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Editors' Overview

In our September issue, we examine the application of ERISA pre-emption to state-law misrepresentation claims by medical providers against ERISA plans or their insurers. The Fifth Circuit, which has issued several of the leading appellate decisions on ERISA pre-emption of provider claims, recently granted en banc review of such a claim in the *Access Mediquip* case. Oral argument is set for September 19, and the en banc ruling will likely have wide-ranging implications regarding the scope of ERISA pre-emption in the context of medical-provider claims. Our lead article reviews the underlying panel decision in *Access Mediquip,* and evaluates the competing approaches taken to pre-emption of medical-provider claims. Our author concludes by examining the policy considerations at issue and potential implications of the *Access Mediquip* decision for ERISA practitioners.

As always, be sure to review the section on Rulings, Filings, and Settlements of Interest. This month's offering includes a trilogy of cases in the ever-changing field of retiree rights, as well as an issue of first impression in withdrawal-liability litigation.

ERISA Pre-emption in Provider Misrepresentation Claims: An Overview of the Jurisprudence Leading Up to the Fifth Circuit's *En Banc* Review of *Access Mediquip* and What Lies Ahead*

Contributed by Christopher L. Williams

The U.S. Court of Appeals for the Fifth Circuit recently granted en banc review of its decision in *Access Mediquip LLC v. UnitedHealthcare Ins. Co.*[1] to address a frequently recurring issue arising in health care litigation: whether ERISA Section 514 preempts a third-party provider's state law claims premised on allegations that it was misled by an insurer's statements regarding patient coverage.

The Fifth Circuit's decision to rehear the *Access Mediquip* case provides an occasion to take a deeper look at provider reimbursement claims and the state of the law governing these disputes. We also take the opportunity to analyze the Fifth Circuit's ERISA pre-emption jurisprudence leading up to *Access Mediquip*, the three-member panel's decision, and the issues likely to be addressed en banc. Finally, we offer our thoughts on the legal and policy considerations that will likely influence the en banc panel in its adjudication of *Access Mediquip*.

Background

Lawsuits filed by health care providers against insurers seeking to recover payment for medical services typically involve the same fact pattern. Before providing medical treatment, the health care provider attempts to verify benefits by calling the patient's insurer. After verifying coverage, the provider treats the patient with the expectation of being paid for its services. After the provider treats the patient, the insurer denies benefits and refuses to pay the provider's bill. Left "holding the bag," the provider then seeks to compel payment by suing the insurer based on the misrepresentations regarding coverage.

It is against this backdrop that ERISA pre-emption comes into play. But for ERISA's broad pre-emption provisions, the health care provider would be able to assert a variety of state law claims against the insurer, such as negligent misrepresentation, promissory estoppel, and breach of contract. If ERISA preempts these state law claims, however, the health care providers have to bring derivative claims under ERISA as assignees of the participants. Whether ERISA governs the dispute is important because of the statute's limited remedies. While some state law claims provide for punitive damages and statutory penalties such as treble damages, ERISA precludes the recovery of any such relief and could preclude relief altogether.

ERISA Pre-emption

In relevant part, Section 514(a) of ERISA provides that the statute shall "supersede any and all State laws insofar as they may now or hereafter *relate to* any employee benefit plan."[2] The U.S. Supreme Court has broadly interpreted this provision of ERISA, determining that "[a] law 'relates to' to an employee benefit plan…if it has a connection with or reference to such a plan."[3] Notwithstanding this expansive interpretation, the court has consistently recognized that the scope of ERISA's "relate to" language must be subject to some limitations or " pre-emption would never run its course."[4] Thus, reviewing courts "must go beyond the unhelpful text and the frustrating difficulty of defining its key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive."[5]

ERISA Pre-emption and Provider Reimbursement Claims

Although a clear majority of courts have determined that ERISA does not preempt a health care provider's state law claims based on insurer misrepresentations, at least one appellate court has reached the opposite conclusion.

