Proskauer

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Editors' Overview

In this month's edition, we feature two articles addressing hot-button issues in ERISA litigation. Our lead article reviews the recent decision in *Janese v. Fay*, in which the Second Circuit held that the trustees of multiemployer plans act in a non-fiduciary capacity when amending the plans they administer. Our authors examine the decision and its implications, and conclude by discussing some of the unresolved issues that may arise in the aftermath of the decision.

Following up on previous coverage, our second article looks at the impact of the Affordable Care Act (ACA) on benefits claims under ERISA. The authors illustrate the changes ACA will bring to existing benefits-determination procedures. The article also considers two open issues that are likely to result in litigation: the fiduciary status of independent review organizations (IROs) established by the ACA, and the standard of judicial review applicable to those IROs.

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

Second Circuit Rules That Amending A Multiemployer Plan Is Not a Fiduciary Act, But Leaves Many Questions Unanswered*

Contributed by Myron Rumeld and Anthony Cacace

In *Janese v. Fay*, No. 10-5369-cv(L), — F.3d — 2012 WL 3642315 (2d Cir. Aug. 27, 2012)(166 PBD, 8/28/12; 39 BPR 1679, 9/4/12), the Second Circuit put to rest the question of whether trustees of multiemployer benefit plans are acting in a fiduciary capacity when they amend the terms of their plans.

Contrary to prior Second Circuit authority, but based on intervening Supreme Court authority governing single-employer plans, the court unequivocally stated that trustees of multiemployer benefit plans do not act in a fiduciary capacity under the Employee Retirement Income Security Act when amending plan terms, but rather are acting in a settlor capacity.

While the holding is clear, questions still linger as to the broader implications of this decision, including: whether there are circumstances under which trustees can nevertheless face exposure to claims arising from plan amendments and, if so, the standard of conduct that will govern those claims.

Background and Procedural History

The lawsuit was brought by participants and beneficiaries of the former Niagara?Genesee & Vicinity Carpenters Local 280 Pension and Welfare Funds (funds) against present and former trustees and managers of the funds. The complaint alleged that the defendants depleted the assets of the funds by passing amendments designed to manipulate pension calculations in order to grant higher payouts to certain trustees and the manager of the funds.

The complaint also alleged that other trustees failed to monitor the conduct of their co-fiduciaries, thereby permitting the adoption of the improper amendments of the plans, and also voted in favor of inappropriate amendments.

Defendants asserted that all but one of the counts of the complaint were time?barred because the alleged wrongful conduct on which they were based occurred outside of the six-year limitations period for breaches of fiduciary duty under ERISA. Plaintiffs argued that their claims were governed by the "fraud and concealment" exception set forth in ERISA's statute of limitations, pursuant to which the limitations period does not run until six years from the date the breach is, or should have been with due diligence, discovered; and that they did not become aware of the alleged breaches committed by defendants until discovery had been conducted in an earlier lawsuit that suggested that the Fund manager had breached his fiduciary duty in connection with his improper weighting of fringe benefits due to him.

Defendants also argued that those claims specifically challenging plan amendments (including several of the claims alleged to be time-barred)
should be dismissed because amending the plan documents was not fiduciary conduct under ERISA. Plaintiffs contended that the trustees acted in a fiduciary capacity in amending the plans, relying on prior Second Circuit authority (as discussed below) indicating that amendment of a multiemployer plan was a fiduciary function.

The district court dismissed several of the claims as time-barred. However, the court rejected the defendants' arguments that the illegal plan amendment claims should be dismissed on the grounds that plan amendments are not fiduciary actions. In so ruling, the court relied on Second Circuit case law that had previously been understood to establish that amendments to multiemployer plans that concern "'the allocation of a finite asset pool to which each participating employer has contributed' could properly be treated as fiduciary functions." *Siskind v. Sperry Ret. Program*, 47 F.3d 498, 506 (2d Cir. 1995).

Following the judgment in the district court, the parties cross-appealed to the Second Circuit. Plaintiffs challenged the district court's ruling that certain claims were time-barred, while defendants challenged the district court's conclusion that amending a multiemployer plan was a fiduciary function.

The Second Circuit's Decision

The issue of whether plan amendments are fiduciary decisions turned on whether pre-existing Second Circuit pronouncements on this issue were still valid, notwithstanding intervening Supreme Court precedent.

Chambless v. Masters, Mates & Pilots Pension Plan, 772 F.2d 1032 (2d Cir. 1985), has been cited for the proposition that the act of amending multiemployer pension plans should be treated as a fiduciary function under ERISA, and as such, obligates the fiduciaries of the plan to discharge their duties solely in the interest of the participants and beneficiaries of the plan.

