ERISA Research

ERISA and Obamacare

SOURCE 1:

The Impact of External Reviews on Discretion in ERISA Health Litigation

https://www.americanbar.org/groups/labor_law/publications/ebc_news_archive/winter-2019-issue/impact-of-external-reviews/

- The uptick in external medical reviews for ERISA health claims has potential consequences when plan administrators seek to assert a discretionary standard of review in federal court. The Affordable Care Act has increased the usage of the federal external review process, in addition to state external review programs. As the final, and optional, appeal opportunity, external reviews make medical necessity decisions that are binding on ERISA administrators. In doing so, the external reviews may result in ERISA administrators relinquishing discretionary authority over health claims.
- ***De Novo is the Default Standard of Review in ERISA Cases***
    - The default standard of review in an ERISA matter is de novo because an administrator is presumed to have no discretion to interpret the terms of an ERISA plan. The administrator bears the burden of showing that the written ERISA plan unambiguously confers such discretion on the administrator. Where that burden is met, the administrator's denial of benefits is reviewed for abuse of discretion. Where that burden is not met, the court reviews the administrator's decision de novo
- ***ERISA Plans Bear the Burden of Proving Discretion Was Delegated and Exercised***
    - To alter the standard of review from de novo to abuse of discretion, ERISA plan administrators have the burden of establishing a delegation evident in an ERISA plan document. ERISA explicitly states that an outside party not named in the plan may only be vested with discretion "pursuant to a procedure specified in the plan."
    - In addition to the delegation of discretion, there must be an actual exercise of that discretion. When an administrator is delegated with discretion, that fact alone is insufficient to confer a discretionary standard of review if an administrator fails to actually exercise discretion in the claims decision. If there is no exercise of discretion, it follows that the benefit decision cannot be reviewed for abuse of discretion. For example, numerous courts have held that where a plan fiduciary fails to act within time limits prescribed by ERISA regulations, a "deemed denied" decision is not entitled to deference under *Firestone* regardless of any grant of discretionary authority. In the same

vein, courts hold that decisions made by an entity that was not delegated discretionary authority are to be reviewed de novo.

- ***Decisions Addressing External Reviews and ERISA Health Claims***
    - External reviewers are usually called upon to decide questions of medical necessity pursuant to plan terms. The external reviewers are not named in the ERISA plan and are independently chosen. Therefore, the reviewers remain relatively unknown to claimants. Numerous courts have held "[d]ecisions made outside the boundaries of conferred discretion are not exercises of discretion, the substance of the decisions notwithstanding." In such cases, because the decision of the external reviewer is not within the boundaries of the discretion conferred on the administrator, and the external reviewer had not itself been granted discretionary authority, courts must consider whether the decision on external review is entitled to deference. The question is further complicated by the fact that external reviews are binding on the administrator but not binding on the claimant who is still entitled to additional remedies, including legal action.
    - The few decisions addressing ERISA health claims and external reviews offer some guidance. In *Bailey v. Chevron Corp. Omnibus Health Care Plan,* the court held that the external review process was not mandatory and the Affordable Care Act did not require an external review to exhaust administrative appeals pursuant to ERISA.
    - In *Adele E. v. Anthem Blue Cross,* the court held that the state law banning discretionary clauses applied to the policy and that the claimant did not forgo a de novo standard of review by availing herself of the state's external review process.
    - In *B. v. Horizon Blue Cross Blue Shield of New Jersey,* the court held that documents reviewed during an external review were part of the ERISA administrative record. But the opposite conclusion was reached in *Yox v. Providence Health Plan*.
    - Courts are also split on whether an external review decision causes an ERISA administrator to relinquish its discretionary authority. In *K.F. ex rel. Fry v. Regence Blueshield*, the court held that the state's external review procedure extinguished the administrator's discretionary authority because the administrator was compelled by law to implement the external review's final determination:
    - As discussed in *Rush Prudential*, 536 U.S. at 2169 n. 16 and 2170, states are permitted to remove the administrator's discretionary authority to determine an insured's eligibility for benefits by incorporating binding external review procedures into the terms of the plan. Washington has done so through RCW 48.43.535, and the mandatory implementation provision set forth in subsection 7 became part of the benefit plan. In such circumstances, Regence's adoption and implementation of the IRO's decision wasmechanical and did not involve the exercise of discretion. The de novo standard of review therefore applies.
    - Likewise, in *Alexandra H. v. Oxford Health Ins., Inc.*, the court held that the New York external appeal process "requires a plan to divest its discretion in favor of

the external reviewer's decision" and therefore a de novo standard of review is appropriate. Although most courts have declined to follow the *Fry*decision, the question remains the extent to which discretion and standard of review are affected by external reviews in ERISA health cases.

SOURCE 2:

Where ERISA And the Affordable Care Act Collide

https://www.ebglaw.com/content/uploads/2014/06/58687_Where-ERISA-And-The-Affordable-Care-Act-Collide-Kara-Maciel-Adam-Solander.pdf

Law360, New York (December 05, 2013, 3:48 PM ET) -- In July 2013, the Obama administration announced a delay of the employer mandate provision of the Affordable Care Act for one year (i.e., the employer mandate). While back in July a one-year delay seemed like an eternity, the reality is that given the way in which most employers will determine whether an employee is classified as full-time, and therefore is eligible for coverage, as a practical matter, in very short order employers may be forced to make staffing decisions that could expose them to liability. This article will examine some of the risks associated with employer staffing decisions and how those risks maybe mitigated.

In general, the employer mandate requires that certain "applicable large employers" make an offer of coverage to their employees who work on average 30 hours or more each week. The regulations implementing the employer mandate allow employers to select a "look-back" period of time between three months to one year to use as a measurement period to determine if an employee worked an average of 30 hours or more per week. If the employer determines that an employee was employed on average at least 30 hours of service per week during the "look-back" period, then the employer must treat the employee as a full-time employee during a subsequent "stability period," regardless of the number of hours of service the individual works over that time period. Because employers may use a look-back period of up to one year, many employers will start counting the number of hours their employees work beginning Jan. 1, 2014. Thus, in many cases, employer staffing decisions must be made soon.

There is very little doubt, especially in industries that employ large numbers of part-time workers, that the 30 hour classification of "full-time" employees will increase the number of employees who are eligible for coverage and as a result will increase the cost of the employer's benefits. Being rationale actors, it seems reasonable that employers will generally seek to maximize their staffing in a manner that minimizes the impact of the 30 hour threshold. In some cases, this may mean that to reduce the cost of coverage employers will reduce part-time

workers' hours below 30 hours per week and consequently ensure that employees who typically work over 30 hours per week work more hours.

A strategy of reducing employee hours could potentially expose employers to liability under Employee Retirement Income Security Act of 1974 section 510. In general, section 510 of ERISA prohibits interfering with employee benefits and protects employees' rights to present and future entitlements. In the context of the ACA, claims may be made that an employer's workforce management efforts interfered with an employee's right to health coverage. In this regard, the most obvious plaintiff would be an employee who averaged 30 hours or more a week previously and whose employer reduced his or her workload below 30 hours per week in response to the employer mandate. In such a situation, arguments could be made that the change was made with the intent to deny that individual a right to which he or she would have been entitled (i.e., health coverage).

This risk was recently brought to light during a U.S. House of Representatives Committee on Small Business, Subcommittee on Health and Technology hearing into "The Effects of the Health Law's Definitions of Full-Time Employee on Small Businesses." During that hearing, the chair of the subcommittee raised this issue and stated his opinion that the application of ERISA section 510 to employer mandate workforce management situations represents a conflict of law. Regardless of whether a conflict exists, the merits of ERISA section 510 claims are likely to be tested in the courts. Thus, it is important for employers to understand the claims that may be brought against them in this regard and the steps that maybe taken to reduce the chance of such claims succeeding.

ERISA section 510 is enforced through the civil enforcement framework laid out in section 502 of ERISA. Depending upon the nature of the action, ERISA section 502 allows for both private parties as well the secretary of labor to bring civil actions to enforce ERISA. While all of the arguments a plaintiff might make in an ERISA section 510 claim might make is not entirely clear in the context of the employer mandate, and without commenting on the merits of such claims, enforcement actions could involve the following several provisions of ERISA section 502(a):

First, under section 502(a)(1)(B), a participant or beneficiary may bring a civil action to recover benefits due to him under the plan, to enforce his rights under the plan, or to clarify his rights to future benefits under the plan.

Second, section 502(a)(2) allows the secretary of labor, a participant, a beneficiary, or a fiduciary may bring an action against a fiduciary for breach of fiduciary duty in accordance with section 409 of ERISA.

Third, a participant, beneficiary, fiduciary, and in certain cases the secretary of labor, is authorized to bring an action under section 502(a)(3) to (1) enjoin any act or practice which violates ERISA or the terms of the plan, or (2) obtain other appropriate equitable relief to redress violations or enforce any provisions of ERISA or the terms of the plan.

Typically, plaintiffs bringing ERISA section 510 claims seek redress under the first and third options above. Under these options, monetary relief is limited. The first option restricts potential monetary relief to benefits due under the plan. However, section 502(a)(3), the so-called "catch-all provision," makes available "other appropriate equitable relief." The interpretation of the third option has been the subject of considerable legal debate.