The Majority View

The Fifth Circuit is the principal architect of the legal framework adopted by those courts that have concluded that ERISA does not preempt health care provider misrepresentation claims. In *Memorial Hosp. Sys. v. Northbrook Life Ins. Co.*,[6] the hospital brought, among others, a statutory state law claim based on allegations that the insurer refused to pay for a patient's medical treatment despite previously verifying coverage. The Fifth Circuit synthesized its prior pre-emption case law and set forth a two-pronged test to determine whether a plaintiff's state law claims "relate to" an ERISA plan. The court found that such claims can be preempted if they have at least two unifying characteristics:

- the state law claims address areas of exclusive federal concern, such as the right to receive benefits under the terms of an ERISA plan; *and*
- the claims directly affect the relationship among the traditional ERISA entities—the employer, the plan and its fiduciaries, and the participants and beneficiaries.[7]

Applying this test, the court held that the hospital's statutory misrepresentation cause of action was not preempted by ERISA.[8]

In reaching this conclusion, the court first observed that the "commercial realities" facing health care providers require that providers be able to rely on insurers' representations of coverage when providing medical care to patients.[9] Second, the court determined that the hospital's claim implicated a "classically important state interest," *i.e.*, enforcing the allocation of risks between commercial entities for which state law normally provides a remedy.[10] Third, the court found that allowing pre-emption would discourage health care providers from providing health care to patients and thereby defeat ERISA's goal of "enhancing employees' health and welfare benefit coverage."[11] In addition to these policy-based arguments, the court determined that the hospital's claim did not directly affect relations between traditional ERISA entities and therefore was beyond the reach of the statute.[12] Put another way, the hospital was not an ERISA entity and therefore not a party to the "bargain" struck by Congress when enacting the statute; accordingly, it should not be deprived of a remedy.[13]

The majority of circuit courts have followed the rationale articulated in *Memorial Hospital* and likewise concluded that ERISA does not preempt health care provider claims premised upon insurer misrepresentations.[14] These decisions are grounded upon the same policy reasons articulated by the Fifth Circuit in *Memorial Hospital* and emphasize that health care providers will be reluctant to provide treatment to patients without prepayment if deprived of a remedy because of ERISA pre-emption.

The Minority View

In contrast, the Sixth Circuit has concluded that provider misrepresentation claims are preempted by ERISA.[15] In *Cromwell*, a third-party provider asserted various state law claims based on the plan administrator's alleged "oral assurances of coverage" provided in response to inquiries on whether the health care services would be covered.[16] Over a vigorous dissent, a divided panel of the Sixth Circuit held that the application of ERISA should not depend on whether there is recourse available to the provider, concluding that this concern was not relevant to the analysis.[17] The concurring opinion articulated several policy reasons as to why ERISA should preempt the state-law claim: (1) a judgment against the plan would leave fewer resources to pay claims; (2) payment of any award would require actuarial adjustments, since it would not have been included in the plan's initial projections; and (3) subjecting the plan to a patchwork of differing state laws concerning the damages recoverable in tort would increase the costs of plan administration.[18]

Related Fifth Circuit Jurisprudence

As noted above, the Fifth Circuit's decision in *Memorial Hospital* is the landmark case determining that ERISA does not preempt health care provider claims for misrepresentation of coverage and its reasoning has served as the touchstone for other courts addressing the issue. Nonetheless, the Fifth Circuit and lower courts alike have had difficulty reconciling the holding in *Memorial Hospital* with its other precedent, namely the companion decisions in the *Hermann Hospital* cases.[19]

In *Hermann I*, a hospital provided medical services to a patient after being informed by the plan administrator that the patient was covered by an ERISA plan.[20] While treating the patient, the hospital made unsuccessful efforts to obtain payment from the plan, which asserted that the claim had neither been approved nor denied, but was being "investigated."[21] Ultimately, the plan refused to pay the claim. The Fifth Circuit concluded that ERISA preempted the hospital's state law misrepresentation claims for two reasons: (1) the causes of action were seemingly inconsistent with the hospital's assertion that it was an assignee of the patient-beneficiary, and (2) permitting the claims would allow nonenumerated parties who lacked standing to sue under ERISA to circumvent its provisions by asserting claims under state law, thereby obtaining advantages denied to parties enumerated under the statute.[22]

In a footnote in the Fifth Circuit's decision in *Memorial Hospital*, decided two years later, the court rejected the insurer's argument that *Hermann I* controlled and required pre-emption by stating that the *Hermann I* analysis considered the provider's claims "to be dependent on, and derived from, the rights of the plan beneficiaries to recover benefits under the terms of the plan."[23] In *Memorial Hospital*, the court further noted that an intervening Supreme Court decision,[24] "place[d] a different light on state law actions brought by non-ERISA entities against an ERISA plan or fiduciary."[25]