In a subsequent opinion, the Second Circuit noted that amendments of single?employer plans were not fiduciary decisions, but in so doing adhered to the view expressed in *Chambless* with respect to multiemployer plans because "trustees amending a pension plan 'affect the allocation of a finite asset pool' to which each participating employer has contributed." *Siskind v. Sperry Ret. Program*, 47 F.3d 498 (2d Cir. 1995) (quoting *Musto v. American General Corp.*, 861 F.2d 897, 912 (6th Cir. 1988)). The distinction between a finite and non-finite asset pool was considered important because with a finite asset pool the interests of the plan trustees would be aligned with those of the participants and beneficiaries of the plan, rather than the collective bargaining parties who created the plan, and thus would tend to be fiduciary, and not settlor, in nature. *See Siskind*, 47 F.3d at 506.

Since the time of these decisions, the Supreme Court issued a number of rulings concerning the distinction between settlor and fiduciary functions in the single?employer setting, including:

- *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73 (1995), which, in connection with a welfare plan, noted that employers and plan settlors are "generally free under ERISA, for any reason at any time, to adopt, modify, or terminate welfare plans";
- *Lockheed v. Spink*, 517 U.S. 882 (1999), which extended the ruling of *Curtiss-Wright* to include pension plans and found that plan sponsors amending the terms of a plan "do not fall into the category of fiduciaries," and are analogous to "settlors of a trust"; and
- *Hughes Aircraft Co. v. Jacobson*, 525 U.S. 432 (1999), which concluded that the holding in *Lockheed* applied to plans funded by both employer and employee contributions and added that "without exception" plan settlors that amend plan terms do not act as fiduciaries.

Plaintiffs contended that the Second Circuit's prior pronouncements in *Chambless* and *Siskind* were still controlling since the Supreme Court had not specifically ruled on the settlor/fiduciary issue in connection with multiemployer plans.

The Second Circuit rejected plaintiffs' contention and held the distinction between multiemployer and single-employer plans drawn in *Chambless* and *Siskind* was abrogated by the Supreme Court's reasoning in *Curtiss-Wright*, *Lockheed*, and *Hughes Aircraft*.[1] In so ruling, the Second Circuit cited decisions by the Third, Sixth, and Federal Circuit Courts of Appeals that all concluded, based on these Supreme Court rulings, that amending a benefit plan was not a fiduciary function and that nothing in those Supreme Court decisions could be interpreted to "create [ ] an exemption for multiemployer plans."

The court cited a decision from the Third Circuit that reasoned that since *Lockheed* ruled that a "plan sponsor" amending a plan did not act as a fiduciary, and ERISA defines "plan sponsor" for both single and multiemployer plans, there is no reason to analyze actions of the plan sponsor differently in the multiemployer context. *See Walling v. Brady*, 125 F.3d 114 (3d Cir. 1997).

The court also took note of various district court decisions within the Second Circuit that held that in light of these three Supreme Court rulings, the multiemployer plan distinction set forth in *Chambless* and *Siskind* was no longer valid. The court further opined that there was no "compelling reason" to rule contrary to its sister circuits, and maintaining a circuit split on the "issue of trustee liability as fiduciaries for amending multiemployer plans is inadvisable."

Accordingly, the court vacated the district court's ruling and held that plaintiffs' claims asserting a breach of fiduciary duty in connection with defendants' amendment of the plans were subject to dismissal because defendants were not acting as fiduciaries when amending the plan documents. In addition, the court reversed the district court's dismissal of certain counts of the complaint as time?barred, finding that there was a question of fact as to when plaintiffs knew or should have known of the alleged wrongful conduct of some of the defendants. Thus, the case will move forward in the district court with respect to the claims not related to the plan amendments.

Unresolved Issues Following the Second Circuit Ruling

Although the Second Circuit ruling on its face appears to be relatively straightforward, it leaves unresolved a series of questions that appear not to have been considered, but which could substantially impact the administration of multiemployer Taft-Hartley benefit funds. For example:

- If the Second Circuit's prior reasoning has been rejected, is it safe to assume that the trustees' interests are properly aligned with those of the collective bargaining parties as the plan settlors, rather than the participants? If so, can employer and union trustees take a position with respect to plan amendments based solely on the interests of the respective collective bargaining parties, even if doing so conflicts with the interests of the participants?

- What standard would govern if trustees deadlock over a proposed amendment and the dispute proceeds to deadlock arbitration? Since the dispute appears to be among trustees acting in their capacity as agents of the collective bargaining parties, rather than as plan fiduciaries, would the arbitration be conducted as an interest arbitration? Does the arbitrator even have authority to conduct the arbitration if fiduciary conduct is not at issue? To what extent do the answers to these questions depend on the particular terms of the trust agreement?

