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The ERISA Litigation Newsletter

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Editor's Overview

Our focus this month is on two recent case-law developments affecting the administrative claims process for benefit claims and how they may impact plan administrators. First, Deidre Grossman reviews a decision from the U.S. Court of Appeals for the Second Circuit, which held that Taft-Hartley funds (administered by boards of trustees consisting of an equal number of union and employer representatives) are inherently conflicted when making benefit determinations, and that this conflict needs to be considered by federal district courts when reviewing plan determinations under an arbitrary and capricious standard of review. As Deidre discusses below, the decision could potentially lead to significantly increased risks of liability and litigation costs for Taft-Hartley funds.

The second article takes a look at the statute (or contract) of limitations period for ERISA benefit claims and efforts plan sponsors may be able to take to trigger the limitations period prior to a claim being fully exhausted at the plan administrative level. As the authors Myron Rumeld, Russell Hirschhorn, and Brian Neulander discuss below, such techniques — if proven to be effective — could serve as a tremendous benefit to plans trying to avoid the burdens and risks of defending benefit claims based on dated information and events

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

Second Circuit Holds Taft-Hartley Funds Are Inherently Conflicted When Making Benefit Determinations[1]

By Deidre A. Grossman

In a case of first impression in the Second Circuit, the U.S. Court of Appeals held, in *Durakovic v. Building Service 32 BJ Pension Fund*, No. 09-3651-cv, 2010 WL 2519645 (2d Cir. June 24, 2010), that Taft-Hartley funds (administered by boards of trustees consisting of an equal number of union and employer representatives) are inherently conflicted when making benefit determinations because, like insurance companies and employers administering their self-insured plans, they both evaluate and pay claims. In so ruling, the Second Circuit extended to the Taft-Hartley sector the Supreme Court's holding in *Metropolitan Life Ins. Co. v. Glenn*, 128 S. Ct. 2343 (2008) that insurance companies that both adjudicate and pay benefit claims labor under a structural conflict created by their dual roles. Given the significant differences between the decision-making structures of Taft-Hartley funds and insurance companies, the Second Circuit's extension of *Glenn*'s principles to this sector was hardly a foregone conclusion, and could certainly be questioned.

The Second Circuit's Decision

In *Durakovic*, a long-time office cleaner who suffered chronic pain and weakness in the years following a 1999 automobile accident applied for disability benefits from her union-sponsored plans. The disability plan provided benefits to persons who are "totally and permanent unable . . . to engage in any further employment or gainful pursuit." The Funds denied Durakovic's claim and appeal, finding that she did not meet the requirement for benefits because independent physicians and vocational experts concluded that she could perform certain sedentary work for which she was vocationally qualified. Durakovic filed suit in federal district court challenging the denial of benefits under ERISA Section 502(a)(1)(B). The district court granted summary judgment for the defendant Funds, finding that their decision to deny benefits was not arbitrary and capricious.

On appeal, neither party disputed that the challenged decision was subject to an arbitrary and capricious standard of review by the court, since the plan documents granted the Board of Trustees discretion to make benefit determinations. Both parties challenged, however, the district court's decision that "the Funds' conflict [was] a factor, albeit a relatively unimportant one." The Funds argued that they were not conflicted within the meaning of *Glenn* because Taft-Hartley funds are administered by an entity composed equally of union and employer representatives. Durakovic argued that the conflict should have been accorded more weight.

The Second Circuit rejected the Funds' position and ruled that Taft-Hartley funds are inherently conflicted because these funds both adjudicate and pay benefits, with the evaluation of claims being "entrusted . . . to representatives of the entities that ultimately pay the claims allowed." The court reasoned that, while the employer representatives on the board of trustees have fiduciary interests that weigh in favor of the trusts' beneficiaries, they also have representational and other interests that weigh to the contrary. The fact that union representatives have an equal say in benefit determinations, the court stated, does not negate the conflict, but rather may impact the weight the conflict is afforded. "And that the administrator is here a trust, rather than the employer itself or a third-party for-profit institution, does not control[,]" the court added, since, according to the court, "[t]he rejection of claims will reduce future employer contributions."

