Proskauer

The ERISA Litigation Newsletter

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Editor's Overview

This month, two articles highlight the unique limitations contained in ERISA's civil enforcement mechanism. First, we discuss the evolution of case law addressing the ability of ERISA plans to recover mistaken payments from participants pursuant to a plan's reimbursement or offset provisions, or in circumstances involving errors or participant wrongdoing. The article examines how the courts have struggled to assess the viability of such actions under ERISA § 502(a)(3) following the Supreme Court's decisions in *Great West* and *Sereboff*.

A second article examines the viability of a different category of claims under 502(a)(3) – those seeking monetary relief where a participant claims to have incurred expenses due to mistaken advice from plan representatives. The article discusses the Seventh Circuit's recent decisions in *Kenseth v. Dean Health Plan, Inc.*, and *Smith v. Medical Benefits Adm'rs Grp. Inc.*, which confirm that participants who seek monetary relief for an individualized claim of fiduciary breach may be without a remedy.

As always, be sure to review the section on *Rulings, Filings, and Settlements of Interest*. This month, we include a follow-up to last month's article about hybrid FLSA/ERISA actions with a review of the Third Circuit's decision in *Henderson v. Univ. of Pittsburgh Med Ctr.*, affirming the dismissal of ERISA claims premised upon the defendants' failure to maintain records of uncompensated hours allegedly worked by employees "off the clock."

The Evolution of ERISA § 502(a)(3) Cases Seeking Monetary Recovery From Plan Participants[1]

Contributed by Brian S. Neulander

Although ERISA is most frequently looked to as a vehicle for plan participants to recover plan benefits, there are a variety of circumstances in which plans seek recovery of payments made to plan participants, including the following three common scenarios:

(i) Enforcement of subrogation and reimbursements provisions;

(ii) recovery of paid disability benefits after the participant receives an award of retroactive Social Security benefits; and

(iii) recovery of an overpayment resulting from, for example, a mistakenly calculated benefit payment or a misrepresentation by a participant that induced the plan to make a payment, or stream of payments, that was in fact not owing.

Claims by plans or their fiduciaries to recover payments made to participants are inhibited by the strictures of ERISA's civil enforcement scheme. The only recognized avenue for recovery, ERISA § 502(a)(3), limits recovery to equitable relief. In *Great-West Life Ins. & Annuity Co. v. Knudson*, 534 U.S. 204 (2002), the Supreme Court held that this provision authorizes only those forms of relief that were available from the courts of equity in the days of the divided bench. Following *Great-West*, courts struggled to determine whether and in what circumstances plan fiduciaries can recover money from plan participants. Based on the Supreme Court's more recent decision in *Sereboff v. Mid Atlantic Medical Services, Inc.*, 547 U.S. 356 (2006), however, courts have permitted relief against participants when the plan contains clear overpayment recovery and/or offset provisions. Within the last year, some courts have allowed recovery even without the identification of specific, identifiable funds from which reimbursement is sought.

The Supreme Court's Framework for Equitable Relief Under Section 502(a)(3)

In *Great-West*, a participant was injured in a car accident and the proceeds from a settlement with the tortfeasor were placed in a special needs trust. The Court held that the plan could not enforce its subrogation provision to recover already paid medical costs from the participant because the funds at issue were held in trust, *i.e.*, the settlement proceeds sought by the plan were not in the participant's "possession." In so ruling, the Supreme Court interpreted § 502(a)(3) as authorizing only relief that was traditionally available in courts of equity. The Court specifically held that because Great-West sought legal relief, *i.e.*, the imposition of personal liability to obtain money damages, a remedy was not available under § 502(a)(3). To obtain the equitable remedy of restitution, the Court held that the funds sought to be recovered must (i) be specific and identifiable; (ii) belong in good conscience to the plan; and (iii) be in the defendant's possession.

In *Sereboff*, the Court confirmed that § 502(a)(3) authorizes only traditional forms of equitable relief. Justas in *Great-West*, the participant was involved in a car accident, and the plan expended money to cover medical costs; a settlement was eventually reached with the tortfeasors; and relying on the plan's subrogation provision, the fiduciaries sought to be reimbursed for the medical benefits already paid to the participant. Unlike in *Great-West,* however, the settlement funds were not placed in trust, but were paid directly to the participant, and the participant agreed to hold the funds in a special, separate account to avoid commingling of assets until the litigation resolved. Thus, the fiduciaries were seeking recovery of particularly identifiable funds in the defendant's possession, and the impediment to recovery in *Great-West* did not exist. Further, the plan included subrogation and reimbursement provisions that created an "equitable lien by agreement" on any future recovery by the participant for the same injury; in this case, the settlement funds. Under this theory of recovery, the Court stated, a fiduciary seeking reimbursement pursuant to a plan's subrogation and reimbursement provisions states a cognizable claim if it relies on plan language that identifies both the fund from which reimbursement is sought and the portion of the fund to which the plan claims entitlement.

Recovery Based on the Plan's Subrogation and Reimbursement Provisions

In post-*Sereboff* cases involving the enforcement of subrogation and reimbursement provisions to recover benefit payments, the courts have uniformly held that plans have viable claims for equitable relief under ERISA § 502(a)(3) when they seek to recover particular, identifiable funds in the hands of a participant or a third-party. In *Administrative Committee for the Wal-Mart Stores, Inc. Associates' Health and Welfare Plan v. Horton*, 513 F.3d 1223 (11th Cir. 2008), the court held that the plan had a viable equitable remedy under § 502(a)(3) to enforce a subrogation provision to recover overpayments from a special needs trust. *See also Administrative Committee for the Wal-Mart Stores, Inc. Associates' Health and Welfare Plan v. Shank*, 500 F.3d 834 (8th Cir. 2007) (same); *AT&T Inc. v. Flores,* 322 F. App'x 391 (5th Cir. 2009) (ruling that plan could enforce clear subrogation clause against specifically identifiable funds, belonging in good conscience to the Plan, held in trust by the participant's lawyer). A recent case applied *Sereboff's* equitable lien principle to allow recovery even though the funds at issue were not held in a separate account. In *Longaberger Co. v. Kolt*, 586 F.3d 459 (6th Cir. 2009), the court held that a plan could enforce its subrogation provision against a lawyer when settlement funds were distributed to him as attorney's fees. In so ruling, the court determined that the plan's subrogation rights superseded the attorney's fee claim, even when the settlement funds were commingled with the attorney's other assets.

