ERISA UPDATE

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Introduction

Recent developments in the area of ERISA benefits litigation include some U.S. Supreme Court decisions that, not surprisingly, are sure to spawn even more litigation. One significant area involves the enforceability of contractual limitations periods in ERISA plans. *Heimeshoff v. Hartford Life & Accident Ins. Co.*[1] resolved a circuit split on this issue, holding that a three-year contractual limitations period that began to run when written proof of loss was required to be furnished was enforceable. The decision, however, was based in part on the fact that the plan participant still had some time to sue under that limitations period after the administrative appeal ended. In *US Airways, Inc. v. McCutchen*,[2] the Supreme Court addressed a circuit split regarding equitable remedies, holding that a plan participant cannot assert an equitable defense that contradicts the plain terms of an ERISA plan. The following is a review of some recent developments in ERISA, including the areas of parties and fiduciaries; limitations periods; preemption; breach of fiduciary duty; equitable relief; full and fair review; the treating physician rule; the fiduciary exception to attorney-client privilege; and attorneys' fees, but is not a comprehensive survey. Finally, this review addresses "coming attractions" with respect to some cases currently on appeal in the Supreme Court and the Fourth and Ninth Circuits.

I. Parties and Fiduciaries

Courts continue to reach varying conclusions with respect to who are proper plaintiffs and defendants in ERISA benefits claims. The role each individual or entity plays is critical in such determinations. In *Brooks v. Pactiv Corp.*,[3] the Seventh Circuit noted that "[i]t is well established

[1] 134 S. Ct. 604 (2013).
[2] 133 S.Ct. 1537 (2013).
[3] 729 F.3d 758 (7th Cir. 2013).

that an ERISA claim for benefits due ordinarily should be brought against the employee-benefits plan itself."[4] It further noted,

> "An ERISA § 502(a)(1)(B) claim is 'essentially a contract remedy under the terms of the plan.' " *Larson*, 723 F.3d at 911–12 (quoting *Ponsetti v. GE Pension Plan*, 614 F.3d 684, 695 (7th Cir.2010)). As such, "a cause of action for 'benefits due' must be brought against the party having the obligation to pay" the benefits. *Id.* at 912–13. In the usual case, "the plan owes the benefits and is the right defendant." *Id.* There are other possibilities as well, *see id.* at 912–15, but we need not explore them here. Brooks has not mounted a serious challenge to the district court's ruling that the Plan was the right defendant on the benefits claim. By failing to meaningfully challenge the court's ruling, Brooks has waived any claim of error. *See Senese v. Chi. Area I.B. of T. Pension Fund*, 237 F.3d 819, 823 (7th Cir.2001).

In *Brooks*, a former employee brought an ERISA action against his former employers. The district court dismissed the employee's claim under section 501(a)(1)(B), and the Seventh Circuit affirmed, in part because the plaintiff failed to sue the Plan itself. The Seventh Circuit also affirmed the dismissal of the plaintiff's ERISA fiduciary duty claim, holding that the employer was not acting as an ERISA fiduciary when it terminated the employment relationship and canceled the plaintiff's health insurance. The Plan is not always the only proper ERISA defendant, however.[5]

[4] *Id.* at 764.

[5] *See Greenwald v. Liberty Life Assurance Co. of Boston*, 932 F. Supp. 2d 1018 (D. Neb. 2013) (the court held that the plan administrator, rather than the claims administrator, was the proper defendant); *Ayotte v. Prudential Ins. Co. of Am.*, 900 F. Supp. 2d 814 (N.D. Ill. 2012) (insurer, which was the plan administrator, was a proper defendant because the insurer and the plan were "closely intertwined" – the insurer paid benefits and had sole discretion to interpret the plan and to determine eligibility); *Clark v. Nationwide Mut. Ins. Co.*, 933 F. Supp. 2d 862 (S.D. W. Va. 2013) (Plan sponsor was a proper defendant: "Nationwide's apparent control over Clark's claim justifies Nationwide being named as a defendant").

II. Limitations Periods

ERISA, of course, does not provide for a limitations period, and in the absence of reasonable and enforceable contractual limitations periods, courts will borrow the most analogous limitations period from the appropriate state court. Several decisions, including one from the Supreme Court, recently addressed the enforceability of contractual limitations periods. In light of these cases, ERISA defendants should be even more vigilant in assessing the applicability of such periods.

In *Heimeshoff v. Hartford Life & Accident Ins. Co.*,[6] the Supreme Court affirmed a Second Circuit decision and resolved a circuit split, holding that in the ERISA context, a contractual limitations provision—three years after the time written proof of loss is required to be furnished—was enforceable. The ERISA plan stated: "[w]ritten proof of loss must be sent … within 90 days after the start of the period for which The Hartford owes payment. …." The plaintiff stopped working in June 2005, allegedly due to her claimed disability. She filed her claim for benefits in August 2005. The insurer denied the claim a month later for lack of sufficient proof of loss. The plaintiff provided the insurer with additional information from a treating physician in October 2006, along with additional medical evidence. After a peer review was conducted, Hartford denied the claim in November 2006. The plaintiff submitted her appeal in September 2007, after requesting an appeal deadline extension. The insurer issued its final denial on November 26, 2007. The plan participant filed suit on November 18, 2010, which was less than three years after the final denial, but more than three years after proof of loss was due. The insurer successfully moved to dismiss, arguing that the suit was time-barred. The Second Circuit affirmed.