- Are there circumstances involving plan amendments that could still give rise to fiduciary breach claims? The Supreme Court has already recognized that the implementation of a plan amendment, as opposed to designing a plan, is a fiduciary function. *See Lockheed*, 517 U.S. at 890. And in other contexts the Department of Labor and the courts have recognized that a plan fiduciary may be obliged to breach the terms of a plan if implementation of those terms would give rise to a breach of fiduciary duty. *See, e.g., DiFelice v. U.S. Airways, Inc.*, 497 F.3d 410, 420 (4th Cir. 2007); *Laborer's Nat'l Pension Fund v. N. Trust Quantitative Advisors,* Inc., 173 F.3d 313, 322 (5th Cir. 1999). If a plan amendment threatened the financial condition of the fund, for example, would the trustees still face liability for passing and implementing that amendment? Conversely, if a fund were threatened with bankruptcy, would the trustees face liability for failing to pass an amendment that decreased benefit obligations?

- What role does plan counsel play in connection with discussions over plan amendments if the trustees conducting those discussions are acting in the interests of the collective bargaining parties rather than the plan participants?

Proskauer's Perspective

The Second Circuit's ruling, at first blush, may generate a sigh of relief from multiemployer plan trustees who understandably would wish to limit the circumstances under which they face exposure to fiduciary breach claims. It may also leave them feeling less constrained when debating the merits of plan amendments, insofar as the ruling may give them more license to act in the interests of the collective bargaining parties, rather than the plan participants.

But given the many unresolved issues, the ruling may also substantially complicate the administration of these plans in the near term. Furthermore, given the close relationship between plan amendments—at least those affecting the benefit formula—and the plan's financial viability, one must question whether in many instances decisions relating to plan amendments may still give rise to fiduciary breach claims.

Hopefully, the courts will have the opportunity in the relatively near future to address some of the implications of this ruling, so that the trustees of jointly administered multiemployer plans will have clearer guidance as to what the scope of their authority is when amending the terms of their plans. In the meantime, multiemployer trustees are advised to proceed with caution.

How ACA Modifies ERISA's Benefit Claims Procedures*

Contributed by Brian Neulander, Kara Lincoln, and Robert Rachal

The Affordable Care Act amended the Employee Retirement Income Security Act in a variety of ways, creating an array of litigation risks.[1] Among other things, it expanded ERISA's benefit claims procedures to include external review for plans that are not grandfathered. These nongrandfathered ERISA plans must now provide participants with the option of external, independent claims review following exhaustion of ERISA's existing internal claims procedures.

External review must be conducted by qualified independent review organizations (IROs) and results in a binding and final administrative benefit determination. Thus, the new external review mandate limits the authority of plan administrators and drastically alters the litigation landscape for claimants seeking to reverse benefit denials in federal court. This article addresses two questions relevant to such cases:

- ???Are the IROs subject to ERISA's fiduciary duties when they make final and binding benefit determinations?
- ???What standard of review will courts apply to benefit claims denied by plan administrators and IROs?

ERISA's Benefit Claims Procedures

ERISA requires that every employee benefit plan contain written administrative claim procedures to ensure "full and fair review" to participants whose claims for benefits have been denied.[2] The purpose of ERISA's internal review process is to reduce litigation and thereby reduce the cost of benefit claim disputes.[3]

The existing Department of Labor regulations governing ERISA benefit claims establish procedures for the organized flow of information between ERISA plan administrators and claimants during the internal review process.[4] During the exhaustion process, claimants challenge "adverse benefit determinations." The exhaustion process concludes when a named fiduciary, generally bestowed with discretionary authority to interpret the plan, renders a final and binding benefit decision. Courts require that claimants exhaust these internal claims procedures as a prerequisite to filing suit.[5]

Amendment of ERISA's Claims Procedures to Require External Review

One of the ways that ACA amended ERISA was that it mandated an additional and binding external level of claims review by IROs.[6] In relevant part, except for plans that are considered grandfathered plans, ACA requires that health insurance issuers, including self-insured group health plans, "implement an effective external review process that meets minimum standards established by the Secretary."[7]

Under the ACA, the Secretaries of the Internal Revenue Service, the Department of Labor and the Department of Health and Human Services share authority to promulgate regulations. On July 22, 2010, the Secretaries issued interim final regulations regarding the ACA's external review processes.[8] Among other changes, the interim final regulations expanded the definition of "adverse benefit determination" and established the framework for state and federal external review protocols.[9]

