. Brown's first admission was an emergency admission for a sinus condition and his second admission was for sinus surgery three days later. Blue Cross initially denied both admissions and then later covered the first admission because it was an emergency.

One of Brown's theories interpreting the plan was that the second admission was a continuation of the first admission. The plan did not define a single admission for purposes of an emergency; however, it did define "single confinement" within the context of the number of days for which major medical coverage is available during a single confinement to a hospital. It stated that "successive admissions to a hospital or hospitals shall be deemed to result in a 'single confinement' if discharge from and readmission to a hospital or hospitals occur within a ninety day period."

Blue Cross' interpretation of that portion of the plan was that the language referred to a "confinement" and not to an "admission."

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146 Id. at 1559-1566. The Eleventh Circuit cases subsequent to Firestone equate the arbitrary and capricious standard and the abuse of discretion standard which the Brown court uses interchangeably. See id.
147 See id. at 1567. The rule is an extension of the settled federal common law rule developed under the Labor Management Relations Act and subsequently applied in another context under ERISA. See id.
148 See id. at 1558.
149 See id.
150 See Brown, 898 F.2d at 1558.
151 See id.
152 See id.
153 Id. at 1570.
154 Id.
155 Brown, 898 F.2d at 1570.
The court found Blue Cross’ distinction to be “illusory.” However, the court indicated that “Blue Cross may be able to explain why it is justified in treating Brown’s readmission only three days after discharge differently from the conclusive presumption imposed in the plan for the limitation of benefits payable . . . .”

The court also found that evidence existed in the medical record revealing that oral pre-certification was obtained prior to the second admission. The contract provided for written pre-certification; however, Blue Cross’ counsel represented at oral argument that oral approval of pre-certification is commonplace. Brown’s hospital record for the second admission indicated Blue Cross’ telephone number and the notation “Pre-Cert with Judy.” There was also a Blue Cross record of inquiry which showed contact between Blue Cross and Brown’s hospital and noted “PAC” and “hospital verification complete.” One inference that the court drew was that a call was made and oral pre-certification was obtained.

Under the “burden shifting” approach, the Brown court held that the fiduciary was arbitrary and capricious because the initial hospitalization was denied and then later covered based on the same medical record. Moreover, the claim for the second admission was denied without pursuing the possibility that there was oral pre-certification for the second admission. Blue Cross also adopted an interpretation of the plan which was inconsistent with the practice of oral pre-certification.

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156 Id.
157 Id. The court also stated that the need for that information prevented it from granting summary judgment to Brown. See id.
158 See id. at 1570-71.
159 See id. at 1571. The plan required the patient and the physician to fill out a written form, deliver it to Blue Cross and then await written notice by mail from the insurance company. See id.
160 See Brown, 898 F.2d at 1570.
161 Id. at 1571.
162 Id.
163 See id. at 1571. The court also inferred that Blue Cross acted arbitrarily and capriciously in denying Brown’s claim if it did not further pursue the possibility that oral pre-certification was given. Since Brown’s counsel did not present any argument to the district court regarding the oral pre-certification, the Eleventh Circuit would not disturb the district court’s grant of summary judgment on an issue not raised. See id.
164 See id.
165 See Brown, 898 F.2d at 1570-71.
166 See id. at 1571.
failed to meet its burden of proof that denial of coverage for the second admission was not tainted with self-interest.

The Brown case has been consistently cited in conflict of interest cases where ERISA benefits have been denied, although few circuits have adopted the actual burden shifting approach.\(^{167}\) The Brown decision is also frequently cited for its language regarding the amount of deference to be accorded which "may be slight, even zero" by courts that do not impose a burden shifting approach but follow the other tests.\(^{168}\)

**The Decreased Deference Approach of the Fourth and Tenth Circuits**

The Fourth\(^{169}\) and Tenth\(^{170}\) Circuits apply a "decreased deference" approach to the review of benefit denials by fiduciaries where there is a conflict of interest. This standard is also referred to as a "sliding scale"\(^{171}\) or "continuum" test.\(^{172}\) The standard is applied when there is a substantial conflict of interest.\(^{173}\) A substantial conflict of interest exists when an insurer acting as a plan fiduciary has discretion to avoid claims which would promote its own profit.\(^{174}\) The standard is triggered when a fiduciary acting with discretionary authority interprets a disputed contract term which furthers the financial interests of the fiduciary.\(^{175}\)


\(^{168}\)Brown, 898 F.2d at 1564. The entire quotation that is most frequently cited is "when the members of a tribunal -- for example the trustees of a pension fund -- have a serious conflict of interest, the proper deference to give may be slight, even zero; the decision if wrong may be unreasonable." *Id.* at 1564 (quoting Van Boxel v. Journal Co. Employees Pension Trust, 836 F.2d 1048, 1052 (7th Cir. 1987)).

