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Editors' Overview

This month our focus is on the Supreme Court's decision to consider whether a party must be a "prevailing party" in order to obtain an attorney's fee award under ERISA. As the author discusses below, even if the Supreme Court concludes that a party need not be a prevailing party in order to obtain attorney's fees under ERISA § 502(g)(1), the Court's ruling may not have much of a practical impact, since district courts may still exercise their statutorily provided discretion not to award attorney's fees to non-prevailing parties.

As always, please be sure to review the Rulings, Filings and Settlements of Interest. This month we highlight a wide variety of issues, including discovery issues after *MetLife Insurance Co. v. Glenn*, disclosure claims, Section 510 claims, proper defendants in a benefits claim and stock-drop claims.

U.S. Supreme Court To Consider "Prevailing Party" Status as A Requirement to Entitlement to Attorney's Fee Award under ERISA

By Bridgit DePietto

On January 15, 2010, the U.S. Supreme Court granted *certiorari* in *Hardt v. Reliance Standard Life Ins. Co.*, No. 09-448, and agreed to consider the question of whether a party in an ERISA action must be a "prevailing party" to be entitled to an award of attorney's fees and costs under Section 502(g)(1), 29 U.S.C. § 1132(g)(1). Although the Supreme Court also agreed to consider whether a court-ordered remand of a benefits claim to an ERISA plan for further consideration is sufficient to allow for the recovery of attorney's fees and costs, this issue may only be relevant, as discussed below, if the Court concludes that there is a "prevailing party" requirement under the statute.

Bridget Hardt was an employee of Dan River, Inc., which offered benefits to qualified participants in its Group Long-Term Disability Insurance Program Plan (the “Plan”). Dan River administered the Plan, but Reliance Standard Life Insurance Company (“Reliance”) decided whether a particular individual was entitled to benefits and, if so, paid for such benefits. After Hardt underwent surgery for carpal tunnel syndrome, Reliance agreed to provide Hardt with long-term disability (“LTD”) benefits under the Plan for twenty-four months based on her inability to perform her current position. During the twenty-four-month period, Hardt was diagnosed with a separate condition called hereditary small-fiber neuropathy, and was awarded disability insurance benefits from the Social Security Administration based on its finding that she could not return to gainful employment due to her neuropathy and other ailments. A few months later, Reliance notified Hardt that it was terminating her LTD benefits at the end of the twenty-four-month period because it concluded that she was no longer totally disabled as defined by the Plan. Hardt appealed and Reliance denied her appeal. After exhausting her administrative remedies, Hardt filed a complaint in the U.S. District Court for the Eastern District of Virginia, alleging that Reliance violated ERISA by wrongfully denying her LTD benefits and requested that the court award her LTD benefits under the Plan.

Both parties moved for summary judgment, and both motions were denied by the district court. The district court first observed that the administrative record provided compelling evidence that Hardt was totally disabled due to her neuropathy, and, on this basis, was inclined to rule in Hardt’s favor. The court also observed, however, that the record demonstrated that Hardt did not get the kind of review to which she was entitled under ERISA. Thus, the court determined that it would be “unwise” to rule in Hardt’s favor in the first instance and remanded the case to Reliance to fully and adequately assess her claim. In remanding the claim, the district court instructed Reliance that if it did not adequately consider all of the evidence discussed in the court’s opinion within thirty days, then the court would issue judgment in favor of Hardt. On remand, Hardt provided additional medical records to Reliance for its consideration, and Reliance reversed its earlier decision and awarded Hardt LTD benefits until she reached age 66, along with retroactive benefits for the time already elapsed.

Hardt subsequently filed a motion with the district court seeking attorney's fees and costs pursuant to ERISA § 502(g)(1). Section 502(g)(1) provides: "In any action under this subchapter … by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney's fee and costs of the action to either party." The district court granted Hardt's motion and awarded her $39,149.00 in fees. In so ruling, the district court explained that "[t]he defendant, under threat of judgment against it, reversed its decision and chose to award the plaintiff the precise relief she was seeking." In the district court's view, this "[c]learly" constituted "judicially sanctioned relief" entitling Hardt to an attorney's fee award as the "prevailing party."

Reliance appealed the district court's award of attorney's fees to the Fourth Circuit, arguing that the district court's remand of Hardt's claim for LTD benefits to the Plan for further consideration was not tantamount to a "judgment on the merits" or "judicially sanctioned relief." Instead, Reliance argued that this was at best a case of "tactical mooting" and that there was no enforceable judgment on the merits or judicially sanctioned relief. In an unpublished opinion, the Fourth Circuit agreed with Reliance and vacated Hardt's attorney's fees award. *See Hardt v. Reliance Standard Life Ins. Co.*, 2009 WL 2038759 (4th Cir. July 14, 2009).