In CIGNA Corp. v. Amara, the Supreme Court indicated in dicta that such equitable relief may include monetary relief in certain situations, which would not necessarily be limited to the value of a lost plan benefit. Thus, in section 510 claims plaintiffs maybe entitled to relief that extends beyond monetary relief for benefits due under the plan in certain circumstances.

ERISA section 510 claims are generally evaluated by the courts using a three-step process. The most relevant aspect of such an evaluation is that a plaintiff must generally establish that the employer was motivated by the specific intent to avoid providing the benefit. As discussed above, the most likely plaintiff in an ERISA section 510 situation would seem to involve an employee who averaged 30 hours per week prior to the employer's staffing decision, but whose hours were reduced to below 30 hours per week.

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Given the need to make staffing decisions in the short term, there are steps an employer may take that may limit the risk of a section 510 enforcement action or suit. The crux of managing section 510 exposure rests on the employer's ability to limit the argument that they acted with a specific intent to deny an employee a benefit to which he or she would have been entitled. Perhaps most significant, is the need to manage both internal and external communications relating to staffing decisions.

From an external standpoint, employers should refrain from discussing their benefit strategy or staffing decisions with the media. Further, employers should be cognizant that internal communications may also be used to establish specific intent. Thus, employers should create a centralized message relative to the company's response to the employer mandate and convey that message to all employees.

—By Adam C. Solander and Kara M. Maciel, Epstein Becker Green PC

SOURCE 3:

The Need to Strengthen ERISA

http://www.americanhealthpolicy.org/Content/documents/resources/The_Need_to_Strengthen_ERISA_Preemption.pdf

Preemption

Introduction

The Employee Retirement Income Security Act of 1974 (ERISA) created preemption principles that are integral to the robust operation of self-insured employer-sponsored health plans. Without ERISA, multi-state self-insured employer-sponsored plans would find it nearly impossible to operate under a variety of cumbersome and potentially conflicting state-based rules. Yet recent developments in Washington are raising concerns about ERISA's potential to maintain uniform operating rules across multiple states.

The latest series of challenges began in 2010, with the passage of the Affordable Care Act, which poses significant hurdles to the uniform administration of employer-sponsored health plans, creating administrative burdens that subvert certain bedrock preemption protections under ERISA. But Republican reform efforts present ERISA challenges as well. Although the GOP effort to repeal and replace the ACA is stalled in Congress, the employer-sponsored health system may see significant policy changes as the Trump Administration implements Executive Order 13765 to provide more state flexibility. Moreover, key policymakers and stakeholders have signaled a preference for a state-driven health care delivery solution instead of the heavily regulated federal regime created by the ACA. In this challenging environment, any ACA reforms should remedy its current indifference to the vital role that ERISA plays in enabling multi-state employers to offer uniform low-cost health care benefits to employees and their dependents no matter where they live or work. Increasing state flexibility and innovation should not disrupt ERISA, which is essential to the continued success of the employer-based system.

I. The Significance of ERISA Preemption

Before ERISA, multi-state employers were subject to different state laws, which prevented the uniform administration of health care benefits, increased the cost of those benefits, and blunted the ability of large employers to improve the efficiency of the U.S. health system. In order to address this problem and to encourage employers to provide health care benefits,3 Congress crafted ERISA to supersede or preempt any and all state laws as they relate to any employee benefit plan as defined under the law.4 In addition, ERISA prohibits states from regulating benefit plans as insurance in an effort to circumvent ERISA preemption.5 These provisions generally protect self-insured employer-sponsored health care plans from state laws that would otherwise mandate benefit requirements or impose administrative burdens, bind employers particular plan designs, or preclude employers from implementing uniform plan administrative practices across states. As a result, ERISA preemption significantly reduces costs for self-insured health care plan sponsors, participants, and beneficiaries.

ERISA's preemption provisions allow plan sponsors to seek lower-cost, nationwide pricing for health care services, allowing for uniformity of benefits design and equity across an employer's workforce. It also enables large employers to drive innovation in benefit and plan design, foster new health care cost controls, and improve the quality of care. These innovations have included consumer directed benefit designs, payment reform, provider transparency initiatives, and wellness programs. Any weakening of the foundation provided by ERISA preemption not only

increases the cost and complexity of health benefits for employees and employers, but also frustrates further health care market innovation.

II. ERISA Preemption and the Affordable Care Act

The legislative history of ERISA makes clear that Congress intended ERISA's preemption provisions to be very broad. For the first 20 years after the law was enacted, courts applied ERISA's preemption mandate "literally and capaciously" to preempt a wide variety of state laws.6 However, since 1995, the courts have significantly narrowed preemption protections. For example, in 1995 the Supreme Court held that ERISA did not preempt a state law imposing cost burdens on a health plan if those burdens only ''indirectly affect what an ERISA or other plan can afford or get for its money,"7 and in 1997, the high court held that ERISA did not preempt a New York State tax imposed on the gross patient receipts of operators of medical facilities, including those operated by ERISA plans.8 Then in 2016, the Sixth Circuit Court of Appeals held in Self-Insurance Institute of America v. Snyder that ERISA does not preempt a one percent Michigan State tax on the benefits paid by ERISA health care plans.

Despite the Supreme Court's comparatively broad reading of the ERISA preemption in Gobeille v. Liberty Mutual Insurance Co. in 2016, prior court decisions have narrowed preemption in an manner that could threaten the long-term stability of employer-provided health care benefits should state taxes and fees on ERISA plans continue to proliferate.10 In fact, the Sixth Circuit Court of Appeals decision in Snyder may provide a means by which state laws with incidental reporting and record-keeping requirements can continue to operate unimpeded by ERISA.1

ACA also threatens fundamental ERISA preemption protections. For instance, ACA regulations require self-insured plans to defer to states for determining key compliance aspects of the law, such as the definition of essential health benefits protected from annual and lifetime benefit limits.12 Further, certain states have construed federal agency regulations interpreting section 1311 of the ACA to allow states to impose taxes on self-insured health plan claims to help pay for state health insurance exchanges.13 The ACA also authorizes states to apply for federal innovation waivers that endow states with the flexibility to pursue their own strategies for providing comprehensive and affordable health care.14 Although the U.S. Department of Health and Human Services (HHS) issued a final rule in 2012 establishing the procedural framework for states seeking such waivers, the substantive rules governing the scope and subject matter of state waivers were never issued.15 However, in response to public comments, HHS clarified that "no federal laws or requirements may be waived that are not within the Secretaries' authority." While this suggests there may be certain limits on state innovation waivers, states remain at liberty to adopt requirements that may unintentionally, but dramatically, erode the ERISA preemption and impact self-insured plans should policymakers remain indifferent to its significance. For example, the Secretary for the Massachusetts Department of Health and Human Services has asked HHS for a waiver to create an alternative to the ACA employer mandate and penalties, and to allow the state "to develop creative ways for employers to offer coverage to their employees," including tailoring the use of Health Reimbursement Arrangements and Section 125 cafeteria plans.

III. The Impact of State Taxes and Fees on Self-Insured Plans on ERISA Preemption Protections

State taxes and fees on self-insured plans made subject to ERISA are one of the most impending threats to ERISA preemption. States have used such assessments to fund a variety of state health programs. These include the Alaska Vaccine Assessment Program, Kentucky's ACA exchange fee, the Maryland Health Care Commission Fund, the Massachusetts Vaccine Purchase Trust Fund, the Oregon Transitional Reinsurance Pool, the Rhode Island Childhood Immunization Program, and the Vermont Immunization Program. Further, Michigan enacted a one percent tax on the health care claims paid by all employer-sponsored plans in the state, including self-insured plans. Almost a dozen other states are considering similar taxes to fund their health care programs. The more states are empowered to impose burdensome tax and reporting requirements on employers, the more they will do so. This slippery slope represents a serious threat to the viability of self-insured health care benefit plans, and thus to the purposes of ERISA preemption.

Large employers are concerned about the proliferation state taxes and fees on their multi-state operations. Forty-two percent of large employers say the erosion of the ERISA preemption would motivate their company to consider a significantly different approach to health care.17 Ninety-one percent of large employers say that if Congress opens the door to health care reform being addressed on a state-by-state basis, the substantial variances that are likely to arise among the states would create considerable administrative problems for multi-state employers,18 and 86 percent say the most important regulatory action the Trump Administration could take would be to protect ERISA preemption as state innovation waivers are implemented.

IV. ERISA Preemption and Congressional Health Care Reform

Key stakeholders involved with current health care reform efforts favor a state-driven solution that would enable states to tailor individualized health care regulatory schemes, but may not recognize the importance of maintaining preemption protections. Preference for this state by-state reform approach began as a groundswell among several Republican governors who met just prior to President Trump's inauguration to voice their support for state flexibility as a key priority in the health care reform debate.20 This support was echoed in President Trump's Executive Order 13765, which directed the executive agencies to "…prepare to afford the States more flexibility and control to create a more free and open healthcare market."21 Following suit, a February 2017 white paper outlining the House Republican health care reform plan foreshadowed legislation that would empower states to modernize their health care programs and allow each jurisdiction to "best take care of their unique patient populations."22 The American Health Care Act (H.R. 1628), as passed by the U.S. House of Representatives on May 4, 2017, effects this state-by-state approach by providing states with the flexibility to allow each state to craft their health care programs as they see fit, including mandates that could impact employer sponsored plans. In the Senate, the Better Care Reconciliation Act of 2017 would also provide "states additional flexibility to use waivers" in the ACA to free their health insurance markets from costly regulations.23 Importantly, neither legislation explicitly protects the ERISA preemption for self-insured plans, and thereby runs the risk of unintentionally weakening ERISA protection for multi-state, self-insured health plans.

