ERISA LITIGATION UPDATE 2015

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This article covers ERISA cases in the Supreme Court, Second Circuit, and District of Connecticut. They are intended to include a balanced selection of national and local cases regardless of whether the case is 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, what plans are 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.

I have started an ERISA blog: http://ctltdlawyer.blogspot.com/. It is aimed to ERISA claimants who are applying for, receiving, or appealing disability benefits, health insurance benefits, and other ERISA welfare benefits. While it is more a practical guide for individuals rather than lawyers, it has information that could be of use to ERISA practitioners. I'd be happy to hear any comments anyone has on it.

I. Supreme Court

A. Recent Supreme Court Cases

Fifth Third Bancorp v. Dudenhoeffer, 2014 U.S. LEXIS 4495, 27 (U.S. June 25, 2014)
No presumption that an ESOP fiduciary's investment in employer's stock is prudent

The holding makes it appear that this decision was favorable to the plaintiffs, the case as a whole throws up some road blocks for plaintiffs to prove a fiduciary breach resulting from a drop in value of the employer's stock.

After the 2008 financial crisis caused the stock in employee stock ownership plans to crash, many suits were brought against the ESOP fiduciaries that by continuing to buy and hold the employer stock, they violated ERISA's duties of prudent investing. Most circuits, including the Second Circuit, have made it difficult for such cases to survive the pleading stage. These circuits 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. Some circuits rejected the Moench Presumption (Brown v. Medtronic, Inc., 628 F.3d 451, 453 (8th Cir. Minn. 2010), so the Court heard the case to resolve the split among the circuits.

In Dudenhoeffer, the Court rejected the presumption:

> The proposed presumption makes it impossible for a plaintiff to state a duty-of-prudence claim, no matter how meritorious, unless the employer is in very bad economic circumstances. Such a rule does not readily divide the plausible sheep from the meritless goats.

at 27.

Once it found the presumption didn't exist, the Court remanded the case for decision on the motion to dismiss without applying the presumption. The Court gave the appellate court guidance on how to decide the motion. The Court's standards, however, make it unlikely the plaintiffs will survive the motion:

- The plaintiffs claimed the market had overvalued the stock, so the fiduciaries should have stopped buying it even before the stock plunged. The Court held that fiduciaries are entitled to rely on market price as a fair price, so a claim that the market is "overvaluing" a stock is meritless.
- The plaintiffs also claimed the fiduciaries knew material non-public information on the financial condition of the company that should have caused them to stop investing in the employers' stock. But, the Court said to rely on this, the plaintiffs would have to show that the fiduciaries have acted on the information without violating insider trading laws.

The court remanded the case to the Court of Appeals to decide motion to dismiss under these standards.

M&G Polymers USA, LLC v. Tackett, No. 13-1010, 2015 WL 303218 (U.S. Jan. 26, 2015) **Sixth Circuit Presumption that Retiree Health Benefit Vest Overturned**

The Sixth Circuit in the case of International Union, United Auto, Aerospace, & Agricultural Implement Workers of America v. Yard-Man, Inc., 716 F.2d 1476 (6th Cir. 1983), held that there was a presumption that retiree health benefits vested on retirement, so that the benefits could not be reduced or eliminated after the participant retired. The Sixth Circuit was the only court that applied this presumption, which was rejected by every other circuit. The Supreme Court finally resolved this long-standing anomaly in this decision.

Tibble v. Edison Int'l, 2015 U.S. LEXIS 3171 (U.S. May 18, 2015)

Six-Year Statute for Breach of Fiduciary Duty Claims Doesn't Bar Suit for Imprudent Investment Options Established More Than Six Year Ago

A 401k fiduciary has a duty to assure that all investment options offered to plan participants are prudent. In this case, the plaintiff alleged that the plan acted imprudently by offering six higher priced retail-class mutual funds as Plan investments when materially identical lower priced institutional-class mutual funds were available. The plan asserted, and the Ninth Circuit agreed, that the claims were barred as to three of the funds that had been offered for more than six years by ERISA's six year statute of limitations for fiduciary breach claims. The Supreme Court, in a unanimous decision written by Justice Breyer, overturned the decision. Citing to general principles of trust law, rather than any specific provision of ERISA, the court held that a prudent fiduciary had a duty to monitor investments and remove imprudent ones, in light of changing circumstances. The Court remanded the case to the Ninth Circuit to determine if the plan had violated this duty during the six-year statute of limitations period.