Shortly after *Memorial Hospital*, the Fifth Circuit issued its opinion in *Hermann II*. The hospital urged the court to revisit its earlier pre-emption analysis in *Hermann I*, arguing that the *Mackey* and *Memorial Hospital* decisions amounted to intervening "controlling authority" supporting its contention that ERISA did not preempt its state law misrepresentation claims.[26] The *Hermann II* court, however, gave short shrift to the hospital's argument, concluding that the state law claims were "based upon the failure of [the plan] to pay benefits to which [the hospital] was entitled," and therefore, "ha[d] a nexus with the ERISA plan and its benefit system."[27] Notably, the *Hermann II* court attempted to limit the reach of its holding by stating that its decision was governed by "the law of the case" doctrine:

As the tort dicta in *Mackey* has no effect on our holding in *Hermann I* that ERISA preempted [the hospital's] state law claims, the dicta in *Memorial Hospital* discussing *Hermann I* in light of *Mackey* likewise does not change the law of the case.[28]

Based on the foregoing, *Hermann II* concluded that ERISA preempted the hospital's state law misrepresentation claims.

Five years later, the Fifth Circuit addressed another third-party provider reimbursement claim in *Cypress Fairbanks Medical Ctr. v. Pan-American Life Ins. Co.*[29] Notably, *Cypress Fairbanks* characterized the *Hermann II* decision as doing "nothing more than hold[ing] that our pre-emption determination in *Hermann I* was the law of the case" and therefore "add[ing] nothing to our understanding of ERISA pre-emption."[30] In concluding that ERISA did not preempt the provider's state law claim for misrepresentation, *Cypress Fairbanks* attempted to reconcile the *Memorial Hospital* and *Hermann I* decision in the following manner: "the proper [pre-emption] inquiry is whether the beneficiary under the ERISA plan was covered *at all* by the terms of the health care policy, because if the beneficiary was not, the provider of health services acts as an independent, third party subject to our holding in *Memorial*."[31] Because the patient had no coverage at all under the health care policy in question, there was no ERISA pre-emption.[32]

Two years later, in *Transitional Hosps. Corp. v. Blue Cross & Blue Shield Inc.*[33] another Fifth Circuit panel established a two-step framework for evaluating this issue in light of the previous decisions in *Memorial*, *Hermann*, and *Cypress Fairbanks*. According to the court in *Transitional*, the first question is whether the patient was covered under an ERISA plan.[34] If not, the provider's claim is not preempted and no further analysis is necessary.[35] If there is coverage, the court must then "take the next analytical step and determine whether the claim in question is dependent on, and derived from the rights of the plan beneficiaries to recover benefits under the terms of the plan."[36]

The *Access Mediquip* Panel Decision and Petition for En Banc Review

The circumstances surrounding the dispute between the provider and insurer in *Access Mediquip* are substantially similar to those arising in the other cases described above. In short, Access sued UnitedHealthcare and claimed that it refused to pay some or all of Access's claims for services provided in connection with patients insured under ERISA plans after UnitedHealthcare provided assurances that the claims were eligible for reimbursement.[37] After limited written discovery, UnitedHealthcare argued that summary judgment should be granted in its favor because Access's claims were preempted by ERISA and the district court agreed.[38]

Because the patient claims at issue in *Access Mediquip* were covered by an ERISA plan, both the district court and the appellate panel agreed that the dispositive inquiry was whether Access's causes of action were "dependent on, and derived from the rights of the plan beneficiaries to recover benefits under the terms of the plan."[39] Citing the *Transitional* decision, the district court interpreted this language to mean that:

to the extent a state law cause of action is based on a misrepresentation that the patient *is covered* under an ERISA plan, the cause of action is *not* preempted. To the extent, however, that a state law cause of action is based on misrepresentations regarding *the extent of coverage* under an ERISA plan…the cause of action *is* preempted.[40]

Applying this test, the district court held that Access's state law causes of action were preempted because they did not involve allegations that United misrepresented the *existence of coverage*.[41]

On appeal, the Fifth Circuit rejected the district court's "existence of patient coverage analysis versus extent of patient coverage analysis" under which claims based on "extent" misrepresentations are preempted.[42] Noting that the claims in *Transitional* were premised on alleged misrepresentations regarding the extent of coverage and were not preempted, the court observed that "[i]t is difficult to see why pre-emption should depend on whether a provider alleges that it was misled by explicit promises of future payment or by statements about coverage that conveyed a false impression of future payment."[43]