Under the interim final rules, external review applies to any adverse benefit determination, except for benefit denials based on the claimant's lack of eligibility to participate in the health plan.[10] Plans must now contract with IROs to provide external review following exhaustion of the traditional internal administrative claims procedures.[11]

Although IRO determinations are generally final and binding on the plan and claimant, participants and the plans may challenge them pursuant to other state or federal laws, such as ERISA.[12] Accordingly, claimants who are denied benefits during internal and external review may presumably still rely on ERISA's private cause of action to seek reversal of the adverse benefit determination in federal court.[13] Similarly, plans may have remedies against IROs that, for example, grant benefit claims in contravention of the terms of the governing plan.[14]

On Aug. 23, 2010, and June 22, 2011, the DOL issued additional guidance for ERISA group health plans, including self-insured plans, regarding the new external review procedures.[15] This guidance noted that IROs must review
claims de novo and are not bound by any decisions or conclusions reached during the plan's internal claims process.[16] Although IROs may not defer to the decisions of plan administrators, it is not clear whether federal courts may defer to IRO determinations.

On June 24, 2011, based on public comments, the Secretaries of the IRS, DOL and HHS promulgated amendments to the interim final regulations to assist with implementation of the external review mandate.[17] The amendments temporarily narrow the scope of adverse benefit determinations subject to external review, pending further guidance, to give plans time to implement the new processes.[18]

Currently, the claims eligible for external review are those involving medical judgments and rescission of coverage.[19] The amendments, however, did not address the fiduciary status of IROs, and the DOL did not comment further on the appropriate standard of review once participants challenge IRO benefit claim denials in court.

ERISA's Fiduciary Duties: Do IROs Possess Discretionary Authority?

ERISA divides benefit plan administration into two camps: fiduciary and nonfiduciary. Fiduciaries have authority to interpret the plan and make final and binding benefit determinations.[20] In contrast, nonfiduciaries partake in day-to-day ministerial functions, such as drafting and sending notices to participants and calculating benefits owed.[21]

ERISA provides that a person is a fiduciary with respect to a plan to the extent that "he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets ... or he has any discretionary authority or discretionary responsibility in the administration of such plan."[22]

It is well established that benefit claim determinations are the province of ERISA fiduciaries because such determinations require the exercise of discretionary authority. As noted by the Supreme Court: "the ultimate decisionmaker in a plan regarding an award of benefits must be a fiduciary and must be acting as a fiduciary when determining a participant's or beneficiary's claim."[23]

In response to the interim final regulations, and related guidance from the DOL, industry groups have asked for clarification regarding the fiduciary status of IROs. Specifically, the ERISA Industry Committee (ERIC) and the American Benefits Counsel (ABC) note that fiduciary status "is centrally important in defining the scope of the IRO's authority and responsibility" because
ERISA fiduciaries are obligated to follow plan terms when making
benefit determinations.[24]

Both ERIC and ABC note that the ACA's external review processes place IROs in the role traditionally occupied by plan administrators because IROs now make final and binding benefit determinations.[25] Thus, the industry groups assert that ERISA's fiduciary duties should attach to IRO decisionmaking.[26]

Current Supreme Court precedent arguably supports the conclusion that IRO decision-making is fiduciary in nature under ERISA. In *Pegram v. Herdrich*,[27] the Supreme Court ruled that medical judgments, and even mixed decisions involving medical treatment and benefit eligibility, when done by the medical provider, were not subject to ERISA's fiduciary duties.[28] However, in *Aetna Health Care v. Davila*,[29] the Court clarified that even decisions involving medical judgment to resolve claims remained fiduciary decisions when they are made by someone other than the medical provider.

Regardless of whether the Secretaries issue additional guidance in response to the requests from industry groups, the fiduciary status of IROs will likely be litigated. Under the current, suspended scope of external review, IROs are limited to reviewing medical judgments and rescissions but may still be deemed fiduciaries after *Davila*. Once the suspension period is lifted, the broader array of benefit denials subject to review by IROs will provoke a renewed inquiry into their fiduciary status that is again likely to be resolved by litigation.[30]

Firestone and the Deferential Standard of Review

For ERISA-governed plans, IRO determinations may be challenged by plan participants as contrary to the plan's terms and/or procedurally flawed. The seminal ERISA standard of review case was *Firestone Tire & Rubber Co. v. Bruch*[31], under which federal courts applied the arbitrary and capricious standard to benefit claim cases when the governing ERISA plan bestows discretionary authority upon the plan administrator. Otherwise, benefit determinations are reviewed de novo.[32] In *Metropolitan Life Ins. Co. v. Glenn*, [33] the Supreme Court reaffirmed that the arbitrary and capricious standard applied to the review of ERISA benefit claims.[34]

Even where the plan confers discretionary authority, though, determinations may be subject to de novo review where such so-called "discretionary clauses" are unenforceable. Discretionary clauses are prohibited by some state laws (and by the standards of the National Association of Insurance Commissioners), and these prohibitions may render those provisions unenforceable, even those in ERISA-governed insured plans.[35]

Deferential Review of IRO Determinations?