\(^{169}\)See Doe v. Group Hosp. & Medical Serv., 3 F.3d 80, 86 (4th Cir. 1993).

\(^{170}\)See Pitman v. Blue Cross & Blue Shield of Okla., 24 F.3d 118, 121 (10th Cir. 1994).

\(^{171}\)Van Boxel v. Journal Co. Employees Pension Trust, 836 F.2d 1048, 1052-53 (7th Cir. 1987) (describing the "sliding scale" standard); Atwood v. Newmont Gold Co., 45 F.3d 1317, 1322 (9th Cir. 1995) (calling the review done by the Fourth and Seventh Circuits the "sliding scale" test).

\(^{172}\)Whitney I, 920 F. Supp. 477, 484 (S.D.N.Y. 1996) (calling the test of the Fourth Circuit and the Seventh Circuit a "continuum approach" which involves "a continuum of deference that they will apply to decisions made by conflicted fiduciaries.")

\(^{173}\)See id.

\(^{174}\)See Doe, 3 F.3d at 86.

\(^{175}\)See id. at 87.
standard is triggered, the court will not act as deferentially as would otherwise be appropriate if no conflict of interest existed. In *Doe v. Group Hospitalization & Medical Services Inc.*, the Fourth Circuit held that when a substantial conflict of interest exists, the deference accorded the fiduciary decision will be decreased to neutralize any untoward influence resulting from the conflict. The court described the “decreased deference” standard as follows:

> [W]e will review the merits of the interpretation to determine whether it is consistent with an exercise of discretion by a fiduciary acting free of the interests that conflict with those of the beneficiaries. In short, the fiduciary decision will be entitled to some deference, but this deference will be lessened to the degree necessary to neutralize any untoward influence resulting from the conflict.  

This standard was derived from the common law principles of trust and from the *Firestone* case which noted that the same principles apply in the ERISA context. In *Doe*, Blue Cross was compensated by a fixed premium, and when it paid claims, it funded the payments from the premiums collected. The court’s rationale for this rule is that even the most conscientious fiduciary may unconsciously favor its profit interest over the interest of the plan rather than acting objectively leaving beneficiaries vulnerable.  

In *Doe v. Group Hospitalization & Medical Services*, the Fourth Circuit held that Blue Cross abused its discretion when the “decreased deference” standard was factored into the review because of its financial interests. In *Doe*, the plaintiff sought health insurance benefits for HDC-ABMT and radiation therapy prescribed for multiple myeloma, a rare blood cancer. Blue Cross insured and administered his firm’s

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170 See id.
171 See id. at 87; RESTATEMENT (SECOND) OF TRUSTS § 187 cmt. d. (1957).
172 See Doe, 3 F.3d at 87.
173 See id. at 86.
174 See id. at 86-87.
175 See id. at 80.
176 See id. at 88.
177 See Doe, 3 F.3d at 82.
employee welfare benefit plan. The plan had been amended and specifically excluded "services or supplies for or related to" autologous bone marrow transplants for multiple myeloma. The plaintiff sued pursuant to ERISA for the denial of benefits and the district court granted summary judgment in favor of Blue Cross.

Blue Cross' interpretation of the plan was that, since the ABMT was not covered for multiple myeloma, the high dose chemotherapy and radiation treatment were "services or supplies for or related to" the ABMT and therefore were also not covered. The court in Doe found that the HDC and radiation constitutes the treatment for the cancer and that the ABMT provides no treatment, but protects the bone marrow from damage caused by the treatment. The cancer treating procedures consisting of the chemotherapy and the radiation were covered services in another section of the contract. The court stated that while "Blue Cross is well within its rights to exclude from coverage the ancillary bone marrow transplant procedure, the exclusion should not, in the absence of clear language be construed to withdraw coverage explicitly granted elsewhere in the contract." Since there was ambiguity in the "related to" language the court construed the ambiguity against the drafter.

In applying the "decreased deference" standard, Blue Cross was not entitled to the deference the court might have otherwise accorded it because of the conflict of interest. Had the Court accorded more deference to Blue Cross' decision, it would have found that the HDC was not covered since Blue Cross had discretion to interpret and construe the terms of the contract. In the absence of the conflict of interest, the court would have upheld Blue Cross' decision unless there was an abuse of discretion. Under the Brown "burden shifting" approach, the court would have come to the same conclusion or held that the ABMT was also covered if the fiduciary was unable to prove that the decision to deny

184 See id. at 82. The treatment was sought from Group Hospitalization and Medical Services, Inc., doing business as Blue Cross and Blue Shield of the National Capital Area. See id.
185 Id. at 88.
187 See Doe, 3 F.3d at 82.
188 Id. at 88.
189 See id. at 87.
190 See id.
191 See id. at 88.
192 Doe, 3 F.3d at 88.
193 See id. at 88.
benefits was not tainted with self interest. Applying either test results in decisions contrary to the interpretation by the fiduciary, and unfavorable to the insurance company because there is a conflict of interest.