Having rejected the "existence of coverage" versus "extent of coverage" analysis employed by the district court, the panel next determined that the substance of Access's state law claims was not "dependent on, and derived from the rights of the [patients] to recover benefits under the terms of the plan."[44] In reaching this conclusion, the appellate panel observed that the "state law underlying Access's misrepresentation claims does not purport to regulate what benefits United provides to the beneficiaries of its ERISA plans, but rather what representations it makes to third parties about the extent to which it will pay for their services." Because state law claims of this kind "concern the relationship between the plan and third-party, non-ERISA entities who contact the plan administrator to inquire whether they can expect payment for services," [45] the panel concluded that "[t]he administrator's handling of those inquiries is not a domain of behavior that Congress intended to regulate with the passage of ERISA."[46] In conclusion, the court noted that:

ERISA pre-emption protects plans from unexpected financial consequences that could result from routine exposure to state-law claims. State-law claims premised on misrepresentations to a third party provider do not greatly implicate this concern, because an ERISA plan can avoid liability under such claims by taking care that it does not mislead providers regarding what they can expect to be paid if they render services for the plan's insureds.[47]

UnitedHealthcare's petition for panel rehearing raises two central arguments germane to the issues discussed in this article. First, UnitedHealthcare argues that the panel erred by failing to mention, let alone substantively discuss, either of the two *Hermann* decisions and their impact on the ERISA pre-emption analysis. Thus, UnitedHealthcare contends that the panel's omission caused it to overlook the holdings in the *Hermann* decisions, which support ERISA pre-emption of a third-party provider's state law misrepresentation claims based upon allegations that it was misled by statements regarding the extent of coverage under an ERISA plan. Second, UnitedHealthcare argues that the panel ignored the *Hermann* decisions' expressed policy concerns that nonenumerated parties like health care providers should not be allowed remedies unavailable to plan participants.

Proskauer's Perspective

In its review of the *Access Mediquip* decision, the en banc panel will likely address two principal issues. First, the court will have to reconcile any inconsistencies between the *Hermann* decisions and its subsequent holdings in *Memorial Hospital*, *Cypress Fairbanks*, and *Transitional*. Second, the en banc panel is likely to address the competing policy considerations between a third-party provider's right to obtain payment for services rendered based upon an insurer's coverage statements and the concerns associated with expanding insurer liability and increased costs of plan administration.

As for the first issue, the overall weight of authority among the circuits points in favor of the en banc panel following the reasoning expressed in *Memorial Hospital*. As noted, the rationale underlying the *Memorial Hospital* court's decision to permit health care provider claims premised on *independent* representations by the insurer has been endorsed by the majority of appellate courts and by subsequent panels of the Fifth Circuit. The panel may thus expressly overrule the *Hermann* decisions to the extent they support the "existence/extent" approach rejected in *Access Mediquip*.

Alternatively, the panel could distinguish the *Hermann* rulings. Notably, the *Hermann* decisions never formally adopted any "existence/extent" approach test, and thus those cases could conceivably be limited to their particular facts, i.e., the substance of the provider's claims were premised on its rights as an assignee of the patient. If, conversely, the en banc panel disclaims the reasoning of *Memorial Hospital* and its progeny, however, the decision will have far-reaching effects not only in the Fifth Circuit, but also in courts across the country.

In advocating their positions, the parties likely will raise the “parade of horribles” they believe will result from an adverse decision. From the health care provider’s viewpoint, circumstances often require that they rely on insurer representations when treating patients and thus it makes sense to place the risk of loss on the entity making the inaccurate representation. If not, health care providers may well demand upfront payments before providing treatment or impose other requirements on patients to ensure they are paid for their services.

At the same time, however, insurers and plan administrators understandably desire predictable and consistent results so that they can make accurate projections as to the cost and coverage of plan participants. Subjecting plan administrators to conflicting standards of liability and damage awards would seem to make this task even more difficult. Both sides would probably agree that it would be helpful to have greater clarity on these important issues.