In this decision, as in earlier decisions about the scope of ERISA duties such the Mertens and Amara case, the Court looked to general principles of trust law, as set forth in standard treatises, to decide what duties an ERISA fiduciary had. This incorporation of general principles of trust law has served to expand the remedies and fiduciary duties beyond the limited remedies and duties set forth in the text of ERISA.

B. Supreme Court Cases to Watch

Spokeo, Inc. v. Robbins, 2015 U.S. LEXIS 2947, 83 U.S.L.W. 3819
Can Congress Confer Statutory Standing in the Absence of Any Harm?

The Court agreed to hear this case from the Ninth Circuit, Spokeo, Inc. v. Robbins, 742 F.3d 409 (9th Cir. 2014) whether Congress may confer Article III standing upon a plaintiff who suffers no concrete harm, and who therefore could not otherwise invoke the jurisdiction of a federal court, by authorizing a private right of action based on a bare violation of a federal statute. While the case arises under the Fair Credit Reporting Act, it has significance for all statutory schemes, like ERISA, that authorize suit for violations of the law even if the plaintiff has suffered no concrete harm.

Board of Trustees of the National Elevator Industry Health Benefit Plan v. Montanile
Can the Plan Be Reimbursed for Health Insurance Claims Paid Were the Personal Injury Recovery Has Been Dissipated? Is the SPD a Plan Document?

The Supreme Court granted cert in the unreported Eleventh Circuit case of Bd. of Trs. of the Nat'l Elevator Indus. Health Benefit Plan v. Montanile, 2014 U.S. App. LEXIS 22438, 593 Fed. Appx. 903, 911 (11th Cir. Fla. 2014). The decision addresses two important issues:

- Plan Reimbursement

  In US Airways, Inc. v. McCutchen, 133 S. Ct. 1537 (U.S. 2013), the Supreme Court gave plans liberal rights to be paid out of personal injury awards for any medical expenses the plan paid out regarding the accident at issue. The Supreme Court potentially allowed plans to recover the entire amount of the settlement from the participant, even though a portion of the settlement was paid to the attorney and for litigation costs.

  One open question was whether the plan can assert its lien if the settlement funds have been dissipated. In the McCutchen case, the settlement funds had been deposited in a client funds account, and so there was a source of funds for the lien to attach. In Montanile, the Supreme Court will decide whether the lien can attach even when the fund has been dissipated. The Second Circuit has held that the right to reimbursement can be exercised even when the fund has been dissipated. Thurber v. Aetna Life Ins. Co., 712 F.3d 654, 664 (2d Cir. N.Y. 2013).

- Is the Plan Document Part of the Plan?

  The Supreme Court in Amara held that the Summary Plan Description was not a plan document, so provisions that were in the SPD but not in the plan documents themselves could not be enforced. The issue is significant for plans because they frequently want to take advantage of a provision that is in the SPD, but not in the plan document, such as the language reserving discretion to the plan that allows a court to apply arbitrary and capricious review rather than *de novo* review. In Montanile, the plan wanted to enforce a reimbursement provision that was in the SPD and not the plan. The Eleventh Circuit allowed the plan to enforce the right. It held that Amara only barred consideration of an SPD provision when the SPD provision *conflicted* with a plan document. Here, there was no conflict. Further, the Court held that even though the document was called a summary plan description, it could constitute a plan document if the SPD itself so provided.

II. Circuit Court Cases

A. Second Circuit

Amara v. CIGNA Corp., 775 F.3d 510(2nd Cir.2014).
Remedies under ERISA

No one can resist referring to this Connecticut case as a saga. Going from a trial court decision by Judge Kravitz, to the Second Circuit, to the Supreme Court, back to the trial court before Judge Arterton, and on to the Second Circuit again, and destined to return to the Supreme Court, the case has generated significant decisions regarding the scope of remedies available under ERISA.

