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The ERISA Litigation Newsletter

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Editor's Overview

The first article in this month's newsletter focuses on whether specific language in ERISA employer-provided disability insurance plans confer discretionary authority to plan administrators to determine eligibility of benefits. Recently, courts have focused on whether discretion is conferred to a plan administrator when the plan requires that claimants present "proof satisfactory to us" to receive benefits. The article discusses the split in the circuits on this issue, with four circuits ruling that such language grants discretionary authority and thus the arbitrary and capricious standard applies and six circuits holding that lush language does not provide a clear grant of discretionary authority. The second article in this month's newsletter focuses on a new IRS notice, expanding the cafeteria plan "change in status" rules to allow health plans to offer employees the option to revoke their elections for employer-sponsored health coverage to purchase coverage through a Health Insurance Marketplace.

As always, be sure to review the section on Rulings, Filings, and Settlements of Interest including, recent case law on ERISA preemption in the Sixth Circuit, changes to the waiting period in California, and an update on mental health parity litigation.

A Court's Review Of A Disability Benefit Claim May Hinge On The Meaning "Satisfactory To Us"

By Joe Clark

Twenty-five years ago, the U.S. Supreme Court ruled that courts should review an ERISA participant's claim for benefits under a de novo standard of review unless the plan gives the plan fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan. Since then, courts have considered what type of plan language suffices to grant plan fiduciaries discretionary authority to warrant the more deferential arbitrary and capricious standard of review.

The issue has garnered a fair amount of attention in the context of employer-provided disability insurance plans. Courts have been particularly focused on whether the requisite discretion is conferred when the plan requires that claimants present "proof satisfactory to us" (*e.g.*, the plan administrator) to receive benefits. Four circuits [the Sixth, Eighth, Tenth and Eleventh Circuits] have ruled that such language clearly grants discretionary authority to the plan administrator, and claim denials in those cases have been subject to an arbitrary and capricious standard of review. However, six circuits [the First, Second, Third, Fourth, Seventh and Ninth Circuits] have held that such language does *not* provide a clear grant of discretionary authority to a plan administrator and thus claim denials in these cases were subject to de novo review by a court.

Whether a court reviews a benefit claim denial (i) de novo, thus empowering the court to substitute its own judgment for that of the plan fiduciary, or (ii) under the highly deferential arbitrary and capricious standard of review, can sometimes be outcome determinative. This article sheds some light on the reasoning behind each view and suggests steps that plan drafters can take to better ensure that claim denials are subject to deferential review by the courts.

The *Firestone* Standard

It is well established that a benefit claim denial being challenged under ERISA is subject to de novo review by courts "unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan."[1] If the plan provides the administrator or fiduciary with discretionary authority to determine eligibility for benefits, however, courts review the decision under the highly deferential arbitrary and capricious standard of review. A plan administrator bears the burden of establishing that the arbitrary and capricious standard should apply.

Courts Finding "Satisfactory To Us" Allows For Arbitrary And Capricious Review

Several circuit courts have concluded that a plan's statement that proof of disability must be "satisfactory to us" is sufficient to warrant application of an arbitrary and capricious standard of review. In fact, three circuit courts of appeals determined that such language triggered an arbitrary and capricious standard of review based solely on the fact that the language, on its face, clearly gives the plan administrator discretion to determine benefits eligibility.

For instance, the Eleventh Circuit found, without stating its reasoning, that a long-term disability policy requiring "satisfactory proof of total disability to the plan administrator" provided the plan administrator discretion to determine eligibility for benefits, and concluded that it should review the benefit denial under an arbitrary and capricious standard of review.[2] The Eighth Circuit reached the same conclusion in a case involving a long-term disability plan that required claimants to provide written proof of total disability that was "satisfactory to the plan administrator."[3] The Sixth Circuit also applied an arbitrary and capricious standard of review even in the absence of the "to us" in "satisfactory to us." It found that "[a] determination that evidence is satisfactory is a subjective judgment that requires a plan administrator to exercise his discretion," and "the only reasonable interpretation of the [plan] language" was that the plan administrator "retain[ed] the authority to determine whether the submitted proof of disability [was] satisfactory."[4]