Rulings, Filings, and Settlements of Interest

Retiree Rights:

- In *Maytag Corp. v. Intl. Union, United Automobile, Aerospace & Agricultural Implement Workers of America*, No. 11-2931-cv, 687 F.3d 1076 (8th Cir. Aug.7, 2012), an employer sued a union and a class of retirees for a declaratory ruling that it could unilaterally modify retiree health care benefits provided under a collective bargaining agreement (CBA). The union and retirees brought a “mirror image” suit in another venue, which was ultimately dismissed in favor of the employer’s declaratory action. The district court rejected a challenge to the employer’s standing to sue, and after a trial, issued a declaratory judgment that the retirees had no vested right to lifetime health care benefits. In holding that the employer had standing to sue, the appeals court first noted the prevalence of retiree-rights litigation, and after observing that litigation over medical coverage was “inevitable,” the court found that the employer “reasonably concluded that the contractual dispute was real, substantial and existing.” On the vesting issue, the court focused attention on the parties’ 2004 CBA, since this was the sole agreement the retirees relied upon in their “mirror image” suit. The court emphasized that reservation-of-rights language in the 2004 Summary Plan Description (SPD), which the union actively participated in editing, established that the company did not intend for retiree medical benefits to vest. The court concluded that there must be an “affirmative indication of vesting in the plan

documents to overcome an unambiguous reservation of rights."

- In *Coriale v. Xerox Corp*., No. 11-1724-cv, 2012 WL 3140418 (2d Cir. Aug.3, 2012), the Second Circuit affirmed, in a summary order, the dismissal of Xerox retirees' claims that Xerox plan fiduciaries repeatedly promised lifetime health care benefits, then violated ERISA when Xerox stopped providing those benefits. The court ruled that that none of "the language contained in plan documents…can reasonably be interpreted to create a promise of vested lifetime benefits." The court further observed that even if the plan documents contained such a promise, it would likely have been unenforceable in light of reservation-of-rights language in plan documents. Lastly, with respect to plaintiffs' claim that the fiduciaries of the plans breached their duty of loyalty by knowingly deceiving participants with oral misrepresentations about lifetime benefits, the court concluded that the plaintiffs failed to allege sufficient facts to sustain claims that defendants misrepresented any material information regarding lifetime health care benefits.

- In *Moore v. Menasha Corp.,* No.10 CV 2171, 2012 WL 3590858 (6th Cir. Aug. 22, 2012), the Sixth Circuit reversed a lower-court decision that had reached a mixed result in a retiree-medical benefits dispute, and remanded for entry of judgment in favor of plaintiffs on all claims. The defendant-employer (Menasha) provided health care benefits for retirees and their spouses pursuant to CBAs negotiated in the 1990s. After Menasha announced a plan for gradual premium increases in 2006, a class of retirees and spouses brought suit alleging that these changes breached the terms of the applicable CBAs. The lower court ruled in favor of the retirees, concluding that they were entitled to health care benefits, but ruled for Menasha with respect to spousal coverage. Each side appealed the adverse aspects of the lower court's decision. The Sixth Circuit reversed, reasoning that the district court should have considered extrinsic evidence of the parties' intent to resolve ambiguities in the CBAs and plan documents. After conducting its own review of the evidence, the Sixth Circuit found that the extrinsic evidence was "overwhelmingly" in plaintiffs' favor, and that it showed an intent for retirees and their spouses to receive vested health care benefits. In reaching this conclusion, the court applied the so-called *Yard-Man* presumption (discussed in detail in our June 2012 issue), which in "close cases" favors lifetime vesting of benefits. Applying this presumption, the court found the inclusion of a reservation-of-rights clause in the plan's SPD was not controlling because it contradicted the terms of the relevant CBAs.

Fiduciary Status:

- In *Guyan Int'l, Inc. v. Professional Benefits Adm'rs, Inc.*, Nos. 11-3126, 11-3640, --- F.3d ---, 2012 WL 2553281 (6th Cir. Aug. 20, 2012), several group-health plans brought ERISA claims against a claims administrator ("PBA") for failing to pay medical providers for claims incurred by plan participants, instead using plan assets for its own purposes. Each plan had entered Benefit Management Service Agreements ("Agreements") with PBA, which made PBA its claims administrator responsible for paying medical providers for claims incurred under the terms of plaintiffs' plans. PBA appealed from a partial summary judgment in plaintiffs' favor, arguing that it was not an ERISA fiduciary, because it lacked discretionary authority and because the Agreements disclaimed fiduciary status as to PBA. The Sixth Circuit held that PBA functioned as a fiduciary, even assuming it had no discretion, because PBA issued checks from plan accounts, selected deposit accounts for plan funds, determined when and how to disburse plan funds, and commingled plan assets with its own funds. The disclaimer language in the PBA Agreements did not alter the finding since, under prior Sixth Circuit decisions, contractual provisions cannot override a party's functional status as an ERISA fiduciary. Characterizing the dispute as a "classic case of self-dealing," the Sixth Circuit also affirmed the finding that PBA had breached its duties to the plans. Finally, although the court found plaintiffs' contract claims were pre-empted, it rejected PBA's arguments that the damages awarded below were not authorized under ERISA, because PBA had failed to raise the issue in the district court.