Recovery Based on the Plan's Social Security Offset Provision

Before *Sereboff*, several courts ruled that plans could not recover retroactively awarded Social Security benefits pursuant to a Social Security offset provision. Post-*Sereboff*, courts have been willing to apply equitable lien principles to allow recovery of retroactively awarded Social Security benefits pursuant to a Social Security offset provision. In so doing, some courts have extended *Sereboff's* reasoning by finding that the equitable lien theory does not require a plan to demonstrate that the funds at issue are in a separate, specifically identifiable fund.

In *Cooperative Benefit Administrators, Inc. v. Ogden*, 367 F.3d 323 (5th Cir. 2004), the court ruled that, after a participant received a retroactive Social Security award, the plan could not recover benefits already paid. The plan conceded that its recoupment claim sought to impose personal liability on the participant in violation of *Great-West's* prohibition on "legal" relief under § 502(a)(3), but argued that it could recover under federal common law. The court rejected the plan's federal common law claim because there was no "gap" in ERISA's remedial provisions, *i.e.,* ERISA § 502(a)(3) provided a cause of action, even if no relief was available.

In a case decided two weeks before *Sereboff*, *Buchanan v. Aetna Life Ins. Co*., 179 F. App'x 304 (6th Cir. 2006),[2] the Sixth Circuit held that Aetna could not recover overpaid disability benefits from a participant. The plan's terms clearly provided that the participant was obligated to reimburse Aetna due to the participant's receipt of plan and Social Security benefits to compensate for the same injury. Yet Aetna failed to satisfy *Great-West's* three-part test for relief under § 502(a)(3) because the funds it sought to recover were no longer clearly in the participant's possession.

Since *Sereboff*, the trend has reversed, and courts have generally permitted claims seeking recovery of retroactively awarded benefits. In *Dillard's Inc. v. Liberty Life Assurance Co. of Boston*, 456 F.3d 894 (8th Cir. 2006), the court held that the plan had a viable equitable claim against the participant to recover overpayments based on the fact that overlapping Social Security payments were received. The court determined that the plan satisfied the "possession" requirement because the Social Security payments constituted a particular fund that belonged in good faith to the plan and was separate from the participant's general assets. More recently, in *Cusson v. Liberty Life Ins. Co.,* 592 F.3d 215(1st Cir. 2010), the court relied on *Sereboff* to hold that a plan could recover overpayments from a participant, even though the participant dissipated the plan's funds. Applying *Sereboff's* reasoning that ERISA plans are like contracts, the First Circuit allowed the plan to impose an equitable lien on the participant's Social Security award. In *DeBenedictis v. Hartford Life and Accident Ins. Co*., 701 F. Supp. 2d 1113 (D. Ariz. 2010), the court relied on *Sereboff* and *Cusson* to allow recovery from a participant, even when the funds at issue were commingled with other assets.

Reducing Future Benefits to Offset Past Overpayments.

Some courts have allowed plans to recover disability overpayments without the equitable relief constraints of *Great-West* and *Sereboff*, by allowing plans to offset future benefit payments against previous overpayments. In *Northcutt v. Gen. Motors Hourly-Rate Employees Pension Plan*, 467 F.3d 1031 (7th Cir. 2006), the court ruled that the equitable relief limitations discussed in *Great-West* and *Sereboff* did not apply to the reduction of monthly benefits on a going-forward basis because the plan contained a clear offset provision. In this case, the plan suspended future benefit payments when plaintiffs refused to repay the plan after receiving retroactive Social Security awards. The Seventh Circuit noted that judicial remedies under § 502(a)(3) were extremely limited, but that these constraints did not apply here because the plan had not filed a civil action, nor had the plan sought judicial relief to recover the overpayments. Similarly, in *White v. Coca-Cola Co*., 542 F.3d 848 (11th Cir. 2008), the court held that the plan could enforce its own terms by reducing future benefit payments as a setoff for overpayments to participants. The court rejected the participants' argument that withholding benefits was akin to impermissible legal relief. The court held that because the plan did not use ERISA's remedial provisions as the vehicle to cut the participants' benefit stream, § 502(a)(3)'s restrictions did not apply.

Mistaken Overpayments

There are a variety of circumstances in which plans mistakenly overpay benefits that they subsequently seek to recover, including, for example: benefit calculation errors; payments to the wrong beneficiary; and misrepresentations by participants to establish or maintain eligibility for benefit payments. Because of the variety of circumstances in these cases, it is difficult to discern a formula for a successful claim under § 502(a)(3). If *Great-West's* "possession" requirement is not satisfied, the viability of these claims depends on whether a clear overpayment recovery provision exists so that courts have a basis to apply *Sereboff*'s contractual lien principles.

Cases Denying Recovery Under Section 502(a)(3). In *Honolulu Joint Apprenticeship and Training Committee of United Ass'n Local Union No. 675 v. Foster*, 332 F.3d 1234 (9th Cir. 2003), the Ninth Circuit held that a union plan could not recover monetary relief from a participant after he breached the terms of a scholarship agreement by working for a non-union employer. The plan sought the monetary relief to cover the costs of training the participant as a plumber. The plan argued that recovery was authorized because the apprenticeship training constituted unjust enrichment after the agreement was violated, and *Great-West* authorized restitution as a traditional equitable remedy. The Ninth Circuit denied recovery because the participant-defendant had no money in his possession identified as belonging in good conscience to the plaintiff. Training and/or knowledge was not an identifiable *res* of funds. Thus, the plan could not rely on § 502(a)(3) to impose personal liability on the participant to pay for his training.

In *Kroop v. Rivlin*, No. 04 Civ. 1401 DLC, 2004 WL 2181110 (S.D.N.Y. Sept. 27, 2004), the plan sought recovery of nearly $100,000 in pension payments that were mistakenly made because a pensioner's son misrepresented to the plan that the pensioner was alive for eight years following his death. Without the benefit of *Sereboff*, the court relied solely on *Great-West* to deny relief. Because the son spent the pension check funds as they arrived each month, the court held that the plan was pursuing an impermissible claim for legal reliefbecause the money at issue was no longer in a defendant's possession and thus "equitable" restitution was not available.