The Fourth Circuit began its analysis of the fee award by observing that, in the Fourth Circuit "[i]t is well settled that 'only a prevailing party is entitled to consideration for attorney's fees in an ERISA action.' To be a prevailing party, 'a plaintiff [must] receive at least some relief on the merits of his [or her] claim.'" As discussed below, some Circuits contemplate the award of attorney's fees even to nonprevailing parties.

Citing the Supreme Court's decision in *Buckhannon Bd. & Care Home, Inc. v. W. Va. Dep't of Health & Human Res*., 532 U.S. 598 (2001), for what constitutes "relief on the merits" of a particular claim, the court stated that only "enforceable judgments on the merits and court-ordered consent decrees create the material alteration of the legal relationship of the parties necessary to permit an award of attorney's fees." The court also added that there is no exception to this "bright-line boundary" for "tactical mooting" — that is, the situation where a defendant chooses to settle rather than risk an award of attorney's fees. This is because "tactical mooting concerns are simply insufficient to overcome the statutory requirement that a party applying for a fees and costs award must first have been accorded some relief in the district court."

Applying this reasoning to the district court's remand of the claim to the Plan for additional consideration, the Fourth Circuit found that no court had entered judgment in favor of Hardt awarding her benefits. Instead, it was Reliance that concluded that Hardt was eligible for benefits during the remand. Because the district court did not require Reliance to award benefits to Hardt (which was the only relief Hardt requested), the Fourth Circuit concluded that the remand to Reliance to provide Hardt with an appropriate review of her claim (which Hardt did not request as relief) did not constitute an "enforceable judgment on the merits" as required to qualify Hardt as a "prevailing party" eligible for an award of attorney's fees.

Hardt thereafter petitioned for *certiorari* before the Supreme Court. Hardt argued that the petition should be granted to resolve two important issues. First, Hardt requested that the Court resolve "a widely acknowledged, long-standing and frequently recurring circuit division on an important question of law — whether § 502(g)(1) requires prevailing party status for an award of attorney's fees." In Hardt's view, the Fourth Circuit's decision that "only a prevailing party is entitled to consideration for attorney's fees in an ERISA action" is incorrect and directly conflicts with the rulings of other circuits. Second, Hardt asked the Court to determine whether a claimant is entitled to attorney's fees under § 502(g)(1) where she secures a remand to her plan administrator for reconsideration of her benefits claim after persuading the district court that the plan administrator violated ERISA. After granting *certiorari*, the Court set an expedited briefing schedule. Hardt's brief is due by February 25, 2010, and Reliance's brief is due by March 25, 2010.

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It would appear that a ruling by the Supreme Court will only substantially impact current practice among the Circuit Courts if it were to affirm the Fourth Circuit's ruling and hold both that attorney's fees are limited to prevailing parties and that the plaintiff is not a prevailing party merely by obtaining an order from the district court that her case should be remanded to the plan administrator. Whether or not they require a party to prevail on her claim, most courts presently apply a multi-factored test in their fee determination, which includes consideration of: (i) the degree of the offending party's bad faith or culpability; (ii) the ability of the offending party to satisfy an award of attorney's fees; (iii) whether an award of fees would deter other persons from acting similarly under like circumstances; (iv) the relative merits of the parties' positions; and (v) whether the action conferred a common benefit on a group of pension plan participants. If the Supreme Court were to apply a "prevailing party" standard, then plaintiffs, like Hardt will lose the opportunity to recover attorney's fees under this test, unless the Court also determines that a remand order qualifies a plaintiff as a prevailing party..

On the other hand, a ruling in favor of Hardt could have the unintended effect of discouraging plans from awarding benefits in claims that are remanded for further consideration for fear that doing so could entitle the participant to attorney's fees. One could argue, therefore, that ERISA's goal of encouraging administrative resolution of benefit claims would be better served by a ruling that strictly limited recovery of attorney's fees to participants who obtain an award of benefits in district court.