The Second Circuit acknowledged that its finding of an inherent conflict was at odds with the view of the Ninth Circuit in *Anderson v. Suburban Teamsters of N. Ill. Pension Fund Bd. of Trs.*, 588 F.3d 641, 648 (9th Cir. 2009). In *Anderson*, a participant sued a multi-employer Taft-Hartley plan and its board of trustees for enhanced disability benefits. The Ninth Circuit concluded that the trustees did not have a conflict of interest within the meaning of *Glenn* because they had no personal incentive to grant or deny benefits, since the various participating employers – rather than the trustees – funded the plan. Moreover, the benefit determinations in the Taft-Hartley sector are made by a balanced board of trustees, the Ninth Circuit explained. The Second Circuit gave the decision short shrift, stating that it rested on a "shaky foundation," both because it relied on pre-*Glenn* law and because it contradicted earlier Ninth Circuit authority holding, in the single-employer plan context, that, "even when a plan's benefits are paid out of a trust, a structural conflict of interest exists[.]"

Proskauer's Perspective

The Second Circuit's conclusion that Taft-Hartley funds are inherently conflicted appears to us to be based on a fundamental misunderstanding of how most Taft-Hartley plans operate and, as a result, inappropriately extends *Glenn's* principles. To begin with, the premise of the decision – that the employer trustees of these funds are conflicted because the rejection of claims will reduce future employer contributions – is mistaken. Employer contributions to these funds are most often prescribed by the terms of the collective bargaining agreement, not the claims-paying experience of the funds. If a Taft-Hartley fund suffers an unexpected loss in funding due to the payment of claims, its recourse is to reduce the scope of coverage, not to increase employer contributions.

Second, and more fundamentally, regardless of the inclinations of the employer trustees, there is every reason to believe that participants' interests in these funds are well-represented by their union advocates, who can and will take a dispute over a benefit determination to deadlock arbitration if not convinced that the claim should be denied. Thus, if anything, these plans are inherently neutral by virtue of the evenly balanced voting rights of union and employer trustees.

The court's acknowledgment that "[n]o weight is given to a conflict in the absence of any evidence that the conflict actually affected the administrator's decision," provides little comfort to plans defending benefit claims, given the conflicting post-*Glenn* case law on the scope of permissible discovery on the conflict issue. By ruling that Taft-Hartley funds are inherently conflicted under *Glenn*, the court has essentially subjected these funds to conflict discovery requests similar to those that insurance companies and employer-administrators are routinely encountering in benefit claim litigation. And discovery disputes translate into increased litigation expenses, regardless of their outcome.

Since the weight of a conflict may be reduced – "perhaps to the vanishing point" – where a plan administrator has taken measures to ensure that the conflict does not taint a benefit determination, funds should consider including in the administrative claim record evidence of fair and unbiased decision-making. One example may be information regarding the processes employed by the trustees to determine benefit claims, including instances where they have deadlocked over claims. An administrative record enhanced to include this information may not necessarily avert discovery in all cases, but it may provide a platform from which to argue that the "inherent" conflict mistakenly identified by the Second Circuit is of no consequence.

ERISA’s Statute of Limitations for Benefit Claims: Where To Begin?[2]

By Myron D. Rumeld, Russell L. Hirschhorn and Brian Neulander

For plan counsel, the defense of claims for benefits is often complicated by the rather pro-participant nature of ERISA's rules governing the statute of limitations. Typically, the applicable limitations period is a rather lengthy one that replicates the limitations period for state law contract claims. In some states, it is as long as fifteen years. To make matters worse, the claim typically does not accrue until after a participant files and is denied an administrative claim for benefits. In some contexts, particularly pension claims that are filed when a participant reaches retirement age, the claim itself may present issues that depend on information dating back to the participant's earlier years of active employment.