In *Phillips v. Brink's Co*., 632 F. Supp. 2d 563 (W.D. Va. 2009), the plan sought to recover mistakenly paid benefits resulting from its failure to offset the participant's union pension from his disability benefits for seven years. The plan lacked a clear overpayment recovery provision. Without discussing *Sereboff* or *Great-West*, the court enjoined the plan from offsetting future benefits against the previous overpayments. Without a clear offset or overpayment provision, the participant had no notice of the claimed overpayments. Based on a balance of equities, the court held that the proposed monthly reduction of $163.29 would be too much of a hardship to enforce against the elderly and disabled participant.

Cases Allowing Recovery Under Section 502(a)(3). *In Gutta v. Std. Select Trust Ins. Plans*, 530 F.3d 614 (7th Cir. 2008), the plan sought to recover benefits that it paid while it investigated a disability claim that it ultimately determined to be without merit. The plan also discovered that the participant had received disability payments from multiple disability policies, triggering the plan's offset provision. The Seventh Circuit affirmed the district court's ruling that recovery was allowed "even if the benefits it paid to Gutta [were] not specifically traceable to Gutta's current assets because of commingling or dissipation."

In *N. Am. Coal Corp. Retirement Savings Plan v. Roth*, 395 F.3d 916 (8th Cir. 2005), the plan filed a suit for a participant to whom it mistakenly paid the full account balance from a 401(k) account, when a Qualified Domestic Relations Order (QDRO) provided that the balance of a the account was to be split with the participant's ex-spouse. The plan sued for unjust enrichment, as well as an injunction to block dissipation of the funds that had already been transferred to a third party. The district granted the injunction and ruled in favor of the plan, allowing the recovery of the entire sum transferred to the third-party. *N. Am. Coal Corp. Retirement Savings Plan v. Roth*, No. A4-03-124, 2004 WL 434150, at*2 (D.N.D. Mar. 5, 2004). The Eighth Circuit affirmed the district court's ruling, but held that the plan could only recover funds within the participant's possession or any portion of the funds that remained clearly identifiable in the hands of a third-party. Citing *Great-West*, the court refused to allow "personal liability" against the defendants.

Proskauer's Perspective

The conflicting case law in suits to recover overpayments, mistakenly made payments, and the like, is a direct consequence of a fundamental flaw in the design of ERISA, namely its failure to provide an explicit right of action for plans to recover benefits that do not in good conscience belong to participants. To the extent that the plan document and/or summary plan descriptions contain a clear overpayment recovery or offset provision, the opportunity for relief under § 502(a)(3) will clearly be enhanced because this may support a contractual lien theory, and thereby remove the need to satisfy the requirements that the assets being pursued are in the participant's possession and are specifically identifiable. Similarly, plan offset provisions may provide an avenue for prospective relief without having to resort to ERISA's civil enforcement provisions altogether. Nevertheless, there will remain circumstances where, depending on the plan document or the applicable jurisdiction, the pursuit of claims for recovery of plan overpayments may become an exercise of "throwing good money after bad."

Seventh Circuit Revisits Issue of Remedies Available Under ERISA § 502(a)(3) in Reviving Class Action[3]

Contributed by Michael D. Spencer

In *Kenseth v. Dean Health Plan, Inc.*, 610 F.3d 452 (7th Cir. 2010) and *Smith v. Medical Benefits Adm'rs Grp. Inc.,* No. 09-3865 (7th Cir. Mar. 15, 2011),[4] the Seventh Circuit considered whether a plan participant, who was misadvised as to his/her entitlement to medical coverage, was entitled to relief when the participant subsequently learned, after receiving the medical treatment, that coverage was in fact not available. In both cases, the participants sought recovery under § 502(a)(3) of ERISA, arguing that the erroneous preauthorization advice amounted to a fiduciary breach. Although the Court acknowledged that such a cause of action may be viable, it effectively closed the door to recovery of monetary relief. By so ruling, the Court cast serious doubt as to the availability of monetary relief in a broad of array of cases in which a participant claims to have incurred expenses due to mistaken advice from plan representatives.

Remedies Available under ERISA § 502(a)(3)

The challenges posed to the plaintiff participants in *Smith* and *Kenseth*, and similarly situated participants, arise from the unique limitations contained in ERISA's civil enforcement mechanism. ERISA permits the recovery of restitutionary damages only in claims for fiduciary breach brought on behalf of the plan under ERISA § 502(a)(2). For individualized claims for relief, the statute offers two potential remedies: a claim under ERISA § 502(a)(1)(B) to recover plan benefits or a claim under ERISA § 502(a)(3) to "enjoin any act or practice which violates any provision of this subchapter or the terms of the plan" or "obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan[.]" The Supreme Court held in *Great-West Life & Annuity Ins. Co., v Knudsen*, 534 U.S. 204 (2002), that ERISA § 502(a)(3) limits a plan participant to the recovery of equitable relief, and money damages, *i.e.,* legal relief, are not available under ERISA § 502(a)(3).

Kenseth v. Dean Health Plan, Inc.

In *Kenseth*,an ERISA claims administrator for a fully insured ERISA health care benefits plan refused to pay $78,000 in medical expenses related to a participant's surgery, even though the plan admitted that it pre-authorized her treatment. The plaintiff, Kenseth, underwent an expensive surgical procedure to treat an acid reflux condition. Before the surgery, she called a customer service representative of the claims administrator for her plan. After Kenseth described the procedure she was seeking, the representative told her that the surgery was covered by the plan. However, Kenseth failed to tell the representative that the acid reflux condition resulted from a prior vertical gastric banding procedure to treat her obesity, which she underwent years earlier and which was covered by a different plan in which she participated at the time. Because Kenseth's current plan did not cover surgery for treating obesity or any other treatment "related to" such surgery, the claims administrator denied her claim for reimbursement, notwithstanding the prior authorization.