Similarly, in *Pitman v. Blue Cross & Blue Shield of Oklahoma* the Tenth Circuit relied on the Fourth Circuit’s application of *Firestone* in *Doe*. The policy had been changed to exclude coverage for multiple myeloma. Since the plan administrator was also the plan insurer, the Tenth Circuit reversed and remanded the district court’s grant of summary judgment for the defendant because the district court failed to consider the conflict of interest. The Tenth Circuit stated that under the *Firestone* standard of review, the decision to deny benefits is not entirely insulated by the administrator’s discretion. Because of the conflict of interest standard, the court refused to uphold the language of the contract.

**The Heightened Review or Less Deferential Approach of the Ninth Circuit**

The Ninth Circuit applies a “heightened review” or “less deferential” approach to the review of benefit denials by fiduciaries where there is a conflict of interest. This test is also called the “two-step” approach. The standard is applied when there is a conflict of interest. A conflict of interest exists when the employer is acting as the plan administrator. The standard is triggered when the administrator, acting with discretionary authority, has an economic stake in the benefit decisions. When the standard is triggered, the court will not act as deferentially as would have otherwise been appropriate if no conflict of interest existed.

In *Atwood v. Newmont Gold*, the Ninth Circuit held that the traditional abuse of discretion standard applies unless the beneficiary

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194See *Pitman v. Blue Cross & Blue Shield of Okla.*, 24 F.3d 118, 122 (10th Cir. 1994).

195See id. at 120.

196See id.

197See id. at 124.

198See id. at 120.

199See *Atwood v. Newmont Gold Co. Inc.*, 45 F.3d 1317, 1322 (9th Cir. 1994).


201See *Atwood*, 45 F.3d at 1322.

202See id.

203See id.

204See id. at 1323.
shows that the conflicting interest caused a breach of the fiduciary duty. If a breach of the fiduciary duty is shown, the deference normally accorded the fiduciary dissolves and the court reviews the interpretation de novo. The "heightened review" or "less deferential" approach that the Ninth Circuit applied to the Atwood case is as follows:

1. Has the beneficiary provided evidence that the fiduciary's self-interest caused a breach of the fiduciary duty? If not, apply the traditional abuse of discretion.
2. If the beneficiary makes the required showing, the plan bears the burden to show that the conflict did not affect the decision to deny benefits.
3. If the plan cannot carry that burden the court will review the decision de novo without deference to the administrator's tainted exercise of discretion.

Since the plan reserved for Newmont discretion to interpret the term at issue, Firestone's "abuse of discretion" or "arbitrary and capricious" standard was appropriate. The court found support for its holding in other Ninth Circuit opinions that applied a traditional abuse of discretion standard unless the beneficiary could show that the conflicting interest caused a breach of the fiduciary's duty.

This standard was derived from the principles of trust law. The court stated that "the principles of trust law require us to act very skeptically in deferring to the discretion of an administrator who appears to have committed a breach of fiduciary duty." However, before the court will find a breach of fiduciary duty, more than a mere conflict of interest must be shown. The court stated that "material, probative

\[\text{See id. 1322-23.}\]
\[\text{Atwood, 45 F.3d at 1322.}\]
\[\text{See id.}\]
\[\text{Id. at 1321 (discussing the difference between the "abuse of discretion" standard of review and the "arbitrary and capricious" standard the court cited cases using both terms and noted that "[t]he standards differ in name only").}\]
\[\text{See id. at 1322.}\]
\[\text{Id. at 1323.}\]
\[\text{Atwood, 45 F.3d 1323 (citing Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 111 (1989)).}\]
\[\text{See id.}\]
evidence beyond the mere fact of an apparent conflict” must be provided by the beneficiary.213

In Atwood, the plaintiff resigned and requested severance pay.214 Both severance pay plans governed by ERISA denied severance benefits for voluntary resignation unless the resignation followed a “significant diminution in duties or responsibilities.”215 Atwood, a shop foreman, had been reassigned several times without any change in his salary or grade level prior to his resignation.216 The company concluded that his “last position as shift foreman did not entail substantially less responsibility than [his] previous assignments and denied severance benefits.”217 Atwood sued for denial of his benefits.218 The district court granted summary judgment in favor of the defendant.219