[6] 134 S. Ct. 604 (2013).

Essential to the Supreme Court's decision was the fact that the parties agreed contractually to begin the limitations period at a particular time. "The principle that contractual limitations provisions ordinarily should be enforced as written is especially appropriate when enforcing an ERISA plan. 'The plan, in short, is at the center of ERISA.'"[7] In addition, the plaintiff had a year left to file suit after the administrative appeal ended. Thus, the Supreme Court did not determine that the limitations period was either unreasonably short. In addition, it did not determine that a "controlling statute" prevented the period from taking effect. Moreover, the Supreme Court rejected the plaintiff's argument that the contractual limitations period should be tolled during internal review because such tolling – which ERISA regulations did not contemplate - would reconstitute the contractual limitations period. Finally, the Supreme Court found it unnecessary to borrow a State's statutory limitations period.

In light of this decision, plan fiduciaries should keep in mind that the enforcement of such limitations periods may depend in part on how much time the plan participant had to sue after the administrative appeal ended. Specifically, the Supreme Court noted that courts generally require the exhaustion of administrative remedies before filing suit.[8]

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[7] *Id.* at *7 (*quoting US Airways, Inc. v. McCutchen*, 133 S.Ct. 1537, 1548 (2013)).

[8] *Id.* at *3; *see also Simmers v. Hartford Life & Accident Ins. Co.*, No. 11-C-1009, 2014 WL 107002 (E.D. Wis. Jan. 9, 2014) (where contractual three-year limitations period was reasonable and enforceable, and *pro se* plan participant abandoned his equitable tolling argument, plan participant's ERISA claim was time-barred); *Moyer v. Metropolitan Life Ins. Co.*, No. 120-cv-10766, 2013 WL 765306 (E.D. Mich. Feb. 28, 2013) ("Plaintiff filed this lawsuit on February 20, 2012, more than one year after the contractual limitation period expired. Plaintiff has failed to present any other facts that support his claims that inadequacies in the SPD caused him to file this lawsuit more than one year after the contractual limitation period ended"); *Rusch v. United Health Group Inc.*, No. 2:12-CV-00128, 2013 WL 3753947 (S.D. Tex. July 15, 2013) (The Court enforced as reasonable the 36-month contractual limitations periods regarding Plaintiff's claim for disability benefits, noting nothing required tolling of the limitations period); *Upadhyay v. Aetna Life Ins. Co.*, No. C 13-1368, 2014 WL 186709 (N.D. Cal. Jan. 16, 2014) (Contractual limitations period was enforced. The court noted, "Plaintiff has not provided the Court with any authority holding that a showing of prejudice is required to prevail on a limitations defense challenging the timeliness of an ERISA action"); *Barriero v. NJ BAC Health Fund*, No. 13-1501, 2013 WL 6843478 (D.N.J. Dec. 27, 2013) (Court enforced three-year contractual limitations period, where plan participant had nine months left after administrative appeals were exhausted in which to file suit); *Laskin v. Siegel*, 728 F.3d 731 (7th Cir. 2013) (Participant alleged breach of fiduciary duty, which has 3-

In contrast, in *Clark v. Nationwide Mut. Ins. Co.*,[9] the court stated that it would enforce a valid contractual provision in the plan governing limitations if the provision is reasonable. The plan in this case, however, contained two limitations provisions—one for three years and one for one year. The court held that it would construe the plan to allow for the three-year provision because even if the one-year period applied only to benefits actions, nothing in the plan indicated that the three-year period did *not* apply to benefits actions, and the one-year period was buried in an amendment in the plan.

Equitable tolling defenses by plan participants are considered an extraordinary measure, certainly not guaranteed to succeed. For example, in *Prabhakar v. Life Ins. Co. of N. Am.*,[10] the court held the plan participant did not meet her burden of proof regarding her equitable tolling argument. The court noted:

> The sole issue is whether Plaintiff only received a copy of the Policy that was missing this provision, and should therefore be exempted from the shorter limitations period. This issue sounds in equitable tolling, an "extraordinary measure" and one that ought not to apply to "thwart actuarial prediction of plan liability and thereby threaten the ability of [ERISA] plans to prepare in advance to meet financial obligations simultaneously to both beneficiaries and adverse litigants.[11]

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and 6-year statutes of limitations with an exception for fraud or concealment by the fiduciary. Here, the participant's limitations period expired in 1997, so she alleged that the fiduciary committed fraudulent concealment. The Seventh Circuit held that, because the participant provided no evidence of it, the fiduciary's conduct in this case was not fraudulent concealment, and the claim for breach of fiduciary duty was time barred).

[9] 933 F. Supp. 2d 862 (S.D. W. Va. 2013).

[10] No. 09-CV-05530, 2013 WL 4458728 (E.D.N.Y. Aug. 16, 2013); *see also Riley v. Metropolitan Life Ins. Co.*, No. 12-10531, 2013 WL 5009618 (D. Mass. Sept. 11, 2013) (the court applied the limitations period borrowed from Massachusetts tort actions. The court declined to adopt an "installment contract" approach to the statute of limitations and held the action was untimely and that participant was not entitled to equitable tolling).