Plan designers have been able to alleviate somewhat the difficulties of defending dated claims by inserting shorter limitations periods into the plan documents. Courts have looked favorably on such provisions, provided that they are reasonable and communicated clearly. But these rules do not change the fact that, however short the limitations period is, the period ordinarily still will not begin to run until the administrative claim has been filed and denied. One means to address this concern is with plan provisions that prescribe the period in which claims accrue. Recent case law addressing the enforceability of such provisions provides some hope that they may serve as a vehicle for further protecting plans from the difficulties, and exposure risks, of defending dated benefit claims.

Applicable Limitations Period for Benefit Claims

Because ERISA's civil enforcement scheme does not provide a statute of limitations for benefit claims under Section 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), courts have universally borrowed the "most analogous" state statute of limitations, which in most cases is the state statute of limitations that governs written contracts.[3] In New York, for example, courts apply the state's six-year contract statute of limitations. *See*, *e.g.*, *Carey v. Electrical Workers Local 363 Pension Plan*, 201 F.3d 44, 46-47 (2d Cir. 1999). Some states and commonwealths have lengthier contract statutes of limitations, including Ohio, Puerto Rico and Illinois. *See Daill v. Sheet Metal Workers' Local 73 Pension Fund*, 100 F.3d 62, 65 (7th Cir. 1996) (ten-years); *Meade v. Pension Appeals & Review Comm.*, 966 F.2d 190 (6th Cir. 1992) (fifteen years); *Martinez v. Johnson & Johnson Baby Products, Inc.*, 184 F. Supp. 2d 157, 159-62 (D.P.R. 2002) (fifteen years).

Courts have generally permitted plans to establish their own limitations period, which may be shorter than the period that would otherwise apply under state law. The only requirements are that the contractual limitations period be "reasonable" and adequately described to participants, *i.e.*, the limitations period appears clearly in the plan or summary plan description. *See*, *e.g.*, *Rice v. Jefferson Pilot Financial Insurance Co.*, 578 F.3d 450 (6th Cir. 2009); *Abena v. Metropolitan Life Insurance Co.*, 544 F.3d 880, 883 (7th Cir. 2008). In addition to shortening the limitations period that otherwise would apply, these rules also serve to unify the litigation process, in that the length of the limitations period will not be subject to the happenstance of where the participant resides or elects to commence a lawsuit.

Rules Governing the Accrual of Benefit Claims

Although state law determines the relevant statute of limitations period for benefit claims, federal common law determines when a claim for relief accrues. *See*, *e.g.*, *Guilbert v. Gardner*, 480 F.3d 140, 148-49 (2d Cir. 2007);*Daill v. Sheet Metal Workers' Local 73*, 100 F.3d at 65. Under the federal discovery rule, "a plaintiff's cause of action accrues when he discovers, or with due diligence should have discovered, the injury that is the basis of the litigation." *Guilbert*, 480 F.3d at 149 (citing *Union Pacific Railroad Co. v. Beckham*, 138 F.3d 325, 330 (8th Cir. 1998)). In the ERISA context, the discovery rule has been construed to mean that a benefit claim accrues upon "a clear repudiation by the plan that is known, or should be known, to the plaintiff — regardless of whether the plaintiff has filed a formal application for benefits." *Carey*, 201 F.3d at 46-47; *see*, *e.g.*, *Miller v. Fortis Benefits Insurance Co.*, 475 F.3d 516, 520-21 (3d Cir. 2007); *but see Hoover v. Bank of America Corp.*, 286 F. Supp. 2d 1326, 1333 n.12 (M.D. Fla. 2003) (requiring a formal application for benefits to be denied to trigger the statute of limitations and recognizing the tension between the standard adopted in this circuit and others), *aff'd without opinion*, *Hoover v. Bank of America Corp.,* 127 Fed. Appx. 470 (11th Cir. Jan. 5, 2005).

