

*Presenting a live 90-minute webinar with interactive Q&A*

## ERISA Denial of Benefits Litigation

Navigating Exhaustion of Administrative Remedies, Discovery,  
Deference to Administrator's Decision, Statute of Limitations, and More

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TUESDAY, MAY 14, 2013

1pm Eastern | 12pm Central | 11am Mountain | 10am Pacific

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Today's faculty features:

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Victoria V. Johnson, Partner, **Davis Graham & Stubbs**, Denver

Nancy Pridgen, Partner, **Monnolly Pridgen**, Atlanta

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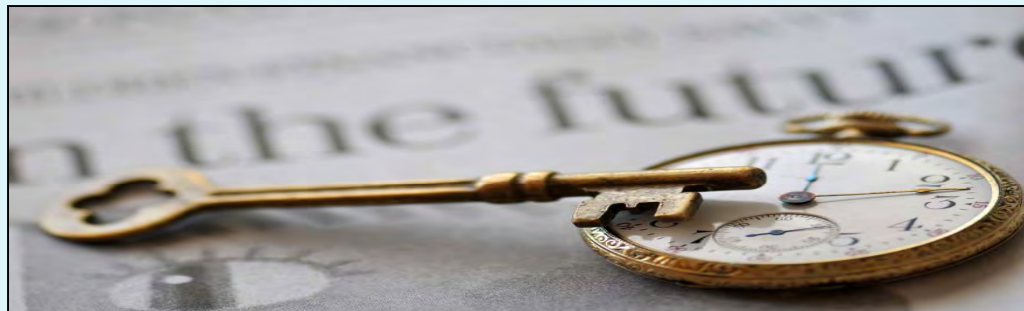


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ERISA Denial of Benefits Litigation

Administrative Remedies

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# ERISA Litigation – Developments and Practical Advice

## Outline and Overview

1. *Big Bang for the Buck*– Exhaustion of Remedies and the New ACA Claims Requirements.
1. *Something Old, Something New*– Attorneys fees awards and Potential Claim Remedies, Fee Shifting and the impact of CIGNA v. Amara

# **1. Exhaustion of Remedies Including Process after the Affordable Care Act**

## **The Basics A Review - ERISA Claims Procedure, ERISA Section 503; 29 C.F.R. §2560.503-1**

Obligation to Establish – Regulations state the minimum requirements:

- ✓ All procedures must be stated in the SPD;
- ✓ They cannot inhibit or hamper the start of the process (such as a fee);
- ✓ Must permit and authorized representative to help;
- ✓ Must have safeguards to verify consistent application; and
- ✓ If subject of collective bargaining, they may include the bargained process, including any grievance or arbitration.

# 1. Exhaustion of Remedies Including Process after the Affordable Care Act

## Obligation to Establish (cont'd)

### A reasonable procedure must:

- Not require more than two appeals prior to civil action (except External Review – see below;
- May not contain any mandatory arbitration rule unless included in the two appeal levels and may not restrict civil actions; and
- May permit voluntary appeals, as long as:
  - the plan waives any right to claim exhaustion if there is no voluntary appeal filed;
  - plan tolls statute of limitations during voluntary appeal;
  - claimant files voluntary appeal after first two appeal levels; and
  - plan discloses voluntary appeal process fully and does not charge.



# 1. Exhaustion of Remedies Including Process after the Affordable Care Act

## Timing of Benefit Determination

1. Notice of adverse determination within the required period (see chart);
2. May be extended if Plan Administrator determines that extension is necessary due to matters beyond control. Watch timing of extension and how it may occur and in what period
3. Must notify of extension before first period expires; and
4. May be extended for another period – see chart.

# 1. Exhaustion of Remedies Including Process after the Affordable Care Act

Timing considerations (cont'd)

In the case of an extension (WATCH THESE REQUIREMENTS) , notice must specifically:

- ✓ Explain the standards on which entitlement to benefits is based;
  - ✓ State the unresolved issues that prevent a decision;
  - ✓ If additional information is needed to resolve the issues it must be stated; and
  - ✓ If such information is to come from the claimant, – claimant must be given minimum period to respond.
- Period of Time may be tolled when waiting for claimant to respond to request for information, but only from the date of an extension.