The Tenth Circuit concluded that "satisfactory to us" conveys the message that the evidence of disability must be persuasive to the plan administrator, and thus applied an arbitrary and capricious standard of review. It did, however, note that the issue was a close call and cautioned: "plan drafters who wish to convey discretion to plan administrators are ill-advised to rely on language that is borderline in accomplishing that task."[5]

Courts Finding That "Satisfactory To Us" Warrants De Novo Review

The more recent trend among the circuit courts has been to find that "satisfactory to us" is insufficiently clear to result in deferential review of benefit denials. In reaching this conclusion, courts have reasoned that: (i) the language is confusing as to the quality of "proof" that must be submitted to the plan administrator; (ii) the language fails to sufficiently convey to prospective employees whether a plan confers discretion on a plan administrator, and this is a fact that may impact the employment decision; (iii) the language does not adequately notify employees that an administrative denial will be insulated from *de novo* review; and (iv) it is relatively easy for plan drafters to draft clear language.

The Second Circuit observed that "satisfactory to us" could cause confusion among participants and beneficiaries. In particular, the Court stated it was not clear whether the language meant only that the claimant must submit *to the plan administrator* proof that is satisfactory or that the claimant must submit proof that is *satisfactory to the plan administrator*.[6] The court thus reviewed the benefit denial de novo.

The Seventh Circuit took a similar view:

No single phrase such as "satisfactory to us" is likely to convey enough information to permit the employee to distinguish between plans that do and plans that do not confer discretion on the administrator. And this is a matter that may well be of interest to employees considering where to work: some may prefer the certainty of plans that do not confer discretion on administrators, while others may think that the lower costs that are likely to attend plans with reserved discretion are worth it.[7]

In the same vein, the Fourth Circuit expressed concern about the effect that the language could have on a claimant's presentation during the administrative claim stage. It found that "proof satisfactory to us" was ambiguous and that without clear language notifying employees that their claim would be insulated from plenary judicial review, employees who file claims for benefits may not be fully aware of the gravity of administrative proceedings or the necessity of developing as complete a record as possible early in the claims process.[8]

Finally, the First and Ninth Circuits concluded that the relative ease with which plan drafters could draft clear language is yet another reason courts find that "satisfactory to us" should not subject a benefits denial to arbitrary and capricious review.[9]

The View From Proskauer

Given the relative ease in drafting clear, unambiguous discretion-granting plan language, plan sponsors should undertake a review of their plans to make certain that they in fact clearly confer on the plan fiduciary the discretionary authority to determine eligibility for benefits or to construe the terms of the plan. There are no "magic words" required to ensure that discretion-granting plan language is sufficiently clear. However, drafters might consider using language that has been suggested by the courts, such as "[b]enefits under this plan will be paid only if the plan administrator decides in his discretion that the applicant is entitled to them,"[10] or "[t]he plan administrator has discretionary authority to grant or deny benefits under this plan."[11] The importance of clear discretion-granting plan terms, and plan terms overall, cannot be overstated.

IRS to Amend Cafeteria Plan Regulations to Facilitate Enrollment in Marketplace Coverage

By Paul M. Hamburger, Peter Marathas, Stacy Barrow and Tzvia Feiertag

On Thursday, September 18, 2014, the Internal Revenue Service ("IRS") released Notice 2014-55, which expands the cafeteria plan "change in status" rules to allow plans to offer employees an option to revoke their elections for employer-sponsored health coverage to purchase a qualified health plan through a Health Insurance Marketplace ("Marketplace"). The notice is effective immediately and will appear in IRB 2014-41, to be published Oct. 6, 2014.

The notice addresses two specific situations in which a plan could allow an employee to revoke a cafeteria plan election (other than a health FSA election): due to enrollment in the Marketplace; and due to a reduction in hours of service. This should be a welcome relief to employers that may have been struggling with how to allow employees to change coverage from under the employer's plan to a Marketplace or other group health plan.

Revocation Due to Enrollment in the Marketplace

Under current cafeteria plan rules, an employee may not revoke an election for coverage under a group health plan solely to purchase a Marketplace plan. This is not a concern for employees who are eligible for a calendar year cafeteria plan because they may transition to a Marketplace plan during open enrollment with no gap in coverage, as both the employer plan and the Marketplace would have an open enrollment period for coverage effective January 1. However, an employee covered by a non-calendar year cafeteria plan is unable to synchronize the change – Marketplace coverage only operates on a calendar year open enrollment period. Thus, employees covered by non-calendar year cafeteria plans who wish to enroll in Marketplace coverage would experience a period where there is either dual coverage or no coverage, depending on when they are able to drop the employer-provided coverage.