As noted above, IROs are required to review each benefit claim de novo,[36] but the question remains as to the appropriate standard of review courts will apply to the IROs' benefit determinations. If plans do not confer discretionary decision making authority upon IROs, courts may apply the de novo standard since *Firestone* required the plan to confer discretionary authority to trigger abuse of discretion review. On the other hand, if plans confer discretionary authority upon their IROs, then *Firestone* provides good grounds to argue that courts should review IROs decisions deferentially, *i.e.*, for an abuse of discretion.[37]

An additional argument for deferential judicial review of IRO determinations arises from the governing regulations and agency guidance. Because current guidance explicitly provides for IRO determinations on claims involving medical judgments,[38] which are inherently discretionary decisions, IROs may be viewed as bestowed with discretionary authority.

Conclusion

Courts have yet to confront key litigation questions arising from the ACA's new external claims review mandate for nongrandfathered ERISA-governed plans. Under current case law, IROs will likely be considered fiduciaries, and thus, be subject to ERISA's fiduciary duties and liable under ERISA's remedial scheme for their benefit determinations.

Although it is certain that IRO determinations will be challenged in court, it remains to be seen whether plans will bestow discretionary authority upon IROs. If ERISA plans grant such authority to IROs, courts will then need to decide whether *Firestone*'s arbitrary and capricious standard of review covers IRO decision-making.

If plan sponsors and fiduciaries decide to require class action waivers, arbitration agreements should expressly state that claims in arbitration are limited to individual claims. These polices should appear in the plan document and summary plan description and should be made clearly known to all participants and beneficiaries.

Rulings, Filings, and Settlements of Interest

Preemption

???In *Access Mediquip, L.L.C. v. UnitedHealthcare Insurance Co.*, — F.3d —, No. 10-20868, 2012 WL 4747260 (5th Cir. Oct. 5, 2012), the Fifth Circuit, *en banc*, held that ERISA does not preempt a third-party medical provider's state law claims based on a health plan insurer's misrepresentations of coverage. As reported in our September newsletter, Access alleged that it provided services in reliance on UnitedHealthcare's representations regarding how much, and under what conditions, UnitedHealthcare would pay Access for those services, and UnitedHealthcare breached its obligations and representations to Access by failing and refusing to pay and/or reimburse Access for such services. The district court held that Access's claims for negligent misrepresentation, promissory estoppel, and violations of the Texas Insurance Code based on UnitedHealthcare's misrepresentations were not preempted by ERISA Section 514. In so ruling, the district court distinguished between claims based on the *extent* of coverageand those based on the *existence* of coverage. On appeal, a three-judge panel rejected that distinction, and instead framed the dispositive issue as whether the state law claims are "dependent on, and derived from the rights of [the beneficiaries] to recover benefits under the terms of their ERISA plans." The panel held the claims were not preempted because the merits of Access's misrepresentation claims did not depend on whether its services were fully covered under the beneficiaries' plans; the state laws underlying Access's misrepresentation claims did not purport to regulate what benefits UnitedHealthcare provided 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; and the state law claims concerned the relationship betweenthe plan and third-party, non-ERISA entities who contact the plan administrator to inquire whether they can expect payment for services they are considering providing to an insured. On rehearing, the *en banc* panel agreed, and overruled three prior opinions to the extent they were inconsistent with its opinion.

???In *Loffredo v. Daimler AG*, No. 11-1824, 2012 WL 4351358 (6th Cir. Sept. 25, 2012), the Sixth Circuit held that ERISA preempts state law claims for breach of fiduciary duty, promissory estoppel, and silent fraud brought by former Chrysler executives, but reinstated their age discrimination claim. Plaintiffs lost most of their benefits in their top-hat plan after Chrysler declared bankruptcy. Plaintiffs alleged the plan would have survived the bankruptcy if properly managed, and that its assets purchased annuities to replace the benefits of some younger, active executives in the plan. The Sixth Circuit affirmed the lower court's decision that ERISA preempted most of their claims, finding that plaintiffs': (1) breach of fiduciary claims were preempted, even against non-fiduciaries, because state law may not create an alternative to ERISA; (2) fraud claims, based on an alleged state law duty to disclose Chrysler's financial position, were preempted as conflicting with ERISA's