V. The Impact of a State-by-State Replacement Solution on ERIS Governed Health Plans

While the flexibility offered by a state-by-state approach to health care reform may be preferable to many, this solution could threaten self-insured employer-sponsored health plans if ERISA preemption is ignored. Adopting a state-by-state approach resurrects various practical concerns rooted in the preemption threats posed by the ACA, and could create new threats as well, including: (1) laws and regulations that could allow states to collect health care claims data and fees from self-insured plans; (2) state compliance schemes that potentially compromise the consistent administration of large employer-sponsored health plans; and (3) ACA alternative approaches that prioritize flexibility over preemption protections in the name of state health care innovation.

A. Health Care Reform Should Protect Self-Insured ERISA Plans from State Efforts to Collect Claims Data and Impose Taxes and Fees on Health Plans

If federal legislative efforts encourage states to pursue individualized health care reform, states will inevitably seek to gather claims information from large employers and the plans they sponsor. In fact, as many as 17 states are currently pressing employer-sponsored plans for demographic and claims information through mandatory all-payer state claims databases and/or are imposing fees relating to such claims.24 Although a recent Supreme Court decision held that state demands for plan-level data are currently applicable only to fully-insured employer health care plans,25 federal health care reform efforts that favor state-level reforms may allow states to again sweep self-insured plan data into the purview of state regulation. Moreover, the Sixth Circuit Court of Appeals decision in Self-Insurance Institute of America v. Snyder, which explicitly attempts to narrow ERISA preemption in such cases, may provide the means by which state reporting and record-keeping requirements can circumvent ERISA preemption.2

More importantly, under current case law, it remains unclear whether ERISA preempts state taxes on the benefits paid by ERISA health care plans in all cases. The uncertainty surrounding the courts' treatment of state taxes and fees on self-insured plans threatens the long-term stability of employer-provided health care plans. The proliferation of such taxes and fees on ERISA plans, even if coming as part of understandable health care reform efforts to empower greater state flexibility, could destabilize the employer sponsored health care system. Clear standards supporting ERISA preemption are therefore necessary in order to prevent multiple jurisdictions from imposing differing, or even parallel, regulations, creating wasteful administrative costs and threatening to subject self-insured plans to wide-ranging liability. Failure to preempt state taxes and fees could subject self-insured health plans to 50 or more potentially conflicting and burdensome assessments and are likely to create serious administrative problems. If each State is free to go its own way, each independently assessing taxes and fees on self-insured plans, the result could well be an unnecessary, duplicative, and conflicting maze of reporting requirements, any of which can mean increased confusion and increased cost.

B. Health Care Reform May Expose Employer-Sponsored Health Plans to Inconsistent Compliance Regimes

A state-by-state approach to health reform may also obligate large employers to comply with as many as 50 different regulatory regimes for plan administration. For large employers that operate in multiple states, this may mean different notice and reporting obligations for employees in different states. As noted in the recent Supreme Court decision in Gobeille v. Liberty Mutual, state-specific regulations, even with minimal individual impact, create burdens through the mere "possibility of a body of disuniform [sic] state reporting laws" when considered in the aggregate.

Even beyond reporting requirements, each state could have the flexibility to create its own regulations regarding preexisting conditions, mandatory benefits, and the valuation of coverage provided.28 For instance, in its current form the House-passed American Health Care Act would allow each state to choose whether to use block grant funds to mandate preventive health services as a key component of its health care market requirements. The bill does not explicitly limit state intervention to the individual or "small group" market, meaning that states would be free to mandate benefit changes to employer-sponsored plans as well. Not only could this approach lead to the inconsistent administration of employer-sponsored health coverage, but as state funding priorities shift and benefit mandates change, employers may be required to constantly revise and update plan offerings in order to remain in compliance in various jurisdictions. If ACA reforms prioritize state flexibility over ERISA preemption protection, large self-insured plans could be forced to spend considerable resources to comply with changing, and perhaps conflicting, health care regulatory and benefit requirements for their covered population.

C. Prioritizing State Flexibility Could Weaken ERISA Preemption and Expose Self-Insured Health Plans to Coverage Mandates

Large employers remain concerned that the current preference for a state-by-state ACA solution may signal a general erosion of ERISA preemption as a valid exercise of Congressional power. As perhaps the most significant threat to the employer-sponsored plan structure, this erosion of preemption exposes employers to state-based employee coverage mandates akin to the "pay-or-play" laws enacted by states over a decade ago.29 These initiatives were implemented by states in an effort to respond to a federal failure to execute a broad-based healthcare solution. Although state coverage mandates were eventually struck down by federal courts, with strong Congressional support for state flexibility, and the courts' recognition of the "wide latitude enjoyed by states to regulate healthcare providers,"30 a state-by-state ACA replacement approach exposes employers to pay-or-play once again.

Congress and the current Administration cannot sacrifice strong support for ERISA preemption while it attempts to maximize state health care coverage innovation. The Supreme Court has upheld a presumption against ERISA preemption of state laws absent a clear indication of Congressional intent, so that state laws can be given the fullest effect possible.31 The Court has also held that matters of health and safety have traditionally been regulated by states, further supporting the presumption against preemption of such state health care laws that only impact

plans economically.32 Unless Congress clearly states its intent to preserve ERISA preemption, states will use this latitude to place direct cost burdens on self-insured plans under a traditional ERISA preemption analysis.

In addition, Congress has never clearly exercised its preemption authority on a number of state law issues that indirectly impact self-insured plans. For instance, states are still permitted to regulate third-party administrators that provide services to self-insured plans. States may also regulate insurers that provide health care stop-loss insurance to self-insured plans. If ACA reforms do not clearly prohibit states from regulating in these areas, states will continue to indirectly mandate such changes to self-insured plans, quietly and indirectly eroding ERISA's fundamental preemption principles.

As noted by the Supreme Court in Gobeille, ERISA preemption is necessary to prevent states from imposing "novel, inconsistent, and burdensome"33 requirements on employer-sponsored health plans. A patchwork of state ACA legislative and regulatory alternatives that would impact the administration of employer-sponsored plans is wholly inconsistent with the framework of ERISA.

Conclusion

While health care reforms should offer states greater flexibility to free their individual and small group health insurance markets from costly ACA regulations, those reforms should not place new mandates or burdens on health plans governed under ERISA. Congress should not adopt or amplify the ACA's indifferent approach to ERISA preemption in the interest of state flexibility and innovation. While states should still have broad authority to regulate health care providers and health care insurers, ACA reforms must clearly and explicitly prohibit approaches that permit state regulation of ERISA plan benefits, force plans to provide sensitive claims data, or impose new state-mandated taxes and fees. Health care reform is clearly needed, but it should not disrupt the uniform administration of ERISA on a nationwide basis through mandates or other requirements, nor should it prioritize flexibility over preemption. Instead, ACA reforms must explicitly direct states to use innovation to develop workable, low-cost alternatives to the ACA that do not damage the employer-sponsored health care system.

SOURCE 4:

Circuit Round-up of Key Appellate ERISA Decisions from February-September 2018

https://www.americanbar.org/groups/labor_law/publications/ebc_news_archive/fall-2018-issue/Circuit_Round-up_of_Key_Appellate_ERISA_Decisions_from_February-September_2018/

First Circuit

Ellis v. Fid. Mgmt. Tr. Co., 883 F.3d 1, 63 EB Cases 1807 (1st Cir. 2018) (breach of fiduciary duty).

In this certified class action alleging that Defendant breached its duties of loyalty and prudence under ERISA, the First Circuit affirmed the district court's grant of summary judgment to Defendant. The court held that: (1) the participants failed to establish that there was a conflict of interest in the administrator's pursuit of wrap insurance; (2) the administrator did not violate its duty of loyalty under ERISA by picking a conservative performance benchmark for its stable value fund; (3) the participants failed to establish that the administrator's pursuit of wrap insurance breached its duty of prudence under ERISA; (4) the administrator's choice of a performance benchmark for its portfolio could not be imprudent, in violation of ERISA, by virtue of being too conservative; and (5) there was no evidence that the administrator's decisions regarding the portfolio were unreasonable under the circumstances at the time.

Barchock v. CVS Health Corp., 886 F.3d 43, EB Cases 2011 (1st Cir. 2018) (breach of fiduciary duty).

The court affirmed the district court's dismissal of Plaintiffs' allegations that the fiduciaries of an employer-sponsored retirement plan breached their fiduciary duties by investing too heavily in cash or cash-equivalents for the years at issue and thus that the plan was imprudently managed and monitored. Imprudence cannot be inferred solely from the charge that Galliard's cash-equivalent allocation "departed radically" from both industry averages and the underlying financial logic of stable value management, as "the complaint alleges no harm other than the stable value fund's underperformance as result of [CVS Defendant's] alleged misallocation of the fund's assets. Because of our determination that this alleged harm is not cognizable under ERISA, there remains no basis for supporting a claim against the CVS Defendants."