The case involved a cash balance pension plan conversation by CIGNA, which involves converting from a defined benefit plan (a plan where a participant is entitled to a certain amount monthly on retirement) to a cash balance plan (where on retirement the participant

is paid an amount equal to the balance of the participant's account). Judge Kravitz decided the case at the trial court level on behalf of a certified class, and decided that CIGNA had breached its duty under ERISA by providing summary plan descriptions and summaries of material modifications that were false. Specifically, he said CIGNA told participants that they would accrue greater benefit under the plan, and that cost savings to CIGNA were not a reason for the change, when in fact, CIGNA would save $10 million a year from the plan, and particularly with respect to early retirement benefits, would provide substantially worse benefits for man participants. In addition to the issue of whether CIGNA had violated its duty was what the plaintiffs needed to show to be entitled to relief. CIGNA argued that each plaintiff had to show that he or she detrimentally relied on the erroneous disclosure, requiring an individualized determination of liability that was inconsistent with the class-action status of the case. Judge Kravitz rejected the argument, holding that the plaintiffs only had to show that as a group, they were likely harmed by the violation. The liability decision is at 534 F. Supp. 2d 288 (D. Conn. 2008).

The Supreme Court in the case held that traditional equitable remedies were available to potentially enforce provisions of the SPD, even when it was not part of the plan. 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. The Court remanded the case to determine what relief would be available under 502(a) (1) (b). On remand, Judge Arterton held that the relief afforded by Judge Kravitz in the original decision under 502(a) (2) was also available under 502(a) (1) (b). Amara v. Cigna Corp., 925 F. Supp. 2d 242 (D. Conn. 2012).

In the most recent case, Amara v. CIGNA Corp., 775 F.3d 510(2nd Cir.2014), the Second Circuit affirmed Judge Arterton's decision. First, the Court held that class treatment for a reformation action pursuant to Rule 23(b) (2) (which does not require notice to individual class members) was proper. While monetary relief would ultimately go to the class members, the only relief the court had to issue was an injunction to comply with the SPD's promise of unreduced pension benefits. Second, the Court held that each individual class member did not have to prove that the class member misunderstood the plan terms because of the misleading promises of unreduced benefits. The evidence that the vast majority of class members read and relied upon the statements was sufficient.

The remarkable thing about this case, when viewed from a larger perspective is that it is likely that the case will have to go to Supreme Court twice to determine if there is a remedy for a plan lying to its participants. This shows the gross deficiencies in ERISA's remedial scheme as established by the courts over the past decades, but also shows that the courts are struggling to free themselves from the remedial straight jacket resulting from the Mertens decision and other cases finding limited remedies under ERISA.

Mead v. Reliastar Life Ins. Co., 768 F.3d 102 (2d Cir. Vt. 2014)
Remand To Administrator Not Final Judgment

The trial court's order remanding the case to the administrator for a determination of the claimant's eligibility for the "any occupation" standard was not a final judgment, and so was not appealable.

Donachie v. Liberty Life Assur. Co., 745 F.3d 41 (2d Cir. 2014).
Attorneys' Fees: Bad Faith Not Necessary

The trial court entered summary judgment for the plaintiff, but denied attorneys' fees because the judge concluded the decision was wrong but not made in bad faith. In the decision, the Second Circuit clarified its standard for awarding attorneys' fees in ERISA. The Second Circuit had traditionally applied five factors originally set forth in the case of In Hardt v. Reliance Standard Life Ins. Co., 560 U.S. 242, 254-55, 130 S. Ct. 2149, 176 L. Ed. 2d 998 (2010), the Supreme Court held that requiring the five-part test was wrong, and rather that the proper standard was whether the plaintiff had achieved some success on the merit. The Second Circuit said a court can consider the five factors, but in the absence of special circumstances (which it did not define), a plaintiff who has some success on the merits should be awarded attorneys' fees.

B. Other Circuits

Templin v. Independence Blue Cross, No. 13-4493, 2015 WL 2151778 (3d Cir. May 8, 2015).
Attorneys' Fees

The catalyst theory of attorneys' fees is available under ERISA. Where the plan gave the requested relief after its motion to dismiss was granted, attorneys' fees could be awarded to the plaintiff, even if no judgment in favor the plaintiff was issued.

