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CLIENT BULLETIN

Recent Stand-Out ERISA Decisions from the Seventh and Second Circuits

Craig M. Bargher | cbargher@cmn-law.com
Georgia L. Joyce | gjoyce@cmn-law.com

As case law interpreting ERISA continues to evolve, two recent decisions from the Seventh and Second Circuits stand out. The Seventh Circuit foreclosed any further arguments that Illinois' anti-discretionary clause regulation is preempted either expressly or indirectly by ERISA, holding that the regulation is specifically directed toward entities engaged in insurance and that it substantially affects the risk pooling arrangement between the insurer and the insured. In another decision favorable to ERISA plaintiffs, the Second Circuit held that a plan participant stated a Section 502(a)(3) claim, in addition to a Section 502(a)(1)(B) claim based on an alleged violation of the Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a(a)(3)(A)). The Second Circuit also acknowledged that the plaintiff, if he prevails on both claims, could ultimately receive equitable relief under Section 502(a)(3) in addition to monetary damages under Section 502(a)(1)(B).

Seventh Circuit Cements *De Novo* Review of Benefit Denials under Insured ERISA Plans Offered or Issued in Illinois

In a lengthy decision in *Fontaine v. Metro. Life Ins. Co.*, No. 14-1984, 2015 WL 5173039, at *1 (7th Cir. Sept. 4, 2015), the Seventh Circuit recently slammed the door on y arguments that insured ERISA plans offered or issued in Illinois may contain language affording discretionary authority to plan administrators. Affirming a Northern District of Illinois decision, the Seventh Circuit held that ERISA does not expressly or impliedly preempt Illinois' anti-discretionary clause regulation in 50 Ill. Admin. Code § 2001.3. The court also held that the regulation applied to the plan at issue, making the district court's *de novo* review appropriate.

The regulation provides that:

> [n]o 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 a 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 inconsistent with the laws of this State.

50 Ill. Admin. Code § 2001.3. To avoid ERISA preemption, the regulation "'must be specifically directed toward entities engaged in insurance … [and] the state law must substantially affect the risk pooling arrangement between the insurer and the insured.'" *Fontaine*, at *3 (quoting *Kentucky Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 342 (2003)).

Relying on *Miller*, the Seventh Circuit rejected the argument that the regulation "is not specifically directed toward entities engaged in insurance because it prohibits a plan sponsor … from delegating discretionary authority to the insurer of an employee benefit plan." *Fontaine*, at *3. It also refused to adopt what it called a "hyper-technical argument" that "the discretionary clause in this case is not actually in an insurance policy but in an ERISA plan document," calling it an "artificial distinction." *Id.* at *3-4.

Applying the Supreme Court's "broader, more practical standard," the court stated that Section 2001.3 substantially affects the risk pooling arrangement between the insurer and the employer in this case "by altering 'the scope of permissible bargains ….'" *Id*. In addition, it noted that "[t]he Supreme Court has repeatedly upheld state laws that operate in this manner

against ERISA preemption arguments." *Id.* It rebuffed, as an "attempt to narrow artificially the Supreme Court's interpretations," the argument that the regulation does not "affect risk pooling because it does not 'determine whether a class of risks is covered, does not extend coverage to a class of previously excluded risks, and does not mandate new claim review procedures.'" *Id.* The Seventh Circuit joined the Sixth and Ninth Circuits in concluding "that a state law prohibiting discretionary clauses squarely satisfies" the risk pooling requirement. *Id.* (citing *American Council of Life Insurers v. Ross*, 558 F.3d 600 (6th Cir. 2009); *Standard Ins. Co. v. Morrison*, 584 F.3d 837 (9th Cir. 2009)).

