ERISA LITIGATION UPDATE 2013

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This article covers ERISA cases in the Supreme Court, Second Circuit, District of Connecticut, and significant cases from other circuits. They are intended to include a balanced selection of national and local cases regardless of whether the case is a case favorable to claimants or the plans. The practice notes and case commentaries reflect the fact that the author is a claimants'-side attorney, but he hopes the materials will be useful to both sides of the ERISA litigation forum. The materials do not cover ERISA compliance or multi-employer plans.

These materials assume some basic familiarity with ERISA litigation such as standards of review, plans subject to ERISA and the administrative review process. ERISA litigation updates from prior years provide more background explanation. If you would like prior years' updates, please email me and I would be happy to send them to you.

It was a quiet year for ERISA, with the most significant Supreme Court ERISA case of more concern to personal injury practitioners, but the courts did continue to process the two significant cases from the last three years: MetLife v. Glenn and Cigna Corp. v. Amara.

I. Supreme Court Cases

The most significant Supreme Court case this year, U.S. Airways v. McCutchen, 2013 WL 156371 (2013) involved the right of health benefit plans to obtain reimbursement from personal injury plaintiffs for medical expenses incurred. McCutchen, a U.S. Airways' employee, was involved in a car accident where a young driver front-ended him and he was rear ended by a truck, incurring serious injuries. The medical benefit plan paid $66,866 on his behalf. Due to the tortfeasors' limited insurance, McCutchen only recovered $110,000 in damages. His net recovery after paying attorneys fees and expenses was less than $66,000. The Plan, pursuant to a plan provisions requiring reimbursement, demanded the entire recovery, including amounts that went to the claimant's PI attorney for fees and costs. If the plan won, McCutchen would have to pay about $25,000 out of pocket, and he would be in a worse position than if he had never sought any tort recovery at all.

The Third Circuit reversed the trial court's decision in favor of the plan. Citing Cigna Cor. V. Amara, 131 S.Ct. 186 (2011), which theoretically allowed greater general equitable principles to apply to ERISA, the court held it would be inequitable to allow the plan to recover its full amount, even though the effect would be that McCutchen would not get what the plan was supposed to provide: full payment of medical expenses. The Third Circuit pointed out that the plan did not exercise its subrogation rights, or contribute to the cost of obtaining the recovery, so any recovery would be a windfall for the plan. The most significant legal principle behind the court's decision was that it interpreted the word "appropriate" as used in the phrase "appropriate equitable relief" ERISA Sec. 501(a)(3) to modify "relief," (allowing a court to award any relief that would be appropriate), rather than reading it to modify "equitable," which would limit relief to equitable relief.

The Supreme Court reversed the Third Circuit's decision. The Court unanimously held that equitable principles could not overcome the explicit plan provision that the plan was entitled to be paid out of the recovery from the third party, rather than being paid out of the funds actually received by the participant. The Supreme Court did note that the language of the plan did not negate the Common Fund Doctrine (which would reduce the plan's lien to the same extent McCutchen's recovery was reduced by fees and costs), or whether the plan should bear any share of the attorneys' fees and costs spent to obtain the recovery. A five to four majority remanded the case for a determination of how much the plan's reimbursement should be reduced by the attorneys' fees that had to be paid. The court said a plan could provide in the plan documents that the right to reimbursement would not be affected by the Common Fund Doctrine or any sharing of costs to obtain the recovery. One can expect that plans will do so, and the Court's allowance of consideration of this doctrine in the absence of a plan provision to the contrary will be moot.

The Fifth Circuit in ACS Recovery Servs. v. Griffin, 2013 U.S. App. LEXIS 9324, 27 (5th Cir. Tex. May 7, 2013), held that a Plan could seek reimbursement from a special needs trust which was funded with the proceeds of an annuity that was purchased with tort settlement proceeds. The fact that the funds in the trust were from the annuity, rather than from the tortfeasor directly, did not immunize the trust from reimbursement liability.

II. Cases Interpreting Amara & Glenn v. MetLife

The most important recent Supreme Court cases involving ERISA are Glenn v. MetLife, 554 U.S. 105, 113, 128 S. Ct. 2343, 171 L. Ed. 2d 299 (2008) discussing discovery in ERISA cases and the effect of conflict of interests on standards of review, and Cigna Corp. v. Amara, 131 S. Ct. 1866 (2011), discussing relief available under ERISA and the effect of inconsistencies between the SPD and the plan documents. The consequences of both these cases are still be determined by courts, as discussed below.