Rulings, Filings and Settlements of Interest

- In *Pollitt v. Health Care Serv. Corp.*, 558 F.3d 615 (7th Cir. Mar. 10, 2009), *cert. granted* (Oct. 13, 2009), the Seventh Circuit vacated and remanded the district court's finding that the Federal Employees Health Benefits Act ("FEHBA") preempted a participant's claim that Health Cares Services Corporation ("HCSC") acted in bad faith by terminating her son's coverage and seeking reimbursement of benefits previously provided. In so ruling, the court reasoned that removal under the "complete preemption" doctrine was not warranted because federal law does not completely occupy the field of health insurance coverage for federal workers. The Seventh Circuit remanded the case to the district court for evidentiary proceedings to determine: (i) whether HCSC was merely following a directive from

the Department of Labor to terminate Ms. Pollitt's son's benefits, thereby entitling the matter to jurisdiction under the federal officer removal statute, 28 U.S.C. § 1442(a)(1); or (ii) whether HCSC was acting on its own initiative and thus appropriately sued in state court. The Supreme Court granted HCSC's petition for *certiorari* on October 13, 2009 and agreed to consider the propriety of the Seventh Circuit's decision with respect to applicability of the complete preemption doctrine and the federal officer removal statute. Oral argument before the Supreme Court is scheduled for March 3, 2010.

- On January 19, 2010, the U.S. Supreme Court declined plaintiffs' petition for *certiorari* in *Hecker v. Deere & Co*., 556 F.3d 575 (7th Cir. 2009), *rehearing denied*, 569 F.3d 708, *cert. denied*, 2010 U.S. LEXIS 675 (U.S. Jan. 19, 2010). (The Seventh Circuit's decision was discussed in the March 2009 Newsletter.) Several organizations, including the AARP, had filed *amici* briefs on behalf of plaintiffs, arguing, among other things, that: (i) it is inherently imprudent for fiduciaries of multi-billion dollar 401(k) plans to only offer retail mutual funds; (ii) the Seventh Circuit improperly expanded the scope of ERISA § 404(c); and (iii) the Seventh Circuit failed to give proper deference to DOL's preamble.

- In *Richards v. Hewlett-Packard Corp*., No. 08-2538 (1st Cir. Jan. 19, 2010), the First Circuit reviewed *de novo* the decision of the long-term disability plan administrator's determination to deny plaintiff benefits after ten years. The court agreed with the plan administrator and granted defendant's motion for summary judgment. In so ruling, the court held that: (i) plaintiff's proffered physician's report should not be given controlling weight in the face of other medical reports; (ii) the Social Security Agency's determination that plaintiff was disabled should only be given a high degree of deference in the rare case where the statutory criteria for disability are identical to the plan's criteria, which was not the case here; and (iii) Prudential was not required to physically examine claimants merely because it had the right to do so, and could instead rely on medical records.

- In *Cusson v. LibertyLife Assurance Co. of Boston*, 2008 WL 118384 (1st Cir. Jan. 14, 2010), the First Circuit, applying *MetLife Insurance Co. v. Glenn*, 128 S. Ct. 2343 (2008), recognized that defendant LibertyLife was operating under a structural conflict of interest by virtue of both paying for and determining claims for disability benefits. The First Circuit declined to accord the conflict any special weight in determining whether LibertyLife's decision to deny plaintiff benefits was an abuse of discretion, however, ruling that none of the facts or circumstances surrounding

LibertyLife's determination established that "Liberty's decision was improperly influenced by its structural conflict of interest." In so holding, the First Circuit rejected the plaintiff's argument that it was LibertyLife's "burden to show that the conflict did not affect its decision[.]" Rather, it stated, as with "any other aspect of an ERISA claim for improper denial of benefits . . ., [the plaintiff] bears the burden of showing that the conflict influenced Liberty's decision."

- In *Dandridge v. Raytheon Co.*, 2010 U.S. Dist. LEXIS 5854 (D.N.J. Jan. 26, 2010), the court rejected plaintiff's argument that *MetLife Insurance Co. v. Glenn* permits unlimited discovery in ERISA benefit claims. In so ruling, the court concluded that: (i) plaintiff was not entitled to discovery concerning the merits of defendants' decision to deny benefits; (ii) plaintiff was entitled to discovery concerning defendants' alleged conflict of interest; and (iii) plaintiff was not entitled to discovery concerning the alleged procedural irregularities because none of the alleged irregularities provided "a sufficient indicia of fraud, bias or mistake to permit unlimited discovery."