**Practice Hint: Always follow the Plan and SPD**

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# 1. Exhaustion of Remedies Including Process after the Affordable Care Act

## Content of the Notice of Denial

Notification must be in writing, and must contain:

- ❖ Specific reasons for the denial;
- ❖ Plan provisions relied upon for the decision;
- ❖ Description of what claimant needs to perfect the claim, and why such items are necessary;
- ❖ Description of plan's review procedure and time limits, including a statement of right to bring suit following appeal;
- ❖ If any rule, guideline or protocol or similar criteria was used, it must be provided, or a statement must be provided making these items available free of charge upon request;
- ❖ If denial was based upon medical judgment, an explanation of the use of the medical information as it applies under the Plan and its application to the claimant's circumstance, or a statement that such information will be provided free upon request. upon request.

# 1. Exhaustion of Remedies Including Process after the Affordable Care Act

Appeal of an Adverse Determination (a denial)

**Full and Fair Review – the procedure must:**

- ☐ Provide claimants the opportunity to submit written comments, documents records and other;
- ☐ Provide that claimants shall be given free of charge, reasonable access to and copies of documents, records and information with respect to the claim that is relevant; and
- ☐ Provide for a review that permits comments and the submission of documents related to the claim, regardless of whether such was submitted at the initial determination phase.

# 1. Exhaustion of Remedies Including Process after the Affordable Care Act

## Additional Process Requirements:

- ❖ Claimants must have 180 days to file an appeal;
- ❖ The review must “not afford deference to the initial adverse benefit determination and [be]...conducted by an appropriate named fiduciary of the plan who is neither the individual who made the adverse determination..., nor the subordinate of such individual;
- ❖ If medical judgment is involved, the named fiduciary must consult with a medical professional with appropriate training and experience;
- ❖ Provide for identification of the medical or vocational experts used; and
- ❖ The medical professional in (iii) must not be the same and must not be a subordinate of that professional.

# 1. Exhaustion of Remedies Including Process after the Affordable Care Act

## Appeal Timing - **Timing and Notification of the Benefit Determination on review:**

- Unless tolled, the claimant must be notified of the decision on review (appeal) within a reasonable time, but no later than the applicable period (chart) after receipt of the claimants request for review.
- If the administrator determines that special circumstances require and **extension of time**, then additional time is permitted – follow rules.
- The extension notice must **indicate the special circumstances requiring** the extension of time and the date by which the plan expects to render its determination.
- Time **begins when the appeal is filed** regardless if all information is provided by the claimant.
- The period may be tolled only in the event that the period of time is extended due to a claimants failure to submit necessary information. It is **tolled from the date that notice of the extension** is sent until the claimant responds.

# **1. Exhaustion of Remedies Including Process after the Affordable Care Act**

## **Manner and Content of Notice of Determination on Review (Appeal)**

Notification must be in writing, and must contain:

- ❖ Specific reasons for the denial;
- ❖ Plan provisions relied upon for the decision;
- ❖ A statement that the claimant may receive on request and free of charge, access to and copies of documents regarding the claim.
- ❖ A statement describing any voluntary appeals procedure offered by the plan
- ❖ A statement of right to bring suit following appeal;
- ❖ If any rule, guideline or protocol or similar criteria was used, it must be provided, or a statement must be provided making these items available free of charge upon request;
- ❖ If denial was based upon medical judgment, an explanation of the use of the medical information as it applies under the Plan and its application to the claimant's circumstance, or a statement that such information will be provided free upon request. upon request