The plaintiff argued that, because he interpreted the plan to mean that his resignation followed a substantial diminution in his duties and Newmont interpreted the plan to mean just the opposite, the contract was ambiguous and should be construed against the employer pursuant to contra preferentum.220 The court found that the terms “following” and “substantial” were not ambiguous, but that the plaintiff merely took issue with Newmont’s determination of how closely the resignation must follow the job change and how substantial the reduction in duties must be.221 The court stated that the plan clearly granted discretion to Newmont to interpret the plan.222 The court also looked at Newmont’s Summary Plan Description (SPD) and found that, pursuant to ERISA, the SPD sufficiently informed Atwood that he would be ineligible for benefits if he resigned.223 The court determined that it was not an abuse of discretion for Newmont to conclude that the plaintiff’s resignation did not follow a substantial diminution in responsibilities.224

213 Id.
214 See id. at 1320.
215 Id.
216 See Atwood, 45 F.3d at 1320-21.
217 Id. at 1320.
219 See id.
220 See id. at 1324.
221 See id. at 1321-22.
222 Atwood, 45 F.3d at 1324.
223 See id. The specific language in the plan that granted discretion to Newmont was “[Newmont] shall be the sole and exclusive judge as to whether or not a termination is qualified for benefits under the terms of this Plan.” Id. at 1321.
224 See id. at 1323-24.
If the *Atwood* case had been decided under the *Brown* "burden shifting" standard, the result would have been different. The court would have found a substantial conflict of interest because the employer was the plan administrator and had discretion to interpret the term at issue. The burden of proof would have shifted to the plan administrator to demonstrate that the decision to deny severance pay was not tainted with self interest. If the defendant was unable to carry that burden, the plaintiff would have prevailed. Under the "decreased deference" standard of the Fourth Circuit, the court would have decreased the deference accorded the defendant's interpretation of the plan to neutralize the conflict of interest. The result would have been indeterminate under the "decreased deference" standard. Of significance to the court in *Atwood* was that the plaintiff's pay did not decrease and that the SPD informed the plaintiff that if he voluntarily resigned he would not be entitled to severance pay. The court also referred to the conflict of interest as an "apparent conflict." Under the court's test an apparent conflict is not enough to show a breach of fiduciary duty.

Under the Ninth Circuit standard, if the plaintiff had met his burden and had proven that the conflict of interest caused a breach of the fiduciary duty according to the common law of trusts, the fiduciary's decision would have been presumptively void. Where the beneficiary has proven a violation of fiduciary duty, the court will not defer to an administrator's presumptively void decision. Under the Ninth Circuit's "heightened review" or "less deferential" review, if the plaintiff can prove a breach of the fiduciary duty the plaintiff will most likely prevail.

**The Two Step Approach of the Second Circuit**
The Second Circuit uses a "two-step" approach to review benefit denials where the fiduciary has a conflict of interest. This standard is applied where there is a substantial conflict of interest. A substantial conflict of interest exists when an insurer is administering claims under a policy

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225 See id. at 1320-22.
226 *Atwood*, 45 F.3d at 1324.
227 See id.
228 See id. at 1323.
229 See id.
230 Whitney v. Empire Blue Cross & Blue Shield, 106 F.3d 475 (2d Cir. 1997) (hereinafter *Whitney II*).
231 See id.
issued by the insurer, and for which it is financially responsible. The standard is triggered when a fiduciary, acting with discretionary authority, interprets a contract provision and denies benefits in an unusually expensive and high incidence disease. When the standard is triggered the court will not act as deferentially as would otherwise be appropriate if no conflict of interest existed.

In Whitney v. Empire Blue Cross & Blue Shield, the Second Circuit held that when there is a substantial conflict of interest the court should apply the arbitrary and capricious standard of review unless the conflict of interest affected the choice of a reasonable interpretation. The Second Circuit adopted the following “two step” approach for determining whether the administrator’s interpretation of the plan is arbitrary and capricious when there is a conflict of interest:

1. Determine whether the plan interpretation made by the administrator is reasonable, in light of possible competing interpretations of the plan.
2. Determine whether the evidence shows that the administrator was in fact influenced by such conflict. If the Court finds that the administrator was in fact influenced by the conflict of interest, the deference otherwise accorded the administrator’s decision dissolves and the court interprets the plan de novo.