reporting and disclosure provisions, and also failed because no such duty exists under state law; and (3) promissory estoppel claims were preempted as duplicative of, or an impermissible alternative to, ERISA — and failed because no broken promise was alleged. Notably, the judges disagreed as to whether the state law claims were *expressly* preempted under ERISA Section 514 or *completely* preempted by way of Section 502. The court also held that amending the complaint to assert ERISA claims would be futile because plaintiffs did not allege they were entitled to benefits under the terms of the plan, or that defendants had particular funds that rightfully belonged to them. Finally, the court found that plaintiffs' age discrimination claim was not preempted because ERISA does not preempt other federal laws or state laws that enforce them.

Benefits Litigation

- In *American Dental Ass'n v. WellPoint Health Networks*, No. 11-11208, 2012 WL 5233562 (11th Cir. Oct. 23, 2012), the Eleventh Circuit affirmed the district court's decision to grant summary judgment in favor of an insurance company where an out-of-network service provider failed to exhaust administrative remedies challenging a partial benefit denial prior to filing a class action lawsuit. After the insurer (WellPoint) made only partial reimbursement for an out-of-network service charge, the provider sent WellPoint a letter requesting "documentation of the data" used to calculate WellPoint's usual, customary and reasonable rates. WellPoint provided the basis for its calculations, and instructed the provider to contact its customer service department with any further questions. The provider then joined with the American Dental Association to bring a class action challenging WellPoint's method for determining customary reimbursement rates. The district court entered judgment on a magistrate judge's recommendation, finding the provider had not exhausted his administrative remedies. The Eleventh Circuit affirmed, noting that the provider's letter did not convey any demand for review or affirmative challenge to WellPoint's decision, and thus did not trigger the administrative review process. The court also rejected the provider's contention that any appeal would have been futile, noting that the provider's failure to seek review left the court to speculate as to what WellPoint would have conducted a thorough and adequate review.

- In *Advanced Rehabilitation, LLC v. UnitedHealth Group, Inc.*, No. 11-4269, 2012 WL 4354782 (3d Cir. Sept. 25, 2012) (unpublished), the court affirmed dismissal of plaintiff's first amended complaint for failure to state a viable cause of action. Plaintiffs, out-of-network health care providers, filed suit seeking reimbursement for providing a medical procedure called manipulation under anesthesia (MUA). Plaintiffs alleged that defendant routinely denied payment for MUA because this procedure was considered "experimental" and not "medically necessary." The court

ruled that plaintiffs failed to satisfy *Twombly's* pleading standards because defendant had discretionary authority to make benefit determinations, and plaintiffs offered merely "naked assertions" that MUA was a benefit covered under the plans at issue. The court also found that plaintiff's claim that defendant had a company-wide policy of routinely denying claims without regard to the merits of individual claims fell short of plausibility because if MUA procedures were either "experimental" or not "medically necessary," then the routine denial of payment for MUA may have been proper under the terms of the plans.

- In *A.J. v. UNUM*, No. 11-3578-cv, 2012 WL 5055132 (8th Cir. Oct. 19, 2012) (per curiam), the Eight Circuit affirmed a ruling holding that children of the insured decedent lacked standing to recover proceeds from an accidental death policy. The insurer (Unum) denied the estate's claim on the ground that the decedent had engaged in unlawful conduct that contributed to his own death. The administrator of the decedent's estate failed to appeal this denial. Decedent's children brought suit as putative beneficiaries, arguing that they "may become entitled to benefits" (and thus fall within ERISA's definition of a beneficiary) because the Unum plan gave Unum the right to pay family members, instead of the estate, where no beneficiaries were named. The district court rejected this argument and the Eight Circuit agreed, reasoning that there was no colorable claim to benefits because the estate elected not to appeal the denial of benefits, in order to preserve estate assets. Accordingly, there was no timely claim for benefits outstanding, and thus no potential entitlement to benefits.

Section 510 Claims

- In *Shrable v. Eaton Corp.*, No. 12-1404, — F.3d —, 2012 WL 4511621 (8th Cir. Oct. 3, 2012), the Eighth Circuit affirmed dismissal of a Section 510 claim, rejecting plaintiff's assertions that his complaints about retirement programs led to his termination. After plaintiff had received multiple reprimands and been placed on a performance improvement plan, the employer (Eaton) terminated plaintiff's employment in July 2009. Plaintiff brought suit, claiming Eaton fired him for criticizing changes to Eaton's 401(k) plan in a January 2009 meeting. Emphasizing Eaton's showing that the changes were not formalized and announced to participants until February 2009 – a month after plaintiff claims to have made his comments – the court found plaintiff had not established any protected activity. In doing so, the Eighth Circuit declined to decide whether informal complaints warrant Section 510 protection, an issue which has split other circuit decisions reaching the issue. In addition, the court found that plaintiff had not shown any causal connection between his January 2009 comments and his termination in July 2009, and expressed doubt "whether a plaintiff may establish a prima facie case of

retaliation when termination occurs six months after the protected activity." Applying a virtually identical rationale, the court also dismissed retaliation claims under the Fair Labor Standards Act.