# 1. Exhaustion of Remedies – Standard Timing

<u>Description</u>	Timing Rules Effective 1/1/02 Medical and Disability Plans				Pension Plans
	Urgent Care Claim	Preservice Claim	Post-Service Claim	Disability Claims	Pension
Claim Beginning Time	When Claim Is Filed				
Notice of Improperly Filed Claim	ASAP < 24 hours	ASAP < 5 days	N/A	N/A	N/A
Claimant Claim Cleanup Time	Not less than 48 hours	At least 45 days	At least 45 days	At least 45 days	N/A
Plan Initial Determination	ASAP, <48 hours after earlier of receipt of information to “clean up” improperly filed claim or end of claimant claim clean up time (clean claim) <72 hours if initial claim not improperly filed	15 days (may extend 15 days x1)	30 days (may extend 15 days x1)	45 days (may extend 30 days x2)	90 days (may extend 90 days x1)
Claimant Appeal Deadline	180 days	180 days	180 days	180 days	60 days
Plan 1 <sup>st</sup> Level Appeal Response Time	72 hours	15 days	30 days	45 days	60 days (may extend 60 days x 1)
Plan 2 <sup>nd</sup> -Level Appeal Response Time (Only Two Appeals can be Required)		15 days	30 days	45 days	60 days
Plan Extension Time	48 hours	15 days	15 days	45 days with extension (30 days initial level; 45 days appeal level)	60 days with extension
Review/Appeal Maximal Limit	72 hours	30 days (one Appeal) 15 days (two appeals) - for each	30 days (two appeals) 60 days (one Appeal) - for each	90 days without billing	120 days

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# 1. Exhaustion of Remedies - Affordable Care Act

## Internal and External Review Requirements – Medical Plans

The Basics: Non-grandfathered medical plans must have an external review process. If state has process that meets the regulatory requirements, then use the state process. Otherwise, the federal general process is used.

Adds: Another layer of claims review and extends the timing of resolution of claims beyond the second level denial

Basis: ERISA 715(a), Public Health Services Act Sec. 2719  
29 CFR 54.9815-2719T  
29 CFR 2590.715-2719  
45 CFR 147.136

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# 1. Exhaustion of Remedies - Affordable Care Act

## Basic Process Requirements

- Claimant receives notice of right to elect external review if the claim file reflects certain types of medical rationale is involved in claim denial
- Claimant has period of time to elect external review (see timing considerations below)
- Claimant requests external review
- File is sent to external review Independent Review Organization (“IRO”) which is one of three IRO entities contracted with the Plan
- IRO conducts review and makes written determination on specified forms
- Claimant is notified of decision and plan **MUST** follow decision of IRO

# 1. Exhaustion of Remedies - Affordable Care Act

## Selection of IRO –

- ❖ Plan sponsor must select 3 IRO providers and rotate amongst the three. (Should vet and have written contracts)
- ❖ IRO must be URAC (Utilization Review Accreditation Certification) Certified
- ❖ Plan must bear cost of delay in decision and cost of IRP review

# 1. Exhaustion of Remedies - Affordable Care Act

## Process

- Claimant has 120 days to file for External Appeal
- Claim must be sent to IRO for review promptly
- IRO result due in 45 days
- Plan Must Follow IRO response.

## Timing Impact

- ❑ Old claim Process took up to 140 Days
- ❑ New Process can take up to 310 Days.



## **ERISA DENIAL OF BENEFITS LITIGATION:**

Standard of Review, Scope of Conflict Discovery, and Other Discovery Issues

May 14, 2013

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## ■ Basics

- Usually deferential to Plan administrator and fiduciary
- Deference is dependent on having certain Plan language
- Less deference if there is a conflict of interest
- No deference if key language not in Plan



## SUMMARY OF THREE STANDARDS OF REVIEW

- *De Novo*
  - No discretion in Plan
- Arbitrary and capricious
  - Discretion in Plan
- Heightened arbitrary and capricious
  - Due to a conflict of interest

*Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989);  
*Metropolitan Life Ins. V. Glenn*, 554 U.S. 105 (2008)

*But see Capone v. Aetna Life Ins. Co.*, 592 F.3d 1189 (11<sup>th</sup> Cir. 2010),  
Articulating a six-part analysis

## DEFERENTIAL STANDARD OF REVIEW

- Look at Plan language
  - Arbitrary and capricious standard of review if Plan gives administrator or fiduciary discretionary authority to:
    - determine eligibility for benefits or
    - construe Plan terms
  - Firestone v. Bruch*, 489 U.S. 101 (1989)
  - Administrator's interpretation of Plan upheld if reasonable
  - Decision will not be disturbed unless an abuse of discretion or not supported by substantial evidence



