Proskauer

The ERISA Litigation Newsletter

May 2010

Editor's Overview

In what many are already predicting will become the most often quoted and cited ERISA decision *ever*, the U.S. Supreme Court ruled in *Conkright v. Frommert* that everyone — even plan administrators — make mistakes. And, the mistake made in this case did not warrant stripping the plan administrator of the deference it deserved in fashioning a remedy for plaintiffs' claim. Heather Magier discusses below the decision's implications, including the fact that the Supreme Court appears to have charted a path pursuant to which we are going to see district courts more frequently remand benefit claims to the plan administrator for additional consideration rather than rule outright against the plan.

Next, Deidre Grossman discusses the scope of conflict of interest discovery after the U.S. Supreme Court's ruling in *Metro. Life Ins. Co. v. Glenn*, 128 S. Ct. 2343 (2008). As the cases illustrate, courts have taken different positions, with many (but not all) recognizing that limited discovery may be warranted in some circumstances to determine the extent of a conflict.

Finally, Nicole Eichberger provides a review of the Eighth Circuit's decision in *Chorosevic v. MetLife Choices*, 2010 WL 1253778 (8th Cir. Apr. 2, 2010), which reminds us that the affirmative defense of failure to exhaust administrative remedies, though more frequently considered in single plaintiff cases, can be effective for purposes of defeating class claims as well.

As always, be sure to review the section on *Rulings, Filings and Settlements of Interest*.

Supreme Court Rules That "Single Honest Mistake" Does Not Justify Stripping Administrator Of Judicial Deference[1]

by Heather G. Magier

In its April 21 decision in *Conkright v. Frommert*, No. 08-810, 2010 WL 1558979, the Supreme Court extended the reach of the deferential standard of review it established 20 years ago for ERISA plan administrators, holding that the determination of an administrator with discretionary authority to interpret a plan is entitled to deference from a reviewing court even if the administrator's prior determination with respect to the same claim had been held invalid. Soundly rejecting the "one-strike-and-you're-out" approach, the Court held that ERISA's "interests in efficiency, predictability, and uniformity" are best served and protected by requiring judicial deference without exception.

In its seminal ruling in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110-11 (1989), the Supreme Court had held that when an ERISA plan grants discretionary authority to a plan administrator to interpret the terms of the plan, the administrator's interpretation is entitled to deference from reviewing courts. The Court more recently expanded this principle in *Metropolitan Life Ins. Co. v. Glenn*, 128 S. Ct. 2343, 2350-52 (2008), holding that deference continues to be required even if the plan administrator is operating under a conflict of interest. In *Frommert*, the Court refused again to carve out an exception to the *Firestone* rule. Writing for the majority, Chief Justice Roberts stated: "*Firestone* . . . set out a broad standard of deference without any suggestion that the standard was susceptible to ad hoc exceptions like the one adopted by the Court of Appeals. . . . ERISA law [is] already complicated enough without adding 'special procedural or evidentiary rules' to the mix . . . . If, as we held in *Glenn*, a systemic conflict of interest does not strip a plan administrator of deference, . . . it is difficult to see why a single honest mistake would require a different result."

Procedural History

In lawsuits filed in 1999, participants in a Xerox pension plan, who had received lump sum distributions of their pension benefits in connection with prior terminations, alleged that the method used to calculate their pension benefits after being rehired unlawfully reduced their benefits. Under the plan terms, participants received credit for their total years of service, including time prior to a break in service. To avoid giving rehired participants duplicative benefits, the plan required an adjustment to their current pension benefits. The adjustment was based on a "phantom account" methodology, pursuant to which the participants' current pension benefits were offset by the amount of their prior lump sum distributions plus earnings that hypothetically would have accrued on these distributions. As noted by the district court, a participant who had earlier received a statement estimating his monthly pension benefit at $2,482 was advised that, as a result of the "phantom account" offset, his current benefit would be reduced to $5.31 per month.

Applying a discretionary standard of review, the district court granted summary judgment to the plan administrator. The court concluded that the plan administrator's consistent application of the "phantom account" methodology was not arbitrary or capricious, had not been applied as a result of an improper plan amendment, and did not reduce accrued benefits. *Frommert v. Conkright*, 328 F. Supp. 2d 420 (W.D.N.Y. 2004); *see also Frommert v. Conkright*, 206 F. Supp. 2d 435 (W.D.N.Y. 2002).

The Second Circuit reversed. It found that a detailed description of the phantom account method had not been added to the plan via a proper amendment until 1998. *Frommert v. Conkright,* 433 F.3d 254 (2d Cir. 2006). As a result, application of the offset to employees rehired prior to 1998 violated ERISA §204(g) because it impermissibly reduced their accrued benefits, and violated ERISA §204(h) because the company had failed to give advance notice of the amendment's adoption. The Second Circuit instructed the district court on remand to craft a remedy "utiliz[ing] an appropriate pre-amendment calculation to determine their benefits . . . employ[ing] equitable principles. . . ." 433 F.3d at 268.

