

NOT FOR PUBLICATION

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

FILED

OCT 15 2007

CATHY A. CATTERSON, CLERK
U.S. COURT OF APPEALS

DONALD E. BUCHANAN, M.D.,

Plaintiff - Appellant,

v.

STANDARD INSURANCE COMPANY,

Defendant - Appellee.

No. 05-16651

D.C. No. CV-03-00639-RLH

MEMORANDUM*

Appeal from the United States District Court
for the District of Nevada
Roger L. Hunt, District Judge, Presiding

Argued and Submitted September 26, 2007
San Francisco, California

Before: GIBSON**, BERZON, and BEA, Circuit Judges.

Donald Buchanan appeals the district court's order granting Standard Insurance Company summary judgment as to all claims arising from its denial of benefits to Buchanan under a long term disability plan governed by the Employee

* This disposition is not appropriate for publication and is not precedent except as provided by 9th Cir. R. 36-3.

** The Honorable John R. Gibson, Senior United States Circuit Judge for the Eighth Circuit, sitting by designation.

Retirement Income Security Act (“ERISA”). Buchanan raises five issues on appeal. We have jurisdiction pursuant to 28 U.S.C. § 1291. We affirm on all but one issue, and remand to the district court for further proceedings under *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955 (9th Cir. 2006) (en banc). Because the facts are known to the parties, we revisit them only as necessary.

The district court properly held Nevada state law does not govern the interpretation of the term “total disability” in Standard Insurance’s long term disability policy. The interpretation of terms in an ERISA insurance policy is governed by federal common law, not state law. *Evans v. Safeco Life Ins. Co.*, 916 F.2d 1437, 1439–40 (9th Cir. 1990) (holding state common law of contract interpretation is preempted by ERISA and does not qualify for ERISA’s “savings clause”¹).

The district court properly held the “process of nature” rule was inapplicable to Buchanan’s disability claim. This common law doctrine applies only to insurance contract provisions requiring that an injury manifest itself within a certain time period after the accident causing the injury takes place. *See Willden v. Washington Nat’l Ins. Co.*, 557 P.2d 501, 503–04 (Cal. 1976). Standard Insurance’s long term disability policy contains no such provision. Because the

¹ 29 U.S.C. § 1144(b)(2)(A).

process of nature rule is inapplicable to Buchanan's claim, we need not address whether it is preempted by federal ERISA law.

The district court properly held it should review for abuse of discretion Standard Insurance's decision to deny Buchanan benefits. When an ERISA plan unambiguously confers discretionary authority on the plan administrator to determine eligibility for benefits or to construe the terms of the plan, courts must review for abuse of discretion the administrator's decision to deny benefits. *Abatie*, 458 F.3d at 963. Standard Insurance's long term disability plan unambiguously conferred discretionary authority on its plan administrator. *See Bendixen v. Standard Ins. Co.*, 185 F.3d 939, 943 (9th Cir. 1999) (holding an identically worded "Allocation of Authority" provision "clearly confers discretion on Standard to decide whether a claimant is disabled.").

Citing Nev. Rev. Stat. §§ 689B.080(3), (5)–(6), Buchanan contends Nevada state law prohibits the grant of discretionary authority to insurance plan administrators. Buchanan further claims these statutes are not preempted by federal ERISA law. Because the discretionary clause in Standard Insurance's disability policy purportedly is invalid under Nevada state law, Buchanan claims the administrator's decision to deny him benefits should not be reviewed under an abuse of discretion standard. The statutes cited by Buchanan, however, do not

prohibit the grant of discretionary authority to insurance plan administrators; they instead regulate the timing and frequency of payments that must be made if benefits are due under the policy. Because the statutes are inapplicable to Buchanan's claim, we need not address whether the statutes are preempted by ERISA.

When conducting its review for abuse of discretion, the district court analyzed Standard Insurance's "structural" conflict of interest (as both the funding source and the administrator of the disability plan) using a two-part burden-shifting methodology. After the district court's decision, this court disapproved this burden-shifting methodology in *Abatie*, 458 F.3d at 967. *Abatie* fundamentally altered how courts apply the abuse of discretion standard by ensuring the plan administrator's structural conflict of interest would always be taken into account, without requiring the plaintiff to produce "smoking gun" evidence of actual conflict. *Id.* at 968–69. This court identified several factors courts could consider when determining the level of skepticism with which to examine a conflicted

administrator's decision to deny benefits.² One such factor was the failure to credit a claimant's "reliable evidence." *Id.* at 968. In the instant case, Buchanan claimed Standard Insurance failed to credit the July 19, 2001, letter from Dr. Kurlinski—Buchanan's supervisor—stating Buchanan had significant ambulatory disability starting in July 1999. *Abatie* also listed failure adequately to investigate a claim or ask for additional evidence as a factor courts could consider when evaluating the plan administrator's conflict of interest. *Id.* In its final letter denying benefits, Standard Insurance noted the February 4, 2003, letter sent by Buchanan's treating physician, Dr. Kerr, was not supported by medical documentation. It does not appear from the record that Standard Insurance investigated the medical basis for Dr. Kerr's letter any further. Standard Insurance also refused Buchanan's request for an independent medical evaluation.³ Under

² "A court may weigh a conflict more heavily if, for example, the administrator provides inconsistent reasons for denial, fails adequately to investigate a claim or ask the plaintiff for necessary evidence, fails to credit a claimant's reliable evidence, or has repeatedly denied benefits to deserving participants by interpreting plan terms incorrectly or by making decisions against the weight of evidence in the record." *Id.* at 968–69.

³ *Abatie* listed the use of "truly independent medical examiners or a neutral, independent review process" as evidence an ERISA plan administrator could produce to demonstrate its decisionmaking process was not influenced by a conflict of interest. *Id.* at 969 n. 7.

Abatie, this is evidence from which a finder of fact could infer Standard Insurance's decision to deny benefits was influenced by its conflict of interest.

Abatie also recognized the district court may, in its discretion, weigh facts and circumstances outside the administrative record when evaluating what effect the plan administrator's conflict of interest had on its decision-making process. *Id.* at 970. Because *Abatie* so significantly shifted the abuse of discretion analysis, and the district court can consider facts beyond the administrative record, the district court should apply *Abatie* in the first instance. We remand to the district court for further proceedings under *Abatie*.

AFFIRMED IN PART; REVERSED AND REMANDED IN PART.

Each party shall bear its own costs.