This test was derived from Sullivan v. LTV Aerospace & Defense Company and the Firestone case. Subsequent to the lower court decision in Whitney, the Second Circuit rendered its opinion in Sullivan

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233 See id.
234 See id.
235 See Whitney II, 106 F.3d at 477.
236 Id. at 475 (citing Sullivan v. LTV Aerospace & Defense Co., 82 F.3d 1251, 1255-56 (2d Cir. 1996)).
238 See id. at 1254.
which expressly rejected Brown's burden shifting approach as being contrary to the traditional burden of proof in a civil case.\textsuperscript{240} In Sullivan the Court rejected the standard of review in Brown.\textsuperscript{241} The court reasoned that, unless the conflict affected the choice of a reasonable interpretation, in cases turning on whether the decision was based on an alleged conflict of interest, the arbitrary and capricious standard of review is appropriate.\textsuperscript{242}

In Whitney, the plaintiff was denied benefits for HDC and peripheral stem cell support (PSCS) by Empire who insured her employee welfare benefit plan governed by ERISA.\textsuperscript{243} Empire denied the treatment under an experimental exclusion of the policy,\textsuperscript{244} determining that the treatment was experimental because it was provided pursuant to a Phase I research protocol.\textsuperscript{245}

The plaintiff's interpretation of the plan was that the definitional standards which mandate that a treatment be supported by medically acceptable proof of efficacy and appropriateness should be controlling.\textsuperscript{246} However, the definitional standards are followed by five discretionary T.E.C criteria.\textsuperscript{247} The district court found the criteria in the policy so elastic as to be almost meaningless.\textsuperscript{248} The district court relied on credible physicians' testimony that HDC-ABMT is effective, appropriate, and

\textsuperscript{240}See Sullivan, 82 F.3d at 1254.
\textsuperscript{241}See id.
\textsuperscript{242}See id.
\textsuperscript{243}See Whitney I, 921 F. Supp. 477, 479 (S.D.N.Y. 1996). Empire paid the cost of the treatment under a reservation of rights. See id. at 479-81. The treatment was administered in February and March of 1993, but Whitney died in July of 1993. See id. Her daughter was substituted in the lawsuit as executrix of her estate. See id.
\textsuperscript{244}See id. at 481. The Experimental Exclusion relied on by Empire to deny coverage states in relevant part: Unless otherwise required by law . . . we will not cover any treatment . . . if, in our sole discretion, it is not medically necessary in that such technology is experimental or investigational. Experimental or investigational means that the technology is: (1) not of proven benefit for the particular diagnosis or treatment of the Covered Person's particular condition; or not generally recognized by the medical community as reflected in the published peer-reviewed medical literature as effective or appropriate for the particular diagnosis or treatment of the Covered Person's particular condition. Id. at 481. This section was followed by five discretionary T.E.C. criteria. See id.
\textsuperscript{245}See id. at 481. The protocol was supervised by an I.R.B., and she had to sign an informed consent advising her of the unproven nature of the treatment. See id. The purpose of the study was to determine the maximum tolerated dosage of the drug combinations. See id.
\textsuperscript{246}See id. at 486.
\textsuperscript{247}See id.
\textsuperscript{248}See Whitney I, 921 F. Supp. at 486.
proven beneficial, and that each of the criteria was met.\textsuperscript{249} There was also testimony regarding numerous peer-reviewed articles demonstrating the efficacy of the treatment.\textsuperscript{250}

Empire sought to negate plaintiff’s reliance on abstracts,\textsuperscript{251} but in approving coverage for multiple myeloma it relied on five articles, two of which were abstracts.\textsuperscript{252} The most compelling case of inconsistent application of the TEC criteria was coverage for multiple myeloma for which no phase III trials had been completed.\textsuperscript{253}

The Second Circuit’s “two-step” standard is very similar to the test used by the Ninth Circuit in \textit{Atwood v. Newmont Gold}.\textsuperscript{254} The differences are that the Ninth Circuit requires proof that the conflict caused the breach of fiduciary duty\textsuperscript{255} and the Second Circuit requires proof that the conflict affected the choice of a reasonable interpretation.\textsuperscript{256} Since the policy covers HDC-ABMT for multiple myeloma, which is a rare disease that affects a fraction of the patients affected with breast cancer, it is very likely that on remand the plaintiff will be able to prove that the conflict affected the choice of a reasonable interpretation and caused the denial of benefits.

Under a burden shifting approach the insurer usually loses unless the insurer can successfully demonstrate to the court that expensive benefits were denied for the purpose of benefiting the other plan participants and beneficiaries.\textsuperscript{257} The “decreased deference” or “sliding scale” standard also does not benefit the insurer. It gives the court an opportunity to decrease the deference normally accorded a fiduciary’s decision and come to a conclusion that is not provided for in the contract. If a conflict situation cannot be eliminated the most favorable standards for the insurance company are the “heightened review” or “less deferential” standard of the Ninth Circuit\textsuperscript{258} or the “two-step” approach of the Second Circuit which require the plaintiff to establish that the conflict caused a

\begin{itemize}
\item \textsuperscript{249}See id.
\item \textsuperscript{250}See id.
\item \textsuperscript{251}See id. at 487.
\item \textsuperscript{252}See id.
\item \textsuperscript{253}See Whitney I, 921 F. Supp. at 487.
\item \textsuperscript{254}Atwood v. Newmont Gold Co., Inc., 45 F. 3d 1317 (9th Cir. 1995).
\item \textsuperscript{255}See id. at 1323.
\item \textsuperscript{256}See Whitney II, 106 F.3d at 1255.
\item \textsuperscript{257}See Brown v. Blue Cross & Blue Shield of Ala., 898 F.2d 1556, 1569 (11th Cir. 1990).
\item \textsuperscript{258}Atwood, 45 F.3d at 1323.
\end{itemize}
breach of fiduciary duty or that the conflict affected the choice of a reasonable interpretation of the plan.\textsuperscript{259}