- In *Skinner v. Northrop Grumman Retirement Plan B*, 2010 U.S. Dist. LEXIS 6591 (C.D. Cal. Jan 26, 2010), the court granted defendants' motion for summary judgment on plaintiffs' claim for additional retirement benefits. In so ruling, the court determined that plaintiffs failed to demonstrate "reasonable reliance" on the 1998 SPD, which plaintiffs contended did not provide them sufficient notice of the plan's offset provision. Although the court acknowledged that the Ninth Circuit had not directly ruled that plaintiffs must demonstrate "reasonable reliance" to recover benefits under a defective SPD, the court determined that a strict liability standard was inappropriate because it may cause employers to reduce or eliminate benefits.

- In *Zappley v. The Stride Rite Corp.*, No. 09-198 (W.D. Mich. Jan. 13, 2010), the district court concluded that a *pro se* plaintiff's Section 510 claim was barred by the statute of limitations, but allowed his claim for benefits under Section 502(a)(1)(B) to proceed. With respect to his Section 510 claim, the court applied the three-year statute of limitations applicable to Michigan employment discrimination or wrongful termination claims, as Section 510 does not contain its own statute of limitations, and concluded that plaintiff's claim accrued in 1987 when he allegedly was wrongfully discharged in order to preclude his plan benefits from vesting. The court allowed plaintiff's claim for benefits to proceed, however, because, according to the court, the failure to exhaust administrative remedies is an affirmative defense, the existence of which did not appear on the face of plaintiff's complaint.

- In *Staelens v. Staelens*, 2010 WL 94518 (D. Mass. Jan. 11, 2010), a district court declined to remand to state court an action brought by the estate of a deceased participant, upon ruling that a waiver by the participant's ex-wife, made during a divorce settlement, was not specific enough to be enforceable. Although the waiver stated that the participant would "retain" his 401(k) benefits and the ex-wife would "renounce any interest in" his retirement benefits, the court concluded it was not specific enough to be a waiver because it did not expressly mention the participant's designation of his ex-wife as the beneficiary.

- In *Nationwide Children's Hospital, Inc. v. D.W. Dickey & Son, Inc. Employee Health and Welfare Plan*, No. 08 Civ. 1140 (S.D. Ohio Jan. 27, 2010), the district court, in denying defendant's motion for judgment on the pleadings, held that a third-party administrator of a self-insured health plan is a proper defendant in a claim for benefits under Section 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), provided that the TPA controlled the administration of the plan or functioned as a fiduciary regardless of formal designation. In so ruling, the court rejected defendant's reliance on 29 U.S.C. § 1132(d)(2), which provides that "[a]ny money judgment under this subchapter against an employee benefit plan shall be enforceable only against the plan as an entity and shall not be enforceable against any other person unless liability against such person is established in his individual capacity under this subchapter." Observing that there is a split of authority within the Sixth Circuit, as well as among other Circuits, the court found that its conclusion was supported by those cases that, while not addressing explicitly the § 1132(d)(2) issue, concluded that a plan is not the only proper defendant in a suit to recover benefits under Section 502(a)(1)(B).

- In *In re Hartford Financial Services Group*, 2009 WL 135186 (D. Conn. Jan. 13, 2010), the district court denied, with very little analysis, Hartford's motion to dismiss plaintiffs' fiduciary breach claims associated with an ESOP's investment in company stock because: (i) the *Moench* presumption of prudence was not applicable since the plan did not require investment in company stock; and (ii) the complaint complied "more than amply" with *Twombly*.

- In *Fitts v. UNUM Life Ins. Co. of Am.*, Civ. No. 98-00617 (D.D.C. Jan. 13, 2010), the court addressed an application for attorney's fees, following a resolution of a lawsuit after ten years of litigation, including two trips to the Court of Appeals. The underlying action alleged, *inter alia*, that UNUM violated ERISA by classifying her

bipolar disorder as a “mental” illness, as opposed to a “physical” illness, thereby limiting her entitlement to disability benefits to 24 months. One of the provisions of the settlement agreement provided that plaintiff would be awarded “reasonable” attorney’s fees. When plaintiff requested more than $1.3 million in fees, UNUM objected. In ruling on plaintiff’s motion for fees, the court found: (i) a determination of whether the plaintiff was a “prevailing party” was not necessary because the plaintiff was entitled to fees as a result of the settlement agreement; (ii) the fact that UNUM’s attorney’s fees were significantly lower than plaintiff’s fees was not indicative of the reasonableness of plaintiff’s requested fees; and (iii) because some of plaintiff’s attorney’s billing entries were “less specific than is appropriate,” the court decided to reduce plaintiff’s requested fees by 15%, resulting in fees equaling $1,176.509.00.

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