[11] *Prabhakar*, No. 09-CV-05530, 2013 WL 4458728, at *13; *Engleson v. Unum Life Ins. Co. of Am.*, 723 F.3d 611 (6th Cir. 2013) (the Plan administrator did not affirmatively waive contractual limitations provision in LTD plan through a letter to participant where the letter lacked clarity, directness, and decisiveness that the general waiver rule ("voluntary relinquishment of a known right") demanded. Also, as participant did not diligently pursue his benefits, he was not entitled to equitable tolling of the contractual limitations period).

III. Preemption of State Law Claims

Courts continue to address ERISA preemption of state statutes. In *Liberty Mut. Ins. Co. v. Donegan*,[12] the Second Circuit reversed the District Court for the District of Vermont's decision granting summary judgment for the State of Vermont, and held that Section 504 of ERISA preempted Vermont's statute requiring all health insurers to file reports with the state with claims data and other "information relating to health care."

In *Novak v. Life Ins. Co. of N. Am.*,[13] the court held Illinois' Department of Insurance regulation prohibiting discretionary authority language in plan was not preempted by ERISA. The DOI Regulation (50 Ill. Adm.Code tit. § 2001.3) provides:

> No policy, contract, certificate, endorsement, rider, application or agreement offered or issued in this State, by a health carrier, to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services or of disability may contain a provision purporting to reserve discretion to the health carrier to interpret the terms of the contract, or to provide standards of interpretation or review that are consistent with the laws of this State.[14]

IV. Breach of Fiduciary Duty

In *Killian v. Concert Health Plan*,[15] the Seventh Circuit held that because the plan documents did not identify which providers were in-network and participants were told to call a

[12] No. 12-4881-cv, 2014 WL 401708, at *1 (2d Cir. Feb. 4, 2014).
[13] No. 12 C 9434, 2013 WL 3455844 (N.D. Ill. July 9, 2013)
[14] *Id.*
[15] No. 1:07-cv-04755, 2013 WL 5942703 (7th Cir. Nov. 7, 2013); *but see Danza v. Fidelity Management Trust Co.*, 533 F. App'x 120 (3d Cir. 2013) (Participant in ERISA-governed plan brought action against the providers of recordkeeping and administrative services to such plans, alleging breach of fiduciary duty because providers violated ERISA by charging excessive fees for reviewing domestic relations orders. The Third Circuit held that the providers were not liable for breach of fiduciary duty because (1) at the time they negotiated fees with the plan, they weren't fiduciaries and (2) at the time they reviewed the DROs, they were fiduciaries, but they had no discretion to change the fee structure. The Court also held that the providers weren't liable as co-fiduciaries (who can be liable for the breach of other fiduciaries) for any conduct of the plan because at the time of the plan's alleged conduct, the providers owed no fiduciary duty).

phone number to make that determination, the plan exposed itself to liability for the mistakes that plan representatives made in answering questions on that subject. The court also held that a reasonable trier of fact could conclude that participant's husband did not need to obtain precertification and that the phone calls made to the plan would have provided information regarding whether the providers were in the participant's network. In fact, the plan had an affirmative obligation to inform the participant that the provider they discussed in the phone call was out-of-network. Thus, the court reversed the district court's grant of summary judgment on the breach of fiduciary claim and remanded to permit the trier of fact to determine (1) whether the phone calls put the plan on adequate notice, thus giving rise to a duty to disclose material information, (2) whether the plan breached this duty, and (3) whether the participant suffered harm (i.e., to perform the breach of fiduciary duty analysis).

Some courts recently addressed claims by health care providers. In *Sanctuary Surgical Centre, Inc. v. Aetna Inc.*,[16] health care providers brought an ERISA action against insurance plan administrators for breach of fiduciary duty. Health care providers ordinarily do not have standing to sue, but they can achieve derivative standing by getting an assignment of rights from a party with standing (i.e., the patient/beneficiary). The Eleventh Circuit held that the medical providers did not have standing to sue for breach of fiduciary duty because, even though they had patients sign agreements that assigned the right to receive benefits, the agreements did not assign the right to assert a claim for breach of fiduciary duty.[17]

[16] Nos. 13-10635, 13-10636, 13-10667, 2013 WL 5969636 (11th Cir. Nov. 5, 2013).
[17] *See also MHA, LLC v. Aetna Health, Inc.*, 2013 WL 705612 (D.N.J. Feb. 25, 2013) (court held similar assignment deficient); *Productive MD, LLC v. Aetna Health, Inc.*, 2013 WL 4587859 (M.D. Tenn. Aug. 28, 2013) (similar assignment language found effective).

The Third Circuit addressed a breach of fiduciary duty claim in the context of retained asset accounts. In *Edmonson v. Lincoln Nat'l Life Ins. Co.*,[18] an ERISA plan participant's wife was entitled to $10,000 in benefits after he died, and insurer paid the benefits by putting the money in a retained asset account. With a retained asset account, the insurance company keeps the money and only transfers funds into the account when the owner of the account writes a check. Until that time, the insurance company retains the money and can invest the assets for its own profit. The wife brought ERISA claim for breach of fiduciary duty because the insurer chose to pay with a retained asset account (thus making a profit off the money while it remained in the account). The Third Circuit, noting that this was a question of first impression in its circuit (and the First and Second Circuits had considered the issue but come to different conclusions) held that (1) the insurer was acting as a fiduciary when it chose to use a retained asset account, (2) it did not breach its fiduciary duties by doing so, and (3) the insurer was not acting as a fiduciary when it invested the beneficiary's retained assets.