- Deference on re-review?
  - If initial interpretation of Plan was an abuse of discretion, deference must be given to the second interpretation of Plan
  - Standard applies if administrator did not act in bad faith or with dishonesty

*Conkright v. Frommert*, 559 U.S. 506 (2010)

## NO DEFERENCE

- If Plan does not provide discretion, review is *de novo*
  - Court reviews Plan documents without deference to interpretation by Plan administrator
  - Similar to a review of a contract claim
- Also, no deference is given to decisions on questions of law



## HOW DOES CONFLICT OF INTEREST CHANGE DEFERENCE?

- Dual conflict of interest
  - Classic: Plan administrator both evaluates claims and funds benefits under a Plan
    - Fiduciary interest may counsel in favor of granting a borderline claim but the immediate financial interests counsel against it
    - Applies even if the Plan administrator is a professional insurance company, but facts might diminish the conflict
      - *Met. Life Ins. Co. v. Glenn*, 128 S. Ct. 2343 (2008).



## CONFLICT OF INTEREST - LESS DEFERENCE

- What does less deference mean post *Glenn*?
  1. Sliding scale approach to review
    - Conflict weighed as a factor in determining whether there has been an abuse of discretion. *Weber v. GE Group Life Assurance Co.*, 541 F.3d 1002 (10<sup>th</sup> Cir. 2008)



## CONFLICT OF INTEREST - LESS DEFERENCE, CONT'D

### 2. Modified sliding scale approach

- Two part test to obtain less deference
  - A palpable conflict of interest or serious procedural irregularity
  - Caused a serious breach of Plan administrator's duty
- *Barnhart v. UNUM Life Ins. Co. of Am.*, 179 F.3d 583 (8<sup>th</sup> Cir. 1999)

### 3. No sliding scale

- Deferential abuse of discretion but conflict is a consideration

*Estate of Schwing v. Lilly Health Plan*, 562 F.3d 522 (3d Cir. 2009)

# Preparing to Win the Procedural Battles in ERISA Benefits Litigation



## ERISA DENIAL OF BENEFITS LITIGATION

MAY 14, 2013

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# Overview

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- ***Removal***
- ***Preemption***
- ***Statutes of Limitation / Plan-Based Limitations Periods***
- ***Motion Practice / Trial***

# Removal

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- ***Federal Courts Jurisdiction And Venue Clarification Act of 2011***

Pub. L. No. 112-63, 125 Stat. 758 (codified at 28 U.S.C. §§ 1332, 1390, 1391, 1404, 1441, 1446, 1453, 1455) (effective for all cases commenced on or after January 6, 2012)

- ***Eliminates “First-Served Defendant” Rule***
- ***“Separate and Independent” State Law Claims Severed, No Jurisdiction***



# Removal

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- ***Citizenship of Corporations & Insurers***
  - Corporations are citizens of every state of their incorporation and their principal place(s) of business.
    - ✦ *Denies diversity jurisdiction in: (1) an action between a foreign corporation with its principal place of business in U.S. state and a citizen of the same state; and (2) a suit between a citizen of a foreign country and a U.S. corporation with its principal place of business abroad.* H.R. Rep. No. 112-10, at 9.
  - 28 U.S.C. § 1332(c)(1)(A): in direct actions against insurers, insurer is deemed citizen of “every [vs. any] State” of which insured is citizen
    - ✦ *So Does Diversity Jurisdiction Still Exist for ERISA Insurers?*

# Removal

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- ***Is an ERISA claimant's benefits lawsuit ever a "direct action" against an insurer?***
  - *Kenyon v. Fidelity & Guar. Life Ins. Co.*, 2012 WL 4478983 (M.D. Fla. Sept. 11, 2012) (action to recover *life insurance benefits*)
  - *Jeffers v. MetLife Ins. Co.*, 2013 WL 1411832 (M.D. Tenn. Mar. 25, 2013) (action to recover *disability benefits*)
  - *Ward v. North Pointe Ins. Co.*, 2013 WL 1315970 (S.D. Ohio Mar. 29, 2013) (defendant was *conceding* to remand!)