On remand, the district court directed the administrator to pay the plaintiffs rehired before 1998 a lump sum representing the difference between the benefits already received and the amount of the recalculated benefits, without applying any phantom account offset or otherwise accounting for the time value of money. *Frommert v. Conkright,* 472 F. Supp. 2d 452 (W.D.N.Y. 2007). The court rejected an alternative method proposed by the administrator that offset the value of the prior distribution by converting it to an annuity payable at age 65. The court stated it favored its own methodology because it was "straightforward," prevented the employees from receiving a windfall, and "most clearly reflects what a reasonable employee would have anticipated" based on language in the plan documents. 472 F. Supp. 2d at 458.

The Second Circuit affirmed the district court's choice of remedy, holding that its refusal to defer to the plan administrator's proposed plan interpretation violated neither the plan terms nor any law. Given the pension plan's "ambiguity, contradiction[,] or silence" regarding how to calculate plaintiffs' benefits, it saw "no problem with the . . . selection of one reasonable approach among several reasonable alternatives." *Frommert v. Conkright,* 535 F.3d 111, 120 (2d Cir. 2008). The appeals court rejected defendants' argument that the district court "erred by failing to adopt the remedy proposed by the plan administrator, or, at least, by failing to remand to the administrator the task of fashioning a remedy." 535 F.3d at at 118. The Second Circuit held that the *Firestone* standard of review was inapplicable here, because the district court "had no decision to review" and defendants "identified no authority in support of the proposition that a district court must afford deference to the mere *opinion* of the plan administrator in a case, such as this, where the administrator had previously construed the same terms and we found such a construction to have violated ERISA." 535 F.3d at 119. The Second Circuit also held that defendants had not identified anything that could be gained by remand to the administrator, as they had been given the opportunity to, and did, explain the administrator's proposed remedy to the district court.

It is worth noting that although the Second Circuit heard argument in this case on June 19, 2008, the day that the Supreme Court issued its decision in *Glenn*, its decision one month later did not address *Glenn*. In August 2008, the defendants-appellants filed an unsuccessful petition for panel rehearing and rehearing en banc, arguing among other things that the Second Circuit's creation of an exception to the general rule of deference conflicted with *Glenn* and *Firestone*. 2008 WL 5869500 (2d Cir. Aug. 7, 2008). They successfully petitioned, however, for certiorari to the United States Supreme Court.

The Supreme Court's Decision

Writing for the majority, Chief Justice Roberts stated:

> People make mistakes. Even administrators of ERISA plans. That should come as no surprise, given that [ERISA] . . . is "an enormously complex and detailed statute," *Mertens v. Hewitt Associates,* 508 U.S. 248, 262, 113 S.Ct. 2063, 124 L.Ed.2d 161 (1993), and the plans that administrators must construe can be lengthy and complicated. . . . We held in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), . . . that an administrator with discretionary authority to interpret a plan is entitled to deference in exercising that discretion. The question here is whether a single honest mistake in plan interpretation justifies stripping the administrator of that deference for subsequent related interpretations of the plan. We hold that it does not.

Although the Supreme Court relied on principles of trust law when establishing the broad standard of deference in *Firestone* and then expanding its reach in *Glenn*, the Court found trust law to be unclear regarding whether courts owe deference to an administrator's plan interpretation after the administrator had abused its discretion – in this case, by making "one good-faith mistake." Looking instead to the guiding principles that underlie ERISA, the Court stressed the need to "preserve the 'careful balancing,'" established by ERISA, between ensuring fair and prompt enforcement of plan rights, and encouraging employers to create benefit plans in the first place.

Firestone deference, the Court explained, protects and promotes "efficiency, predictability, and uniformity" – the factors that keep administrative and litigation expenses in check and induces employers to offer ERISA benefit plans. Because these interests "do not suddenly disappear simply because a plan administrator has made a single honest mistake," no exception to *Firestone* deference is justified. The Court analyzed how adherence to the deference rule would support each of these interests:

Efficiency: The Court observed that if the district court on remand had applied a deferential standard of review, *i.e.*, evaluating only whether the administrator's interpretation was reasonable, the case would have been concluded more efficiently, without the need for the district court to interpret the plan itself. The Court found that respondents' proposed structure for determining whether deference by the court on remand was required or permissible "would only further complicate ERISA proceedings" and increase litigation costs.

Predictability: Instead of deferring to the plan administrator, the district court adopted a plan interpretation that failed to account for the time value of money. The Supreme Court noted that "[i]n the actuarial world, this is heresy, and highly unforeseeable," and in addition "would place respondents in a better position than employees who never left the company." Deference, according to the Court, helps prevent such unexpected windfalls because plan administrators have a duty to all beneficiaries to preserve limited plan assets.

Uniformity: The Court stated that if courts are permitted to adopt their own plan interpretations, rather than defer to that of the administrator, "[s]imilar Xerox employees could be entitled to different benefits depending on where they live, or perhaps where they bring a legal action," potentially placing Xerox in an "impossible situation." In fact, the Supreme Court noted, in litigation in the Ninth Circuit over the same plan, the court adopted a plan interpretation that utilizes actuarial principles to value the prior distributions. Thus, if the Second Circuit's decision were allowed to stand, the plan would be subject to different interpretations in different locations.