<u>Second Circuit</u>

Montefiore Medical Center v. Local 272 Welfare Fund, 712 F.App'x 104, 2018 EB Cases 66976 (2d Cir. 2018) (provider claims).

The court affirmed the district court's grant of summary judgment to the medical center. The dispute centered on the interpretation of plan language regarding payment of out-of-network services, specifically, "the maximum amount the Plan would have paid an in-network provider for the same service." The Second Circuit agreed that the Plan's language is unambiguous and mandates that the Fund determine the rates it pays all of its in-network providers for a certain service and then select the maximum rate among the various in-network provider rates.

Allen v. Credit Suisse Sec. (USA) LLC, 895 F.3d 214, 2018 EB Cases 243334 (2d Cir. 2018) (breach of fiduciary duty).

In this putative class action against twelve banks and their affiliates for breach of ERISA fiduciary duties owed to various ERISA plans or, in the alternative, for Defendants' knowing

participation in prohibited transactions as non-fiduciary parties-in-interest, the court determined that Plaintiffs failed to state plausible ERISA claims because the facts alleged do not show that Defendants exercised the control over Plan assets necessary to establish ERISA functional fiduciary status. The district court did not abuse its discretion or commit legal error by denying adjournment in anticipation of further amendment to the complaint.

In re DeRogatis, No. 16-3549-CV, __F.3d__, 2018 WL 4370990 (2d Cir. Sept. 14, 2018) (breach of fiduciary duty).

Plaintiff appeals two separate cases denying relief against the Pension Fund and Welfare Fund due to a lower pension benefit she received following the death of her husband. Plaintiff alleged that misrepresentation by plan fiduciaries caused her and her husband to delay submitting her husband's retirement application, thereby inadvertently forfeiting the ability to apply for the 100% Joint Annuity benefit. As relief, she seeks a surcharge to compensate her for the difference between the Preretirement Annuity she is receiving and the 100% Joint Annuity her husband intended her to have. The court affirmed the judgment of the District Court in favor of the Pension Fund on Plaintiff's claim for benefits and for breach of fiduciary duty. However, it vacated the district court's judgment in favor of the Welfare Fund and remanded the case for further proceedings. It explained that:

"With respect to the Welfare Fund, however, we perceive a dispute of material fact bearing on the question of fiduciary breach: that is, whether the Fund's written plan materials, combined with purported misrepresentations by the Fund's employees, failed to adequately inform the DeRogatises about the effect that Frank's early retirement would have on the couple's health benefits under the Welfare Plan. We therefore vacate the award of summary judgment to the Welfare Fund and remand to the District Court for consideration of whether, on the present record, a factfinder could reasonably conclude that DeRogatis is entitled to equitable relief. If not, then the Welfare Fund may be entitled to summary judgment, notwithstanding the dispute of fact as to whether the Fund breached a fiduciary duty."

Third Circuit

Am. Orthopedic & Sports Med. v. Indep. Blue Cross Blue Shield, 890 F.3d 445, 2018 EB Cases 173478 (3d Cir. 2018) (provider claims).

In a challenge by a healthcare provider against an insurance company concerning its anti-assignment clauses, the court held that anti-assignment clauses in ERISA-governed health insurance plans were generally enforceable; the insurers did not waive their right to enforce the anti-assignment clause by accepting and processing the claim and failing to raise the anti-assignment clause as a defense during the administrative appeals process; the anti-assignment clause did not prevent the insured from conferring authority on the healthcare provider, as his agent through power of attorney, to assert claim against plan on his behalf; and the provider waived its arguments concerning the power of attorney by failing to raise them in its opening or reply brief.

Cup v. Ampco Pittsburgh Corp., No. 17-2349, __F.3d__, 2018 WL 4101049 (3d Cir. Aug. 29, 2018) (procedure).

The court reversed and remanded the district court's decision to compel arbitration of this dispute over retiree medical benefits because these benefits are not subject to the CBA. "As the Company correctly points out, 'there is no provision in the CBA regarding retiree medical benefits,' and the MOA does not provide for arbitration. Nor did the CBA include retirees in its definition of 'employees' or incorporate the MOA's provisions regarding retiree health benefits." (internal citations omitted).

Fourth Circuit

Wagner v. American United Life Insurance Company, 731 F.App'x 495, 2018 EB Cases 157151 (6th Cir. 2018) (disability benefit claims).

In an unpublished decision the Sixth Circuit Court of Appeals reversed the decision and ordered AUL to pay Plaintiff long-term disability benefits. The Court found significant that "[e]very professional who met Wagner agreed that he should not return to work. DRMS's own vocational rehabilitation counselor said that Wagner was 'not capable of full time employment' a year before his benefits ended, due to the 'pain flashes' and grogginess from lack of sleep." The court found that Wagner never recovered from his initial disability when his benefits ended.

In addressing AUL's arguments, the court noted that DRMS's medical reviewer concluded that Wagner was lying based on 20 minutes of surveillance video. "That type of credibility opinion is entitled to little weight when based on a paper review—especially when the insurer can order an in-person examination." The court found that the surveillance was "weak evidence" since Wagner and his doctors explained that his pain would come and go.

On the issue of the remedy, the court rejected AUL's argument that it should only have to pay him two months of benefits since the stricter "total disability" standard applies beyond then. The court explained that DRMS could have made that decision at month 36 but it chose to forgo that opportunity when it wrongly decided that Wagner was no longer entitled to benefits at month 34. The court ordered that Defendant must pay Wagner the three years of benefits that he has missed.

Gordon v. CIGNA Corp., 890 F.3d 463, 2018 EB Cases 171836 (4th Cir. 2018) (fiduciary status).

The court affirmed the district court's decision in favor of LINA on Plaintiff's claim seeking additional life insurance benefits on the theory that LINA breached its fiduciary duties to the insured. Here, the insured paid premiums on life insurance policies that totaled $300,000 but he had only been approved for $150,000 in coverage due to mistakes made by the employer. The Fourth Circuit held that the insurance plan constituted a "guaranteed benefit policy," which was excluded from ERISA's definition of plan assets over which insurer was a

fiduciary; the excess premiums paid by the insured to his employer did not create a fiduciary duty on the part of LINA where there was none before; the insurer was not a fiduciary under ERISA with respect to the life insurance policy issued to the insured through his employer; and the denial of Plaintiff's motion to conduct discovery prior to ruling on LINA's summary judgment motion was appropriate.

Fifth Circuit

Kopp v. Klein, 894 F.3d 214 (5th Cir. 2018) (breach of fiduciary duty).

On the case's third trip to the Fifth Circuit, the court affirmed the district court's dismissal of this action alleging breach of fiduciary duty in connection with the loss of millions of dollars of retirement savings. The court held that the plan managers did not breach the fiduciary duty of prudence in relying on the market price of company's stock as the fair assessment of the stock's value; the allegation that plan managers failed to discuss a possible course of action regarding a plan's investment in the employer's stock was insufficient to state claim for breach of the duty of prudence; and the fact that the plan managers' personal wealth was directly tied to the company's financial performance was insufficient to establish a breach of the duty of loyalty for ERISA fiduciaries.

Chamber of Commerce of United States of Am. v. United States Dep't of Labor, 885 F.3d 360, 63 EB Cases 1957 (5th Cir. 2018) (breach of fiduciary duty).

The court reversed the district court's grant of summary judgment to the Department of Labor in this lawsuit brought by business groups against the DOL challenging the "fiduciary rule" that broadly reinterpreted the term "investment advice fiduciary." The Fifth Circuit held that the DOL's expansion of the scope of its "fiduciary rule" to include a broker-dealer and insurance agents conflicted with plain text of ERISA. ERISA's definition of "investment advice fiduciary" was unambiguously limited to the common law definition of fiduciary.

Singh v. RadioShack Corp., 882 F.3d 137, 63 EB Cases 1681 (5th Cir. 2018) (breach of fiduciary duty).

Plaintiffs, who are retirement plan participants, brought a putative class action against Defendants alleging that they breached their fiduciary duties by allowing participants to invest in RadioShack's stock despite its descent into bankruptcy. The district court dismissed Plaintiffs' first and second amended complaints for failure to state a claim pursuant to FRCP 12(b)(6).

On appeal, the Fifth Circuit affirmed the district court's dismissal of the claims. The court held that: (1) absent special circumstances, the plan administrative committee did not breach the duty of prudence by relying on the market price as a fair indicator of the value of the employer's stock; (2) no special circumstances existed that would make the committee's reliance on the market price imprudent; (3) participants failed to allege that the plan administrative committee possessed any inside information that would have made its decision

to purchase the employer's stock at market price imprudent; (4) participants failed to state a duty of prudence claim based on insider information; (5) the fact that directors personally owned employer's stock, without more, did not indicate that they breached their duty of loyalty by failing to freeze the plan investment; and (6) participants lacked Article III standing to assert any claims for breach of fiduciary duty related to the Puerto Rico plan.

White v. Life Ins. Co. of N. Am., 892 F.3d 762, 2018 EB Cases 209549 (5th Cir. 2018) (AD&D benefit exclusion)

This case involves a dispute over life insurance benefits based on the application of an exclusion for death caused by intoxication or drug abuse. Here, the insured was driving on the highway in the late afternoon in broad daylight. Plaintiff, the life insurance beneficiary, was riding as a passenger. For unknown reasons, the insured failed to turn when the highway curved right, crossed three lanes of traffic, and then collided head-on with an oncoming truck. The drug screen indicated that the insured tested positive for amphetamines, cocaine, opiates, benzodiazepine, and cannabinoids. None of the tests measured the level of these drugs in his system. He later died from what the coroner described as multiple trauma, cocaine abuse, and amphetamine abuse.