Attorneys' Fees

???In *Cross v. Quality Management Group, LLC*, No. 11-15146, 2012 WL 4465227 (11th Cir. Sept. 27, 2012) (unpublished), the court affirmed the lower court's ruling that neither party was entitled to attorneys' fees following settlement of a benefit claim. Plaintiff filed suit seeking entitlement to 100% of her retirement benefits after the plan maintained that she was only 60% vested. The parties reached an agreement that plaintiff would receive 75% of her benefits. Following settlement, both sides moved for fees under ERISA Section 502(g). The district court applied *Hardt v. Reliance Std. Life Ins. Co*., 130 S. Ct. 2149 (2010) to determine whether plaintiff achieved "some success on the merits," and then analyzed the fee claims in light of the Eleventh Circuit's pre-*Hardt* five-factor test. Plaintiff argued that the district court applied an improper legal standard in denying her fees by using the five-factor test and clearly erred in finding that the defendants did not litigate in bad faith and in assessing the participant's claims. The defendants argued that the district court abused its discretion in how it assessed the five-factor test to deny them fees. The Eleventh Circuit rejected plaintiff's argument that the district court committed clear error when applying the five-factor testl, finding that the Supreme Court held that once a court concludes that a party achieved "some success on the merits," a court may consider the five-factor test developed prior to *Hardt* in determining whether an award of fees and costs is appropriate. The Eleventh Circuit also found that there was not sufficient proof of deliberate wrongdoing to show that the district court
clearly erred.

Settlements

???In *Holling-Fry v. Coventry Health Care of Kansas Inc*., No. 07-cv-00092 (DGK) (W.D. Mo. Oct.12, 2012), the court granted final approval of a $2.67 million settlement resolving a class action lawsuit brought against Coventry Health Care. Plaintiffs alleged that Coventry violated Missouri law by charging copayments exceeding the statutory limit of 50% of the covered charge. In addition to the settlement payment, the company will pay $500,000 in attorneys' fees and a $7,500 class representative award.

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[1] The court questioned whether the language in *Curtiss-Wright/Lockheed/Hughes Aircraft* was "sufficiently related to the Court's ultimate rulings to be considered as holdings or only highly persuasive dicta," but, in any event, decided the language provided "ample justification" to abrogate the contrary statements in *Chambless* and *Siskind*.

* This article was published in the Expert Analysis section of Employment Law360, Healthcare Law360, Public Policy Law360, and Insurance Law360 on Oct. 9, 2012.

[1] *See* Rachal & Neulander, The Affordable Care Act and Its Coverage Mandates for Employers: A Potent Recipe for ERISA Class Actions *available* here(noting that ACA amends ERISA by creating Section 715, which in turn incorporates by reference ACA's coverage mandates); *see also* Shapiro, Napoli, Lincoln & Neulander, PPACA Victory Sets The Stage For New Wave of Litigation *available* here.

[2] ERISA § 503, 29 U.S.C. § 1133.

[3] *E.g., Edwards v. Briggs & Stratton Ret. Plan*, 639 F.3d 355, 360 (7th Cir. 2011) (noting ERISA's administrative claims procedures helps reduce frivolous lawsuits, promote consistency, and provide a non-adversarial method of claims settlement).

[4] *See* 29 C.F.R. § 2560.503.

[5] *E.g., Kennedy v. Empire Blue Cross & Blue Shield*, 989 F.2d 588, 594 (2d Cir. 1993) (noting the "firmly established federal policy favoring exhaustion of administrative remedies in ERISA cases") (internal quotation and citation omitted).

[6] ACA § 2719, 42 U.S.C. § 300gg-19 (amending the Public Health Service Act, and incorporated by reference into ERISA § 715, 29 U.S.C. § 1185d, requires internal and external appeals processes).

[7] *Id.*

[8] *See* 26 C.F.R. § 54.9815-2719T (IRS); 29 C.F.R. § 2590.715-2719 (DOL); and 45 C.F.R. § 147.136 (HHS).