The Supreme Court also held that respondents' concerns about the potential problems with continued deference on remand were "overblown." Respondents argued that plan administrators, anticipating second chances, would be encouraged to adopt unreasonable interpretations, and that their ability to proceed through several interpretations would delay resolution of claims, thereby driving up costs and discouraging participants from challenging benefits decisions. The Court stated that the lower courts could withhold deference in such "extreme circumstances." Additionally, the Court noted that adhering to the *Firestone* deferential standard of review does not guarantee a decision in the administrator's favor, but "means only that the plan administrator's interpretation . . . 'will not be disturbed if reasonable.'"

The opinion by Chief Justice Roberts was joined by Justices Scalia, Kennedy, Thomas, and Alito. Justice Sotomayor did not participate.

In his dissent (joined by Justices Stevens and Ginsburg), Justice Breyer argued that there was no basis in trust law for requiring a court to defer to an administrator's second attempt at exercising discretion; rather, trust law provided that after an abuse of discretion has occurred, the court itself has the authority to decide whether to defer anew, or to craft a remedy itself. Justice Breyer asserted that the majority's "absolute 'one free honest mistake' rule" was impractical because it would require courts to evaluate whether the mistake was "honest," and would encourage appeals and delays. Additionally, he opined that the majority's decision would create incentives for administrators to draft ambiguous plans, with the expectation that they would have repeated opportunities for interpretation.

Proskauer's Perspective

Having participated in the filing of an amicus brief in support of the Petitioners, this firm obviously is pleased with the Supreme Court's decision. The ruling in *Frommert* hopefully will encourage the creation of ERISA plans by eliminating at least one deterrent: the specter of courts having the final say regarding how a plan should be administered and how benefits thereunder should be paid. We also hope that the decision will achieve the other results intended by the Court: reducing the complexity and costs of ERISA litigation, and protecting the statute's underlying principles of uniformity, predictability, and efficiency.

It is interesting to note that the underlying ERISA violation giving rise to the issue confronted by the Court was not a mistaken benefit claim determination, but a breach of statutory notice and anti-cutback rules. That the majority so readily bestowed on the administrator the discretion to fashion the remedy for these statutory breaches is an indication of the breadth of the decision. It would certainly appear now that courts will be expected to defer to plan administrators for a broad array of determinations relating to claims for benefits.

The likely outcome of this broad endorsement of deference principles is that district courts will more frequently remand benefit claims to the plan administrator for additional consideration, rather than rule outright against the plan. This is certainly the expectation of Chief Justice Roberts, who, less than a week after issuing *Frommert*, stated during oral argument in *Hardt v. Reliance Standard Life Ins. Co.*(No. 09-448)(April 26, 2010), that after *Frommert*, in a "typical case" under ERISA, "the likely relief is going to be sending it back rather than making a judicial decision . . . ." Justice Scalia likewise opined that in light of *Frommert*, "[f]uture claimants will not ask for summary judgment from the district court, ... They will ask that the case be remanded."

The right to judicial deference arises only, however, where the plan document confers on the plan administrator the discretion to interpret the plan and make benefit determinations. Plan drafters therefore should be vigilant in their efforts to ensure that their plans expressly and unequivocally grant such discretionary authority.

The Latest Uncertainty in Benefit Claim Litigation – The Proper Scope of Conflict Discovery After *Glenn*[2]

By Deidre A. Grossman

In *Metropolitan Life Insurance Co. v. Glenn*, 128 S. Ct. 2343 (2008), the Supreme Court held that the structural conflict affecting insurance companies that both decide and pay claims for benefits is a factor for courts to weigh in determining whether the insurance company abused its discretion in denying a claim for benefits, but does not modify the arbitrary and capricious standard of review that ordinarily applies to such determinations. A conflict may weigh heavily, the Court explained, "where circumstances suggest a higher likelihood that it affected the benefits decision," such as where there is a "history of biased claims administration," or it could be accorded little to no weight if the administrator “has taken active steps to reduce potential bias and to promote accuracy, for example, by walling off claims administrators[.]” The Court’s decision in *Glenn* resolved a significant and long-standing split among the circuits on the relevance of conflicts to the standard of review. However, it left unanswered the question of whether, and the extent to which, a conflict’s impact on the benefit determination process can be explored in discovery.

Before *Glenn,* courts generally agreed that judicial review under the arbitrary and capricious standard was confined to the evidentiary record compiled during the administrative claims review process. Nevertheless, manycourts permitted limited discovery beyond the administrative record relating to an administrator’s alleged conflict of interest, primarily because they held the view (prior to *Glenn*) that the extent of the conflict and whether or not it tainted the benefit determination in question should affect the applicable standard of review. Recognizing that discovery beyond the administrative record is generally disfavored in benefit claim litigation, some of these courts conditioned discovery on some threshold showing of a conflict and/or procedural irregularities. *See*, *e.g.*, *Semien v. Life Insurance Company of North America*, 436 F.3d 805, 815 (7th Cir. 2006) (barring discovery except in "exceptional circumstances" where claimant can "identify a specific conflict of interest or instance of misconduct[,]" and "make a prima facie showing that there is good cause to believe limited discovery will reveal a procedural defect in the plan administrator’s determination"). For many courts, a mere allegation of conflict or bias was insufficient. *Johnson v. Connecticut General Life Insurance Co.*, 324 F. Appx. 459, 466-67 (6th Cir. 2009) (surveying Sixth Circuit law prior to *Glenn*).