A. Cases Interpreting Amara

1. Supreme Court's Amara Decision

The most important ERISA case in the last few years is Cigna Corp. v. Amara, 131 S. Ct. 1866 (2011). The case originated in the Connecticut District Court. The case is continuing after remand by the Supreme Court, and is likely to involve further significant decisions in the Second Circuit and possibly a return to the Supreme Court.

Amara involved a cash balance conversion plan. Cigna knew that the conversion would result in "wear away," where the benefits under the original plan would loose value for some participants, which would result in many employees receiving less benefits under the new plan than under the existing plan. In disclosures to the participants, however, Cigna stated that no one would have a reduction in benefits from the conversion. Judge Kravitz held that by making this mis-representation, Cigna had violated its fiduciary duty. The remedy he awarded was that each participant be awarded **both** benefits under the original defined benefit plan and the cash balance plan. This was significant, because no plan documents provided for anyone to be paid the amount of both plans. Prior to Amara, most courts had interpreted the Mertens decision as largely barring any relief other than ordering an award of benefits under the terms of the plan. Mertens v. Hewitt Associates, 508 US 248 – 1993.

Amara addressed two major issues in ERISA litigation: the effect of provisions that are in the SPD but not the plan, and the types of equitable relief available for plaintiffs under ERISA.

The SPD. In any ERISA benefit plan, the two most important documents are the plan document itself, which is the lengthy, legalese-filled document that actually governs the plan and benefits, and the summary plan description, which is intended to tell participants in plain language what benefits they are entitled to. There has always been a tension between requiring information to be included in the SPD to let participants know the most important facts about their benefits, but not including so much information that it no longer serves its purpose of clearly and simply explaining the benefit plan.

The Amara court overruled the law of some circuits that plan in the event of an inconsistency between the SPD and the plan, the SPD provisions could be enforced as part of the plan. The significance of this holding is that if the SPD provision is part of the plan, then it can be enforced under Section 502(a) (1) (B), which is ERISA's breach of contract provision.

Since the Court could not use 502(a)(1)(B) to grant relief by incorporating the SPD's promise that no one would be worse off under the new plan than the old one, it had to find a remedy, if any, under ERISA's general equitable relief provision, 502(a)(3). The court was restrained in what relief it could afford however, by the decision in Mertens v. Hewitt Assocs., 508 U.S. 248 (1993), which held that only the most traditional types of non-monetary relief could be granted under 502(a)(3). The court held that there were three traditional equitable remedies that could afford relief when an SPD was inconsistent with the plan: estoppel; reformation of the plan; and surcharge. One significant clarification of prior law was that by allowing reformation of the plan and surcharge, equitable relief could be granted absent detrimental reliance by the claimant or malfeasance by the fiduciary. Killiam v. Concert Health Plan, 2012 U.S. App. LEXIS 7880 (April 19, 2012). Amara was significant in that it recognized that just because a remedy may provide for payment of money, it could still be an equitable remedy available under ERISA. The Supreme Court's decision in Mertens had been interpreted by some courts as precluding any type of relief that involved payment of money. The Court there approved a remedy that provided for benefits not provided under the plan as a remedy for the plan's breach of fiduciary duty, as discussed further below.

2. Amara Decision on Remand

Judge Arterton in Amara v. Cigna Corp., 2012 U.S. Dist. LEXIS 180355 (December 20, 2012), issued the latest installment in the case. Judge Arterton's decision has been appealed, so we can expect this case to generate more significant law, but Judge Arterton's decision is an interpreting exploration of the Supreme Court's opinion. The Supreme Court had remanded the case to the trial court for a determination whether the plaintiff had proven any of the three equitable theories it held were available under 502(a)(3).

Judge Arterton found that the relief ordered by Judge Kravitz under 502(a)(1)(B) (benefits under both the old and the new plan) was also appropriate under 502(a)(3).