Rochow v. Life Ins. Co. of Am., 737 F.3d 415 (6th Cir. 2013), overturning Rochow v. Life Ins. Co. of Am., 737 F.3d 415 (6th Cir. 2013).
Overturning Decision Allowing Extraordinary Remedies under ERISA

The original case, decided by a three-judge panel, affirmed a decision awarding extraordinary remedies in an ERISA benefit denial case. In addition to awarding the wrongfully denied LTD benefits, the court also ordered disgorgement of the profits the insurer had earned on the unpaid benefits, and awarded $2.9 million for disgorgement of profits earned, and a benefit award of about $1 million. As most ERISA practitioners predicted, the decision was overturned *en banc*. The federal courts have been creative in finding remedies under ERISA to benefit plans, such as requiring reimbursement of medical expenses in the McCutcheon case discussed above. The panel's decision in Rochow was one of the few courts that was as creative to find a remedy for a plaintiff. Maybe it is an indication that the courts will be more creative in the future on the plaintiffs' side. The Gabriel case discussed below may also be a step in this direction.

Gabriel v. Alaska Elec. Pension Fund, 773 F.3d 945 (9th Cir. 2014).
Surcharge Is a Remedy for Participants, Not Just Plans

The Supreme Court's decision in Cigna Corp. v. Amara, 131 S. Ct. 1866 (2011) opened up the possibility of more expansive relief under ERISA, and courts have been struggling since then to determine the scope of remedies available under ERISA other than just paying the benefits that otherwise would have been due. In the Ninth Circuit panel decision in Gabriel v. Alaska Elec. Pension Fund, 755 F.3d 647 (9th Cir. Alaska 2014), the court essentially held that the equitable

remedy of surcharge was only available to **plans** to recover overpayments, and that it was not available to plan participants who had wrongfully been denied benefits. The court *en banc* reversed the decision, holding that surcharge was available to participants, and not just the plans, and remanded the case for the district court to consider the issue of surcharge.

Sexton v. Panel Processing, Inc., 754 F.3d 332 (6th Cir. Mich. 2014)
Section 510 Does Not Protect "Unsolicited Comments"

Section 510 is the section of ERISA that protects employees from being retaliated against for exercising their rights under ERISA, including the right to participate in an "inquiry." The Sixth Circuit held that this protection does not extend to an employee who sends an internal email alleging ERISA violations, since it was not a communication in connection with an "inquiry." The court said Section 510 was not intended to be general whistleblower statute.

C. District Court Cases

D'Iorio v. Winebow, Inc., 920 F. Supp. 2d 313 (E.D.N.Y. 2013) a New York federal trial court case raises the possibility of that consequential damage and punitive damages may be available when a plan breaches its fiduciary duty to disclose plan terms to a plan participant. But the court does note that the burden to show such damages is high, requiring fraud or actual malice (that is, a motivation to personally hurt the plaintiff), and that the plaintiff is unlikely to be able to show that such damages are recoverable in the case. However, the court said it was too early in the case to decide that she could not recover such damages, and denied the motion to rule in the plan's favor at that point in the proceedings.

Spears v. Liberty Life Assur. Co. of Boston, 2015 U.S. Dist. LEXIS 42095 (D. Conn. Mar. 31, 2015) (Bryant). Holding denial was arbitrary and capricious. The court did find that the inherent conflict of interest arising from Liberty being both the entity that made the decision and the payer of the benefits affected the decision-making process. The finding, though, was based on procedural irregularities involving the claim, since Liberty had structural protections in place to insulate the examiners from the effect of their decisions on the company's finances. The main deficiencies identified by the court included using a different physician to conduct a medical file review for the second appeal, rather than using the doctor from the first appeal, who had found the plaintiff disabled. Further, Liberty asked the doctor to opine on a certain time period, and then used the conclusion to apply to a different time period than that which the doctor had given his opinion. The court did find that the inherent conflict of interest arising from Liberty being both the entity that made the decision and the payer of the benefits affected the decision making due to the procedural irregularities involving the claim, even though Liberty had structural protections in place to insulate the examiners from the effect of their decisions on the company's finances. This case shows that the weighing of a potential conflict of interest is rarely outcome determinative. It is pretty clear from the decision that Judge Bryant would have made the same decision even without consideration of the conflict of interest.