In the wake of *Glenn*, courts have taken different positions on the proper scope of discovery, with most – but not all – recognizing that discovery may be warranted in some circumstances to determine the extent of a conflict. *See Denmark v. Liberty Life Assurance Co.*, 566 F.3d 1, 10 (1st Cir. 2009) (stating that *Glenn* "fairly can be read as contemplating some discovery on the issue of whether a structural conflict has morphed into an actual conflict[,]" but noting that such discovery "must be allowed sparingly" and "only to the extent that there are gaps in the administrative record"); *but see Roberts v. Amer. Elec. Power Long-Term Disability Plan*, No. 07-CV-00593, 2009 BL 166832 (S.D. W. Va. Aug. 6, 2009) (acknowledging pre-*Glenn* law allowing conflict discovery to determine proper standard of review, but concluding that no discovery was permissible after *Glenn* "because the standard of review is consistent whether or not a conflict exists").

The cases generally seem to fall into one of the following categories:

Courts allowing limited discovery into the factors identified by Glenn. The majority of courts to have allowed for discovery after *Glenn* have limited such discovery to the factors identified by *Glenn* as affecting the weight of a conflict, including: (i) claims history and handling procedures; (ii) financial incentives of those deciding a plaintiff's claim; and (iii) steps taken by the administrator to promote neutrality of the decision-makers. *See, e.g., Almeida v. Hartford Life and Accident Insurance Co.*, 09-CV-01556, 2010 BL 44886 (D Colo. March 2, 2010) (allowing discovery into *Glenn* factors, including into other cases where claimants were encouraged to apply for Social Security benefits, but administrator then ignored Social Security award in denying claim for long-term disability benefits). These courts have emphasized, however, that such discovery must be narrowly tailored to conflict issues and not inquire into the merits of the underlying determination. *See*, *e.g.*, *Dandridge v. Raytheon Co.*, No. 08-CV-04793, 2010 BL 15647 (D.N.J. Jan. 26, 2010) (barring merits discovery).

Courts imposing threshold/*prima facie* showing as a condition to discovery. A subset of those courts permitting limited discovery have nevertheless held that the existence of a structural conflict, standing alone, is insufficient to warrant discovery beyond the administrative record. These courts have required the plaintiff to make some threshold showing of a conflict or procedural irregularity as a prerequisite to discovery. In *Pretty v. Prudential Insurance Company of America*, No. 08-CV-00060, 2010 BL 48665 (D. Conn. Mar. 5, 2010), for example, the district court denied the plaintiff's motion to compel the deposition of a Prudential representative having information about the administration of her long-term disability claim and adjudicated the claim based solely on the administrative record because the plaintiff had failed to identify "any specific evidence" in the administrative record indicating biased decision-making and, consequently, had not shown "a reasonable chance that the requested discovery [would] satisfy the good cause requirement [for admissibility of evidence outside the administrative record]."

In the Seventh Circuit, some – but not all – district courts continue to follow *Semien v. Life Insurance Company of North America*, 436 F.3d 805, 815 (7th Cir. 2006), which allowed for discovery only in "exceptional circumstances" and conditioned discovery on a prima facie showing of good cause to believe that discovery would reveal a procedural defect in the benefit determination. *See, e.g.*, *Marszalek v. Marszalek & Marszalek Plan*, No. 06-CV-03558, 2008 BL 191878 (N.D. Ill. Aug. 26, 2008) (applying *Semien* to deny plaintiff's request for discovery, finding no "exceptional circumstances" from: (i) fact that administrator's executives had received substantial bonuses; and (ii) plaintiff's unsupported assertions that administrator had concealed other lawsuits allegedly reflective of biased claims administration). *See also Johnson v. Connecticut General Life Insurance Co.*, 324 F. Appx. 459, 466-67 (6th Cir. 2009) (suggesting that conditioning discovery on threshold evidentiary showing would run contrary to "the Supreme Court's admonition in *Glenn* discouraging the creation of special procedural or evidentiary rules for evaluating administrator/payor conflicts of interest," but adding that "[t]hat does not mean, however, that discovery will automatically be available any time the defendant is both the administrator and the payor under an ERISA plan").