After exhausting her administrative appeals, Kenseth sued the claims administrator, asserting a breach of fiduciary duty claim under ERISA § 502(a)(3) for failing to explain the plan adequately, identify a procedure for obtaining preapproval for treatment, and process claims consistently with respect to similarly situated claimants. In addition, Kenseth asserted a claim for equitable estoppel under ERISA common law, arguing that the plan was estopped from denying benefits because she relied on incorrect information provided by defendant's customer service representative. Kenseth also asserted a third claim for an alleged violation of a state insurance law that provided a time limit on exclusions for pre-existing conditions. Kenseth argued that her acid reflux arose from a pre-existing condition for which she had undergone the prior gastric banding procedure. Notably, Kenseth did not assert a claim under ERISA § 502(a)(1)(B) for benefits due under the plan.

The district court granted summary judgment against Kenseth on all three claims. The Seventh Circuit upheld the dismissal of the estoppel claim and the state law claim, but remanded the fiduciary breach claim for further consideration.

The Seventh Circuit upheld the trial court's dismissal of the estoppel claim because such claims require a plaintiff to prove that the party to be estopped knew the relevant facts at the time of the misrepresentation. The Seventh Circuit found that this burden could not be sustained here because, when she inquired into coverage, Kenseth did not inform the customer service representative that her condition was related to her prior procedure for obesity.

The Seventh Circuit upheld the dismissal of the state insurance law claim because it found that, although Kenseth's banded stomach could be understood as a preexisting condition, that was not the basis for the decision to deny to the claim. Instead, the Court found that the denial was based on exclusions in the plan for surgeries designed to deal with morbid obesity and for any conditions related to such non-covered services. The Court held that the state law did not prohibit an insurer from "establishing limitations or restrictions on the amount, level, extent, or nature of benefits or coverage for similarly situated individuals enrolled under the plan."

With respect to the fiduciary breach claim, the Seventh Circuit agreed with the district court that Kenseth was not entitled to compensatory damages, but it found that the facts in the record supported a breach of fiduciary duty claim. The district court dismissed the claim because it concluded that the plan administrator did not have a fiduciary duty to provide Kenseth with an independent means of determining coverage, since "no reasonable person reading the plan would have difficulty determining that the plan would not cover plaintiff's 2005 surgery." The Seventh Circuit disagreed, finding that the defendant, as an ERISA fiduciary, "has an obligation to convey complete and accurate information material to the beneficiary's circumstance, even if that requires conveying information about which the beneficiary did not specifically inquire." The Seventh Circuit held that a fact finder could reasonably conclude that the plan administrator breached its fiduciary duty by failing to take reasonable steps to ensure that plan participants like Kenseth understood that they could not rely upon the coverage advice of the plan's customer service agents, and by failing to ensure that plan participants knew where and how they could obtain coverage advice upon which they could rely.

In light of its finding that Kenseth demonstrated facts sufficient to establish a breach of fiduciary duty, the Seventh Circuit remanded the case back to the district court to determine whether she was "seeking any form of equitable relief that is authorized by [ERISA § 502(a)(3)], 29 U.S.C. § 1132(a)(3)." In its discussion of appropriate remedies under ERISA § 502(a)(3), the Seventh Circuit noted that "[r]estitution, which holds out the prospect of monetary relief to the plaintiff, can be either legal or equitable in nature . . . [but] is permitted only when it may accurately be characterized as an equitable remedy." The Seventh Circuit explained that restitution may constitute appropriate *equitable* relief when the defendant has wrongfully obtained or withheld the plaintiff's money or property, and a constructive trust or equitable lien is imposed to ensure that the defendant disgorges his ill-gotten gain and the plaintiff receives that to which he is entitled. The Court expressed doubt that Kenseth's claim would warrant restitution as equitable relief because "the relief that Kenseth truly seems to seek is relief that is legal rather than equitable in nature." The Court noted that Kenseth alleged in her complaint that she suffered a pecuniary loss and other consequential damages as a result of the plan administrator's actions.

Following the remand, the district court recently concluded that Kenseth was not entitled to any relief because her request that "defendant . . . 'hold her harmless for the cost of her surgery and treatment' was a thinly disguised request for compensatory damages that may not be awarded under § 1132(a)(3)."

Smith v. Medical Benefits Adm'rs Grp. Inc.

Based on facts similar to those presented in *Kenseth*, the plaintiff in *Smith* filed a putative class action against a third party administrator seeking monetary and injunctive relief under ERISA after his claim for benefits – relating to gastric bypass surgery which had been preauthorized – was denied because the plan did not in fact cover surgery and other medical services related to obesity. Smith alleged that the third party administrator routinely ignored and failed to comply with its duties under ERISA when deciding requests for pre-approval and/or preauthorization of medical services. Smith contended that the claims administrator made delayed preauthorization decisions and had a practice of preauthorizing treatment without considering whether the treatment was, in fact, covered. As a result of these alleged breaches, Smith sought "an appropriate award of damages, restitution, and/or other monetary relief" as compensation for the financial injury he suffered in undergoing a surgery that the claims administrator later determined was not covered by the plan. Smith also sought an order from the Court enjoining the administrator from issuing preauthorizations and then invoking coverage exclusions or other defenses.

The district court dismissed Smith's claim for failure to state a claim, finding that (1) Smith could not obtain relief under ERISA § 502(a)(1)(B) because the Plan did not cover gastric bypass surgery; (2) that Smith was not entitled to relief under ERISA §502(a)(2) because he was seeking to be personally compensated for the loss to "his own pocketbook" instead of making good to the Plan any losses suffered by the Plan; and (3) that Smith was seeking relief that would modify the terms of the Plan instead of seeking to uphold the terms of the Plan.

On appeal, the Seventh Circuit agreed with the district court that Smith failed to state a claim under ERISA § 502(a)(1)(B) as no benefits were owed to Smith under the terms of the Plan because the Plan explicitly excluded gastric bypass surgery from coverage. The Court also concluded that Smith failed to state a claim seeking "appropriate relief" under ERISA § 502(a)(2) because he sought relief for individualized injuries that he suffered as a result of the claim administrator's alleged actions and was not seeking to obtain relief that would inure "to the benefit of the plan as a whole."