LINA sent the reports to a Dr. Fochtman, who noted that it was impossible to estimate the level of the insured's intoxication, and thus his level of impairment, at the time of the crash. LINA denied benefits to Plaintiff on the basis that his death was caused at least in part by intoxication or the voluntary ingestion of narcotics or drugs.

The district court found in favor of LINA. The Fifth Circuit reversed the district court's decision and instructed the court to enter judgment in favor of Plaintiff. The court found that four considerations supported its conclusion that "LINA abused its discretion in denying benefits: (A) LINA's conflict of interest; (B) LINA's failure to address Dr. Fochtman's report in any of its denials; (C) LINA's withholding of Dr. Fochtman's report; and (D) the closeness of the evidence to support LINA's determination that intoxication or drug abuse caused David's death."

The court found Dr. Fochtman's report to be support for the claim that the level of drugs in the insured's system could not be determined and the cause of death speculative. This is important "because Arkansas defines 'intoxicated' as being influenced by alcohol or drugs 'to such a degree' that the driver is 'a clear and substantial danger' to himself and those around him." Thus, "the inability to determine whether David was under the influence of alcohol or drugs at the time of the accident does not afford a reasonable conclusion that his death was caused by intoxication or drug abuse." The only evidence supporting the application of the exclusion is the fact that the insured went straight while the road curved right. The court found that this, on its own, was insufficient to support a rational conclusion that the driver was intoxicated while driving. "Thus, in accordance with the Supreme Court's instruction in *Glenn*, and taking into account all facets of this case, we conclude that LINA's conflict of interest 'affected the benefits decision,' and, accordingly, we may not uphold its decision."

Ariana M. v. Humana Health Plan of Texas, Inc., 884 F.3d 246, 63 EB Cases 1909 (5th Cir. 2018) (standard of review).

Since 1991, the Fifth Circuit Court of Appeals, which presides over Texas, Mississippi, and Louisiana federal law, has administered a rule in employee benefit cases. That rule stated that federal courts were required to show deference to the factual findings of a benefit plan administrator, regardless of whether the benefit plan conferred such authority on the administrator. *Pierre v. Conn. Gen. Life Ins. Co.*, 932 F.2d 1552 (5th Cir. 1991).

The rule was unusual because the Fifth Circuit was the only Circuit Court in the United States that had such a rule. The other circuits only show deference to the factual findings of plan administrators if the benefit plan specifically provides for such deference. The majority of the Fifth Circuit panel agreed to overrule its decision in *Pierre*. Of the 14 appellate judges, 8 joined in the majority opinion and 6 dissented. On the merits of Ariana M.'s claim, the majority remanded the case to the district court to apply the appropriate *de novo* standard of review.

(Note: On remand, the district court found that Ariana M's continued partial hospitalization was not medically necessary after she had been covered for 49 days. *Ariana M. v. Humana Health Plan of Texas, Inc.*, No. CV H-14-3206, 2018 WL 4384162 (S.D. Tex. Sept. 14, 2018))

Innova Hosp. San Antonio, Ltd. P'ship v. Blue Cross & Blue Shield of Georgia, Inc., 892 F.3d 719, 2018 EB Cases 207808 (5th Cir. 2018) (provider claims).

In this case brought by out-of-network medical services providers alleging underpayment or non-payment of reimbursement amounts pursuant to terms of various health benefit plans, the court affirmed in part, reversed in part, and remanded. The court held that: (1) the provider stated a claim under ERISA for plan benefits without identifying specific language of every plan provision at issue; (2) the provider stated a breach of contract claim against the insurer without identifying specific language of every health insurance plan provision at issue; (3) the briefing on appeal was inadequate as to the provider's claims under ERISA alleging failure to provide full and fair review and violations of claims procedure, and therefore it forfeited them; (4) the provider had an adequate mechanism for redress, and therefore it could not recover on the ERISA breach of fiduciary duty claim that requested equitable relief in the form of surcharge; and (5) the provider forfeited the argument that district court abused its discretion in denying its motion for leave to amend its complaint out of time.

Hager v. DBG Partners, Inc., No. 17-11147, __F.3d__, 2018 WL 4258968 (5th Cir. Sept. 6, 2018) (statutory penalties)

In *Hager,* the court addressed an issue of first impression for the Fifth Circuit concerning the availability of a remedy for a COBRA notice violation. The court determined that payment of all medical expenses is compensatory damages which is not available under ERISA Section 502(a)(3). But, a penalty is available under Section 502(c)(1) and the court could "discern no barrier to the court awarding the amount of [the participant's] medical expenses as a

penalty." The court remanded the case to the district court to determine whether to award a penalty and the amount of such penalty.

Sixth Circuit

Fletcher v. Honeywell Int'l, Inc., 892 F.3d 217 (6th Cir. 2018) (retiree health benefits)

The Sixth Circuit reversed the district court's decision holding that the relevant CBAs were ambiguous and relied on extrinsic evidence for its conclusion that the parties intended retiree healthcare benefits to vest for life. The court held that the CBAs are unambiguous. The fact that the CBAs expressly provide lifetime healthcare for surviving spouses and dependents but not for the retirees themselves shows that the they knew how to provide vested benefits and chose not to for retirees. Because the language is unambiguous, extrinsic evidence can no longer be considered.

Springer v. Cleveland Clinic Employee Health Plan Total Care, 900 F.3d 284, 2018 EB Cases 289413 (6th Cir. 2018) (Article II standing).

In *Springer*, the plan administrator denied the plan participant's claim for coverage for air ambulance transportation because he did not seek preauthorization. The Sixth Circuit affirmed the district court's determination that the plaintiff has standing to bring his claim despite the failure to allege a financial loss. The court noted that "[e]very circuit court to consider this issue agrees that a plaintiff in Springer's shoes does not need to suffer financial loss. The Fifth, Ninth, and Eleventh Circuits have each held that the denial of plan benefits is a concrete injury for Article III standing even when patients were not directly billed for their medical services." *Springer*, 2018 WL 3849376 at *2, *citing to North Cypress Med. Ctr., Operating Co., Ltd. v. Cigna Healthcare*, 781 F.3d 182, 192–94 (5th Cir. 2015); *Spinedex Physical Therapy USA Inc. v. United Healthcare of Arizona, Inc.*, 770 F.3d 1282, 1289–91 (9th Cir. 2014); *HCA Health Servs. of Georgia, Inc. v. Employers Health Ins. Co.*, 240 F.3d 982, 991 (11th Cir. 2001), *overruled on other grounds by Doyle v. Liberty Life Assur. Co. of Boston*, 542 F.3d 1352 (11th Cir. 2008). On the merits, however, the court determined that the plain language of the plan required precertification so it affirmed the district court's decision in favor of Defendant.

Pearce v. Chrysler Grp. LLC Pension Plan, 893 F.3d 339, 2018 EB Cases 218189 (6th Cir. June 20, 2018) (remedies).

In this dispute over the payment of supplemental retirement benefits, the Sixth Circuit affirmed in part, reversed in part, and remanded the district court's grant of summary judgment for the plan. The court held that: (1) the extent of the injury suffered by Plaintiff as well as any benefit the plan derived from denial, had to be analyzed to determine whether the plan engaged in either fraudulent or inequitable conduct as required to reform provision for benefits under plan; (2) fraud or inequitable conduct did not have to arise in the drafting of the plan document in order to seek reform; (3) Plaintiff had the ability to calculate his true benefits, and therefore he could not invoke equitable estoppel to recover supplemental benefits under unambiguous

plan provisions; and (4) the ability of Plaintiff to calculate his true supplemental benefits under the plan had to be determined by looking at the plan, rather than the SPD, in order to invoke equitable estoppel.

Clemons v. Norton Healthcare Inc. Ret. Plan, 890 F.3d 254, 63 EB Cases 2086 (6th Cir. May 10, 2018) (standard of review).

In this dispute concerning the alleged underpayment of pension benefits, the crucial ambiguity in the Plan is whether the "early retirement reducers" apply to the Plaintiff-Retirees. The district court applied *contra proferentem* to find in favor of the Retirees. The Sixth Circuit, however, concluded that *contra proferentem* cannot be used in conjunction with *Firestone* deference and held that when *Firestone* applies, a court may not invoke *contra proferentem* to "temper" arbitrary-and-capricious review.

The court explained that, as a practical matter, *Firestone* deference and *contra proferentem* cannot be applied to the same case without contradiction. First, *Firestone* deference must include the ability to choose between two reasonable interpretations of the Plan, but this is the precise situation in which traditional *contra proferentem* operates against the drafter. "In effect, applying *contra proferentum* [sic] when language is ambiguous generates a paradox where the administrator can only exercise his discretion when it is not needed, i.e., when the plan language is clear." Second, it is doubtful that plan decisions will be influenced by a *contra proferentem* rule, which is a prophylactic rule (be clear *next* time), not a remedial device. Plan decisions are far removed from contract negotiations and the parties cannot reasonably be expected to foresee every possible negative consequence of the language they use. This is the very reason why administrators are vested with discretion. The court did not abandon *contra proferentem* entirely – it should be applied to the threshold question of whether *Firestone* deference exists.