A similar issue occurs when an employee experiences an event such as a birth or marriage. In these situations, it may be more advantageous for some employees to purchase a Marketplace plan for themselves and their families rather than to add family members to the employer's group health plan. Despite the fact that birth and marriage are both special enrollment events for Marketplace coverage, the cafeteria plan rules do not allow an employee to make a mid-year revocation of coverage for employer-sponsored coverage based on a desire to enroll in Marketplace coverage.

For all of these reasons, the IRS Notice permits a cafeteria plan to allow a participating employee to revoke an election in order to obtain coverage through the Marketplace under the following conditions:

1. The employee is seeking to enroll in Marketplace coverage during the Marketplace's annual open enrollment period or during a special enrollment period; and
2. The employee enrolls, along with any related individuals who cease coverage due to the revocation, in a Marketplace plan effective immediately following the revocation.

An employer may rely on the reasonable representation of an employee who is enrolling in Marketplace coverage that the employee and related individuals have enrolled or intend to enroll in a Marketplace plan that is effective immediately following the revocation (i.e., there is no gap in coverage). In other words, employers do not have to require employees to prove that Marketplace coverage was actually elected once they cease to participate in the employer's plan.

As a reminder, the special enrollment rules for Marketplace coverage include entry due to an individual:

- losing other health coverage;
- gaining a dependent (or becoming a dependent) through marriage, birth, or adoption;
- newly gaining status as a citizen, national or lawfully present individual;
- unintentionally or inadvertently failing to enroll due to an error on the part of the Marketplace;
- demonstrating to the Marketplace that the plan in which the individual is enrolled substantially violated a material provision of its contract in relation to the enrollee (this would permit an individual to change Marketplace plans);
- being determined newly eligible (or experiencing a change in eligibility) for subsidized coverage (regardless of whether the individual is already enrolled in Marketplace coverage);
- changing residence such that the individual gains access to new Marketplace options; or
- demonstrating that the individual meets other exceptional circumstances as the Marketplace may provide.

Revocation Due to Reduction in Hours of Service

Under the ACA's pay-or-play mandate, an employer may choose to measure an employee's hours over a period of time (called a measurement period) to determine the employee's status as either full-time or not full-time for the subsequent stability period, using a 30-hour per week average for full-time status. If an employee works full-time during the measurement period, the employee must be treated as full-time—and continue to be offered affordable coverage—during the subsequent stability period if an employer is attempting to avoid pay-or-play penalties.

This creates a potential problem when an employee in a stability period changes from a full-time position to a part-time position and wishes to purchase a Marketplace plan. This might happen because the reduction in hours has triggered eligibility for a premium tax credit or perhaps because the individual simply cannot afford the coverage, as a practical matter, on reduced pay. Under existing cafeteria plan rules, a cafeteria plan could not allow the employee to drop coverage mid-year because there hasn't been a loss of eligibility for coverage in the underlying group health plan.

To fix this issue, the notice provides that a cafeteria plan may allow an employee to revoke prospectively an election of coverage under a group health plan (other than a health FSA) provided the following conditions are met:

1. The employee changes from full-time status to part-time status and is reasonable expected to remain in part-time status; and
2. The employee enrolls, along with any related individuals who cease coverage due to the revocation, in another plan no later than the first day of the second full month following the revocation.

An employer may rely on the reasonable representation of an employee who is changing to part-time status that the employee and related individuals have enrolled or intend to enroll in another plan within the above timeframe.

Employer Action Steps

As with the other cafeteria plan change in status rules, these new permitted election changes are voluntary – an employer is not required to adopt them. Employers that wish to extend the new permitted election change opportunities to employees will need to amend their cafeteria plans to allow the changes. The amendment must be adopted by the last day of the plan year in which the changes are allowed, and may be effective retroactively to the first day of that plan year; however, any election changes may not have a retroactive effect. Note that for plan years beginning in 2014, the employer has until the last day of the 2015 plan year to amend the plan. The IRS intends to amend the applicable cafeteria plan regulations in the future to reflect the guidance in the notice.