The Seventh Circuit departed from the district court ruling, however, insofar as the lower court dismissed Smith's fiduciary breach claim under § 502(a)(3). The Court found it reasonable to foresee that the claims administrator's preauthorization practices might constitute a breach of fiduciary because the claims administrator allegedly preauthorized medical treatment without first determining whether the treatment in question was covered and without warning the participant that coverage may later be denied. By doing so, the claims administrator could be misleading a participant to his/her detriment, possibly breaching a duty of loyalty "encompassing a negative obligation not to mislead the insured, as well as a positive obligation to communicate material information to the insured in circumstances where the fiduciary's silence might itself lead the insured to misapprehend his rights and obligations." The Court also noted that the delays in preauthorization by the claims administrator would be inconsistent with its duties to participants if the delays exceeded the time period allowed by federal regulation. Such a delay would be a breach of the duty of loyalty, to the extent the delay in preauthorization could foreseeably harm the participant by postponing treatment that the participant's physician recommended.

Despite finding that Smith articulated a viable breach of fiduciary duty claim, the Seventh Circuit agreed that Smith was not entitled to monetary relief. The Court determined that Smith's only remedy would be equitable relief under ERISA § 502(a)(3). The Court explained that restitution, in appropriate circumstances, could be deemed equitable rather than legal relief, such as when a fiduciary is wrongfully holding money that belongs to a plaintiff. Here, however, Smith made no such allegations and he conceded the plan excluded coverage for his procedure.

The Seventh Circuit then went on to explain that "meaningful" declaratory and injunctive relief under ERISA § 502(a)(3) might include either (1) a declaration from the court that the plan administrator's method of handling requests for preauthorization does not comply with ERISA or amounts to a breach of fiduciary duty, or (2) an order from the court requiring the plan administrator to modify its preauthorization practices so as to bring them in conformity with ERISA. The Court stated that these forms of relief might be appropriate if what happened to Smith was not an isolated occurrence, but rather was consistent with the claims administrator's routine preauthorization practices.

In reaching these conclusions, the Court cautioned that it had little or no information about what the plan stated about the preauthorization procedures, how clear the plan's exclusionary language was, or the content of communications between the plan administrator and plan participants with respect to preauthorization procedures, all of which would likely impact an evaluation of the breach of fiduciary duty claim.

Proskauer's Perspective

These two decisions confirm that participants who seek monetary relief for an individualized claim of fiduciary breach may be without a remedy. If such a participant pursues his/her claim under ERISA § 502(a)(1)(B), the participant is only entitled to relief if the plan, in fact, provides the benefits sought. If the participant proceeds under ERISA § 502(a)(2), the claim is likely to be dismissed if it arises under unique circumstances, such that the claim cannot be said to be brought on behalf of the plan. And if the participant chooses instead to pursue a claim under ERISA § 502(a)(3), then under the terms of that provision the participant may obtain injunctive and equitable relief, which may inure to the benefit of plan participants generally, but may do little to rectify the out-of-pocket losses of the participant who brought the claim.

Given these circumstances, we can expect the plaintiffs' bar to continue to try to punch holes in this analysis and/or find new vehicles for recovery. Among the most likely avenues to be pursued are: (i) reconsideration of whether monetary relief is available for breaches of fiduciary duty, an argument that the DOL has already advocated in other contexts, such as stock drop claims; and (ii) seeking to expand the circumstances under which benefits can be recovered through plan reformation, which is generally recognized as a form of injunctive relief. Although the existing case law provides little basis for supporting these theories at the moment, when confronted with the circumstances presented in cases like these, some courts may eventually be persuaded to join the plaintiffs' bar in breaking new ground. Hence, the book may not be closed on claims for monetary relief by participants alleging individual claims for fiduciary breach.

Rulings, Filings, and Settlements of Interest

Contributed by Brian S. Neulander

Class Actions Filed:

- In *Palmason v. Weyerhauser Co.*, No. 2:11-cv-00695 (W.D. Wa. April 25, 2011), a participant filed a purported class action complaint alleging that retirement plan fiduciaries breached fiduciary duties by causing or permitting over 81 percent of the plans' pooled assets to be invested in unduly risky and inappropriate "alternative investments," including hedge funds and private equity investments, allegedly reducing the value of the plans' assets by 41 percent, or 2.4 billion dollars. The complaint further alleges that the defendants undertook the challenged investment strategies to improve the company's financial statements and that the large number of "alternative investments" prevented the fiduciaries from performing adequate due diligence.
- In *Slipchenko v. Brunel Energy, Inc.*, No. 4:11-cv-01465 (S.D. Tex. April 15, 2011), a former employee filed a purported class action complaint in connection with the employer's alleged failure, among other things, to provide participants and beneficiaries in its self-sponsored health care plan with notice of their right to elect continued coverage under COBRA. The complaint alleges that the employer/plan sponsor: (1) violated ERISA Section 601 by failing to provide COBRA coverage to participants who lost coverage as a result of a qualifying event, (2) failed to provide a summary plan description as required by ERISA Section 104, (3) violated ERISA Section 606(a)(1) by failing to provide notice of COBRA rights to employees and their spouses upon commencement of coverage under the plan, and (4) violated ERISA Section 606(a)(2) by failing to provide notice of COBRA rights to plan

beneficiaries following a qualifying event. The complaint also alleges claims under the American Recovery and Reinvestment Act of 2009 for an alleged failure to provide premium reduction assistance.

Class certification:

- In *McKay v. Tharaldson*, --- F.R.D. ---, 2011 WL 1206167 (D.N.D. Mar. 31, 2011), the court certified a class of ESOP participants under *Fed. R. Civ. P*. 23(b)(1). The participant class alleges that the former sole director and president of Tharaldson Motels, Inc. breached his corporate duties by engaging his former spouse as a consultant from 1998 to 2007. The participants further claim that the former director, who was also trustee of the ESOP, breached ERISA fiduciary duties by failing to bring a derivative action against himself. The court rejected defendants' arguments regarding the adequacy of the named class representative, finding that the representative had sufficient understanding of the nature of the suit to assist class counsel.
- In *In re Northrop Grumman Corp. ERISA Litigation*, No. CV 06-06213 MMM (JCx) (C.D. Cal. Mar. 29, 2011), the district court certified a class of 401(k) plan participants who alleged that the defendants breached fiduciary duties by paying excessive investment management fees to investment fund service providers. The participants asserted the fees were excessive when compared to the market rate for institutional investment management and alternatives available for the actual services required and provided. The defendants opposed class certification on the grounds that the commonality requirement was not satisfied because excessive fee claims are individualized based on a participant's investment selections. The court rejected this argument, finding that multiple questions of law and fact with respect to the allegedly excessive fees were common to all participants, regardless of what funds they had selected.