V. Equitable Relief

The Supreme Court's decision in *US Airways, Inc. v. McCutchen*[19] will likely spur even more litigation regarding plan fiduciaries' potential equitable relief, and courts across the country still grapple with the effects of *CIGNA Corp. v. Amara*[20] nearly three years later.

Equitable remedies available to plan fiduciaries who have overpaid benefits typically take the form of offsets and equitable liens.[21] Addressing a circuit split, the Supreme Court in

[18] 725 F.3d 406 (3d Cir. 2013).
[19] 133 S.Ct. 1537 (2013).
[20] 131 S.Ct. 1866 (2011).
[21] *See, e.g., Board of Trs of Nat'l Elevator Indus. Health Benefit Plan v. McLaughlin*, Civ. No. 12-4322, 2014 WL 284431, at *2 (D.N.J. Jan. 24, 2014) ("An equitable lien by agreement constitutes equitable relief authorized by §

McCutchen held a plan participant cannot assert an equitable defense such as the common-fund doctrine that contradicts the plain terms of an ERISA plan, yet a plan's silence or ambiguity regarding such defenses will not bar them.[22]

Several courts recently described *Amara* as creating an expansion of kinds of relief available to plan participants and beneficiaries under Section 502(a)(3) of ERISA. For example, the Seventh Circuit in *Kenseth v. Dean Health Plan, Inc.*[23] noted:

> So the relief available for a breach of fiduciary duty under section 1132(a)(3) is broader than we have previously held, and broader than the district court could have anticipated before the Supreme Court's decision in *CIGNA.* Monetary compensation is not automatically considered "legal" rather than "equitable." The identity of the defendant as a fiduciary, the breach of a fiduciary duty, and the nature of the harm are important in characterizing the relief. *Gearlds v. Entergy Servs., Inc.*, 709 F.3d 448, 450 (5th Cir.2013) ("The Supreme Court recently stated an expansion of the kind of relief available under § 503(a)(3) when the plaintiff is suing a plan fiduciary and the relief sought makes the plaintiff whole for losses caused by the defendant's breach of fiduciary duty."). *See also McCravy v. Metropolitan Life Ins. Co.*, 690 F.3d 176, 181 (4th Cir.2012) (under *CIGNA*, "remedies traditionally available in courts of equity, expressly including estoppel and surcharge, are indeed available to plaintiffs suing fiduciaries under Section 1132(a)(3)").[24]

See also Osberg v. Foot Locker, Inc., No. 13-187-CV, 2014 WL 552784, at *2 (2d Cir. Feb. 13, 2014) ("'The Supreme Court has since clarified that the standard of harm that plaintiffs must show depends upon the equitable remedy that plaintiffs seek. … For example, while "detrimental reliance" is a requirement for the remedy of estoppel, it is not a strict requirement for every equitable remedy'"). Indeed, one author suggested "Plaintiff participants and beneficiaries should

502(a)(3) of ERISA. … To qualify as an equitable lien by agreement, the contract must: 1) identify a particular fund distinct from the defendant's general assets; and 2) identify a particular share of the fund to which it is entitled").

[22] 133 S.Ct. at 1551.

[23] 722 F.3d 869 (7th Cir. 2013).

[24] *Id.* at 880.

now argue, in fiduciary breach cases, that the alleged injury and corresponding appropriate remedy falls within one of the equitable remedies identified by the [*Amara*] Court – injunction, reformation, estoppel, or make-whole relief/surcharge."[25]

A. Offset/Reimbursement for Plan Administrators/Insurers

Courts have not been consistent with respect to plan fiduciaries' claims for reimbursement of overpayments. In *Anderson v. Unum Life Ins. Co. of Am.*,[26] the court found that because the insurer sought reimbursement for amounts paid to the participant from the SSA, the insurer's claim constituted a request for equitable relief under section 1132(a)(3)(B). The court dismissed the participant's claim and entered judgment in favor of the insurer for reimbursement. In *O'Brien-Shure v. U.S. Lab., Inc. Health & Welfare Benefit Plan*,[27] the court held that an ERISA plan's overpayment claim can be "equitable in nature 'even if the benefits it paid the insured are not specifically traceable to the insured's current assets due to commingling or dissipation.'"[28] In *Kohls Dep't Stores v. Castelli*,[29] the court held the Plan administrator could assert an equitable lien against the legal fees earned by attorneys in plan participant's personal injury action.

In contrast, plan fiduciaries' reimbursement claims have failed in certain circumstances. For example, in *Jones v. Fed. Express Corp.*,[30] the court granted summary judgment for the plan participant on the employer's reimbursement claim:

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[25] Susan Harthill, *The Supreme Court Fills a Gaping Hole: CIGNA Corp. v. Amara Clarifies the Scope of Equitable Relief Under ERISA*, 45 J. MARSHALL L. REV. 767, 778 (Spring 2012).
[26] No. 5:12-CV-00208, 2014 WL 130490 (E.D. Ark. Jan. 14, 2014).
[27] No. 12 C 6101, 2013 WL 3321569 (N.D. Ill. July 1, 2013).
[28] *See also Unum Life Ins. Co. of Am. v. Alamos*, No. 13-5099, 2014 WL 183315 (W.D. Ark. Jan. 16, 2014) (Summary judgment for insurer, awarding approximately $50,000 for overpayments).