# Recurring ERISA Preemption Issues

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- ***“Safe Harbor” Litigation Abounds***

- *Young v. Paul Revere Life Ins. Co.*, 2013 WL 791547 (W.D.La. Mar. 4, 2013) (established/maintained); *Alquahwagi v. Shelby Enters., Inc.*, 2013 WL 685376 (E.D.Mich. Feb. 25, 2013 (endorsement); *McCann v. Unum Provident*, 2013 WL 396182 (D.N.J. Jan. 31, 2013) (employer contribution); *Taylor ex rel. Estate of Thomson v. Zurich Am. Ins. Co.*, 2012 WL 5031738 (D. Ariz. Oct. 18, 2012) (employer contribution).

- ***Provider Claims against Health Insurers***

- District Court ruled state law claims not preempted: *Seasons Hospice v. Aetna Inc.*, 2013 WL 789178 (D. Del., Mar. 4, 2013). District Court drawing distinction between assignment of *benefits* and assignment of *rights*: *Sanctuary Surgical Centre, Inc. v. UnitedHealth Group, Inc.*, 2013 WL 149356 (S.D. Fla. Jan. 14, 2013) (dismissing, but not on preemption grounds).

- ***Insurance Comm’rs Banning Discretionary Clauses***

- CA, CT, HI, ID, IL, IN, KY, MD, ME, MI, MN, NJ, NY, OR, SD, TX, UT, VT, WA, WY

# Potential Preemption Issues Raised by ACA

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- ***Preemption Issues raised by ACA***

- Mandatory benefit content, appeals procedures and penalties for non-compliance (apply to insured and self-funded plans) – moot preemption?
- Plan fiduciaries may not be making the final determination (IRO)
- ERISA's preemption provisions not modified by ACA
- *Rush Prudential HMO v Moran*, 536 U.S. 355 (2002);  
*Aetna Health, Inc. v. Davila*, 542 U.S.200 (2004)

# Statutes of Limitation Issues

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- ***Benefits SoL = State Breach of Contract***
  - *Schumacher v. AK Steel Corp. Retirement Accumulation Pension Plan*, 711 F.3d 675, 682 (6th Cir. 2013) (pension claim (“whipsaw”); timely under most analogous state SoL); *Raymond v. Barry Callebaut, U.S.A., LLC*, 2013 WL 150232, \*2 (3d Cir. Jan. 15, 2013); *Kifafi v. Hilton Hotels Retirement Plan*, 701 F.3d 718, 728 (D.C. Cir. 2012); *Santaliz-Rios v. MetLife Ins. Co.*, 693 F.3d 57 (1st Cir. 2012); *Serton v. Lockheed Martin Corp.*, 459 Fed. Appx. 463, 465 (5th Cir. 2012); *Muto v. CBS Corp.*, 668 F.3d 53, 58 (2d Cir. 2012).
- ***Accrual Issues – exhaustion, discovery or earlier? Tolling? Forum State?***
- ***Add-On Fiduciary Breach Claims***
  - 29 U.S.C. § 1113 – three years (actual knowledge) or six years
  - Estoppel? *Cigna v. Amara* and its progeny

# Plan-Based Limitation Periods

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- ***Enforced Country-Wide if Reasonable***
  - *Heimeshoff v. Hartford Life & Acc. Ins. Co.*, 496 Fed. Appx. 129, 130 (2d Cir. 2012) (3 year limitations period began to run from when proof of loss was due, reasonable and enforceable under Connecticut law and ERISA); *Belrose v. Hartford Life & Acc. Ins. Co.*, 478 Fed. Appx. 21, 23 (4th Cir. 2012) (plan's 3 year limitations period applied, but did not begin to run until after claim was exhausted); *Gibbons v. Qwest*, 2012 WL 6022210 (D. Utah Dec. 04, 2012) (12 month limitations period enforced).
- ***Enforce Plan-Based Deadlines!***
  - *Gayle v. United Parcel Serv., Inc.*, 401 F.3d 222, 226 (4th Cir. 2005) (“[I]nternal appeal limitations periods in ERISA plans are to be followed just as ordinary statutes of limitations. Failure to file a request for review within [a plan’s] limitations period is one means by which a claimant may fail to exhaust her administrative remedies.”).
- ***Raise Early in Litigation [Rule 12(c)]***