Excessive Fee litigation:

- In *In re YRC Worldwide, Inc. ERISA Litig*., No. 2:09-cv-02593-JWL-JPO, 2011 WL 1457288 (D. Kan. Apr. 15, 2011), 401(k) plan participants claimed that plan fiduciaries breached their duties by offering company stock as an investment option. The fiduciaries asserted that ERISA § 404(c) shielded them from liability because any investment losses were the result of each individual participant's investment choices. Relying on decisions from other circuit courts, the court rejected the 404(c) defense, concluding that the Tenth Circuit would hold that section 404(c) does not shield ERISA fiduciaries from liability regarding the decision to include certain funds in the menu of options available to plan participants.

Stock drop claims:

- In *West v. WellPoint, Inc.*, No. 1:08-cv-0486-SEB-TAB, 2011 WL 1258022 (S.D. Ind. Mar. 30, 2011), the district court granted the defendants' motion to dismiss plaintiff's class action "stock-drop" claims. In so ruling, the court held that plaintiffs had not alleged sufficient facts to show that plan fiduciaries should have known that WellPoint's stock was an imprudent investment option because it was artificially inflated. Plaintiffs had alleged, among other things, that defendants breached their fiduciary duties by continuing to offer company stock as an investment option in the WellPoint 401(k) plan, and maintaining the plan's pre-existing investment in company stock, when it was imprudent to do so; and failing to provide complete and accurate information to participants regarding the company's financial position. The court granted dismissal notwithstanding its finding that, because the plan did not require investment in company stock, the *Moench* presumption of prudence was not applicable.
- In *Griffin v. Flagstar Bancorp, Inc.*, No. 2:10-cv-10610, 2011 WL 1261196 (E.D. Mich. Mar. 31, 2011), the district court granted defendants' motion to dismiss plaintiffs' class action "stock-drop" claims. The plaintiffs had alleged, among other things, that defendants breached their fiduciary duties by continuing to offer company stock as an investment option in the Flagstar Bank 401(k) plan and maintaining the plan's pre-existing investment in company stock when it was imprudent to do so, and by failing to provide complete and accurate information to participants regarding the company's financial position. Although the stock dropped 95% in value during the relevant period, the court, applying the *Moench* presumption of prudence, found that plaintiffs had not shown that the company was on the verge of economic collapse in the context of the "economic maelstrom" of 2008-2009.
- In *In re Coventry Healthcare Inc. Sec. Litig.*, Nos. 08:09-CV-2661-AW, 10-462-AW, 09-3063-AW, 09-2850-AW, 09-3074-AW, 2011 WL 1258524 (D. Md. Mar. 31, 2011), the court denied defendants' motion to dismiss plaintiffs' 401(k) stock drop claims, ruling that the *Moench* presumption did not apply at the pleadings stage. Without the presumption of prudence, the court determined that plaintiffs stated a viable fiduciary breach claim by alleging that the defendants knowingly or recklessly provided misleading financial reports, which in turn allegedly caused the company's stock to decrease in value. The court also rejected defendants' "hard-wire" argument, finding that, without discovery, it could not determine whether the plan's text required the fiduciaries to offer company stock as an investment option.
- In *Carr v. Int'l Game Technology,* No. 09 Civ. 00584, 2011 WL 923944 (D. Nev. Mar. 16, 2011), the district court granted in part and denied in part defendants' motion to dismiss plaintiffs' complaint alleging that fiduciaries of the International Game Technology's ("IGT") defined contribution plan violated their fiduciary duties under ERISA by failing to remove the IGT stock fund from the plan when they knew or

should have known that IGT stock was an imprudent investment option. Applying the presumption of prudence as endorsed by the Ninth Circuit in *Quan v. Computer Scis. Corp.*, 623 F.3d 870 (9th Cir. 2010), the court stated that plaintiffs failed to overcome the presumption, notwithstanding allegations that IGT's stock price declined by 83% and that IGT suffered from company-wide financial instability. However, the court denied defendants' motion to dismiss plaintiffs' disclosure claim, which alleged that defendants breached their fiduciary duties by incorporating by reference IGT's materially misleading SEC filings. Notably, the court also allowed claims against IGT's board of directors for failure to monitor its appointees and co-fiduciaries to survive defendants' motion to dismiss. The court also ruled that plaintiffs who signed severance releases had standing to bring an ERISA suit because the releases only barred individual claims, not claims brought on behalf of the plan.

- In *In re UBS AG ERISA Litig.*, No. 08 Civ. 6696, 2011 WL 1344734 (S.D.N.Y. Mar. 24, 2011), the district court granted defendants' motion to dismiss ERISA "stock-drop" claims arising from the loss in value of UBS stock due to the subprime mortgage crisis. In so ruling, the court applied the presumption of prudence and held that the 69% decline in value of the UBS's share price did "not rise to the level of catastrophic failure necessary to overcome the presumption of prudence." The court also rejected plaintiffs' disclosure claim, stating that "ERISA does not impose an affirmative duty on fiduciaries to disclose information about the company's financial condition to plan participants."
- In *In re American Int'l Group, Inc. ERISA Litigation II*, No. 08 Civ. 5722, 2011 WL 1226459 (S.D.N.Y. Mar. 31, 2011), the district court denied American International Group's ("AIG") motion to dismiss plaintiffs' ERISA "stock drop" claims. Plaintiffs claimed that defendants breached their fiduciary duties by, among other things, continuing to offer AIG stock through the company's three retirement savings plans when it was imprudent to do so, failing to disclose necessary information to co-fiduciaries, failing to monitor fiduciary appointees, and failing to disclose material information to plan participants. In denying defendants' motion to dismiss, the court rejected defendants' argument that § 404(c) of ERISA shielded them from liability, reasoning that Department of Labor regulations and case law dictate that § 404(c) does not absolve defendants from liability if they imprudently select investment options for the plan. The court also allowed plaintiffs' disclosure claim to proceed, finding that "plaintiffs adequately alleged that defendants failed to disclose the true extent of the risk facing AIG as a result of its financial decisions" and that had defendants informed plaintiffs of the "alleged overvaluation of AIG stock," plaintiffs might have challenged the use of AIG stock for employer matching contributions. Plaintiffs' failure to monitor and failure to disclose to co-fiduciaries claims also survived the motion to dismiss. Notably, the presumption of prudence

was not implicated in this case.