The circumstances in which a benefit claim accrues prior to a formal administrative denial have tended to be rare. Several courts have found that, in cases involving claims for wrongful denial of benefits resulting from a misclassification of a worker as an independent contractor, the limitations period commenced when it was made clear to the worker that he or she would not be eligible for benefits. *See*, *e.g.*, *Downes v. J.P. Morgan Chase & Co.*, No. 03 Civ. 8991, 2004 U.S. Dist. LEXIS 10510 (S.D.N.Y. June 8, 2004); *Brennan v. Metropolitan Life Insurance Co.*, 275 F. Supp. 2d 406, 409 (S.D.N.Y. 2003). Some courts also have found that the statute of limitations runs from the time a participant commences receipt of his or her benefit payments. *See*, *e.g.*, *Miller v. Fortis Benefits Insurance Co.*, 475 F.3d at 523; *Chuck v. Hewlett Packard Co.*, 455 F.3d 1026 (9th Cir. 2006). These decisions are not uniform in their approaches, however, and some involve independent facts and circumstances placing the participant on notice of the claim.

Outside these narrow contexts, there are virtually no published decisions finding that claims accrued prior to the exhaustion of administrative remedies. For that reason, many plan sponsors have engaged in efforts to accelerate the limitations period through plan design. Thus, in addition to establishing a limitations period that is shorter than the one provided by state statute, some plans, particularly medical plans, have mandated that claims accrue on the date when proof of loss is required.

Over the past few years, several Circuit Courts have had the occasion to opine on whether a plan may establish its own accrual rules and have concluded, with one exception, that they should be enforced. In *Burke v. Price Waterhouse Coopers LLP Long Term Disability Plan*, 572 F.3d 76 (2d Cir. 2009), the Second Circuit held that a disability plan could require claimants to bring suit no more than three years after proof of loss was required to be submitted to the plan, irrespective of whether a claimant had exhausted his or her administrative remedies. The court reasoned that it should not rewrite a term of the contract when it is clear and unambiguous, as was the policy-prescribed limitations period at issue here, and that it was important that the plan administrator be able to anticipate that suit will be brought within the limitations period. The court also rejected plaintiff's argument that the plan could cause a "runout" of the limitations period by simply delaying administration of the benefit claims, because ERISA's claims regulations specify that a claim will be deemed denied if not timely decided. Finally, the court observed that its decision was in harmony with decisions from the Fifth, Sixth, Seventh and Eighth Circuits in upholding plan terms prescribing limitations periods that begin to run before a claimant can bring legal action. *See Abena v. Metropolitan Life Insurance Co.*, 544 F.3d at 880; *Harris Methodist Fort Worth v. Sales Support Services Inc. Employee Health Care Plan*, 426 F.3d 330 (5th Cir. 2005); *Clark v. NBD Bank, N.A.*, 3 Fed. Appx. 500 (6th Cir. 2001); *Blaske v. UNUM Life Insurance Co. of America*, 131 F.3d 763 (8th Cir. 1997).

The Sixth Circuit subsequently reached the same conclusion in *Rice v. Jefferson Pilot Financial Insurance Co*., 578 F.3d at 450. In so ruling, the court observed that the Supreme Court and the Sixth Circuit had both stated in the context of EEOC claims that "parties could conceivably ... agree[] to a contract" which set a different date of accrual for limitations periods than the statutory one. *Id.* at 455 (citations omitted). While the court acknowledged that there potentially are situations in which a contractual accrual date for ERISA claims would be unreasonable, it found that there was nothing in the language of the plan here to suggest this was the case, particularly since the plan expressly provided that a claim could be considered denied if there was no response to the claim within ninety days.

In contrast to these authorities, the Fourth Circuit held in *White v. Sun Life Assurance Co. of Canada*, 488 F.3d 240, 245 (4th Cir. 2007) that a plan provision requiring that an action be commenced within three years of the date that proof of loss was required, even if the claimant had not exhausted his or her administrative remedies, was not enforceable. The Fourth Circuit expressed concern that a plan administrator would use the administrative process to "undermine[] and potentially eliminate[] the ERISA civil right of action." It did not agree that the ERISA's claims regulations eliminated this concern because, according to the court, depending on the plan limitations period, a plan administrator could "eat up the entire limitations period." In so ruling, the Fourth Circuit rejected an approach whereby courts could assess the reasonableness of the contractual limitations period and/or equitably toll the limitation on a case-by-case basis, finding that such an approach would "run counter to the values of certainty and predictability" of most accrual and limitations rules, and "be particularly incompatible with ERISA, given its written plan requirement."