Separately, if an employer chooses to use these change in status rule exceptions, the employer ought to consider other administrative issues and communication issues that can arise – employees need to be apprised of these new options and the options need to be administered consistently with other plan provisions, including any applicable COBRA provisions. As employers enter into open enrollment season, those employers wishing to permit these changes should consider including a discussion of the new options in enrollment materials.

Rulings, Filings, and Settlements of Interest

Sixth Circuit says ERISA does not preempt state law claim for fraudulent inducement.

By Aaron Feuer

- The Sixth Circuit recently held that ERISA did not preempt a plan participant's claim for state law fraudulent inducement. *McCarthy v. Ameritech Pub., Inc.*, No. 12-4510, 2014 WL 3930572 (6th Cir. 2014). Defendant-API's decided to terminate Plaintiff's employment and gave her two options: (1) she could leave and receive a lump-sum "termination payment"; or (2) she could enter API's Employment Opportunity Pool, where she would receive priority consideration for another position while receiving reduced pay taken from her "termination payment." Because Plaintiff's husband was critically ill, Plaintiff's decision depended on whether she had accrued enough employment service to retain her healthcare benefits upon leaving. Plaintiff's supervisors falsely advised her that, notwithstanding the representations by API's health and welfare plan administrators to the contrary, she was not entitled to retain her healthcare benefits unless she continued working for an additional nine months. As a result of Plaintiff's decision to enter the employment pool, "API . . . received nine months of free labor from [Plaintiff]." Inter alia, the Sixth Circuit held that ERISA did not preempt Plaintiff's state law fraudulent inducement claim because Plaintiff was not seeking any benefits due under the health and welfare plan, but rather fair compensation for the work performed for the nine months she was allegedly induced to remain at API.

California Repeals 60-Day Limit on Waiting Periods

By Stacy Barrow

- On August 15, 2014, California passed Senate Bill 1034, which repealed an insurance law (Assembly Bill 1083) that prohibited insurance companies from including waiting periods in excess of 60 days in their group health insurance

contracts. The new law, effective January 1, 2015, prohibits California insurance companies from applying **any** "waiting or affiliation period" under a group or individual health benefit plan.

So where does that leave California employers, who are permitted under federal law (the ACA) to have a one-month orientation period and up to a 90-day waiting period? They'll be able to continue applying ACA-compliant orientation periods and waiting periods, as the law prohibits carriers—but not employers—from imposing a waiting period. Therefore, the new California law aligns with the ACA and allows insurance carriers in California to administer enrollment in accordance the employer's ACA-compliant orientation period and/or waiting period. It does, however, prohibit carriers from imposing a separate affiliation or waiting period in addition to any imposed by the employer. An affiliation period is the equivalent of a waiting period for coverage obtained in the individual (non-group) market.

The new law is intended to eliminate confusion between the state and federal rules governing health care enrollment waiting periods. Employers operating in multiple states will be able to have consistent waiting periods for employees in different states, if desired, which will make it easier to determine when a new hire or otherwise newly eligible employee must be enrolled in a health care plan.

Until the existing 60-day waiting period law is repealed effective January 1, 2015, employers with California health care plans that renew in 2014 should be able to apply a waiting period in accordance with the ACA (e.g., up to 90 days) as long as the carrier's insurance contract does not impose a separate waiting period in addition to the employer's waiting period.

Mental Health Parity Act: A Litigation Update

By Todd Mobley and Robert Rachal

- The Federal Mental Health Parity and Addiction Equity Act (the "Federal Parity Act"), like many similar state parity laws, mandates that financial requirements (e.g., copayments, coinsurance, or deductibles) and treatment limitations (e.g., limitations on the frequency of treatment, number of out-patient visits, or amount of days covered for in-patient stays) applicable to mental health benefits generally can be no more restrictive than the requirements and limitations applied to medical benefits. These parity laws, which are enforceable under ERISA, have been at issue in an increasing number of cases. Three district courts, all of which are located within the Ninth Circuit, have released rulings over the past few weeks.

  In *A.F. v. Providence Health Plan*, No. 13-cv-776, 2014 U.S. Dist. LEXIS 109507 (D.