**RECOMMENDATIONS FOR INSURANCE COMPANIES TO AVOID THE CONFLICT OF INTEREST STANDARDS**

Pursuant to *Firestone Tire & Rubber Company v. Bruch*,\textsuperscript{260} in order for the reviewing court to apply an arbitrary and capricious or abuse of discretion standard of review in the denial of benefits case, the ERISA plan must specifically grant discretion to the administrator in determining benefits and construing the terms of the plan.\textsuperscript{261} If the plan grants discretion to the administrator and a conflict of interest exists, the standard of review is arbitrary and capricious or abuse of discretion with the conflict of interest being weighed as a factor.\textsuperscript{262} When a conflict of interest exists, the reviewing court will not act as deferentially in applying the arbitrary and capricious or abuse of discretion standard, and, in fact, may shift the burden of proof to the defendant,\textsuperscript{263} find an ambiguity where treatment is specifically excluded,\textsuperscript{264} or accord little or no deference to defendant’s interpretation of the plan.\textsuperscript{265}

The only way to prevent the courts from essentially redrafting insurance coverage agreements and providing coverage that is either experimental or excluded in the policy is to avoid the conflict of interest standard of review. Ideally, two separate entities should administer the plan and insure the plan. Since this separation may not be feasible, the insurer should be aware of the following recommendations.

\textsuperscript{259}Whitney II, 82 F.3d 1251, 1255 (2d Cir. 1997).
\textsuperscript{261}See supra notes 87-89 and Section I. D.
\textsuperscript{262}See Firestone, 489 U.S. at 115.
\textsuperscript{264}See Bailey v. Blue Cross & Blue Shield of Va., Inc., 67 F.3d 53, 56 (4th Cir. 1995); Pitman v. Blue Cross & Blue Shield of Okla., 24 F.3d 118, 121 (10th Cir. 1994).
\textsuperscript{265}See Bailey, 67 F.3d at 58.
Where Coverage Is Specifically Excluded, Courts Will Find That Treatments Not Specifically Excluded Are Covered

Courts have ruled in favor of the plaintiff in cases where insurers have attempted to specifically exclude coverage for HDC-ABMT. The difficulty with specific exclusions is that anything that is not excluded may be deemed to be covered when the court applies the conflict of interest standard.

In Mattive v. Healthsource of Savannah, the court found that, since the agreement specifically provided that “[b]one marrow transplants for all other malignancies, including breast cancer, [are] not covered,” HDC-PSCR was covered. The defendant argued “semantics” and that both treatments were essentially the same thing, but the court found that semantics is “the stuff of contract interpretation.”

The Mattive court applied the Brown “burden shifting” approach to Healthsource’s “inherent conflict of interest” calling it a “heightened arbitrary and capricious” standard. The court also found that Healthsource was legally wrong and arbitrary and capricious in finding that HDC-PSCR was not a “therapeutic service” which could at least be partially administered on an outpatient basis.

Insurers need to be aware that if HDC-ABMT is specifically excluded for breast cancer, a court might find that, because it is not excluded for a different type of cancer, it must be covered. The administrator’s interpretation of the plan will not be given the deference it deserves if the conflict of interest standard is applied. In Mattive, the
Eleventh Circuit “burden shifting” standard was applied which will almost always result in a decision in favor of the plaintiff. If a conflict of interest exists coverage exclusions should be broad enough to avoid the result that occurred in the *Mattive* case.

Where HDC Is Specifically Excluded Courts Will Find Ambiguity If Chemotherapy Is Covered Elsewhere

When specific exclusions are made, if the services appear elsewhere in the contract courts have deemed the contract ambiguous and have construed the ambiguity against the drafter.\(^1\) When the conflict of interest standard is applied, the court will not defer to the defendant’s interpretation of the plan.