[29] No. 12-cv-02990, 2013 WL 4038723 (E.D.N.Y. Aug. 8, 2013).
[30] No. 6:12-cv-771, 2013 WL 6038734 (M.D. Fla. Nov. 14, 2013).

> FedEx has not presented any evidence that it has or can identify a specific fund to which it is entitled, and it has not shown that the funds are still in the possession of Mr. Jones. Because FedEx has not shown any specific fund in the possession of Mr. Jones that belongs in good conscience to FedEx and that is still intact, it cannot assert an equitable restitution claim and its counterclaim fails. There is no genuine dispute of material fact on this issue. FedEx's motion for summary judgment on its counterclaim must be denied, and Mr. Jones's motion for summary judgment must be granted. *See Herman*, 689 F.Supp.2d at 1331. As in *Knudson*, the Court makes no determination as to whether FedEx may otherwise be able to obtain relief under the Plan.

In *Central States, SE & SW Area Health & Welfare: Fund v. Gerber Life Ins. Co.*,[31] an ERISA action by a health benefit plan against a private insurance company providing accident policies to various schools and colleges, the insurance company's motion to dismiss was granted. The court held that the claims for reimbursement for covered individuals' medical expenses was not "other appropriate equitable relief."

B. Participants' Claims

1. Equitable Remedies Unavailable

If adequate relief under Section 502(a)(1)(B) is available to a plan participant, usually equitable relief is not available. For example, the court in *Gross-Rubio v. Metropolitan Life Ins. Co.*[32] noted:

> Gross–Rubio seeks "any appropriate equitable relief ..., including but not limited to enjoining METLIFE from any further breaches of fiduciary duties and/or acts or practices winch violate ERISA and/or the terms of the Long Term Disability Plan[.]" … This amounts to asking the Court to order MetLife to not break the law, which, to say the least, is an overly broad request. More specifically, Gross–Rubio's ultimate goal is to obtain the benefits she alleges are due to her under her benefits plan. Because section 1132(a)(1)(B) provides

[31] No. 13-cv-2994, 2013 WL 6196964 (S.D.N.Y. Nov. 26, 2013).
[32] No. 2:12-cv-01281, 2013 WL 6210638 (D. Nev. Nov. 27, 2013).

> adequate relief for that objective (recovery of the benefits themselves), the equitable remedies available under section 1132(a)(3)(B) are unavailable to her. [33]

2. Disgorgement

When a plan participant's claims fall under Section 502(a)(3), an equitable remedy is appropriate if the plan participant can show the requisite harm. In *Frommert v. Conkright,*[34] the Second Circuit noted the *Amara* court:

> clarified that the standard of harm that plaintiffs must show depends upon the equitable remedy that plaintiffs seek. *See Amara,* 131 S.Ct. at 1881–82. For example, while "detrimental reliance" is a requirement for the remedy of estoppel, it is not a strict requirement for every equitable remedy. *See id.* at 1881. Thus, in considering whether Plaintiffs have made a sufficient showing of harm, the district court must consider this question in tandem with the equitable remedies it may impose.

The plan participants alleged violations of ERISA. This case bounced back and forth among the district court, appellate court, and the Supreme Court, landing in the Second Circuit for the court to consider whether the offset approach violated ERISA's notice requirement. The Second Circuit held that the offset approach violated ERISA's notice provisions. Remanding for further proceedings, the court stated that because the participants' notice claims fell under section 502(a)(3), an equitable remedy was appropriate if the participants have established the requisite level of harm. Disgorgement (restitution of the defendants wrongful gain or profits) has been held to be viable, and in at least one case, was allowed in addition to a claim for benefits under Section

[33] *See also Eweka v. Hartford Life & Accident Ins. Co.*, No. 1:12cv1055, 2013 WL 3381370 (E.D. Va. July 3, 2013) (this case provides a reminder that relief under Section 503(a)(3) is available in the absence of another adequate legal remedy. In that case, a plan participant brought a claim for breach of fiduciary duty against an insurer for allegedly making false insurance fraud referrals to law enforcement. Participant alleged that it caused him pain, humiliation, and suffering and sought money damages. The Court held that the claim failed on legal grounds because section 502(a)(3) only permits equitable relief if there is no other adequate legal remedy, especially given the express statutory language and clear Fourth Circuit authority).

[34] 738 F.3d 522 (2d Cir. 2013).

502(a)(1)(B). In *Edmonson v. Lincoln Nat'l Life Ins. Co.*,[35] the Third Circuit held that although restitution can be a remedy in law or equity, disgorgement is always an equitable remedy available under ERISA. In *Rochow v. Life Ins. Co. of N. Am.*,[36] the Sixth Circuit held that disgorgement is an appropriate equitable remedy under section 502(a)(3) and can provide a separate remedy on top of a benefit recovery.