Or. Aug. 8, 2014), a federal district court in Oregon granted plaintiffs' partial motion for summary judgment, finding that Providence's "Developmental Disability Exclusion" (which excludes coverage for services "related to developmental disabilities, developmental delays, or learning disabilities") violated both the Federal Parity Act and the Oregon Mental Health Parity Act. Plaintiffs alleged that, under the Developmental Disability Exclusion, Providence routinely denied coverage for applied behavior analysis therapy for participants and beneficiaries diagnosed with autism spectrum disorders. Because the Developmental Disability Exclusion applied to services related to developmental disabilities (which are considered mental health conditions), yet did not apply to services related to medical or surgical conditions, the court found that the exclusion is prohibited by the plain text of both statutes.

Similarly, in *R.H. v. Premera Blue Cross*, No. 13-cv-0097, 2014 U.S. Dist. LEXIS 108503 (W.D. Wash. Aug. 6, 2014), plaintiffs commenced a class action lawsuit alleging that Premera, in violation of Washington's Mental Health Parity Act, imposed treatment limitations on applied behavior analysis and neurodevelopmental therapy that were not in parity with the coverage provided for services related to medical conditions. The court granted plaintiffs' unopposed motion for preliminary approval of class settlement, finding that the proposed agreement was fair, reasonable, and adequate. Pursuant to the class settlement, Premera promised to remove the challenged treatment limitations and also to provide a $3.5 million settlement fund to reimburse participants for services that were not covered during the class period.

In *Daniel F. v. Blue Shield of California*, No. 09-cv-2037, 2014 U.S. Dist. LEXIS 111643 (N.D. Cal. Aug. 11, 2014), a federal district court in the Northern District of California denied plaintiffs' motion for class certification in a suit claiming that Blue Shield of California's group and individual health insurance plans exclude coverage of residential treatment services for severe mental health conditions in violation of California's Mental Health Parity Act. In denying certification, the court found that the proposed class definition "is a moving target," in that plaintiffs provided differing definitions in their moving brief, reply brief, and at oral argument. The court concluded that none of the proposed definitions satisfied Rule 23's implied requirement of ascertainability, particularly because ascertaining class membership would necessitate individualized inquiries into whether putative class members participated in plans governed by ERISA and whether their respective mental health conditions (and treatment therefore) are covered under the California Parity Act.

[1] Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989).

[2] *Levinson v. Reliance Std. Life Ins. Co.*, 245 F.3d 1321, 1324-25 (11th Cir. 2001).

[3] *Ferrari v. Teachers Ins. & Annuity Ass'n*, 278 F.3d 801, 806 (8th Cir. 2002). More recently, the Eighth Circuit acknowledged that "proof satisfactory to the plan administrator" was an "arguably ambiguous grant of discretion," but declined to deviate from circuit precedent. *Prezioso v. Prudential Ins. Co. of Am.*, 748 F.3d 797, 803 (8th Cir. 2014).

[4] *Perez v. Aetna Life Ins. Co.*, 150 F.3d 550, 555, 557-58 (6th Cir. 1998) (en banc).

[5] *Nance v. Sun Life Assur. Co. of Can.*, 294 F.3d 1263, 1268, n.3 (10th Cir. 2002).

[6] Kintsler v. First Reliance Std. Life Ins. Co., 181 F.3d 243, 251-52 (2d Cir. 1999).

[7] *Diaz v. Prudential Ins. Co. of Am.*, 424 F.3d 635, 639 (7th Cir. 2005); *see also Viera v. Life Ins. Co. of N. Am.*, 642 F.3d 407, 417 (3d Cir. 2011) (finding that accidental death and dismemberment policy's use of "proof of loss satisfactory to us" fails to alert a participant to the possibility that a plan administrator "has the power to re-define the entire concept of [a covered loss] on a case-by-case basis.").

[8] *Cosey v. Prudential Ins. Co. of Am.*, 735 F.3d 161, 166, 167-68 (4th Cir. 2013).

[9] *Gross v. Sun Life Assur*. Co. of Can., 734 F.3d 1, 16 (1st Cir. 2013); *Feibusch v. Integrated Device Tech, Inc.*, 463 F.3d 880, 883 (9th Cir. 2006).

[10] *Diaz*, 424 F.3d at 638 (internal quotations omitted).

[11] *Feibusch*, 463 F.3d at 883 (internal quotations omitted).

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