Multiemployer Plans:

- In *Janese v. Fay,* No. 11-5369-cv, 12-80-cv, --- F.3d ---, 2012 WL 3642315 (2d Cir. Aug. 27, 2012), the Second Circuit held that trustees of a multiemployer plan do not act in a fiduciary capacity when they amend the terms of the plan. Plaintiffs, participants and beneficiaries of a multiemployer pension plan, brought a multi-count action against present and former trustees, asserting various breaches of fiduciary duty. Among their claims were several counts alleging that the trustees breached their fiduciary duties when they amended certain plan terms. As to these counts, the district court granted the trustees' motion to dismiss on limitations grounds, but rejected their alternative contention that the trustees were not acting as ERISA fiduciaries when they enacted the challenged amendments. The Second Circuit affirmed, and in doing so, expressly observed that intervening Supreme Court precedent abrogated prior Second Circuit jurisprudence holding that the trustees' amendment of a multiemployer plan was subject to ERISA's fiduciary duties. The Second Circuit also vacated the district court's dismissal of several counts arising out of fraudulent activity of a former plan manager. The court reasoned that issues of fact existed as to the time when plaintiffs knew, or should have known, about the plan manager's wrongdoing. Accordingly, the court found dismissal on the pleadings improper, since it was unclear whether the six-year

limitations period applicable to fraud-based claims applied. In discussing the application of the six-year limitations period for fraud, the court observed that the "particularity" requirement of Federal Rule of Civil Procedure 9(b) applied to allegations that a fiduciary breaches ERISA duties through fraudulent conduct.

Withdrawal Liability:

- In *Trustees of the Local 138 Pension Trust Fund v. F.W. Honerkamp Co.*, No. 11-1322-cv, --- F.3d ---, 2012 WL 3538267 (2d Cir. Aug. 17, 2012), the Second Circuit rejected a pension fund's argument that the Pension Protection Act of 2006 (PPA) prohibits an employer from withdrawing from a critically underfunded multiemployer pension plan. Shortly before renegotiating their collective bargaining agreements (CBAs) with Honerkamp, the Fund announced it was in "critical" funding status and began developing a rehabilitation plan as required by the PPA. As part of its rehabilitation plan, the Fund proposed new schedules of reduced benefits and increased employer contributions, but determined it was nevertheless unlikely to emerge from critical status within ten years. After requesting an estimate of its withdrawal liability, Honerkamp negotiated new CBAs under which it would provide employees with a 401(k) retirement plan. When Honerkamp sought to withdraw from the Fund, the Trustees sued Honerkamp, arguing that the PPA prohibited withdrawal after the Fund entered critical status. The Fund also sought retroactive and prospective contributions from Honerkamp, as provided under the rehabilitation plan. In an issue of first impression, the Second Circuit held that the PPA does not block employer withdrawal from critically underfunded plans. Although the PPA does not explicitly address the issue, the court noted that there were several PPA provisions that altered withdrawal-liability calculations in situations involving critical-status plans. The court also observed that PPA amended portions of ERISA addressing withdrawal liability "without the slightest indication that it intended to abrogate" the employers' right to withdraw, even where a plan is in critical status. Finally, the court noted that the Pension Benefit Guarantee Corporation had adopted regulations for calculating withdrawal liability from critical-status plans.