In *Bailey v. Blue Cross & Blue Shield of Virginia*, the specific policy language provided “autologous bone marrow transplants or other forms of stem cell rescue (in which the patient is the donor) with high-dose chemotherapy or radiation are not covered ... for breast cancer.”\(^2\) The plaintiff conceded that SCR was not covered; however, since chemotherapy was listed elsewhere under “covered services,” the district court deemed the policy ambiguous as it related to HDC and construed the ambiguity against the insurer.\(^3\) The Fourth Circuit held that Blue Cross’ discretionary decision was not entitled to deference because there was a “total” conflict of interest; Blue Cross stood as the single beneficiary of a substantial sum of money based on the denial of benefits.\(^4\)

In short, the court found ambiguity because chemotherapy was covered elsewhere. Since there was a conflict of interest in *Bailey*, the court applied the Fourth Circuit’s “decreased deference” standard which resulted in the defendant being ordered to cover the HDC. In a different jurisdiction with a different standard, a court could require coverage of the

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\(^1\) See *Bailey v. Blue Cross & Blue Shield of Va.*, 67 F.3d 53, 58 (4th Cir. 1995).

\(^2\) *Id.* at 55.

\(^3\) *Id.*

\(^4\) *Id.* at 57. Blue Cross interpreted the disputed clause “with high dose chemotherapy” to mean “and high dose chemotherapy.” *Id.* The plaintiff argued that the clause made the contract ambiguous. *See id.* The Fourth Circuit held that the policy should be interpreted with ordinary contract principles by enforcing the plain language in the ordinary sense and construing an ambiguous contract term against the drafter. *See id.* The court noted that if HDC was not a service “related to” ABMT in *Doe* it was reasonable to conclude that the policy exclusion covered only PSCR and not the HDC. *Id.* Therefore, the plan provided coverage for all types of chemotherapy including HDC. *See id.* at 57-58.
entire treatment based on the ambiguity. Because there was a conflict of interest the court had an opportunity to circumvent the intent of the contract drafters. The only way to avoid the result in the Bailey case is by avoiding the conflict of interest standard.

**Coverage Decisions Should Be Referred to Independent Medical Doctors**

Where a conflict of interest exists, the insurer should only deny coverage based on a decision by an independent outside medical entity. The insurer should establish specific criteria for referring coverage decisions to an independent medical entity, particularly when the treatment is expensive or controversial. Decisions to deny coverage should be supported by a complete analysis after a review of substantial evidence.

In *Glauser-Nagy v. Medical Mutual of Ohio*, when the plaintiff requested pre-approval of payment for HDC-PSCR, the request was sent to an independent physician consultant for predetermination in accordance with the defendant’s procedures. The consultant reported that HDC is appropriate in the investigational setting for stage III cancer and that no randomized studies have been completed to assess the efficacy. Outside of a clinical trial, the consultant was unable to determine how much benefit the transplantation affords over chemotherapy, radiation therapy, and hormonal therapy in patients with stage II/III breast cancer. Based on the consultant’s report, the defendant denied coverage for HDC-PSCR as “experimental/investigational.”

Subsequent to defendants denial of coverage for HDC-ABMT for Stage III breast cancer, the plaintiff filed two internal appeals. Each appeal was evaluated by a different oncologist consultant. Both

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275 See Wolf, supra note 73, at 2105 (discussing whether a conflict of interest exists if an insurance company has the right to reject the decision of an independent committee of medical experts).


277 See id. at 1006. Medical Mutual asks its consulting physicians to use guidelines developed by Blue Cross/Blue Shield in conjunction with Kaiser Permanente in evaluating medical necessity. The guidelines state that HDC-PSCR may be approved as medically necessary for patients with Stage IV (metastatic) breast cancer but that it is still experimental/investigational for patients with Stage II or III breast cancer. See id. at 1006-07.

278 See id. at 1008.

279 See id.

280 See id. at 1010.

281 See Glauser-Nagy, 987 F. Supp. at 1010.

282 See id.
consultants reported that, based on the available data, the treatment was investigational. The court found that a conflict of interest existed even though the plan was self-funded by the employer and administered by the insurer. The district court, relying on *Whitney v. Empire Blue Cross & Blue Shield*, stated that, not only does the plaintiff need to show that there is a potential conflict of interest, but also "that the conflict affected the reasonableness of the [administrator’s] decision." The plaintiff made no such showing and the court found no evidence that the defendant applied any pressure to its independent consultants to effectuate the denial of coverage or that the physicians were motivated by a desire to enhance their personal or corporate financial position at plaintiff’s expense.

However, a different result occurred in *Marro v. K-III Communications*, a brain cancer case where treatment for HDC-ABMT was denied. In *Marro*, the defendant referred coverage decisions to two outside doctors whose opinions were relied on to deny pre-certification. The court noted that the experts were used for high technology, high risk, and high cost medical procedures, and that Prudential retained the right to reject the views of the doctors. Although the defendant filed an affidavit specifically stating that, since the plaintiff had already exceeded defendant’s coverage limit no conflict existed, the court granted a preliminary injunction finding that it was unlikely that defendant would be found free of a financial conflict of interest.