The court also found no place for *contra proferentem* as a factor in determining whether there is an abuse of discretion, except in the circumstance where the administrator *deliberately* makes the Plan ambiguous so that it can invoke deference to serve its own interests. Because the Plan was unambiguous on all fronts except for the issue of the early retirement reducers, the court vacated the district court's holding on that issue and remanded the matter for a *Firestone* analysis of Defendant's proposed interpretation.

Doe v. Harvard Pilgrim Health Care, Inc., No. 17-2078, __F.3d__, 2018 WL 4237288 (1st Cir. Sept. 6, 2018) (administrative record/standard of review).

Plaintiff-Appellant appealed the district court's grant of summary judgment to HPHC, upholding its determination that Doe's continued residential treatment was not medically necessary. The district court reviewed HPHC's determination under de novo review. The First Circuit reversed the district court, in part, on the basis that the administrative record reviewed by the district court should have included documents from HPHC's post-filing review of the claim. This is

because HPHC agreed to continue the administrative proceedings and also agreed that the documents would become part of the administrative record before the district court. Significantly, the First Circuit held "that when a district court examines the denial of ERISA benefits de novo, we review the court's factual findings only for clear error." This aligns with the approach of the Second, Fourth, Sixth, and Ninth Circuits. Since the district court did not review the complete record, the First Circuit cannot properly conduct such a "deferential review." The court vacated the summary judgment order and remanded for further proceedings.

Seventh Circuit

Cehovic-Dixneuf v. Wong, 895 F.3d 927, 2018 EB Cases 246102 (7th Cir. July 11, 2018) (life insurance/plan status).

The Seventh Circuit affirmed the district court's grant of summary judgment to the sister, as designated beneficiary, to the supplemental insurance policy at issue notwithstanding the various equitable arguments made by the insured's ex-wife. The court held that the policy was outside of ERISA's safe-harbor provision because the employer maintained substantial administrative functions beyond the limited ones allowed by the safe harbor provision. Thus, the policy is governed by ERISA and benefits must be paid according to the governing documents, including beneficiary designations. The court also held that the district court acted within its discretion in denying the ex-wife's motion to alter or amend judgment.

Estate of Jones v. Children's Hosp. & Health Sys. Inc. Pension Plan, 892 F.3d 919, 2018 EB Cases 208636 (7th Cir. June 13, 2018) (pension benefits).

The Plan administrator denied pension benefits to the participant's daughter since the participant died three days before her pension was to start and only spouses are entitled to benefits under the Plan when a participant dies before the start of her pension. The Seventh Circuit affirmed the district court's grant of summary judgment to Defendant, holding that the plan administrator's determination that the participant's ten-year annuity was not payable to the daughter was reasonable.

Teufel v. Northern Trust Co., 887 F.3d 799, 63 EB Cases 2009 (7th Cir. Apr. 11, 2018) (petition for writ of certiorari filed) (anti-cutback rule).

The Seventh Circuit considered whether an amendment to the Northern Trust pension plan decreased Teufel's accrued benefit and harmed older workers relative to younger ones, in violation of ERISA's anti-cutback rule and the Age Discrimination in Employment Act (ADEA).

In 2012, Northern Trust changed its pension plan from a defined-benefit plan under which retirement income depended on years worked, times an average of each employee's five highest-earning consecutive years, times a constant ("Traditional formula") to a new PEP formula that multiplies the years worked and the high average compensation not by a constant

but by a formula that depends on the number of years worked after 2012. The parties agree that it reduces the pension-accrual rate. For people hired before 2002, Northern Trust provided a transitional benefit that treated them as if they were still under the Traditional formula except that it would deem their salaries as increasing at 1.5% per year, without regard to the actual rate of change in their compensation.

Teufel claimed that the amendment reduced his "accrued benefit" because he expected his salary to continue increasing at more than 5% a year, as it had done since he was hired in 1998. The court held that the sponsor's amendment to the pension plan did not decrease Teufel's accrued benefit in violation of ERISA's anti-cutback rule. This is because the expectation of future salary increases is not an "accrued benefit;" the only benefit that had "accrued" was the amount due for work already performed. "What a participant hopes will happen tomorrow has not accrued in the past." Moreover, the Traditional formula does not guarantee that any worker's salary will increase in future years.

In addition, the court found that the sponsor provided Teufel with a writing that describes the amendment in a manner calculated to be understood by the average plan participant, as required by ERISA. Northern Trust provided its staff with an online tool that showed each worker exactly what would happen under a number of different assumptions about future wages and retirement dates. "A precise participant-specific summation is hard to beat for clarity and complies with § 1054(h)(2)." Lastly, the court held that the amendment did not violate the ADEA because the plan complies with § 623(i). The court noted that the Supreme Court has never held that the disparate impact of an age-neutral pension plan can violate the statute.

Dragus v. Reliance Standard Life Ins. Co., 882 F.3d 667, 63 EB Cases 1737 (7th Cir. Feb. 14, 2018) (disability benefit claims/standard of review).

The Seventh Circuit held that Plaintiff waived the argument that Reliance Standard's failure to render a timely decision on her claim compelled *de novo* review simply because she pursued administrative review through an appeal rather than pursued available remedies when the issue arose (i.e. immediately file a lawsuit). On the merits of the case, the court determined that Reliance Standard's decision was not arbitrary and capricious, where it relied on four independent physicians who did an "unbiased investigation." Additionally, the court held that Plaintiff was not entitled to supplement the claim record with the Social Security Administration's decision finding that Dragus is disabled from any gainful employment.

Hennen v. Metropolitan Life Insurance Company, No. 17-3080, __F.3d__, 2018 WL 4376994 (7th Cir. Sept. 14, 2018) (disability plan limitation).

The dispute centers on MetLife's application of its "neuromusculoskeletal and soft tissue disorders" provision, which limits payment for disabilities caused by these conditions to twenty-four months. Exceptions to this limitation are disabilities caused by radiculopathy. MetLife

defined radiculopathy as "Disease of the peripheral nerve roots supported by objective clinical findings of nerve pathology."

The district court granted summary judgment to MetLife on the basis of its finding that MetLife reasonably interpreted the plan to require proof of "active radiculopathy" in 2014 (at the end of the two-year limitation) and that Hennen did not provide such evidence at that time. Hennen appealed and the Seventh Circuit reversed and remanded the district court's grant of summary judgment in favor of MetLife upon finding that it "acted arbitrarily when it discounted the opinions of four doctors who diagnosed Hennen with radiculopathy in favor of the opinion of one physician who ultimately disagreed, but only while recommending additional testing that MetLife declined to pursue."

The court noted two points that need to be addressed on remand. First, where the plan does not defined radiculopathy as nerve root disorders resulting from ongoing compression, was it reasonable for MetLife to require ongoing compression of a nerve root when that is only one potential cause of radiculopathy? Second, though MRIs and EMGs are highly relevant in diagnosing radiculopathy, medical literature demonstrates that radiculopathies may occur without MRI or EMG findings. Thus, was it unreasonable for MetLife to discount the clinical observations of Hennen's treating physicians in favor of testing that is inconclusive for the condition? If MetLife finds that Hennen has satisfied the radiculopathy exception, then it must determine Hennen's degree of disability, a decision it did not make at the 24-month mark.

Eighth Circuit

Meiners v. Wells Fargo & Co., 898 F.3d 820, 2018 EB Cases 276978 (8th Cir. Aug. 3, 2018) (breach of fiduciary duty).

The court affirmed the district court's dismissal of Plaintiff's lawsuit alleging breach of fiduciary duty against Defendants for failing to remove their expensive and underperforming funds from the 401(k) plan. The court concluded that the Complaint fails to demonstrate that the Wells Fargo Target Date Funds were an imprudent choice. Because the funds were not an imprudent choice, retention of those funds were not unlawful.

In re Harris, 898 F.3d 834, 2018 EB Cases 276811 (8th Cir. Aug. 3, 2018) (breach of fiduciary duty)

The Eighth Circuit affirmed the bankruptcy court's conclusion that Harris had fiduciary obligations regarding the funds that had been withheld from wages for payment to HealthPartners and that he committed defalcation in late March 2009 when he chose to use plan assets to pay himself and other corporate expenses instead of remitting those assets to HealthPartners. The court affirmed the Eighth Circuit Bankruptcy Appellate Panel's decision to affirm the bankruptcy court's grant of summary judgment in the DOL's favor on declaring nondischargeable a judgment entered against Harris.

Zaeske v. Liberty Life Assurance Co. of Boston, No. 17-2496, __F.3d__, 2018 WL 4008944, 2018 EB Cases 303438(8th Cir. Aug. 23, 2018) (disability benefit claims)

The district court determined that substantial evidence did not support Liberty Life's determination that Plaintiff's back condition improved so that he was no longer disabled. Specifically, the district court found that Liberty Life's reviewing physicians, Dr. Stuart Glassman and Dr. Mark Reecer, either ignored objective medical data in the file, failed to appreciate that Zaeke's condition had not improved over time, or did not consider whether he could perform the duties of his occupation given his limitations.