Employer Stock:

- In *Dudenhoefer v. Fifth Third Bancorp.*, No. 11-3012, 2012 WL 3826969 (6th Cir. Sept. 5, 2012), the Sixth Circuit reversed a district court decision granting defendants' motion to dismiss a "stock drop" claim, citing prior rulings in that Circuit that had declined to apply the *Moench* presumption of prudence at the motion to dismiss stage. The complaint alleged, inter alia, that Fifth Third Bank had engaged in lending practices that were equivalent to participation in the subprime lending market, defendants were aware of the risks of such investments, Fifth Third

stock declined 74% during the relevant period, and "business and accounting mismanagement ... coupled with inaccurate and misleading statements" by executives caused the stock price to be artificially inflated before it plummeted. In reversing the lower court's dismissal , the court reaffirmed the court reaffirmed earlier decisions holding that: (i) a plan fiduciary's decision to invest in employer securities should be reviewed for an abuse of discretion, *i.e.*, a "fiduciary's decision to remain invested in employer securities is resumed to be reasonable," and (ii) a plaintiff may rebut the presumption of reasonableness "by showing that a prudent fiduciary acting under similar circumstances would have made a different investment decision." The Court also noted that, unlike other Circuits, the Sixth Circuit had not adopted a requirement that the plaintiff necessarily demonstrate "dire circumstances," to rebut the presumption, and on that basis distinguished other Circuits that had applied the presumption on a motion to dismiss.

Pre-emption:

- In *Trustees of the Carpenters' Health & Welfare Trust Fund of St. Louis v. Darr*, --- F.3d ----, Nos. 10–1682, 10–1793, 10–2579, 2012 WL 3573360 (7th Cir. Aug. 21, 2012), the Seventh Circuit vacated an injunction against a state court suit that sought attorneys' fees from an ERISA plan, holding that state court proceedings may not be enjoined under ERISA unless they will "mak[e] it impossible for a fiduciary . . . to carry out its responsibilities." One of the plan's participants received medical and disability benefits, then recovered from a third-party and repaid the benefits to the plan. The participant's attorney then sued the plan for partial payment of his fees under the "common fund doctrine," contending the plan had a common interest because it was repaid from the participant's recovery. The plan filed a separate suit to enjoined the attorney's state court suit under ERISA Section 502(a)(3). The court granted the application, ruling that the plan's payment of attorneys fees would violate ERISA and the plan's terms. In vacating the injunction, the Seventh Circuit explained that the Anti-Injunction Act prevents federal courts from enjoining state court proceedings unless "expressly authorized by Act of Congress" (or other narrow exceptions apply). In ruling that the injunction was not expressly authorized, the court found the state-court suit would not make the fiduciaries' duties impossible because it was "too far removed from the core federal interests represented by ERISA," and the plan could present its ERISA-based defenses and seek damages for any fees it was ordered to pay in the state court suit.

Benefit Claims:

- In *Wade v. Aetna Life Ins. Co.*, 684 F.3d 1360 (8th Cir. 2012), the Eighth Circuit affirmed summary judgment in favor of the plan administrator, holding that Aetna

did not abuse its discretion in terminating a participant's long-term disability (LTD) benefits even though the participant received LTD benefits from the Social Security Administration (SSA). The court affirmed the lower court's decision that Aetna's decision was properly reviewed for an abuse of discretion, rejecting the participant's contention that *de novo* review should apply due to alleged procedural irregularities that occurred after the benefits decision and did not affect Aetna's determination. In holding that Aetna did not abuse its discretion by allegedly failing to consider the participant's qualification for LTD benefits from the SSA, the court explained that an ERISA fiduciary is not bound by the SSA's determination. The court ruled that substantial evidence supported Aetna's decision, noting that: (1) Aetna's determination occurred five years after the SSA's; (2) Aetna reviewed new evidence, including an independent medical examination and video surveillance; and (3) the SSA would not necessarily have made the same determination based on the new evidence.

- In *Aschermann v. Aetna Life Ins. Co.*, --- F.3d ---, No. 12-1230, 2012 WL 3090291 (7th Cir. July 31, 2012), the court ruled that an agent of the entity entitled to *Firestone* deference was also owed deference, and that plaintiff received "full and fair" review of her administrative claim. Plaintiff argued for *do novo* review of her benefit claim because the plan explicitly bestowed discretionary authority only on the plan administrator and the insurer underwriting the benefits, and a third-party claims administrator actually denied the claim. The insurer had delegated its decision-making authority to the claims administrator via contract, but the plan was not amended to reflect this reality. The court rejected plaintiff's argument that delegation of benefit eligibility decisions to a third-party broke the discretionary chain of authority. First, the court noted that ERISA does not prohibit sub-delegation; second, the claims administrator adopted all of the duties and responsibilities of the insurer; third, the delegation worked to decrease the potential for a conflict of interest because eligibility decisions were no longer made by the underwriter; and finally, the delegation to the claims administrator was akin to the insurer delegating to an in-house working group. The court also disposed of plaintiff's notice claim because the plan's written communications clearly noted the deficiencies in her claim.