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283 See *id.*
284 See *id.* at 1011. A conflict of interest existed because the cost of the procedure requested by the plaintiff was high enough that the stop-loss coverage provided by the defendant would likely be triggered if the requested coverage were provided. See *id.*
285 *Id.* (quoting *Whitney v. Empire Blue Cross & Blue Shield*, 106 F.3d 475, 477 (2d Cir. 1997)).
286 See Glauser-Nagy, 987 F. Supp. at 1012.
288 See *id.* at 248.
289 See *id.* at 249.
290 See *id.* at 253.
291 See *id.* In Glauser-Nagy v. Medical Mut. of Ohio, the court may have found for the defendant because the patient had stage III breast cancer rather than stage IV breast cancer. See Glauser-Nagy v. Medical Mut. of Ohio, 987 F. Supp. 1002, 1006 (N.D. Ohio 1997). HDC-ABMT may still be experimental for certain types of breast cancer, other than stage IV breast cancer and for other cancers. For example in Martin v. Blue Cross & Blue Shield of Va., less than five women received HDC-ABMT for the treatment of epithelial ovarian cancer. See Martin v. Blue Cross & Blue Shield of Va., 115 F.3d 1201, 1209 (4th Cir. 1997). The Fourth Circuit found no abuse of discretion "even the more limited discretion afforded to a fiduciary acting under a possible conflict of interest, in concluding that the procedure here was experimental or
Even under the conflict of interest standards, if the insurer is able to obtain the unbiased opinions of an independent consultant or if the insurer does a thorough investigation before denying benefits for expensive and controversial treatment, the plaintiff will have much difficulty proving that the conflict of interest caused a breach of the fiduciary duty or that the conflict of interest affected the choice of a reasonable interpretation of the plan.

Coverage Denials Should Be Based Upon Substantial Evidence

The decision to deny expensive controversial treatment as experimental should be made only after making a complete analysis and reviewing substantial evidence. A complete analysis of the matter means that information both for and against the treatment is reviewed.

In Healthcare America Plans v. Bossemeyer (HAPI) the United States District Court in Kansas applied the Tenth Circuit's "sliding scale" approach in a conflict of interest case regarding the denial of coverage for HDC-PBSCR for stage II breast cancer. The court in that case held that the defendant did not abuse its discretion in finding that HDC-PBSCR was experimental for stage II breast cancer. The court upheld the denial of coverage under the exclusion for "experimental, unproven or obsolete, investigational or educational as determined by Health Plan." The plaintiff argued that HAPI lacked substantial evidence on which to base its decision to deny coverage, that its Board members were influenced by their conflict of interest, and that it demonstrated bad faith by searching for sources which would support its denial of coverage. The court found that HAPI invested a great deal of time and effort gathering and

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292 Healthcare Am. Plans, Inc. v. Bossemeyer, 953 F. Supp. 1176, 1189 (D. Kan. 1996). The court determined that in deciding whether the plaintiff's proposed treatment was covered "HAPI was operating under a limited conflict of interest." Id. at 1183. Under the Tenth Circuit "sliding scale" approach "the reviewing court will always apply an arbitrary and capricious standard, but the court must decrease the level of deference given to the conflicted administrator's decision in proportion to the seriousness of the conflict." Id. at 1189.

293 See id. at 1191.

294 Id. at 1191.

295 Id. at 1189.
reviewing information from reputable and pertinent sources and based its decision on substantial evidence.\textsuperscript{296} Substantial evidence consists of the following:\textsuperscript{297}

2. Affidavits of medical experts for and against the treatment.
3. Questions regarding the experimental nature of the treatment posed to medical experts.
4. Appellate and District Court opinions.

**CONCLUSION**

The decision to deny coverage for potentially life-saving medical treatment is difficult. The ERISA fiduciary must act in the best interest of all beneficiaries. The duty to protect the assets of a trust is clear where an ERISA plan is self-funded. The distinction becomes blurred where an insurance company not only insures the plan but also administers the plan. The decision to deny benefits under an insurance policy where there is a conflict of interest may not be in the best interest of all of the beneficiaries. It also allows for judicial intervention, which results in inconsistent outcomes. Until the Supreme Court establishes a standard more specific than *Firestone* which requires that a "conflict be weighed as a factor" in determining whether the administrator was arbitrary and capricious, the elimination of a conflict of interest is the best way to make sure that insurance contract language is upheld.

\textsuperscript{296}See id. at 1188. In applying the Tenth Circuit's "sliding scale" approach to HAPI's alleged conflict of interest, the court found no abuse of discretion. Also, the evidence did not show that the defendant applied pressure on its staff or patient care committee to deny coverage. \textit{See id.} at 1191.