- She reformed the plan based on Cigna's fraud in misleading the participants regarding the consequences of the plan conversion. She declined to require that the plaintiffs suffered "actual harm" from the fraud to reform the plan, stating that the Supreme Court, applying traditional principals of equity jurisprudence, stated that actual harm need only be shown for surcharge, not reformation or estoppel. She declined to follow Osberg v. Foot Locker, Inc., 2012 U.S. Dist. LEXIS 173880 (S.D.N.Y. Dec. 6, 2012), which required a showing of actual harm for any type of equitable relief.
- The court found the relief appropriate under a surcharge theory. The court held that once the plaintiff had met its burden of showing a breach of fiduciary duty, the burden shifted to the fiduciary to prove that the breach

did not cause any actual harm to the plaintiff: that Cigna's fiduciary breach did not cause the plaintiffs' diminished retirement benefits. Since Cigna could not show that disclosure of the reduced benefits would not have caused enough employee outcry to force Cigna to change the plan or offer other concessions such as increased salaries, it did not meet its burden and the relief could be ordered under a surcharge theory.

While a discussion of class actions is beyond the scope of this article, the court also held that the relief ordered could be awarded on a class-wide basis since individual questions in calculation of the damages was "incidental" to the relief ordered. This is significant because the Supreme Court limited class actions in the employment context in the case of Walmart Stores, Inc. v. Dukes, 131 S. Ct. 2541 (2011).

3. Other Cases Interpreting Amara

McCravy v. Metro. Life Ins. Co., 690 F.3d 176, 181 (4th Cir. S.C. 2012). Parents had purchased dependent coverage for their daughter through the employer's group insurance plan. While the plan provided that dependents over age 19 were not eligible for the coverage, the insurer accepted the premiums for six years after the dependent turned 20. When the daughter died in an accident at age 25, the insurer denied coverage, and sought to refund the premiums paid. Prior to Amara, on a motion to dismiss, the district court had limited the plaintiff to refund of the premium. Post Amara, the Fourth Circuit held that remedies in excess of the premiums were potentially recoverable, and reversed the trial court decision and remanded the case.

Gearlds v. Entergy Servs., 709 F.3d 448, 452 (5th Cir. Miss. 2013). Plaintiff took early retirement in reliance on the employer's assurance he would be eligible for retiree health benefits. After he received benefits for five years, the employer determined that he was not eligible for benefits, and revoked his coverage. The district court dismissed the suit on grounds that the plaintiff could not obtain the money damages he was seeking. The Circuit Court reversed the decision, since money-type damages could be obtained through the surcharge remedy authorized by Amara.

B. Cases Interpreting MetLife v. Glenn

1. Supreme Court's Decision in MetLife v. Glenn

In MetLife v. Glenn 554 U.S. 105 (2008) the Supreme Court ruled that when the same entity determined benefits claims and paid benefits, there existed an inherent conflict of interest that could lead to a less deferential standard of arbitrary and capricious review. The Court further held that plaintiff could obtain discovery bearing on the existence of a conflict, and whether that conflict had expressed itself in biased handling of the claim.

2. Cases Interpreting Glenn

The circuit courts and district courts have issued wildly different decisions in deciding how an inherent conflict of interest affects the standard of review. In many decisions, it seems to be a make weight argument, cited to support the underlying conclusion of the court rather than an independent deciding factor. Both claimants and plans can find a decision to support their respective positions.

Stephan v. Unum Life Ins. Co. of Am., 697 F.3d 917, 930 (9th Cir. Cal. 2012). Reversing a summary judgment decision on grounds that the trial court should not have decided that no conflict of interest affected the decision without considering evidence of misconduct. What was interesting about the decision was that there was not much evidence presented of a conflict. The court stated the trial court should have looked at the following, possibly in a bench trial: "any relevant evidence about Unum's history of biased decision making; any evidence that its decision making was biased in this case, including the internal memoranda between Stephan's claim analyst and its in-house counsel; as well as any evidence that Unum took steps to reduce the potential impacts."

Alberigo v. Hartford, 891 F. Supp. 2d 383, 397 (E.D.N.Y. 2012). This case illustrates how the conflict of interest principles of Glenn are probably not outcome determinative. The court held that evidence existed that the conflict of interest affected the decision, and that less deferential standard of arbitrary and capricious review should apply, on the following grounds: the insurer stated, in justifying why it denied benefits under the "any occupation" standard after approving benefits under the "own occupation," that the claimant's occupation involved substantial walking. The claim file showed that the insurer had actually identified the occupation as being primarily sedentary at the time of the initial decision; the insurer focused on a medical report by a doctor implying that the claimant was not disabled but ignored several contradictory reports and opinions ("any reasonable person reviewing the record would conclude that, when Dr. Kloth checked that Mr. Alberigo was capable of performing sedentary work on a full-time basis, that was an anomalous statement requiring explanation and clarification"); and the insurer ignored Social Security's determination of disability. These were probably sufficient for the court to find that the decision was arbitrary and capricious even if it held that a strict standard of review would apply. See the case below, where the court acknowledged this fact