Preemption:

- In *Montefiore Medical Center v. Teamsters Local 272*, No. 10–1451–cv, 2011 WL 1498823 (2d Cir. Apr. 21, 2011), the Second Circuit affirmed the district court's denial of Montefiore Medical Center's motion to remand its case against a union and its employee benefit plan (the "Plan") to state court. Montefiore brought suit in state court alleging that the Plan breached its contract with Montefiore when it failed to pay over $1 million to Montefiore for medical services provided to Plan participants and beneficiaries. The Plan removed the case to federal court on the grounds that Montefiore's claims were preempted by ERISA. The district court denied Montefiore's motion for remand, holding that the requirements for ERISA preemption under the Supreme Court's decision in *Aetna Health Inc v. Davila,* 524 U.S. 200 (2004), were satisfied because: (i) Montefiore had standing to bring an ERISA claim for benefits as an assignee of the plan's participants; and (ii) there was no other "independent duty" implicated by the Plan's actions. The Second Circuit agreed, reasoning that Montefiore had "colorable claims for benefits pursuant to ERISA § 502(a)(1)(B)" and that there were no other independent claims for legal action, besides the "right to payment" claims under ERISA, that could be brought by Montefiore. Notably, the Court rejected Montefiore's argument that verbal assurances made by the Plan office that those patients treated by Montefiore were eligible for benefits gave rise to an independent legal duty, and thus, constituted independent grounds for suit.
- In *Garcia v. American United Life Insurance Co.*, No. 10-40388, 2011 WL 1409222 (5th Cir. Apr. 13, 2011), the Fifth Circuit affirmed the denial of a widow's claim under a group life and accidental death policy where the husband had made material misrepresentations about his identity when applying for the policy. The court rejected the widow's argument that Texas law should govern the rescission of an insurance policy, finding that she had only pled federal claims. The Fifth Circuit also affirmed that a discretionary standard of review was applicable to the plan administrator's determination because the beneficiary designation form was expressly incorporated into the policy as a plan amendment, and that form granted discretionary authority to the administrator.
- In *Hansen v. Harper Excavating, Inc*., --- F.3d ---, 2011 WL 1379821 (10th Cir. Apr. 13, 2011), the Tenth Circuit ordered the district court to remand a removed case to state court because ERISA failed to provide federal jurisdiction over plaintiff's claim. Plaintiff had sought to enroll in the defendant employer's medical plan, but the employer failed to properly submit the enrollment to the insurer. Thus, the insurer denied coverage when plaintiff submitted claims. Plaintiff first filed a lawsuit seeking benefits under ERISA Section 502(a)(1)(B), and was awarded

medical costs and attorney's fees. Plaintiff then filed this second claim in state court, alleging fraudulent nondisclosure, negligent misrepresentation, and special damages. Defendant removed the second case to federal court, arguing that plaintiff should be judicially estopped from filing a second suit based on the same facts. The Tenth Circuit held that judicial estoppel was not available because it lacked jurisdiction over the claim. As a result of defendant's failure to enroll plaintiff in the medical plan, plaintiff was not a plan participant; further, because the plaintiff terminated employment, there was no future expectation of becoming a participant. Because plaintiff had no ERISA standing at the time the complaint was filed in state court, there were no grounds for federal jurisdiction based on ERISA preemption, and the court lacked authority to estop the second suit.

FLSA/ERISA hybrid action:

- In *Henderson v. Univ. of Pittsburgh Med Ctr.*, --- F.3d ---, 2011 WL 1238031 (3d Cir. April 5, 2011), the Third Circuit affirmed the district court's decision dismissing ERISA claims premised upon the defendants' failure to maintain records of uncompensated hours allegedly worked by employees "off the clock." In reaching this decision, the court first recognized that the scope of the record-keeping duty imposed by ERISA § 209, 29 U.S.C. § 1059, was contingent upon the specific language of the plan documents at issue. Because the relevant plan provisions tied benefits to compensation actually paid and not to hours worked, the Third Circuit rejected the plaintiffs' argument that the defendants were obligated to maintain records showing the actual amount of time worked by employees. In light of its determination that the plaintiffs' record-keeping allegations had failed to state a viable cause of action under ERISA, the *Henderson* court declined to address the alternative issue raised on appeal – whether ERISA provides for a private cause of action for violations of § 209's record-keeping provision.

Retiree benefits:

- In *Temme v. Bemis Co.*, No. 08-C-90, 2011 WL 1498584 (E.D. Wis. Apr. 18, 2011), the court ordered defendant to reinstate health benefits to a class of retirees who claimed that defendants breached the terms of a 1985 plant closing agreement by changing deductibles and prescription drug coverage in 2005 and 2007. The district court had previously ruled in favor of defendant, but the Seventh Circuit reversed, holding that the 1985 plant closing agreement and the 1985 collective bargaining agreement, when read together, provided for lifetime benefits. On remand, the district court granted the retirees' request for a preliminary injunction, finding that in light of the age and minimal financial resources of the retirees, there was a risk of irreparable harm without immediate reinstatement of medical benefits at the 1985 levels.