Proskauer's Perspective

The ability to control the accrual date through plan design, as several Circuits have now recognized, could have far-reaching implications. Thus far, the cases enforcing such accrual rules have held only that plans can require that the claim accrue from the time proof of loss is due, as opposed to when the claim was exhausted. But these rulings could conceivably lead to the application of accrual rules in other contexts that could serve to more substantially reduce the ability of participants to resurrect stale claims. For example, pension plans that distribute annual statements of a participant's accrued benefits could provide that a challenge to these benefit calculations must be filed within a reasonable period after the receipt of these notices, or when the participant ceases active service, rather than at the point of retirement, when relevant information may no longer be readily accessible.

In short, while still in its nascent stages, the evolving law with respect to plan rules on the accrual of benefit claims could one day serve as a tremendous benefit to plans trying to avoid the burdens and risks of defending benefit claims based on dated information and dated events.

Rulings, Filings and Settlements of Interest

- In the wake of *Hardt v. Reliance Standard Life Ins. Co.*, 130 S. Ct. 2149 (May 24, 2010), in which the Supreme Court held that a party must achieve "some success on the merits" in order to obtain an attorney's fee award under ERISA (see *June Newsletter*), two federal circuits have concluded that the so-called "five-factor test" for determining such awards used by many district courts prior to Hardt remains an appropriate analytical framework for deciding whether to award attorneys fees under ERISA, but only after first concluding that a party has achieved some success on the merits. *See Simonia v. Glendale Nissan/Infiniti Disability Plan*, 2010 WL 2521036 (9th Cir. June 17, 2010); *Williams v. Metropolitan Life Ins. Co.*, 2010 WL 2599676 (4th Cir. June 30, 2010).
- In *Winnett v. Caterpillar Inc.*, No. 08-6236, 2010 WL 2499512 (6th Cir. June 22, 2010), the Sixth Circuit held that retirees' claims for vested, lifetime healthcare benefits were barred by Section 413's three-year statute of limitations because the participants were alerted to the changes to their benefits as early as 1998 when they were notified of changes in the renegotiated collective bargaining agreement.
- In *Stevenson v. Bank of New York Co.*, No. 09-1681, 2010 WL 2365679 (2d Cir. June 15, 2010), the Second Circuit held that a former employee's state law contract claims against his employer were not preempted by ERISA, because they arose from an oral employment contract to maintain his benefits. The court reasoned

that because the employee's state law claims derived from a promise rather than from an ERISA plan, their resolution did not require the court to review the propriety of an administrator's or employer's determination of benefits under the plans. Furthermore, the fact that the plan document would be looked to in order to determine the employee's recovery did not alter this conclusion, according to the court, since any recovery would be obtained from the employer, rather than the plan.

- In *Ringwald v. Prudential Ins. Co. of America*, No. 09-1933-cv, 2010 WL 2471702 (8th Cir. June 21, 2010), the Eighth Circuit ruled that a plan administrator's denial of long-term disability benefits would not be afforded an abuse of discretion standard of review, and instead would be reviewed *de novo*, where the grant of discretionary authority to the administrator appeared in the summary plan description, but not in the plan document. In so ruling, the Eighth Circuit reasoned that "there is no basis for concluding that the purported grant of discretion in the SPD is a procedurally proper amendment of the policy, and therefore 'the policy's failure to grant discretion results in the default *de novo* standard.'"

- In *Pfeil v. Edward Kramer & Sons, Inc*., No. 09-390, 2010 WL 2219061 (W.D. Wis. June 1, 2010), a district court dismissed plaintiff's fiduciary breach and estoppel claims based on a human resources representative's failure to inform her husband and her about their option to accelerate life insurance benefits, and inaccurate advice about the termination date of benefits coverage. In so ruling, the court concluded that there was no duty to affirmatively tell the participant that he could receive "living benefits" during the last year of his life because this was unambiguously explained in the plan's SPD.