Courts relying on the Federal Rules to impose limits on discovery. In *Glenn*, the Supreme Court stated that it would not adopt "special burden-of-proof rules, or other special procedural or evidentiary rules, focused narrowly upon the evaluation/payor conflict[.]" Some – but not all – courts have construed this language to lift previously-imposed limits on discovery in ERISA benefit claim litigation. In their place, however, these courts have looked to the Federal Rules of Civil Procedure to determine the proper scope of discovery. *See, e.g.*, *Hogan-Cross v. Metropolitan Life Insurance Co.*, 568 F. Supp. 2d 410, 413 (S.D.N.Y. 2008) (interpreting *Glenn* as lifting restrictions on discovery unique to benefit claim litigation and concluding that Federal Rules of Civil Procedure provide basis to ensure discovery is sufficiently tailored); *but see Wells v. UNUM Life Insurance Company of America*, 593 F. Supp. 2d 1303, 1305 (N.D. Ga. 2008) (denying request for depositions where plaintiff failed to establish that discovery was relevant to standard of review and noting "[t]he applicable ERISA standard of review, rather than the expansive scope of discovery allowed by Federal Rule of Civil Procedure 26(b), governs the scope of discovery in this case").

Courts curtailing discovery where conflict could not act as a "tie-breaker."
Recognizing that a conflict is only one factor to be considered in determining whether there has been an abuse of discretion, district courts have curtailed discovery where the determination appeared reasonable and, consequently, the conflict could not alter the outcome of the court's review. *See, e.g.*, *Rellou v. JP Morgan Chase Long-Term Disability Plan*, 07-CV-01334, 2009 BL 208866 (S.D.N.Y. Sept. 30, 2009) (denying Rule 56(f) request for conflict discovery, noting that "even assuming arguendo that additional discovery revealed facts showing that First Unum's conflict of interest strongly influenced its decision to deny Plaintiff's claim, such a showing would not create a genuine issue of fact as to the reasonableness of that decision, as that decision was independently dictated by the plain meaning of the Plan documents"); *Florczyk v. Metropolitan Life Insurance Co.*, No. 06-CV-00309, 2008 BL 155604 (N.D.N.Y. July 11, 2008) (denying plaintiff's request for additional conflict discovery where benefit denial was supported by substantial evidence and "there [were] no factors, other than the conflict of interest itself, suggesting an abuse of discretion by Metlife"); *see also Creasey v. Cigna Life Insurance Co. of New York,* 255 F.R.D. 481, 483 (S.D. Ind. 2008) (requiring parties to complete merits briefing before considering plaintiff's request for discovery, where plaintiff had not shown that "case is a close one" justifying conflict discovery), *adhered to on reconsideration*, 255 F.R.D. 483 (2009) ("in a case where the defendant admits that it has such a conflict, the Magistrate Judge believes the better course is for the court to examine the merits of the claim before determining whether further discovery is necessary on the degree to which the conflict may exist"); *Hannagan v. Piedmont Airlines, Inc.*, No. 07-CV-00795, 2010 BL 71161 (N.D.N.Y. March 31, 2010) (stating that "[i]f no other factor weighs in the insured's favor, the insured's claim must fail because the existence of [the conflict] factor alone is insufficient to render the decision arbitrary and capricious") (citation omitted).

Proskauer's Perspective

We would not quibble with the notion that *some* limited discovery into conflict considerations may be warranted in *some* circumstances after *Glenn*. But we are concerned with how far some courts have gone. They seem to have forgotten that individual benefit claims are, in many respects, like administrative review proceedings and that, to treat them like full-blown federal court litigation for discovery purposes undercuts ERISA's goal of resolving such claims inexpensively and expeditiously. We think *Glenn* must be interpreted and applied consistent with such policies and goals. Otherwise, plans will be confronted with the incongruous result of having their defense costs exceed the amount of the benefits being sought.

Requiring a plaintiff to make some threshold evidentiary showing of bias before opening the doors to additional discovery is wholly reasonable given the nature of benefit claim litigation and is one mechanism for containing the cost and complexity of benefit claim proceedings. After all, if something has gone awry in the process of rendering a determination, there will be signs of it in the administrative record. It also makes good sense to limit discovery to the claims history and financial incentives of those responsible for rendering the determination, since *Glenn* teaches that conflicts that affect the determination in question are afforded weight. And, finally, given that conflicts cannot, standing alone, render an otherwise reasonable determination an abuse of discretion, courts should be loath to permit any discovery where the benefit denial appears reasonable on its face.

We are thankful that *Glenn* resolved the long-standing disagreement among the courts with respect to the applicable standard of review in structural conflict cases. The uncertainty over the scope of conflict discovery, however, could prove equally – or even more – problematic from a cost-perspective. Unfortunately, since discovery rulings are not immediately appealable to the circuit courts, it will take some time before a clear consensus emerges among the courts, or if a *Glenn II* will be needed to resolve the issue.

ERISA's Exhaustion of Administrative Remedies Requirement: An Effective Tool to Defeating Class Certification[3]

By Nicole A. Eichberger

Given the stakes associated with ERISA class action litigation, defense counsel will typically search for every means available to defeat class certification, thereby avoiding litigation of class claims on the merits. A recent Eight Circuit decision, *Chorosevic v. MetLife Choices*, 2010 WL 1253778 (8th Cir. Apr. 2, 2010), reminds us that the affirmative defense of failure to exhaust administrative remedies, though more frequently considered in single plaintiff cases, can be effective for purposes of defeating class claims as well.