# Motion Practice / Paper Trials

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- ***Effective/Strategic Use of Fed. R. Civ. P. 12(b) & (c)***
- ***Fed. R. Civ. P. 56 vs. 52 vs. Cross-Motions for Judgment on the Administrative Record***
- ***Trials (Bench vs. Jury)***

## 2012/13 Reminders – No Right to Jury Trial

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- *National Sec. Sys., Inc. v. Iola*, 700 F.3d 65, 79 n.10 (3d Cir. 2012) (no jury trial for (a)(3) claims); *Koehler v. Aetna Health Inc.*, 683 F.3d 182, 191 n.19 (5th Cir. 2012) (no jury right in benefits case); *Schacht v. BASF Corp.*, 2013 WL 1285928, \*2 n.1 (E.D. Mich. Mar. 28, 2013); *Espy v. Independence Blue Cross*, 2013 WL 1164364, \*4 (S.D. Cal. Mar. 20, 2013); *Albert v. Principal Fin. Group*, 2013 WL 1149521, \*2 (D. Minn. Feb. 25, 2013); *Edwards v. Alcoa, Inc.*, 2013 WL 589213, \*10 (E.D. Ky. Feb. 4, 2013); *Grevera v. Microsoft Corp.*, 2013 WL 460345, \*1 (W.D.N.C. Feb. 06, 2013); *Laslavic v. Principal Life Ins. Co.*, 2013 WL 254450, \*10 (W.D. Pa. Jan. 23, 2013); *Karns v. Disability Reins. Mgmt.*, 879 F.Supp.2d 1294, 1298 (N.D. Ala. July 19, 2012); *Humphrey v. Paul Revere Life Ins. Co.*, 2012 WL 928432 (D. Mass. Mar. 15, 2012); *Davis v. American Optical Corp.*, 2012 WL 639698 (W.D.N.Y. Feb. 27, 2012).



# Motion Practice / Paper Trials

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- *7th Circuit – de novo means full-blown bench trial, witnesses, new evidence, etc. See Krolnick v. Prudential Ins. Co., 570 F.3d 841 (7th Cir. 2009).*
- *2d Circuit – parties can elect a bench trial “on the papers” See O’Hara v. National Union Fire Ins., 642 F.3d 110, 116 (2d Cir. 2011) (no jury trial, but “[i]n some circumstances, it may be appropriate for the district court to treat [a motion for judgment on the AR] as requesting ‘essentially a bench trial “on the papers” with the [judge] acting as the finder of fact;” “[if not,] the [judge must] proceed in traditional summary judgment fashion”).*
- ***Oral Argument on Record; Other experiences?***

- Limited
  - Purpose of ERISA is to ensure a speedy, inexpensive and efficient resolution of claims
- General Rule: Discovery of administrative record only unless there exists a conflict of interest
- Some exceptions, such as on *de novo* review

- Extra record discovery
  - Burden on plaintiff to show that discovery is appropriate
- Discovery directed at investigating the conflict of interest



## EXAMPLES OF BURDEN OUTWEIGHING COST OF DISCOVERY

- Financial interest is obvious
- Evidence supporting denial is so one-sided that conflict would not change the result
- Court can evaluate thoroughness of review based on the administrative record



## WHAT DOCUMENTS REVIEWED BY COURT CAN DETERMINE SCOPE OF DISCOVERY

- Administrative Record
- Usually does not depend on deferential or *de novo* standard of review, but not always!
  - Extrinsic evidence considered on a *de novo* review
    - See, e.g., *Luby v. Teamsters Health, Welfare & Pension Tr. Funds*, 944 F.2d 1176 (3d Cir. 1991) (on *de novo* review court can consider whatever documents it finds necessary);
    - *Krolnik v. Prudential Ins. Co. of Am.*, 570 F.3d 841 (7<sup>th</sup> Cir. 2009) (on *de novo* review, look at record in litigation and, if conflicts, in trial)

- Under *de novo* review therefore, additional discovery may be permitted
  - See, e.g., *Rutherford v. Scene 7 Long Term Disab. Plan*, 2008 WL 2788191 (N.D. Cal. July 18, 2008) (deposition of doctor permitted on *de novo* review)

## 2. Attorneys Fees and Remedies

### Statutory Basis for Fees

- ✓ ERISA Section 502(g)(1) provides that in an action “by a participant, beneficiary or fiduciary, the court in its discretion may allow reasonable attorneys fees and costs to either party”
- ✓ Fees is a key component to claim litigation.
- ✓ Issue - Whether fees may only be awarded to a prevailing party, or what “prevailing party” means.