Liberty Life appealed to the Eighth Circuit. On *de novo* review of the district court's decision, the Eighth Circuit found that Liberty Life's denial was based on substantial evidence because it was permitted to rely on the opinions of Drs. Glassman and Reecer. The court determined that Dr. Glassman's opinion was based on a reasonable interpretation of Zaeske's "medical records which did not dictate a conclusion that he was suffering uncontrolled back pain at the time of Dr. Glassman's assessment." This is because his doctors did not always note during visits that he was suffering from "uncontrolled pain."

One of Zaeske's treating doctors had earlier certified his disability and noted that he *expected* Zaeske to return to work within three months. The court found that this was not inconsistent with Dr. Reecer's opinion, a year later, that Zaeske had the capacity to work. "Although the underlying diagnosis did not change for the better, Zaeske's symptoms may have improved during that time, either naturally or as a result of medication. And as already explained, Zaeske's medical records permit that conclusion." But, even if Dr. Reecer's opinion was inconsistent with Zaeske's doctor's opinion, the court explained that Liberty Life has the discretion to choose between two reliable but conflicting medical opinions.

Wengert v. Rajendran, 886 F.3d 725, 63 EB Cases 2021 (8th Cir. Apr. 3, 2018) (pension benefits).

In this matter brought by the widow of a deceased plan participant against members of the ESOP's administrative committee in order to recover the participant's accrued benefit under plan, the court held that the committee did not abuse its discretion in determining that the participant's transfer of funds from the plan to the trust occurred before his death. Here, the plan participant filed for divorce. He requested a lump-sum distribution of his accrued benefit to his trust on a Friday. The funds were wired the same day by the administrative committee. The plan participant died that Sunday and the trust received the funds on Monday.

Pharm. Care Mgmt. Ass'n v. Rutledge, 891 F.3d 1109, 2018 EB Cases 202886 (8th Cir. June 8, 2018) (preemption).

The Arkansas state legislature adopted Act 900, Arkansas Code Annotated § 17–92–507, an amendment to the state's then-existing maximum allowable cost law, in an attempt to address the lack of independent and rural-serving pharmacies in the state. "The Act mandates that pharmacies be reimbursed for generic drugs at a price equal to or higher than the pharmacies'

cost for the drug based on the invoice from the wholesaler." The Act was challenged by pharmacy benefit managers. The court reversed the district court's ruling that the Act is not preempted by Medicare Part D, 42 U.S.C. § 1395w–26(b)(3). It affirmed the district court's ruling that the statute is preempted by ERISA because of its connection with or reference to an ERISA plan. The statute implicitly referred to ERISA by regulating conduct of PBMs administering or managing pharmacy benefits for covered entities.

Ninth Circuit

Benson v. Life Insurance Company of North America, 725 F. App'x 479, 2018 EB Cases 192410 (9th Cir. May 31, 2018) (disability benefit claims/remedies).

The court affirmed the dismissal of Plaintiff's complaint and amended complaintagainst LINA. It held that: (1) the district court did not abuse its discretion by considering evidence of the disability insurance policy and summary plan descriptions submitted with LINA's motion to dismiss; (2) LINA's limited dissemination of private medical records to a disinterested attorney is insufficient to support a negligent infliction of emotional distress claim (but not deciding whether such claim is preempted by ERISA); and (3) Plaintiff's pre-litigation costs and attorney's fees are unavailable as "appropriate equitable relief" under ERISA § 502(a)(3) (this sort of make-whole remedy is typically unavailable in equity to a trust beneficiary).

Cuaresma, Jr. v. Farmers Group Disability Income Plan, et al., No. 16-16946, __F.App'x__, 2018 WL 2439529 (9th Cir. May 31, 2018) (exhaustion of administrative remedies).

Liberty Life denied Plaintiff's claim for long-term disability ("LTD") benefits prior to the expiration of his time to provide proof of claim and a date earlier than the date Liberty Life told him it would make a decision. Specifically, prior to the end of the policy's elimination period (while he was receiving short-term disability benefits), Liberty Life wrote to Plaintiff on September 19, 2014 and advised him that it would begin reviewing his LTD benefit claim. Liberty Life gave Plaintiff until November 2, 2014 to return claim forms and submit medical records. However, Liberty Life denied his claim on October 30, 2014, a few days before its stated deadline. In addition, per the policy's terms, Plaintiff had until at least mid-to-late November to complete claim forms (proof of claim had to be given to Liberty Life no later than 30 days after the end of the 26-week elimination period).

Rather than appeal the claim denial to Liberty Life within the 180-day deadline, Plaintiff submitted a completed application nearly one year later. The district court granted Liberty's motion for summary judgment on the defense that Plaintiff failed to exhaust his administrative remedies.

The Ninth Circuit reversed the district court's decision. It held that genuine issues of fact remain regarding whether Liberty properly handled and denied Plaintiff's LTD claim before the full amount of time authorized under the Policy to submit materials had expired. Even though Plaintiff did not complete his claim submission until nearly a year after the policy deadline, the

court apparently found that of no moment. The court reversed and remanded with instructions to the district court to remand this case to Liberty Life to fully evaluate the merits of Plaintiff's claim in compliance with the Policy.

Dowdy v. Metro. Life Ins. Co., 890 F.3d 802, 2018 EB Cases 173555 (9th Cir. May 16, 2018) (AD&D benefits).

Dowdy was involved in an automobile accident and sustained a serious injury to his left leg, which was eventually amputated below the knee. Dowdy and his wife sought accidental dismemberment benefits, which MetLife denied on the basis that Plaintiff's diabetes contributed to the decision to amputate Plaintiff's leg and the AD&D policy has an exclusion for any loss caused or contributed to by an illness or infirmity. The district court declined to consider evidence outside of the "administrative record." On the merits, the district court found that diabetes caused or contributed to the need for amputation and Plaintiff's loss was excluded under the policy.

On appeal, the Ninth Circuit held that the district court did not abuse its discretion in excluding evidence outside of the "administrative record," and anyerror on that issue was harmless. But, the Ninth Circuit found that Plaintiff'sdiabetes did not substantially contribute to the amputation of Dowdy's leg so it was a covered loss under the policy. The court explained that the Dowdys are entitled to coverage if the car accident was the "direct and sole cause" of the loss, and if amputation "was a direct result of the accidental injury, independent of other causes." The court declined to determine whether the applicable language is conspicuous or inconspicuous as described in *McClure v. Life Ins. Co. of N. Am.*, 84 F.3d 1129 (9th Cir. 1996), because even under the more demanding "substantial contribution standard," the record does not support a finding that diabetes substantially contributed to Dowdy's loss. Here, Plaintiff's doctor opined that Dowdy's wound issues were complicated by his diabetes but faulted the comorbidities and the type of injury as the need for amputation. The district court's application of the substantial contribution standard was overly strict.

Lastly, the court held that the substantial contribution standard applies in interpreting the concepts of cause and contribution in the exclusion for "any loss caused or contributed to by illness or infirmity." Applying this standard, the court found that diabetes did not substantially cause or contribute to the amputation where Dowdy suffered a deep infection related to the original injury and the fracture itself was slow to heal. For these reasons, the court found that Plaintiff is entitled to benefits.

Danny P. v. Catholic Health Initiatives, 891 F.3d 1155, 2018 EB Cases 199395 (9th Cir. June 6, 2018) (residential treatment/mental health parity).

Plaintiffs brought suit against Catholic Health Initiatives and Catholic Health Initiatives Medical Plan–Blue Cross Blue Shield (collectively "the Plan") for denying the cost of Nicole B's inpatient stay in Island View Residential Treatment Center, a residential mental health treatment facility. The district court granted summary judgment in favor of the Plan. It found that the

Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, codified at 29 U.S.C. § 1185a ("Parity Act") did not require that the Plan's coverage for stays at licensed inpatient residential treatment facilities had to be no more restrictive than stays at skilled nursing facilities.

On appeal, the Ninth Circuit reversed and remanded. It explained that the Parity Act directs that benefits and treatment limitations for mental health problems shall be "no more restrictive" than those for medical and surgical problems. In a succinct opinion, the court held that the Plan could not allow room and board costs at a skilled nursing facility where one was inpatient, while denying them at a residential treatment facility where one was inpatient. "Were it otherwise, the lack of equity that the Parity Act was designed to repress would have become renascent."

Munro v. Univ. of S. California, 896 F.3d 1088, 2018 EB Cases 261639 (9th Cir. July 24, 2018) (arbitration).

The court considered whether the arbitration agreements in this caseencompasses the dispute at issue. The court decided that because "the parties consented only to arbitrate claims brought on their own behalf, and because the Employees' present claims are brought on behalf of the Plans, we conclude that the present dispute falls outside the scope of the agreements." The court found that this case is like *United States ex rel. Welch v. My Left Foot Children's Therapy*, LLC, 871 F.3d 791 (9th Cir. 2017), where the court decided that a standard employment arbitration agreement did not cover *qui tam* claims brought by the employee on behalf of the United States under the False Claims Act. The court determined that there are many similarities between *qui tam* suits under the FCA and suits for breach of fiduciary duty under ERISA. In both claims, the plaintiffs are not seeking relief for themselves and the plaintiffs may not alone settle a claim because that claim does not exist for the individual relator or plaintiff's primary benefit.