Wedge v. Shawmut Design & Constr. Group Long Term Disability Ins. Plan, 23 F. Supp. 3d 320 (S.D.N.Y. 2014). No abuse of discretion when the insurer addressed the opinions of each of plaintiff's medical providers and vocational experts, and presented evidence to reject them. A

significant factor in the case may have been that the IME provided an objective basis to assert that the plaintiff had much better vision than he claimed. Also, the case shows the importance of focusing on the **impairment** rather than the **diagnosis**. The insurer didn't fight the diagnosis, but rather that the claimant hadn't shown the impairment resulting from the diagnosis. That fact made the court more willing to accept the insurer's determination, since it was not just saying no to everything.

Rao v. Life Ins. Co. of N. Am., 2015 U.S. Dist. LEXIS 55518 (N.D.N.Y Apr. 23, 2015). Applying arbitrary and capricious review, the court reversed the denial of short-term disability benefits, and remanded for a redetermination of long-term benefits, when the insurer focused on the opinion of the physician who conducted the file review. That physician did not address the substance of the opinions of the treating physicians that she was disabled, but rather discounted the opinions because certain tests were not done, and because the exams were not exactly contemporaneous with the dates of disability. While ERISA does not have a "treating physicians" rule that accords deference, unlike social security, "this is not a license to arbitrarily ignore credible medical evidence simply because it comes from a claimant's treating source.", *citing,* Black & Decker Disability Plan v. Nord, 538 U.S. 822, 833-34, 123 S. Ct. 1965, 155 L. Ed. 2d 1034 (2003); Paese v. Hartford Life & Acc. Ins. Co., 449 F.3d 435, 442 (2d Cir. 2006).

Liyan He v. Cigna Life Ins. Co., 2015 LEXIS 6652 (S.D.N.Y. 2015). When a claim is reviewed *de novo*, there is no automatic discovery into conflict of interest like there is with arbitrary and capricious. Non-record discovery is only available on a showing of good cause.

Feher v. Unum Life Ins. Co. of Am., 2014 U.S. Dist. LEXIS 174536 (D. Conn. Dec. 18, 2014). This case illustrates a dangerous procedural trap with benefit appeals. The attorney for the claimant asked for reconsideration of a benefit denial, but never appealed the decision. After denial of the reconsideration request, the attorney filed suit rather than filing an appeal. Courts hold, however, that a request for consideration does not equal an appeal. You must file something called an appeal, or you won't be considered to have exhausted your administrative remedies.

Delprado v. Sedgwick Claims Mgmt. Servs., Inc., 2015 U.S. Dist. LEXIS 51263, *108 (N.D.N.Y Apr. 17, 2015). Finding that the plan's denial of short-term and long-term disability benefits was arbitrary and capricious, stating:

> After Plaintiff was diagnosed with fibromyalgia and filed her second STD claim, Defendants committed myriad errors in making their decision, including not properly considering her subjective symptoms of pain and fatigue and the opinions of the doctors who examined her that she was disabled, relying on the flawed report of Dr. Payne, failing to issue a formal determination letter regarding her appeal, and failing to provide adequate notice of what information was necessary to show disability due to fibromyalgia.

Insurers are commonly denying fibromyalgia claims like this reflexively on the basis that the only proof of the disability is "self-report." This case illustrates that this is not a sufficient basis on which to deny benefits.

Tretola v. First Unum Life Ins. Co., 2014 U.S. Dist. LEXIS 85407 (S.D.N.Y. June 23, 2014). The Court denied the claimant's motion to supplement the administrative record with news reports and other information regarding Unum's claims handling practices prior to a 2004 regulatory settlement addressing Unum's claim-handling procedures. The Court held that it was irrelevant to the decision Unum made in 2012.

A Request to the Reader: I have been preparing the annual ERISA litigation update for the past six years, and I have never received any feedback. I would appreciate hearing what you think about the materials, how they could be improved in the future, what other topics you think should be included, and whether the tone is appropriate, including whether I make too many editorial comments to the cases. Please email me or call me with any information you can give. I'll send twenty dollar gift card to a local coffee shop for the first person to send me comments. Thanks for any feedback you can give.