- In *Phones Plus, Inc. v. Hartford Life Insurance Co.*,No.06 Civ. 1835 (D. Conn. June 22, 2010), the district court approved a class action settlement that resolved claims alleging that Hartford Life Insurance Company breached its fiduciary duties and engaged in prohibited transactions by collecting revenue sharing payments from the various mutual funds it offered as investment options in 401(k) plans. The terms of the settlement provide that Hartford will pay $13.8 million to class members and make structural changes to its business practices, including disclosure of revenue sharing rates paid to Hartford by mutual funds.

- In *In re Federal National Mortgage Ass'n Secs., Derivative, and ERISA Litig.*, No.04 Civ. 01784 (D.D.C. June 4, 2010), the court granted preliminary approval to a settlement resolving a stock drop action that will provide $7.25 million to all Fannie Mae employees who held accounts in the company stock fund of the ESOP from January 1, 2001 to December 6, 2006.

- In *Mogel v. UNUM Life Insurance Co. of America*,No.07 Civ. 10955 (D. Mass. June 18, 2010), the district court granted preliminary approval of a settlement resolving

fiduciary breach and prohibited transactions claims against UNUM Life Insurance Company of America. Plaintiffs had alleged that UNUM inappropriately set up "security accounts" on behalf of life insurance beneficiaries instead of issuing lump-sum distributions if the amount due to beneficiaries exceeded $10,000. The security accounts operated such that the beneficiaries received a checkbook linked to the accounts from which they could write and cash checks for any amount greater than $250 up to the policy limit. UNUM would only deposit money in these accounts after a check was presented (using the funds for other purposes in the interim). The district court initially dismissed the lawsuit, finding that the use of security accounts did not violate ERISA, but the Fifth Circuit reversed and held that it violated ERISA because the funds were not actually transferred into the account until a check was drawn. The parties eventually settled the action, agreeing that UNUM would pay $5 million to an estimated 22,000 class members.

??? In *Swetic v. Community Nat'l Bank Corp.*, 09 Civ. 2636, 2010 WL 2220248 (M.D. Fla. June 2, 2010), a district court granted Community National Bank Corporation's motion to dismiss plaintiffs' stock-drop action on the grounds that plaintiffs failed to exhaust their administrative remedies and could not prove that exhaustion would have been futile.

??? In *Lanfear v. Home Depot Inc.*, 07 Civ. 197, 2010 WL 2427413 (N.D. Ga. June 7, 2010), a district court granted Home Depot's motion to dismiss plaintiffs' ERISA stock drop action alleging that Home Depot and its directors and officers breached their fiduciary duties by backdating stock options, engaging in improper accounting practices which diminished the value of plan's assets, and continuing to offer company stock as an investment option under the plan when it was no longer prudent to do so. In so ruling, the court refused to apply the *Moench* presumption of prudence because it "runs afoul of ERISA's plain provisions," but nevertheless dismissed plaintiffs' prudence claim upon finding that it was "essentially a claim for a failure to diversify." The court further explained that even if *Moench* was adopted by the Eleventh Circuit, the presumption would still not apply in this case because the plan document mandated that the company stock fund be offered as an investment option, thus rendering the decision to maintain the fund "immune from judicial inquiry." With respect to the plaintiffs' disclosure claim, the court held that representations made in SEC filings are not actionable under ERISA and ERISA does not require disclosure of nonpublic information regarding publicly traded securities.

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[3] A few courts have adopted statutes of limitations covering actions for breach of employment contracts or for recovery of wages. *See, e.g., Mead v. Intermec Technologies Corp.*, 271 F.3d 715, 717 (8th Cir. 2001) (applying Iowa's two-year statute of limitations governing claims for wages to claims for short-term disability payments); *Syed v. Hercules, Inc.*, 214 F.3d 155, 161 (3d Cir. 2000) (applying Delaware's one-year statute of limitations to claims for benefits from work, labor, or personal services rendered); *Gray v. Greyhound Retirement & Disability Trust*, 730 F. Supp. 415, 419 (M.D. Fla. 1990) (applying Florida's two-year statute of limitations for recovery of wages to an action for recalculation of pension benefits).

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