Section 510 Claims:

- In *Berry v. Frank's Auto Body Carstar, Inc.*, No. 11-4150, 2012 WL 3552505 (6th Cir. Aug. 20, 2012), the court affirmed the dismissal of plaintiff's ERISA Section 510 and COBRA claims because he failed to supply sufficient evidence that his firing was pretextual. Plaintiff was terminated after he engaged in a profanity laced argument with another employee. Plaintiff claimed that his firing was a retaliatory act for

seeking medical insurance for his son, who was diagnosed with quadriplegic cerebral palsy and required large quantities of medications and daily physical therapy. The court concluded that the company provided a legitimate, non-discriminatory reason for the firing, and that plaintiff failed to establish that the company's reason was pretextual since there was no evidence that other employees engaged in acts of comparable seriousness but were nevertheless retained. The court also affirmed the dismissal of plaintiff's COBRA claims, having found that the company was not required to provide notification where plaintiff was terminated by reason of his gross misconduct.

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[1] 662 F.3d 376 (5th Cir. 2011).

[2] 29 U.S.C. § 1144(a) (emphasis added).

[3] *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 139 (1990) (quoting *Shaw v. Delta Air Lines*, Inc., 463 U.S. 85, 96-97 (1983)).

[4] New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 655 (1995).

[5] *Id.* at 656.

[6] 904 F.2d 236 (5th Cir. 1990).

[7] *Id.* at 245.

[8] *Id.*

[9] *Id.* at 246.

[10] *Id.* at 246-247.

[11] *Id.* at 247-248.

[12] *Id.* at 249-250.

[13] *Id.*

[14] *See, e.g., The Meadows v. Employers Health Ins.*, 47 F.3d 1006, 1011 (9th Cir. 1995); *Lordmann Enterprises Inc. v. Equicor Inc.*, 32 F.3d 1529, 1533-34 (11th Cir. 1994), *cert. denied*, 516 U.S. 930 (1995).

[15] *Cromwell v. Equicor-Equitable HCA Corp.,* 944 F.2d 1272 (6th Cir. 1991).

[16] *Id.* at 1274-75.

[17] *Id.* at 1276.

[18] *Id.* at 1279.

[19] *Hermann Hosp. v. MEBA Medical & Benefits Plan*, 845 F.2d 1286 (5th Cir. 1988) *(Hermann I); Hermann Hosp. v. MEBA Medical & Benefits Plan*, 959 F.2d 569, 15 EBC 1241 (5th Cir. 1992) *(Hermann II)*.

[20] 845 F.2d at 1287.

[21] *Id*.

[22] *Id*. at 1290-91.

[23] 904 F.2d at 250, n.20.

[24] *Mackey v. Lanier Collection Agency & Service Inc.*, 486 U.S. 825 (1988).

[25] *Id.*

[26] *Hermann II*, 959 F.2d at 578.

[27] *Id.*

[28] *Id.* at 579.

[29] 110 F.3d 280 (5th Cir. 1997).

[30] *Id.* at 284.

[31] *Id.* (emphasis added).

[32] *Id.* at 285.

[33] 164 F.3d 952 (5th Cir. 1999).

[34] *Id.* at 955.

[35] *Id.*

[36] *Id.*

[37] *Access Mediquip,* 662 F.3d at 377.

[38] *Id.* at 377-378.

[39] No. H-09-2965, 2010 BL 232418 (S.D. Tex. Oct. 4, 2010); 662 F.3d at 383.

[40] No. H-09-2965, 2010 BL 232418 (S.D. Tex. Oct. 4, 2010) (emphasis added and internal citations omitted).

[41] *Id.*

[42] 662 F.3d at 383 (internal quotations omitted).

[43] *Id.* at 384.

[44] *Id.* at 383.

[45] *Id.* at 385. The *Access Mediquip* panel found that Access's unjust enrichment and quantum meruit claims were preempted because Access could recover "under these claims only to the extent that the patients' ERISA plans confer on their participants and beneficiaries a right to coverage for the services provided." *Id.* at 386.

[46] *Id.* at 385-386.

[47] *Id.* at 386.

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