C. No Jury Trial

In *Hart v. Capgemini U.S. LLC Welfare Benefit Plan Admin. Document*, No. 13-1001, 2013 WL 6038336 (10th Cir. Nov. 15, 2013), the district court determined that the plan participant was not entitled to a jury trial on his claim for benefits under Section 1132(a)(1)(B). The 10th Circuit affirmed, noting the Tenth Circuit previously held that the Seventh Amendment does not guarantee a right to a jury trial in actions for benefits under section 1132(a)(1)(B) because the relief is equitable rather than legal. The court refused to revisit its previous decision.

VI. Full and Fair Review

Plan administrators must always remain diligent with respect to providing a full and fair review of benefits claims. In *Benson v. Hartford Life & Accident Ins. Co.*,[37] the Tenth Circuit analyzed whether the insurer followed the two step procedure for denying claims: (1) adequate notice and (2) full and fair review. The court noted that full and fair review must give the claimant the opportunity to submit written comments, documents, records, and other information. Here, the court found that full and fair review was met because the beneficiary was free to submit

[35] 725 F.3d 406 (3d Cir. 2013)
[36] 737 F.3d 415 (6th Cir. 2013).
[37] 511 F. App'x 680 (10th Cir. 2013).

information and did not and the insurer was not required to seek out information to refute the opinions of her treating physician and independent reviewers.[38]

VII. Objective Medical Evidence and the Treating Physician Rule

As the Sixth Circuit noted in *Fura v. Fed. Express Corp. Long Term Disability Plan*,[39] plan administrators should articulate reasons for adopting an opinion contrasting those of treating physicians. In that case, as part of the Sixth Circuit's analysis that the plan administrator failed to give a reasoned explanation for its decision, the court discussed how the plan's physicians' conclusions were flawed. The court noted that a plan cannot reject the opinions of a treating physician but must instead give reasons for adopting an alternative opinion. Here, the non-examining physicians' opinions different greatly from participant's treating physicians' conclusions with no explanation, which raised questions about the thoroughness and accuracy of the claim denial.[40]

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[38] *But see Rossi v. Precision Drilling Oilfield Serv. Corp. Emp. Benefits Plan*, 704 F.3d 362 (5th Cir. 2013) (Plan did not substantially comply with the full and fair review requirement because it relied on an entirely different ground for denial on administrative appeal); *Shedrick v. Marriott Int'l, Inc.*, 500 F. App'x 331 (5th Cir. 2012) (Full and fair review is evaluated under the substantial compliance standard. The purpose of Section 1133, which mandates full and fair review, is to afford the beneficiary an explanation of the denial of benefits that is adequate to ensure meaningful review of that denial. The Fifth Circuit held that there was no basis to conclude that participant did not engage in a "meaningful dialogue" with the administrator during the review process because the administrator explained more than once why benefits were being denied and participant had multiple opportunities to provide supplemental documentation during the review process, which lasted over four months); *Fura v. Fed. Express Corp. Long Term Disability Plan*, 534 F. App'x 340 (6th Cir. 2013) (Participant brought ERISA action after administrator terminated his LTD benefits, the district court granted summary judgment for the participant, and the employer and plan administrator appealed. Because the administrator failed to give a reasoned explanation for its decision but the court could not say that participant was totally disabled as a matter of law, the Sixth Circuit remanded the case to the administrator for a full and fair review).

[39] 534 F. App'x 340 (6th Cir. 2013).

[40] *See also Judge v. Metropolitan Life Ins. Co.*, 710 F.3d 651 (6th Cir. 2013) (Participant contended that he was totally and permanently disabled under the language of the plan, and his doctors checked boxes that restricted his sitting, standing, and walking, but no objective medical evidence supported such a conclusion so as to prevent him from doing some other job for which he was fit by education, training, or experience. "Requiring a claimant to provide objective medical evidence of disability is not irrational or unreasonable." As such, the Sixth Circuit held that the plan's decision to deny benefits was neither arbitrary nor capricious); *Greenwald v. Liberty Life Assurance Co. of Boston*, 932 F. Supp. 2d 1018 (D. Neb. 2013) (The Court held that insurer did not abuse its discretion in requiring insured to produce objective evidence of his claimed disability. Where the plan required the insured to provide the necessary information to support the claim, the insured cannot shift the burden to the plan administrator to investigate); *but see Miles v.*

VIII. Fiduciary Exception to Attorney-Client Privilege

Plan administrators and their counsel must be aware that not all of their communications are necessarily privileged. In *Warner v. Unum Life Ins. Co. of Am.*,[41] the court granted the plan participant's motion to compel production of documents. "Under [the fiduciary] exception, a fiduciary of an ERISA plan 'must make available to the beneficiary, upon request, any communications with an attorney that are intended to assist in the administration of the plan.'"[42] The exception does not apply to "[d]ecisions relating to the plan's amendment or termination," which are "not fiduciary decisions."[43] The court found they related to plan administration and did not contain legal advice; the lawsuit was not pending at the time of the communications.

In *Merrill v. Briggs & Stratton Corp.*,[44] the court concluded:

> According to the descriptions on the privilege log, defendants are withholding the documents that plaintiffs seek because they contain legal advice related to Briggs's decision to modify, amend or terminate the class members' health benefits. More specifically, they contain legal advice about whether Briggs had a right to modify or terminate the benefits. Based on the holding in *Bland*,[45] I conclude that these documents are not subject to the fiduciary-duty exception.[46]

Principal Life Ins. Co., 720 F.3d 472 (2d Cir. 2013) (Plan administrator arbitrarily and capriciously relied on participant's failure to provide objective evidence of tinnitus as a reason to deny his claim. Administrator did not give adequate attention to participant's subjective evidence of disability, and the administrator did not consider that the treating physician found subjective complaints, hearing loss, and head pain credible. Further, multiple specialists stated that there was no objective test for tinnitus; although it is consistent with hearing loss, and there was undisputed objective evidence of hearing loss).