The holding in *LaRue v. DeWolff, Boberg & Assocs., Inc.,* 552 U.S. 248, 256, 128 S.Ct. 1020, 169 L.Ed.2d 847 (2008) that an individual may bring an ERISA claim alleging breach of fiduciary duty even if the claim pertains only to her own account and seeks relief for losses limited to that account does not control this case. The claims brought by Plaintiffs here seek financial and equitable remedies to the benefit of the Plans and all affected participants and beneficiaries, not just to the benefit of their own accounts.

The court concluded that "the ERISA § 409(a) claims in this suit are not claims an 'Employee may have against the University or any of its related entities,' and the arbitration agreements cannot be stretched to apply to them." Because the claims fall outside of the scope of the arbitration clause, the court held that the district court properly denied the motion to compel arbitration.

Bd. of Trustees of Glazing Health & Welfare Tr. v. Chambers, No. 16-15588, __F.3d__, 2018 WL 4200961) (9th Cir. 2018) (preemption).

The court held that a 2015 Nevada law, SB223, which limits a state entitlement to hold third-party general contractors vicariously liable for the debts of ERISA plan members, is not preempted by ERISA. The court determined that SB223 lacks a "connection with" ERISA plans because "holding otherwise would constitutionalize a state entitlement that Nevada was under no obligation to provide in the first place." The law "trims a state-conferred entitlement rather than infringes an ERISA-guaranteed right." The court also determined that the law does not invade a federal field regulated by ERISA or interferes with its objectives. The Appellee's obligations under ERISA are unchanged by the law. The court vacated the district court's grant of summary judgment to Appellees.

Hansen v. Grp. Health Coop., No. 16-35684, __F.3d__, 2018 WL 4201162 (9th Cir. Sept. 4, 2018) (preemption).

The court concluded the providers claim that GHC's licensing of the Milliman Care Guidelines, which provides "primary criteria" for authorizing psychotherapy treatment, is unfair and deceptive because the treatment guidance is biased against mental healthcare. The providers also claim that GHC uses its treatment guidelines to avoid complying with Washington's Mental Health Parity Act, and unfairly competes in the marketplace by discouraging its patients from seeking treatment by rival practitioners. The court held that the mental health providers' unfair and deceptive business practice claims were not preempted by ERISA because Washington's law provides an independent statutory duty apart from an ERISA plan's defined terms. In addition, any duty GHC has to refrain from harming its competitors arises under state law, not under the terms of an ERISA plan.

Tenth Circuit

Mkt. Synergy Grp., Inc. v. United States Dep't of Labor, 885 F.3d 676, 63 EM Cases 1985 (10th Cir. Mar. 13, 2018) (breach of fiduciary duty).

The court affirmed the district court's grant of summary judgment in favor of the Department of Labor in this matter where an insurance agency brought suit against the DOL challenging its final regulatory action regarding fixed indexed annuity (FIA) sales. The court held that the DOL's notice of proposed rulemaking provided sufficient notice of its final rule; the DOL's decision to treat FIAs differently than fixed rate annuities in final rule was not arbitrary or capricious; it adequately considered state regulation of FIAs in promulgating the final rule; and the DOL could reasonably have concluded that the benefits to investors from the final rule outweighed the costs to FIA industry of compliance.

Eleventh Circuit

Metlife Life & Annuity Co. of Connecticut v. Akpele, 886 F.3d 998,63 EB Cases 2024 (11th Cir. Mar. 29, 2018) (life insurance).

This case involves an interpleader action brought by MetLife to determine the proper beneficiary to the proceeds of a life insurance policy purchased by Dr. Akpele to fund the AIE Surgical Practice Defined Benefit Plan that he had established as its sole member and trustee pursuant to ERISA. On the issue of which defendant is entitled to receive the funds deposited by MetLife into the registry—the Akepeles or Herrera (the temporary administrator of the estate of Dr. Akpele)—the parties all conceded that the funds should be disbursed to the Plan trustee in the first instance. The Plan trustee is supposed to distribute the money to the widow pursuant to the Plan documents and ERISA. *See* 29 U.S.C. § 1055. However, Herrera contended that the district court incorrectly denied her motions to enforce the settlement agreement reached between her and the Akepeles. The court analyzed the Supreme Court's decision in *Kennedy v. Plan Administrator for DuPont Savings & Investment Plan*, 555 U.S. 285, 129 S.Ct. 865, 172 L.Ed.2d 662 (2009). *Kennedy* left unresolved the question of whether another avenue of recovery might be available to the estate against the ex-wife who received the life insurance proceeds. Then, the Third Circuit decided *Estate of Kensinger v. URL Pharma, Inc.*, 674 F.3d 131, 134 (3d Cir. 2012), which held that after the plan administrator distributed the funds to the ex-wife, the estate may attempt to recover the funds by suing the ex-wife to enforce the waiver. The Eleventh Circuit in this case held that *Kennedy* mandates that a party who is not a named beneficiary of an ERISA plan may not sue the plan for any plan benefits. However, a party may sue a plan beneficiary for those benefits, but only *after* the plan beneficiary has received the benefits (following *Kensinger*). Thus, the district court properly denied Hererra's renewed motion to enforce the settlement.

District of Columbia Circuit

Peck v. SELEX Sys. Integration, Inc., 895 F.3d 813, 2018 EB Cases 252454 (D.C. Cir. July 17, 2018) (severance benefits/standard of review).

Plaintiff was a participant in Defendant SELEX Systems Integration's "top-hat" ERISA-governed deferred compensation plan. After working for SELEX for over fifteen years, the company terminated him when he refused to accept a transfer from his marketing position in D.C. to a different position in quality-control in Kansas. Defendants denied Plaintiff's claims for benefits under SELEX's deferred-compensation plan and its severance policy on the basis that Plaintiff's termination for refusing to transfer positions rendered him ineligible for benefits. The district court granted judgment in SELEX's favor on both claims for benefits. The D.C. Circuit vacated the district court's judgment with regard to the deferred compensation claim but affirmed the judgment with regard to severance pay.

On the issue of the standard of review, the Court noted disagreement among the courts of appeals as to whether *Firestone's* deferential standard of review applies in the case of a top-hat plan that grants the plan administrator discretion to interpret the plan's terms. The Court declined to join the fray: "[W]e have no need in this case to explore the varying approaches or to choose between them. As we explain next, even assuming *Firestone's* deferential standard of review applies in the context of this case, SELEX's denial of Peck's claim for deferred

compensation still cannot be sustained as a reasonable determination under the company's plan."

The Court held that Peck's refusal to accept transfer to a different position with different duties in a different location was not "cause" for termination which would make him ineligible for deferred compensation benefits under the terms of the Plan. The Court also held that Peck was ineligible for severance pay under the terms of SELEX's separation policy because he needed to show that he was terminated for one of the three enumerated reasons: "lack of work, elimination of position, or change in control." Peck was terminated because he would not return to Kansas to serve in a different capacity, not because SELEX was eliminating the marketing position in D.C. Additionally, Defendant was not estopped from claiming that Plaintiff was terminated for a reason other than the elimination of position, in response to Plaintiff's claim for severance pay. The Court remanded deferred-compensation claim to the district court for entry of judgment in Peck's favor and affirmed the judgment in SELEX's favor on the severance pay claim.

Lewis, et al. v. Pension Benefit Guaranty Corporation, No. 17-5068, __F.3d__, 2018 WL 4000484 (D.C. Cir. Aug. 21, 2018) (breach of fiduciary duty/remedies).

Delta and the PBGC agreed to terminate the Delta Pilots Retirement Plan ("the Plan") because the Plan had insufficient assets to support the retirement benefits promised to the pilots. The PBGC became the statutory trustee to collect the Plan's remaining assets and make the promised payments according to a list of statutory priorities. It took six years for the Corporation to finish making final benefit determinations. The pilots claim that the PBGC breached its fiduciary duties in a number of ways which enabled it to control Plan assets for a longer period and collect massive investment returns. The pilots claim that 29 U.S.C. § 1303(f)(1) authorizes individual equitable relief against the PBGC to disgorge itself of the unjust enrichment. The PBGC moved to dismiss this claim on the basis that 29 U.S.C. § 1344(c) prevents disgorgement in this case because it would impermissibly redirect to the pilots the post-termination increase in the value of plan assets. The district court denied the PBGC's motion to dismiss because of the likelihood that such a remedy was not prohibited by § 1344(c). It did resolve all other issues in favor of the PBGC.

On interlocutory appeal, the D.C. Circuit was presented with four controlling questions of law but it only addressed one of them: "[D]oes § 1344(c) preclude the remedy of disgorgement of post-termination investment gains derived as a result of the alleged fiduciary breach?" The court found that the second half of § 1344(c) applies because it expressly governs the allocation of post-termination gains at issue in this case. The court agreed with the PBGC that it is entitled to any post-termination increase in the value of pension assets because Congress has already decided who benefits or suffers the loss from a change in the value of plan assets once the plan has been terminated. It concluded that disgorgement is not an available remedy in this case because 29 U.S.C. § 1344(c) prevents the pilots from recovering any post-termination increase in the value of Delta Plan assets in the same way it shields plan participants from additional loss by the PBGC. The court is reluctant to expand the scope of remedies in a way

that would impose trustee liability on the PBGC in its role as guarantor. The court noted, however, that a remedy that includes removal of the PBGC as statutory trustee of the terminated plan is available as a form of equitable relief.

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