Ingravallo v. Hartford Life & Accident Ins. Co., 2013 U.S. Dist. LEXIS 48397, 20 (E.D.N.Y. Mar. 29, 2013). The court held that while there appeared to be no evidence

that the inherent conflict had affected the claim decision, the decision was arbitrary and capricious in any event, so the court did not have to weigh the conflict. The court cited three factors which illustrated that the decision to discontinue benefits was arbitrary and capricious: first, while it was not bound by the Social Security determination of disability, it could not ignore the decision, especially after it reaped the benefit of the social security offset for many years; second, while the plan did not have to defer to the treating physician's disability determination, it could not reject the decision without addressing a particular MRI result that the treater stated was objective evidence of the impairment; and third, that while a surveillance video showing that the claimant could do things she claimed she could not, it did not demonstrate that she could do her job on a 40 hour a week basis. While not stated explicitly, the nature of the condition suffered by the claimant (relapse-remitting multiple sclerosis) appears to have influenced the court's decision. While patients with the condition can get better for a period of time, the overall course of the disease is degenerative, so evidence of improvement does not show lack of disability at a later time.

Rozek v. N.Y. Blood Ctr., 2013 U.S. Dist. LEXIS 24707, 57 (E.D.N.Y. Feb. 21, 2013) . Decision denying benefits approved. While there was evidence in support of the claimant's disability, the fact that one of her treating physicians agreed that she could work six to eight hours probably doomed the claim, especially since there was no further input from that physician to explain the opinion away. Also, while the claimant was awarded social security, it was a close decision.

III. Breach of Fiduciary Duty

A. Cash Balance Plan Conversions

The shift in pension plans from defined benefit plans (the traditional pension where the plan pays a set monthly benefit based on compensation and years of service) to a cash balance plan, where the plan maintains an account, and the participant then gets whatever the account has accumulated in a lump sum. The individual "account" is a fiction, as no money is set aside, so they still count as defined benefit plans. The investment risk/reward, however, is shifted to the participant from the employer. See Hirt v. Equitable Ret. Plan for Emples., Managers & Agents, 533 F.3d 102, 105 (2d Cir. N.Y. 2008) for an explanation of the difference.

Hirt v. Equitable Ret. Plan for Emples., Managers & Agents, 533 F.3d 102, 105 (2d Cir. N.Y. 2008). The Second Circuit confirmed that it agrees with most circuits that have considered the issue that cash balance plans do not inherently violate ERISA prohibition on amendments that reduce the rate of benefit accruals based on age. Even plans changed before Congress explicitly allowed such plans in 2005 do not necessarily violate ERISA.

B. Stock Drop Cases

ERISA fiduciaries have been regularly sued for breach of fiduciary duty when the value of employer stock or other investments held by the plan dropped, particularly during the recent financial crisis. ERISA was seen as a way to bring a case when a company's stock declined that avoided the procedural roadblocks set up in securities fraud cases by the Private Securities Litigation Reform Act, 15 U.S.C. § 78u-4, and the Federal Rules of Civil Procedure, which do not apply to ERISA claims.

Most circuits, including the Second Circuit, have made it difficult for such cases to survive the pleading stage. These circuits have applied a presumption of prudence, requiring that the plaintiff plead facts showing "imminent collapse" of the company, or "dire circumstances" to survive a motion to dismiss. The presumption is called "Moench Presumption" after the Third Circuit case of Moench v. Robertson, 62 F.3d 553 (3d Cir. 1995) that first set it forth. In Gray v. Citigroup Inc. (In re Citigroup ERISA Litig.), 662 F.3d 128 (2d Cir. N.Y. 2011) and Gearren v. McGraw-Hill Cos., 660 F.3d 605 (2d Cir. N.Y. 2011), the Second Circuit explicitly adopted the Moench presumption.

White v. Marshall & Ilsley Corp., No. 11-2660, __ F.3d, __, 2013 WL 1688918 (7th Cir. Apr. 19, 2013), the Seventh Circuit explicitly adopted the Moench Presumption after indicating in several cases that it was likely to adopt it.