[41] No. 12 C 2782, 2013 WL 3874060 (N.D. Ill. July 26, 2013).
[42] *Id.* at *7.
[43] *Id.*
[44] No. 10-CV-00700, 2014 WL 280373 (E.D. Wis. Jan. 24, 2014).
[45] *Bland v. Fiatallis North America, Inc.*, 401 F.3d 779 (7th Cir.2005).

[46] *Id.* at *165; *see also Jenkins v. Grant Thornton LLP*, No. 13-60957, 2013 WL 3967917 (S.D. Fla. Aug. 1, 2013) (The court noted as follows: "[w]ith regard to Plaintiff's claims that Rose and Alston & Bird LLP served as "claims administrators," Plaintiff has provided no evidence in support of her statement").

IX. Attorneys' Fees

Hardt v. Reliance Standard Life Insurance Co.[47] continues to generate case law. In this 2010 decision from the Supreme Court, the Court rejected the "prevailing party" test, but noted "trivial success on the merits" or a party's "purely procedural victory" will not satisfy an entitlement to fees. "[I]f the court can fairly call the outcome of the litigation some success on the merits without conducting a lengthy inquiry into the question [of] whether a particular party's success was substantial or occurred on a central issue," the party will be eligible for fees and costs under Section 1132(g)(1), pursuant to the court's discretion.

1. Petitions by Plan Participants

In *Lemons v. Reliance Standard Life Ins. Co.*,[48] the plan administrator restored long term disability benefits to the plan participant while the lawsuit was pending. The district court dismissed case as moot and denied participant's request to file motion for attorneys' fees. The Third Circuit held that participant should be permitted to file motion for attorneys' fees because the parties had only briefed arguments as to which fees test should apply (prevailing party versus multi-factor test) but had not had the opportunity to brief the factors.[49]

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[47] 560 U.S. 242 (2010).

[48] 534 F. App'x 162 (3d Cir. 2013).

[49] *Id.* at 165; *see also Geiger v. Pfizer, Inc.*, No. 13-3519, 2013 WL 5911993 (6th Cir. Nov. 5, 2013) (Sixth Circuit affirmed the district court's denial of attorneys' fees because it was within the district court's discretion to make determinations about the culpability or bad faith of the parties, the deterrent effect of an award, and the relative merits of the parties' positions); *Weitzenkamp v. Unum Life Ins. Co. of Am.*, 500 F. App'x 506 (7th Cir. 2013) (Plan participant sued insurer alleging that denial of LTD benefits was arbitrary and capricious, lost at summary judgment stage, appealed, and had summary judgment reversed. Back in district court, participant moved for attorneys' fees as a party who obtained some degree of success. The district court denied the motion because the insurer's litigation position was substantially justified (case dealt with a novel issue in the 7th Circuit regarding the interpretation of plan provisions) and because five-factor test did not weigh in participant's favor. Seventh Circuit held that district court did not abuse its discretion in making these determinations); *Nichols v. Unicare Life & Health Ins. Co.*, Nos. 12-4047, 13-1033, 2014 WL 148731 (8th Cir. Jan. 16, 2014) (District court awarded attorneys' fees and costs to husband of plan participant after he prevailed on underlying claim for wrongful denial. Eighth Circuit reviewed for abuse of

2. Petitions by Plan Administrators/Insurers

In *Scarangella v. Group Health, Inc.*,[50] a plan participant sued an insurer and employer under ERISA, and the insurer and employer cross-claimed against each other. The case was resolved through a combination settlement, partial summary judgment, and the voluntarily dismissal of some claims. The employer moved for attorneys' fees, which the district court denied. Here, the Second Circuit expanded on *Hardt* and discussed what a party must achieve or obtain to show some degree of success on the merits. The Second Circuit vacated and remanded because the employer demonstrated success on the merits as a result of dismissal of the insurer's cross-claims (through both summary judgment and through voluntary dismissal) and because the employer was not required to show that relief it obtained was the direct result of a court judgment or consent decree. In *Laskin v. Siegel*,[51] an ERISA suit by a plan participant, the defendants cross-appealed the district court's denial of their motion for attorneys' fees and costs, which had been filed pursuant to 29 U.S.C. § 1132(g)(1) and FRCP 54(d). The Seventh Circuit held that the district court had not abused its discretion because even though the defendants were entitled to a modest presumption that they would recover fees and costs under ERISA, the plaintiff's suit was justified (although untimely) and the defendants had only offered "the barest of arguments" in support of their motion for fees and costs.

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discretion and analyzed under the five-factor *Lawrence* test and found that the district court did not abuse its discretion); *Lightfoot v. Principal Life Ins. Co.*, No. 12-6322, 2013 WL 5930830 (10th Cir. Nov. 6, 2013) (Participant prevailed on the underlying claim, but the district court denied attorneys' fees and costs. The Tenth Circuit affirmed because it was not abuse of discretion under the circuit's five-factor test to make the determination that there was no evidence that insurer acted in bad faith when denying participant's claim or that any procedural error in claims handling was intentional or reprehensible, that an award would not have a deterrent effect, and that the participant did not seek to benefit all participants and beneficiaries of an ERISA plan).