- In*Coriale v. Xerox Corp.*, No. 09–6492, --- F. Supp. 2d ----, 2011 WL 1327858 (W.D.N.Y. Apr. 6, 2011), the district court dismissed claims based on Xerox's changes to its retiree health insurance plan. In so ruling, the Court found that Xerox had promised retirees they could participate in its retiree health insurance plan but had not promised to provide them a certain level of coverage, and that the plan explicitly reserved Xerox's right to amend or terminate the plan. Accordingly, the participants' claims for benefits failed. The court also found that plaintiffs' breach of fiduciary duty claims under 502(a)(3) failed, because plaintiffs could pursue a claim for benefits under 502(a)(1)(B). The court also found that two of the named plaintiffs lacked standing under ERISA because neither was a participant in the benefit plan to which the benefit modifications were made. Finally, the court found that the plan limitations period requiring participants to being claims for the alleged wrongful denial of plan benefits within one year after the cause of action accrued applied only to denials of new, individual applications for benefits and did not apply to plaintiffs' claims based on a reduction or termination of existing benefits, particularly reductions affecting an entire class of retirees.

Claims for Benefits:

- In *O'Hara v. Nat'l Union Fire Ins. Co.*, No. 10-1433-cv, 2011 WL 1405448 (2d Cir. Apr. 14, 2011), the Second Circuit Court of Appeals vacated and remanded the district court's ruling that a participant of a long-term disability benefit plan could not show that she was disabled, and thus qualified for long-term disability benefits, because during the period of the alleged disability she continued to report to work. The Court of Appeals held that there is no "blanket rule that an employee, as a matter of law, cannot be disabled when she is present at work" and that "[a]n employee's continued presence at her place of employment does not preclude a finding of disability when there is evidence that the employee is incapable of performing her job."
- In *Boyd v. Metro. Life Ins. Co.*, No. 10–1702, --- F.3d ----, 2011 WL 1183006 (4th Cir. Mar. 31, 2011), the Fourth Circuit applied the "plan documents rule" established by the Supreme Court in *Kennedy v. Plan Administrator for DuPont Savings & Investment Plan, 555 U.S. 285 (2009)*, to affirm the district court's ruling that life insurance plan benefits were properly paid pursuant to a participant's beneficiary designation form, despite that (1) the plaintiff was separated from her husband, the named beneficiary, and the husband waived his to benefits under any life insurance policy in their separation agreement, and (2) the plan had no formal mechanism for beneficiaries to refuse benefits.
- In *Huss v. IBM Medical & Dental Plan*, Nos. 10–1061, 10–2749, 2011 WL 1388543 (7th Cir. Apr. 13, 2011), the Seventh Circuit concluded that a health insurance plan

administrator, in determining whether a participant satisfied the requirements for continuing her disabled son's enrollment in IBM's medical and dental plan when he turned 23 years old, should have evaluated the plan documents in effect when the participant's request for continued enrollment was required to be made (when the participant's son turned 23) rather than the documents in effect when the benefits were denied. Additionally, the court found that, in response to the participant's request for ten years' worth of SPDs, the plan administrator was required to provide *only* the operative SPD, because the ones that were "adopted after the controlling SPD, then superseded, and never referenced or relied upon by the Defendants" were not documents "under which the plan is established or operated" and thus fell outside the scope of § 104(b)(4).

- In *Mullins v. AT & T Corp.*, Nos. 04–2135, 04-2136, 07-1717, 10-2010, 2011 WL 1491223 (4th Cir. Mar. 20, 2011), the Fourth Circuit affirmed the denial of long-term disability benefits to a participant with carpal tunnel syndrome, and the request for imposition of statutory penalties against the plan sponsor for its failure to timely provide an SPD in response to the participant's request for all plan documents. In so ruling, the Court held that the plan administrator did not abuse its discretion in refusing to give deference to the participant's primary physician, whose opinion as to her ability to work differed from those of her two specialists, who conducted physical assessments at the plan administrator's request. The court also found that the plan administrator "substantially complied" with its external procedures and, to the extent it varied therefrom, did not abuse its discretion in doing so.

Section 510 claims:

- In *Muth v. LSI Corp.*, No. 10–2567, 2011 WL 1227783 (3d Cir. Apr. 4, 2011), the Third Circuit affirmed that the termination of a retirement plan participant's employment one month before he was eligible for full retirement benefits was not unlawful under ERISA § 510, where the participant was told his termination was due to the sale of his business unit, and even though his employer could have agreed to delay his termination until he became eligible for full benefits, there was no evidence that "all or part of the purpose" of his termination was to discriminate or interfere with his retirement benefits.

Disclosure claims:

- In *Pipefitters Local 636 Ins. Fund v. Blue Cross Shield of Michigan*, No. 09-2294, 2011 WL 1320684 (6th Cir. Apr. 6, 2011), the Sixth Circuit reversed an order requiring Blue Cross to produce documents regarding discount arrangements with medical service providers. On a previous appeal, the Sixth Circuit held that Blue Cross was not liable under ERISA for failing to disclose the discount information, but

remanded for additional consideration of a separate claim. On remand, the Fund filed an amended complaint, purportedly to correct the pleading defects with respect to the dismissed claim. The district court ruled in favor of the Fund, concluding that Blue Cross breached ERISA fiduciary duties when it withheld the discount information, and ordering Blue Cross to provide the information. The Sixth Circuit then determined that the Fund had improperly revived the previously dismissed claim by filing the amended complaint, and thus reversed the district court order requiring the document production.

- In *Legassie v. Raytheon Co. Employee Benefits Admin. Comm.*, No. 10-1850, 2011 WL 1296395 (C.D. Cal. Apr. 4, 2011), the district court held that a retirement plan administrator was not required to send a benefit statement to a vested plan participant who was transferred to another company and no longer accrued plan benefits, but the administrator was required to send him (1) annual plan funding notices; (2) tri-annual benefit statements; and (3) SPDs every five or ten years. With regard to the SPDs, because plaintiff failed to explain either (1) when he last received an SPD, or relatedly, (2) when defendant was required to issue an SPD, the court found plaintiff's allegations insufficient to prove that defendant violated § 104(b)(1). The court further found that even assuming defendant was required to provide an SPD, the equitable relief plaintiff sought for this violation – retroactive reinstatement in the Plan and a determination of future benefits – would not be "appropriate" equitable relief under § 502(a)(3) because plaintiff (1) was not claiming that he was wrongly excluded from the plan, and (2) was not asserting that, had he received an SPD, the SPD would have revealed to him that he was no longer accruing service credit.

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