Although ERISA does not expressly require it, the federal courts uniformly require that claims for benefits be exhausted as a condition for proceeding with a federal court claim, except under narrow circumstances where exhaustion is deemed "futile." *See, e.g., Back v. Danka Corp.*, 335 F.3d 790, 792 (8th Cir. 2003); *Miller v. United Welfare Fund*, 72 F.3d 1066, 1071 (2d Cir. 1995). Exhaustion of benefit claims is viewed as advancing the goals of ERISA by insuring the appropriate development of an administrative record that will streamline judicial proceedings and simplify the court's review, thereby leaving the responsibility for determining claims for benefits primarily within the province of plan administrators. *Id.*

In *Chorosevic*, the Eighth Circuit affirmed the district court's ruling and held that the named plaintiffs' failure to exhaust administrative remedies defeated certification of class claims challenging the denial of benefits under coordination of benefit procedures. The court also granted summary judgment, dismissing the complaint in light of the named plaintiffs' failure to exhaust.

Factual Background

The plaintiffs were: Mrs. Chorosevic, who worked for Metropolitan Life Insurance Co. ("MetLife") and received primary coverage under her employer's plan, entitled "MetLife Choices;" and her husband, who had primary coverage under his employer's plan. Under the two plans' coordination of benefits provisions, Mr. Chorosevic's primary insurer was obligated to pay his medical bills first, and then any outstanding amount due was submitted for review by the MetLife Choices Plan (the "Plan") as secondary insurer. Plaintiffs alleged that the Plan's summary plan description ("SPD") required that the Plan "credit any money saved by being the secondary insurer to a reserve, which could be used to reimburse a claimant for out-of-pocket expenses during the applicable calendar year."

Plaintiffs submitted to the Plan three claims for the reimbursement of out-of-pocket expenses incurred for medical services received by Mr. Chorosevic. The amounts claimed corresponded to the portion of the expenses for which Mr. Chorosevic did not receive reimbursement from his primary carrier. United Healthcare Insurance Company ("United"), the claims administrator for the secondary insurance portion of the MetLife Choices Plan, denied payment for the three claims. Contrary to plaintiffs' assertion, United determined that secondary coverage under the MetLife Choices Plan was available only in those instances where the Plan's secondary coverage was more extensive than under the primary plan, which was not the case here.

United's explanation of benefits included a description of the appeals process, which required that appeals be submitted directly to United. Rather than avail themselves of this process, however, plaintiffs sent correspondence directly to MetLife disputing United's denial of their claims. Following their extensive exchange of correspondence with MetLife, plaintiffs sent correspondence to United. However, the correspondence was beyond the prescriptive period set forth in the SPD.

Procedural History

After exchanging correspondence with MetLife and United over the disputed claims, on June 7, 2005, plaintiffs filed a putative class action asserting claims for benefits under ERISA § 502(a)(1)(B) against MetLife Choices Plan, United, and MetLife. The Complaint asserted that plaintiffs and other Plan participants were entitled to additional benefits, based on plaintiffs' theory that the savings achieved by the Plan by virtue of being a secondary insurer of claims was available to reimburse the portion of benefit claims not reimbursed by the primary carrier.

In response to the complaint, the defendants filed an answer with affirmative defenses, which included the defense that the plaintiffs had failed to exhaust administrative remedies. Following a period of discovery, plaintiffs moved for class certification. Defendants opposed plaintiffs' motion on the grounds that plaintiffs failed to exhaust their administrative remedies, thereby rendering their claims atypical and rendering them inadequate class representatives under *Fed. R. Civ. P.* 23(a)(3) and (a)(4). For that same reason, defendants also cross-moved for summary judgment.

The district court agreed with the defendants, denied the motion for class certification and granted defendants' motion for summary judgment.

Eighth Circuit's Holding

On appeal, plaintiffs challenged the district court ruling on the grounds that: (1) they had in fact exhausted their administrative remedies by virtue of their correspondence with MetLife; (2) their remedies should have been deemed exhausted due to United's alleged failure to respond to certain inquiries, or to include certain information in its explanation of benefits, which plaintiffs contended amounted to violations of ERISA's regulations; and (3) exhaustion would have been futile under the circumstances presented. The Eighth Circuit rejected all three of these arguments.

First, the Court concluded that plaintiffs had failed to exhaust their administrative remedies because the Plan, and the explanation of benefits materials provided to plaintiffs, clearly required that exhaustion be accomplished through the submission of an appeal to United, not MetLife. The Court next concluded that there had been no breach of ERISA's procedures governing the administrative process, since the explanation of benefits provided all the information required under the applicable regulations, and any subsequent correspondence sent by named plaintiffs to United was untimely under the terms of the SPD. *See* 29 C.F.R. § 2560.503-1(1).

Lastly, the Court rejected plaintiffs' futility argument for failure to demonstrate the requisite elements of that narrow exception to ERISA's exhaustion requirement. The futility exception requires that a participant "show that is certain that [his/her] claim will be denied on appeal, not merely that [he/she] doubts that an appeal will result in a different decision." Plaintiffs purported to satisfy this standard based merely on United's explanation of benefits statements. The Eighth Circuit concluded that this was not enough to demonstrate futility, and that plaintiffs' own conduct in pursuing their claims following the initial rejection by United undermined their arguments that any further action would have been futile.