[50] 731 F.3d 146 (2d Cir. 2013).

[51] 728 F.3d 731 (7th Cir. 2013).

3. Fees Denied to Both Parties

In *Tibble v. Edison Int'l*,[52], the Ninth Circuit affirmed the district court's decision not to award attorneys' fees to any party after reviewing the decision-making under an abuse of discretion standard. Here, although the beneficiaries might have been entitled to a limited award of fees and costs because the employer could pay and the beneficiaries prevailed on a weak issue, the district court decided fees were inappropriate because beneficiaries' pursued a "shotgun approach" to litigation with aggressive discovery requests and numerous non-meritorious claims.

4. Final Decision for Appeal

In *Ray Haluch Gravel Co. v. Cent. Pension Fund of Int'l Union of Operating Engineers & Participating Employers,* 134 S. Ct. 773 (2014), the Supreme Court held that a district court's decision on the merits of an ERISA matter is a final decision for purposes of appeal under 28 U.S.C. § 1291, despite a pending attorneys' fee request, whether or not the fee entitlement is based in statute, contract, or both. This case is an expansion of *Budnich v. Becton Dickenson & Co.,* 486 U.S. 196 (1988), and changed the controlling law in a number of circuits.

XII. Coming Attractions

A. *Inciong v. Fort Dearborn Life Ins. Co.,* No. C 10-03384 (N.D. Cal. Mar. 30, 2012), *appeal docketed,* No. 12-15997 (9th Cir. Apr. 27, 2012)

Participant received LTD benefits under the plan's "total disability" standard for approximately 16 years when the insurer performed a period review in

[52] 520 F. App'x 499 (9th Cir. 2013); *see also Barboza v. California Ass'n of Prof'l Firefighters*, No. CIV S-2:08-519, 2013 WL 4012645 (E.D. Cal. Aug. 6, 2013) (Parties' cross-motions for summary judgment were granted in part and denied in part, so Court held that each had achieve some degree of success on the merits. Court denied attorneys' fees and costs to all because the five-factor test was a draw and because this court does not award costs where it grants a portion of each side's request for summary judgment).

2008, found evidence that participant no longer met the "total disability" standard, and terminated benefits. The court reviewed *de novo* and determined that participant could perform "any occupation."

Participant has appealed to the Ninth Circuit, the issues are being briefed, and oral argument will take place in April 2014.

B. *VanderKam v. Pension Benefit Guaranty Corp.*, 943 F. Supp. 2d 130 (D.D.C. 2013), *appeal docketed*, No. 13-5163 (D.C. June 6, 2013)

When the plan participant and plan beneficiary divorce, the divorce decree includes a waiver of rights to plan benefits, and the participant dies before changing plan documents to reflect a new beneficiary, the question arises whether alternative beneficiaries may sue to recover the benefit. In *Kennedy v. Plan Adm'r for DuPont Sav. & Inv. Plan*, 555 U.S. 285, 300 n. 10 (2009), the Court held that when the waiver conflicts with plan documents, the administrator must pay the plan beneficiary and any suit by alternative beneficiaries against the plan are preempted. The Court declined to decide whether the alternative beneficiaries could sue the plan beneficiary or if such suit was also preempted by ERISA. In *Andochick v. Byrd*, 709 F.3d 296 (4th Cir. 2013), the Fourth Circuit affirmed the district court's decision that the alternative beneficiaries could sue the plan beneficiary for the life insurance benefit because such a claim was not preempted by ERISA.

VanderKam, on appeal, is applying similar principles in the context of pension benefits governed by ERISA.

C. *Thurber v. Aetna Life Ins. Co.*, 712 F.3d 654 (2d Cir. 2013), *petition for cert. filed*, No. 13-130 (S. Ct. July 26, 2013)

Participant received STD payments from the insurer while simultaneously receiving no-fault insurance payments. The plan indicated that the insurer "may" reduce STD benefits if the beneficiary receives other income, including no-fault insurance payments. The insurer sought reimbursement, but the district court declined jurisdiction because it believed the remedy to be legal rather than equitable. The Second Circuit held that the insurer's claim for reimbursement was equitable, entitling the district court to subject matter jurisdiction.

The participant has petitioned for a writ of certiorari to the United States Supreme Court on the following issues:

> (1) Whether an ERISA Plan may enforce an equitable lien by agreement under Section 502(a)(3) of ERISA where it has not identified a particular fund that is in the defendant's possession and control at the time the Plan asserts its equitable lien. The First, Second, Third, Sixth, and Seventh Circuits have held that a Plan may do so, and the Eighth and Ninth Circuits have held that it may not; and (2) whether a discretionary clause in an ERISA plan mandating that an abuse-of-discretion standard of judicial review be applied to a Section 502(a)(1)(B) denial-of-benefits claim is enforceable when the clause was never disclosed to the participant in any plan document, as the Second Circuit held here, or whether the Plan must give participants and beneficiaries clear notice of such a clause, as the Seventh Circuit has required.

The Court held a conference on the petition but called for the solicitor general to submit a brief and did not decide whether to grant certiorari or not.