Pension Benefit Guar. Corp. v. Morgan Stanley Inv. Mgmt., 712 F.3d 705, 2013 U.S. App. LEXIS 6710, 33 (2d Cir. 2013). Explaining pleading requirements for showing a breach of fiduciary duty regarding investment decisions. The complaint must discuss the specific process used to choose investments and facts that existed at the time of the investment to show imprudence. A presumption of imprudence does not arise from the fact that the investments crashed. Hindsight alone doesn't show imprudence.

Taveras v. UBS AG, 107 F.3d 436, 445 (2d Cir. N.Y. 2013). Whether the Moench Presumption will apply depends on the language of the plan. The Second Circuit applied the presumption to a plan that required the trustees to offer an option to invest in the employers' stock. The Court did not apply the presumption to a plan that did not so provide. Since the trustees had the option **not** to offer the employer's stock as an investment option, they were not entitled to a presumption of prudence in offering the option.

IV. Disability Benefit Claims

A. Reimbursement Agreements

Group disability plans usually provide that social security benefits offset any benefits paid under the plan. When benefits are paid before social security is awarded, plans commonly require the participant to sign a reimbursement

agreement to pay the plan out of any retroactive lump sum award received for the amount of the benefits that would have been offset in the retroactive period. The Bilyeau case provided a way for claimants to possibly avoid repayment, as discussed below, but the Second Circuit has rejected the holding of Bilyeau in Thurber v. Aetna Life Ins. Co., 712 F.3d 654, 663 (2d Cir. N.Y. 2013). Even though Bilyeau is not good law in our circuit, the case has an interesting discussion of how ERISA limitation on legal relief can be used as a shield by a claimant.

Bilyeu v. Morgan Stanley Long Term Disability Plan, 683 F.3d 1083, 1092-1093 (9th Cir. Ariz. 2012), is one of the few cases where ERISA's limitation on remedies was used to the claimant's benefit. The claimant signed a reimbursement agreement, but by the time the insurer was aware of it, the money had been spent. The plan then attempted to collect from the general assets of the claimant. The court denied the plan relief, and didn't enforce the reimbursement agreement on grounds that the plan was seeking damages for breach of contract, which is legal relief. The court established three requirements for a plan to recover from a claimant under a reimbursement agreement:

> First, there must be a promise by the beneficiary to reimburse the fiduciary for benefits paid under the plan in the event of a recovery from a third party. Second, the reimbursement agreement must "specifically identif[y] a particular fund, distinct from the [beneficiary's] general assets," from which the fiduciary will be reimbursed. Id. at 364. Third, the funds specifically identified by the fiduciary must be "within the possession and control of the [beneficiary].

The court held that the first criterion was satisfied. The court held however, that the second was probably not satisfied. While the social security benefits were an identifiable fund, they could not be assigned under federal law. The plan attempted to say the overpaid benefits was the fund, and that it came into existence as soon as the social security lump sum was received, but the court doubted this would qualify. The court held that in any event, the third factor could not be satisfied. The claimant had spent the money by the time the plan sought to collect it, so any judgment would be paid out of the general assets of the claimant as damages, which would be invalid equitable relief.

The Court pointed out that the First, Third and Sixth Circuits disagreed and either allowed, or implied that they would allow, recovery of overpayments even when the third-party funds had been dissipated, and as noted above, the Second Circuit has rejected the holding as well.

B. Benefit Denial Appeals

Thurber v. Aetna Life Ins. Co., 712 F.3d 654, 2013 U.S. App. LEXIS 5022, 14 (2d Cir. N.Y. 2013). Adequate consideration of subjective complaints of pain when no evidence that pain resulted in any restrictions on function.

Alto v. Hartford Life Ins. Co., 485 Fed. Appx. 482, 484 (2d Cir. N.Y. 2012). Affirming the trial court's holding in favor the plan, the Court stated "where as here, there is no objective evidence of disability and no articulable basis for a finding of a disability by a treating physician, denial of benefits cannot be called arbitrary and capricious." This case once again illustrates the importance of working with treating physicians to provide objective evidence of impairment and articulate the basis for the conclusion that the claimant cannot perform the job.