## 2. Attorneys Fees and Remedies

### The Standard Five (5) Factor Test:

Many Courts have applied a five (5) factor test in awarding fees. The five (5) factors are:

1. Degree of the losing party's bad faith or culpability.
2. Ability of the losing party to pay fees.
3. Deterrent effect of an award for fees.
4. Whether the claimant sought to confer a common benefits on all participants and beneficiaries in a plan or resolve a significant legal issue.
5. Relative merits of the parties' positions.



## 2. Attorneys Fees and Remedies

Determination of Fee Amounts. Loadstar Method – Hourly Rate x Hours

Court assesses reasonable hourly rates and reasonable number of hours. Use of the following factors is favored:

- Time and labor required
- Novelty of issues
- Skill related to services
- Preclusion of other employment by counsel
- Customary fee
- Whether fee is fixed or contingent
- Time limitations involved
- Amount at issue and result
- Experience and ability of attorneys involved
- Level of interest in case or claimant
- Duration of relationship with client
- Awards in similar cases.

Practical Hint:  
Plan's Lawyer  
Fees Will Be  
Impactful to  
Final Fee  
Amounts

## 2. Attorneys Fees and Remedies

When is there a prevailing party – when does one prevail on the merits?

Hardt v. Reliance Standard Life Ins. Co. U.S. Supreme Court Case No. 9-448

**Issue** – whether plaintiff who was awarded benefits on remand was entitled to attorneys fees

**Holding** – ERISA does not limit award to prevailing party

**Clarified** – standard for award was whether either party achieved some “success on the merits” – purely procedural victories are insufficient.

## 2. Attorneys Fees and Remedies

**Multi-Factor Test?** – Not required to determine whether to award fees.

**Really?** - Court in a footnote said that lower courts could consider multi-factor tests after they determine eligibility for an award of fees.

**Lower Courts in Review.** - Many lower courts have found that the Hardt standard of “success on the merits” is now step one of a two step process, where step two is their existing multi-factor tests.

## 2. Attorneys Fees and Remedies

Success on the Merits?

### 1. Success - Stipulated Order after lawsuit?

Yes – more than trivial success

Hackett v. Std. Life Ins. Co., (D. S. Dak. 2010)

### 2. Success – Limited Court Involvement after new evidence submitted?

No - no judicial findings of loss of benefits or whether denial was improper. No remand. New evidence caused reversal, not lawsuit.

(Zacharkiw v. Prudential Ins., (E.D. Pa 2012)

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## 2. Attorneys Fees and Remedies

### 3. How about on remand?

Yes (oosh). Receipt of fresh review constituted success on the merits. Defendants argued that Plaintiff acted prematurely to obtain fees after remand.

Blajei v. Sedgwick Claims Mgmt. Serv., Inc. (E.D. Mich 2010)

### 4. Win or not?

No. Court of Appeals considered case and determined claimant not entitled to relief or trial, but that defendant had failed to show entitlement on one claim. On remand no relief, thus no finding for Plaintiff.

Kenseth v. Dean Health Plan, Inc., 784 F. Supp 2d 1081  
(W.D. Wis. 2011)

## 2. CIGNA v. Amara – Remedies – NEW! Impact and Status

“Old and “New” CIGNA v. Amara, 131 S. Ct. 1866 (2011) -  
Refresher:

Facts: CIGNA defined benefit plan converted from pay and length of service formula to cash balance plan formula.

- CIGNA stated that plan was overall improvement.
- Guaranteed same retirement benefit after change.

Holding:

- Plan document controls, not SPD.
- ERISA 502(a)(1)(B) did not permit reformation.
- Reformation, Estoppel and Surcharge ok under §502(a)(3), even if monetary damages.