The Eighth Circuit then proceeded to apply its failure to exhaust ruling to plaintiffs' class certification motion. Applying the principle that, "as go the claims of the class representatives there go the claims of the putative class," the court held that class certification was properly denied. The court determined that, because of named plaintiffs' failure to exhaust, their claims failed to satisfy Rule 23(a)(3)'s typicality requirement, as well as Rule 23(a)(4)'s requirement that named plaintiffs be adequate class representatives.

Finally, having determined that there was no adequate class representative, the Court held that the claims could not proceed. The court concluded that plaintiffs' individual claims failed because they failed to exhaust their administrative remedies. Accordingly, it upheld the grant of summary judgment, dismissing the complaint in its entirety.

Proskauer's Perspective

In reaching its conclusions, the Eighth Circuit made no distinction between the application of exhaustion requirements in individual and class claims. Insofar as class claims are predicated on an alleged systemic violation by the plan, one might question the need for developing an administrative record regarding the particular facts and circumstances of the named plaintiff's claim. Nevertheless, the *Chorosevic* decision confirms that, absent exhaustion of at least the named plaintiff's claim, there is no basis for proceeding with individual or class claims.

Chorosevic serves as a reminder that the defense of class action claims begins with an analysis of the claims of the named plaintiffs, including all available affirmative defenses thereto. Although courts have sometimes been reluctant to consider other affirmative defenses to ERISA cases at the early stages, based on the principle that the defendant bears the burden of proof with respect to such defenses, the decision demonstrates that the exhaustion defense may fare better. Where, as here, the defense can be successfully presented at the class certification stage, defendants may succeed in using it as a means to avert costly and time-consuming litigation of the merits of high-stakes, class action ERISA lawsuits.

Rulings, Filings and Settlements of Interest

- In *Zurich American Insurance Company v. O'Hara*, 2010 WL 1641369 (11th Cir. Apr. 26, 2010), the Eleventh Circuit held that a plan's insurer could, pursuant to the plan's subrogation clause, recover $263,000 from a participant that it paid for the participant's medical expenses. In so ruling, the court held that subrogation was appropriate because the plan explicitly provided for it regardless of whether the participant's settlement covered his losses. The court explained that the "make-whole" rule — which limits the insured's liability to his carrier only for the excess received in settlement over the total amount of his loss — applies only where the plan is silent as to the plan's subrogation rights.
- In *Wise v. Verizon Commc'ns Inc*., 2010 WL 1376622 (9th Cir. Apr. 8, 2010), the Ninth Circuit reversed the district court's decision to borrow a three-year statute of limitations for an ERISA benefit claim, and determined that the most analogous limitations period in Washington is that state's six-year period for written contracts. In so ruling, the court concluded that federal courts engaged in "limitations borrowing" should select only one limitations period per state for any given federal claim. Here, plaintiff sued within six-years of the "final" administrative denial regarding her long-term disability benefits. Thus, her claim was timely and the case was remanded to the district court for further consideration.
- In *Pender v. Bank of America Corp.*,2010 WL 1434297 (W.D.N.C. Apr. 7, 2010), plaintiffs brought suit claiming that BofA's cash balance plan violated ERISA by not paying the whipsaw associated with calculating participants' lump sum benefit, being impermissibly backloaded and eliminating participants' separate benefit accounts in the 401(k) plan after the 401(k) plan was merged into the cash balance plan. The district court granted PricewaterhouseCoopers' motion to dismiss, concluding that PwC could not be held liable under ERISA as a "knowing participant" in breach of fiduciary duty (or otherwise) because ERISA does not prohibit "designing a plan that is unlawful." The court reserved judgment with respect to BofA's motion to dismiss until after a hearing scheduled at the end of April.
- In *In re Beazer Homes USA, Inc.* ERISA *Litig.,* 2010 WL 1416150 (N.D. Ga. Apr. 2, 2010), plaintiffs alleged that the fiduciaries of Beazer Homes USA's 401(k) Plan breached their fiduciary duties by, among other things: (i) maintaining the Plan's investment in Beazer stock when they knew or should have known that the stock was an imprudent investment; (ii) failing to disclose necessary information to co-fiduciaries; and (iii) failing to provide participants with complete and accurate information regarding the risks associated with investing in Beazer stock. The court dismissed plaintiffs' prudence claim, holding that it was nothing more than a claim for failure to diversify the investments of the plan and, pursuant to ERISA

§ 404(a)(2), there is no duty to diversify a plan's investment in employer securities. The court allowed both of plaintiffs' disclosure claims to proceed, however. In so ruling, the court determined that the disclosure of material information to co-fiduciaries was "necessary to protect the plan." According to the court, plaintiffs sufficiently alleged that defendants' breached their fiduciary duty of disclosure to participants based on allegations that Beazer made false statements about the company's financial condition and that Beazer made misleading SEC disclosures that were incorporated by reference into Beazer's Form S-8 filing.