Levitian v. Sun Life & Health Ins. Co., 486 Fed. Appx. 136, 140 (2d Cir. N.Y. 2012). Affirming the trial court's determination that a decision to discontinue benefits was arbitrary and capricious when the only change in the medical records since the last decision finding the claimant disabled was a report that stated, without providing any evidentiary basis for the contention, that any "database manager" like the claimant would keyboard for less than 4 hours a day so long as he supervised more than two employees, and stated that the claimant supervised more than two employees. There was, however, no evidentiary basis that the claimant actually did supervise more than two employees or that the principle applied had any empirical validity. While the court did apply arbitrary and capricious review, it stated it considered the inherent conflict of interest arising from the insurer being both the decider and payor regarding the benefits.

Spears v. Liberty Life Assur. Co., 885 F. Supp. 2d 546, 553 (D. Conn. 2012) (Bryant). SPD language that plans worked together to "facilitate a seamless transition between Sick Pay, STD and LTD payments" was an aspirational statement that did not give a claimant the right to equitable relief under 502(a)(3). Also, any 502(a)(3) claim failed because the complaint did not allege estoppel, detrimental reliance, or any other equitable claim upon which reformation under the section would lie.

Carroll v. Hartford Life & Accident Ins. Co., 2013 U.S. Dist. LEXIS 46080, 60 (D. Conn. Mar. 28, 2013) (Bryant). This case shows the importance of working with the treating physician. In this case, he told the insurer that he based his restrictions on what the patient told him were her limitations rather than on his exam or testing, and that he "obviously" could not say whether she could work a full day, which statements were fatal to the claim.

Kruk v. Metro. Life Ins. Co., 2013 U.S. Dist. LEXIS 35637 March 13, 2013 (Schien). When claimant was disabled by a combination of psychiatric and physical conditions (comorbidity), and the insurer had an independent medical file review that stated that her physical condition alone would not disable her, not arbitrary and capricious to discontinue benefits after the 24 month limit for mental illnesses expired. The claimant had succeeded in an earlier appeal of the insurer's decision

that she was not disabled at all, when Judge Covello found the decision to be arbitrary and capricious, and remanded the claim. On remand, the insurer found that the claimant was disabled due to a psychiatric condition, and denied benefits beyond the 24-month mental illness payment limitation. The claimant argued that due to the earlier finding of arbitrary and capricious claim denial, the court should review the new determination *de novo*. The Court held that the earlier misconduct did not change the standard of review.

Pachaly v. Benefits Admin. Comm. Unilever United States, Inc., 2013 U.S. Dist. LEXIS 6429, 12 (D. Conn. Jan. 16, 2013) (Chatigney). Plan could discontinue medical benefits for participants who had coverage as a result of receiving long term disability benefits. Since the claimant could not show that the promise of such medical coverage caused him to receive disability benefits, no extraordinary circumstances that would give rise to a promissory estoppel claim under ERISA existed.

Rau v. Hartford Life & Accident Ins. Co., 2013 U.S. Dist. LEXIS 67572, 14 (D. Conn. May 13, 2013) (Hall). Not arbitrary and capricious for the insurer to interpret an exclusion for "injuries sustained while intoxicated" to mean any injury sustained while intoxicated, without having to show that the intoxication caused or contributed to the injury.

Koehler v. Aetna Health Inc., 683 F.3d 182, 188 (5th Cir. Tex. 2012). When requirement of preauthorization has not been clearly stated in SPD, the medical plan could not deny benefits solely on the basis of the failure to obtain preauthorization, and had to determine whether benefits were payable, whether or not out-of-network preauthorization had been obtained.

Hamill v. Prudential Ins. Co. of Am., 2012 U.S. Dist. LEXIS 183429, 28 (E.D.N.Y. Sept. 28, 2012). When the reservation of discretion to interpret the plan was only in the SPD and not the plan itself, the court applied *de novo* review, holding that under Amara, the SPD could not supplement the terms of the plan absent an express incorporation of the SPD into the plan, which was not present here.

Novick v. Metro. Life Ins. Co., 2012 U.S. Dist. LEXIS 178343, 52 (S.D.N.Y. Dec. 17, 2012). Benefit denial was arbitrary and capricious when the claimant's treating physicians were unanimous in finding the claimant to be disabled, and the insurer's file reviewing physicians rejected it solely on the basis that there was not objective evidence of the degree of impairment. The court stated that the insurer's failure to specify that types of additional testing would be necessary to establish disability was an independent basis for finding the decision arbitrary and capricious: "If MetLife wanted something else by way of tests or specific explanations, it could have said so in a manner that would have apprised Ms. Novick of exactly what was needed."