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## 2. CIGNA v. Amara – Remedies NEW! Impact and Status

### Holding Specifics Remedies -

- ✓ 204(h) notice, violations of 102(a) and 104(b) SPD disclosure requirements (district court).
- ✓ Reformation to eliminate undisclosed benefit reduction.
- ✓ Enjoined and ordered to reform plan and recovery of benefits under terms of reformed plan.
- ✓ Surcharge.
- ✓ Interest.

## 2. CIGNA v. Amara – Impact and Status

Case cont'd: Gearlds v. Entergy Serv., Inc., et. al, 2013 U.S. App LEXIS 3831 (5<sup>th</sup> Cir. 2013)(February 19, 2013).

### Holdings:

- Until recently (Amara) equitable relief was limited to mandamus, injunction, restitution, not make whole money damages.
- Amara is expansion of relief available.
- Amara says that equity courts had power to provide money compensation to cure trustee breach or unjust enrichment.
- Surcharge relief available under §502(a)(3).
- District court did not consider surcharge, which is plausible under claims made.

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## 2. CIGNA v. Amara – Impact and Status

Case: McCravy v. Metropolitan Life Ins. Co., 690 F.3d 176 (4<sup>th</sup> Cir. 2012)(July 5, 2012)(R. Hoskins atty for Plaintiff – LaRue)

### Facts:

- McCravy worked full time for Bank of America.
- Participant in Life and AD&D Plans, which permitted coverage for eligible dependent children.
- McCravy paid premiums for coverage for daughter Leslie
- Leslie was murdered in 2007 at age 25.
- Met Life denies claim because coverage goes until age 24 and there was no conversion of coverage.

District Court: State claims preempted, recovery limited to premiums, no claim for breach of duty under §502(a)(2).

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### Holdings:

- Potential recovery includes surcharge and thus, potential relief is not limited to premium refund
- Estoppel regarding right to convert coverage was valid claim.
- To rule otherwise would create incentive for fiduciaries to accept premiums even if they had no idea as to whether coverage existed.
- Vacated and Remanded.

## 2. CIGNA v. Amara – Impact and Status

Case: Liss v. Fidelity Employer Services Co., LLC, et. Al. 2013 U.S. App. LEXIS 4082; 2013 FED App. 0205N (6<sup>th</sup> Cir. 2013)(February 26, 2013) (Not for Full-Text Publication)

### Facts:

- Liss claimed that she was a beneficiary of Mary McDonald's savings and stock investment plan benefits under Ford Motor Company SSIP.
- McDonald died in 2009 and was unmarried.
- Beneficiaries on life insurance were nieces.
- SPD said that SSIP benefits for unmarried persons are to be distributed to persons under life plan, unless other specified
- Form was submitted to change beneficiary to Liss, but Committee determined that it was not valid.

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## 2. CIGNA v. Amara – Impact and Status

Liss continued...

### Holding:

- Liss claimed that SPD did not control, but Amara did not support that view, because there was no conflict between SPD and plan.
- SPD is “one of the documents and instruments governing the plan” and communicated to participant how to apply terms.
- Question of whether SPD was furnished to McDonald and whether form was prior to death or after. Remanded.

*Did the Court Punt?*

## 2. CIGNA v. Amara – Impact and Status

### Practical Impact:

- Obtain Legal Review Coordinated With TPA and Actuaries.
- Amend, Update and Revise – Attend and Don't Let Documents Waste.
- Put Claims Within Claims Process When Possible to Evaluate on Your Terms With Discretion.
- Use Care Before Sending Case to a Judge.
- Incorporate SPDs into Plan Documents and Make Plan Document Language Primary.

# Thank you

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Jeff is the Founder and Principal of Zimon LLC, a boutique employee benefits and compensation firm. He is AV© rated by Martindale Hubbard, in Chambers USA, and is an Ohio Superlawyer. Formerly the Chair of the Employee Benefit and Compensation and ERISA Litigation Group of a large 180 lawyer law firm, Jeff's two decades of experience in ERISA and benefits has afforded him the opportunity to handle a broad range of matters, for clients of all sizes, from 401(k) plans, collectively bargained plans, funding, claims, TPA agreements, plan mergers, and all aspects of benefit dispute resolution and litigation.

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