[9] *Id.*; *see also* Proskauer Client Alert available here. Because of ERISA's broad preemption provisions, the interim final regulations mandated both state and federal external review procedures, to cover health insurance issuers subject to state law, and self-insured ERISA plans subject to federal law. *See* DOL Tech. Rel. 2010-01 (providing compliance standards, *i.e.*, safe-harbor, for non-grandfathered self-insured group health plans not subject to state law).

[10] *See* 29 C.F.R. § 2590.715-2719(d)(1).

[11] *See* DOL Tech. Rel. 2010-01 (noting that group health plans must contract with three different IROs and rotate claims among the IROs to reduce the potential for biased decisionmaking).

[12] 76 FR 37208-01 at 37217, *available* here; 29 C.F.R. § 2590.715-2719(d); *see also* National Association of Insurance Commissioners, Uniform Health Carrier External Review Model Act, at 76-58, § 11 (2010), *available* here.

[13] ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B).

[14] *E.g.,* ERISA § 502(a)(2), 29 U.S.C. § 1132(a)(2); ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3).

[15] DOL Tech. Rel. 2010-01 (Aug. 23, 2010) (noting that each ERISA plan's external review procedures must follow the Uniform Health Carrier External Review Model Act promulgated by the National Association of Insurance Commissioners (NAIC Model Act) to satisfy ACA's requirements); DOL Tech. Rel. 2011-02 (summarizing ACA's external claims review "consumer protection standards").

[16] DOL Tech. Rel. 2010-01, p. 7.

[17] 76 FR 37208-01, *available* here; DOL Tech. Rel. 2011-02, *available* here.

[18] *Id.*

[19] *Id.*

[20] *Aetna Health Inc. v. Davila*, 542 U.S. 200, 218-20 (2004).

[21] 29 C.F.R. § 2509.75-8, Q&A D-2 (non-fiduciary, ministerial functions include: determining eligibility for benefits, calculating benefit payments, and making recommendations to others for decisions with respect to plan administration).

[22] ERISA § 3(21), 29 U.S.C. § 1002(21).

[23] *Davila*, 542 U.S. at 218 (noting benefit determinations are generally fiduciary acts: "a benefit determination is part and parcel of the ordinary fiduciary responsibilities connected to the administration of a plan"); *see also Pegram v. Herdrich*, 530 U.S. 211, 231 (2000) (noting "fiduciary duties characteristically attach to decisions about managing assets and distributing property to beneficiaries").

[24] Comments of the ERISA Industry Committee On The Interim Final Regulations Relating to Internal Claims and Appeals And External Review Processes; Comments of the American Benefits Council.

[25] *Id.*

[26] *Id.*

[27] 530 U.S. 211 (2000).

[28] *Id.* at 232-37.

[29] 542 U.S. 200, 219 (2004).

[30] IROs will likely face litigation and liability regardless of fiduciary status. When IROs contract with ERISA plans to provide external review, they assume a certain amount of liability to perform according to the terms of the plan and accepted medical standards. *See e.g., Autonation, Inc. v. United Healthcare Ins. Co.*, 423 F. Supp. 2d 1265 (S.D. Fla. 2006) (denying motion to dismiss, in part, where ERISA plan asserted state and federal law claims against service provider for overpaying benefits to participants). The contracts between IROs and ERISA plans may also provide that IROs will reimburse the plans for any determinations that, *e.g.*, violate the standards, ERISA itself, or arise from gross negligence. Thus, ERISA plans may be able to pursue various state and federal claims against IROs.

[31] 489 U.S. 101 (1989) (holding courts must defer to benefit decisions of plan administrators, so long as the governing plan document bestows discretionary authority upon the administrator).

[32] *Id.*

[33] 554 U.S. 105 (2008).

[34] *Id.* at 115-16.

[35] *See* Russell L. Hirschhorn & Charles F. Seemann III, A Year-End Review On The Enforceability Of State Bars To Discretionary Clauses (2010) (explaining that Montana and Colorado, as well as the National Association of Insurance Commissioners ("NAIC"), prohibit discretionary clauses in insurance contracts), *available* here.

[36] DOL Tech. Rel. 2010-01, p. 7.

[37] It is important to note that state laws governing the standard of review, at least for insured plans, would likely be enforceable and not preempted by ERISA. *See* Hirschhorn & Seemann, *supra* note 36.

[38] *See* 76 Fed. Reg. 37,208, 37,216 (June 24, 2011) (to be codified at 29 C.F.R. part 2590). Again, whether the statute and governing regulations will be viewed as granting discretionary authority to IROs will be resolved by litigation. Also, it seems that a statutory grant of discretionary authority could conflict with a state law bar on discretionary clauses in insurance policies, which could then be unenforceable.

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