Sewell v. Lincoln Life & Annuity Co., 2013 U.S. Dist. LEXIS 40538, 38 (S.D.N.Y. Mar. 22, 2013). Benefit denial was arbitrary and capricious mainly because the insurer did not analyze the specific requirements of the claimant's position. The insurer's vocational expert classified the claimant's occupation as requiring light physical effort, and then stated that there were light duty positions available. The court agreed that by doing this, the insurer was basically analyzing the claim according to an "any occupation" standard when the "own occupation" standard applied. The claimant based his disability on the following: unpredictable and intractable fatigue, abdominal pain/cramps, nausea, flatulence, incontinence, diarrhea, and vomiting as symptoms that rendered him unable to work. The insurer stated that there were reasonable accommodations for these limitations, but never analyzed what actual accommodations would allow the claimant to perform his duties as a construction manager.

Thomas v. Hartford Life Ins. Co. of Am., 2012 U.S. Dist. LEXIS 183624, 11 (S.D.N.Y. Dec. 21, 2012). Like the Sewell case above, the court found that the denial was arbitrary and capricious because it ignored the actual requirements of the job. While the insurer could look at the claimant's occupation as it exists in the national economy, it could not simply determine the general level of physical demands and then hold that the claimant could do any job with similar demands. Rather, the insurer had to consider that the claimant worked eleven hours a day, and had to frequently walk in determining whether she could perform her occupation.

Demonchaux v. Unitedhealthcare Oxford, 2012 U.S. Dist. LEXIS 182839, 29 (S.D.N.Y. Dec. 20, 2012). Arbitrary and capricious for the insurer to discontinue benefits based on the same evidence that existed when it found the claimant disabled.

C. Exhaustion of Administrative Appeals

Kirkendall v. Halliburton, Inc., 707 F.3d 173, 180 (2d Cir. N.Y. 2013). Plan language that provided for administrative appeal of a "benefit claim" did not provide clear notice to a participant that the procedure applied to a request by a participant for a determination of future benefits, so failure to exhaust administrative procedures was excused.

V. Breach of Fiduciary Duty,

L.I. Head Start Child Development Services, Inc. v. Economic Opportunity Commission of Nassau County, Inc., Case No. 12-2082-cv (2d Cir. Mar. 13, 2013). The Second Circuit expanding standing to bring a 502(a)(2) breach of fiduciary duty claim on behalf of the plan to include a former fiduciary, even though the section only gives standing to participants, beneficiaries and fiduciaries. The case also arguably expanded the relief under the section. 502(a)(2) authorizes relief to the Plan. Some courts had interpreted this to mean any relief that would benefit an individual beneficiary was not permitted. In this case, even though any amounts

recovered by the plan would be paid to a particular participant, the court found the relief permitted by the section.

Coriale v. Xerox Corp., 2012 U.S. App. LEXIS 16086, 490 Fed. Appx. 387, 389 (2d Cir. N.Y. 2012). No cause of action for changing retiree health benefits the documents containing the promises of lifetime retiree health were not official plan documents.

VI. Section 510

Section 510 prohibits actions intended to deprive a participant of qualifying for a benefit. It also prohibits retaliation "against any person because he has given information or has testified or is about to testify in any inquiry or proceeding relating to" ERISA. The Second Circuit has held that to be protected conduct, the "information given" must be part of a formal investigation in response to a complaint or concern. Nicolaou v. Horizon Media, Inc., 402 F.3d 325, 330 (2d Cir. 2005). The Third Circuit in George v. Junior Achievement of Cent. Ind., Inc., 694 F.3d 812, 815 (7th Cir. Ind. 2012), joined the 5th and 9th Circuits in holding that the initial inquiry, before any investigation begins, is protected status as well. Due to the split in the circuits, this issue may be addressed by the Supreme Court in the future.

Hasemann v. UPS of Am., 2013 U.S. Dist. LEXIS 25704, 41 (D. Conn. Feb. 26, 2013) (Bryant). Fact that termination prevented the plaintiff from qualifying for benefits is not sufficient to establish a Section 510 claim without some evidence that the deprivation of benefits motivated the termination decision.