- In *Moore v. Comcast Corp.*, 2010 WL 1375462 (E.D. Pa. Apr. 6, 2010), the district court certified as a class action plaintiff's fiduciary breach claims based on the maintenance of a company stock fund in a 401(k) plan. In so ruling, the court concluded that the release plaintiff had signed did not preclude her from being an adequate class representative, and that she had standing even though she sold her stock before its price fell (while it was still allegedly artificially inflated). The court ruled that plaintiff's losses should be measured under the "alternative investment methodology," and that she suffered an injury-in-fact because the experts opined she would have realized a greater profit with a different, prudent investment.
- In *Dann v. Lincoln Nat'l Corp*. 2010 WL 1644276 (E.D. Pa. Apr. 22, 2010), the district court denied defendants' motion to dismiss plaintiff's 401(k) stock-drop claims. Lincoln National's stock fell from $55 per share in February 2008 to $11 per share in May 2009 due to the company's investments in Lehman Brothers and Washington Mutual, as well as the company's application to participate in the Troubled Assets Relief Program. The stock had rebounded to $23 by September 2009. Applying the *Moench* presumption of prudence, the court determined that the allegations sufficiently stated "dire circumstances" that should have caused a prudent fiduciary to act differently.
- In *Goldinger v. Datex-Ohmeda Cash Balance Plan*, 2010 WL 1270191 (W.D. Wash. Mar. 31, 2010), the district court ruled that a summary plan description controlled over a conflicting plan document even if plaintiffs did not rely on the SPD. The SPD provided for 100% vesting of accrued benefits upon a partial termination, but the plan document provided for vesting *only* to the extent the accrued benefits were funded. Plaintiffs claimed their accrued benefits became fully vested, pursuant to the SPD, because a partial termination occurred when their employer was sold to another company and they could no longer accrue benefits under their plan. Their claims, however, were denied by the plan because their accrued benefits were not funded. The court deferred ruling on whether a partial termination had occurred.
- In *Walsh v. Principal Life Insurance Co.*, 2010 WL 1063738 (S.D. Iowa Mar. 24, 2010), Plaintiff alleged that Principal breached its fiduciary duties by making misrepresentations in letters and telephone calls to induce participants to roll-over

their retirement plan benefits into IRAs managed by Principal. The district court denied plaintiff's motion for class certification, holding that Plaintiff failed to prove that common issue predominated over individual ones, as required under Rule 23(b)(3), because adjudication of plaintiff's claim on a class-wide basis would require inquiry into whether defendants had a fiduciary relationship with each of the putative class members, whether defendants received ill-gotten profits from each of the rollovers and whether the alleged misrepresentations and omissions could be causally linked to each class member's decision to roll over the funds in her or his 401(k) account.

- In *Dorsey v. Jacobson Holman PLLC*,2010 WL 1675571(D.D.C. Apr. 27, 2010), the district court, in what may be a case of first impression, granted defendant's motion to dismiss and required plaintiff to exhaust his plan administrative remedies before filing a complaint challenging the denial of COBRA subsidies. In so ruling, the court reasoned that: (a) the American Recovery and Reinvestment Act specifies, in relevant part, that it shall be treated as a provisions of Title I of ERISA and ERISA requires exhaustion in most contexts; and (b) it is consistent with the emergency nature of the legislation that Congress established a swift and sure administrative review process for any plan or employer or insurer's denial of COBRA premium reduction.
- In *Renfro v.* Unisys *Corp*., 2010 WL 1688540 (E.D. Pa. Apr. 26, 2010), the court followed the analysis and reasoning in *Hecker v. Deere & Co*., 556 F.3d 575, 586 (7th Cir. 2009), in finding that there was no merit to plaintiffs' excessive fee claims against Unisys (plan sponsor and administrator) and Fidelity (plan trustee).
- On March 24, 2010, the court approved a $6.25 million settlement on plaintiffs' excessive fee claims in *Katziff v. Beverly Enterprises Inc*., No. 07-11456-NMG (D. Mass.)
- In *In re Aon ERISA Litig.,* No. 04-CV-6875 (N.D. Ill. Apr. 16, 2010), the court granted preliminary approval of a $1.8 million settlement of a "stock-drop" class action against Aon Corp. In addition to paying the cash amount, Aon agreed to: (a) retain an independent advisor to advise plan fiduciaries in connection with the plan's investment in Aon company stock for the next five years; (b) refrain from imposing restrictions on participants from selling Aon stock for the next five years; (c) amend the plan to ensure that the names of the plan fiduciaries are identifiable by participants in the future; and (d) provide investment education services to participants over the next five years. The court scheduled a fairness hearing for September.
- In *Jones v. NovaStar Financial Inc.,* No. 08-CV-490 (W.D. Mo. Apr. 22, 2010), the parties reached a settlement of plaintiffs' stock drop claims. Pursuant to the terms of the settlement agreement, NovaStar will pay $925,000 to the members of the

class, with over $300,000 of that amount apportioned for attorneys' fees and costs.

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