The Seventh Circuit also disagreed with the argument that ERISA preempts section 2001.3 by conflicting with ERISA's civil enforcement scheme and fitting into the Supreme Court's description of such preemption in *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004). In *Davila*, the Supreme Court held that any "state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted." *Davila*, 542 U.S. at 209. The Seventh Circuit noted that Illinois' regulation "quite obviously" does not duplicate, supplement, or supplant the ERISA civil enforcement remedy and instead only "restore[s] in Illinois ERISA's own default rule of *de novo* review in court cases challenging denials of Health and disability benefits. *Fontaine*, 2015 WL 5173039, at *5. Further, the court noted that "the controlling case on this issue" is *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002), which held that although "'a deferential standard for reviewing benefit denials' is 'highly prized by benefit plans,' it is not required by the 'text of the statute.'" *Fontaine*, 2015 WL 5173039, at *5-6 (quoting *Moran*, 536 U.S. at 384-85). It also rejected MetLife's reliance on *Conkright v. Frommert*, 559 U.S. 506 (2010), stating that "*Conkright* dealt with a judicially created remedy for an insurer's error, not state legislation exercising the 'historic police powers' of the states." *Id.* at *7.

An implied preemption argument fared no better. The Seventh Circuit held:

> [s]eeing no indication from the Supreme Court that *Conkright* overruled or limited *Moran*, and knowing that a 'high threshold must be met if a state law is to be preempted for conflicting with the purposes of a federal Act,' we hold that § 2001.3 is not impliedly preempted by ERISA's civil enforcement scheme.

Id.

Finally, the court rejected arguments that the regulation should not apply to this case, "according to its terms." First, MetLife argued that because the discretionary clause was in the ERISA plan document and "not in an insurance document" it was beyond the reach of the regulation and the Illinois Insurance Director. Relying on *UNUM Life Ins. Co. v. Ward*, 526 U.S. 358, 376 (1999), the court disagreed, noting that "an artificial distinction between 'plan' documents and 'insurance' documents is not tenable." *Id.* at *8. Next, it contended that the insurance policy was offered by the employer, not MetLife. Citing the language of the insurance policy, the Seventh Circuit determined that "MetLife obviously issued [the] disability insurance policy." *Id.* In addition, MetLife argued it did not reserve discretionary authority to itself, but rather that the employer delegated that authority to MetLife. Calling that an "artificial distinction," the court stated that "[w]hat matters is that the policy provision purports to reserve discretion, not who put the provision in the policy." *Id.* Finally, MetLife asserted that the regulation "does not prohibit all discretionary clauses but only clauses reserving discretion 'to interpret the terms of the contract, or to provide standards of interpretation of review that are inconsistent with the laws of this State." The Seventh Circuit refused to accept this argument as well, noting that the Supreme Court in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989) "rejected this 'artificial dichotomy between 'benefit determinations' and 'contract interpretation.'" *Id.*

Although this decision is not surprising, it now makes it clear that for insured ERISA plans offered or issued in Illinois after July, 1 2005, the judicial standard of review for plan administrators' benefits decisions is *de novo*. The case could influence other courts in jurisdictions that take up the issue of ERISA preemption of other states' similar regulations, because it addressed many creative and specific arguments MetLife made,

rejecting them on the basis of various Supreme Court decisions.

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Second Circuit Allows Claim Against Claims Administrator for Violation of Federal Mental Health Parity Statute to Stand Under Section 502(a)(3) of ERISA

The Second Circuit's decision in *New York State Psychiatric Ass'n, Inc. v. UnitedHealth Grp.*, No. 14-20-cv, 2015 WL 4940352, *1 (2d Cir. Aug. 20, 2015), *petition for certiorari docketed by UnitedHealth Grp., Inc. v. Denbo*, U.S. (Sep. 14, 2015), provides a reminder to claims administrators of both insured and self-insured employee benefit plans to be prepared for potentially additional exposure from plan participants under Section 502(a)(3) of ERISA, based on non-ERISA statutes. *New York State Psychiatric Ass'n, Inc.* held, not surprisingly, that the self-funded ERISA plan's claims administrator ("United"), which "enjoyed 'sole and absolute discretion' to deny benefits and make 'final and binding' decisions as to appeals of those denials," was a proper defendant for the Section 502(a)(1)(B) (29 U.S.C. § 1132(a)(1)(B)) claim of ERISA plan participant Jonathan Denbo ("Denbo").[1] Significantly, however, the Second Circuit also held that United was a proper defendant to Denbo's Section 502(a)(3) claim, which was based on an alleged violation of the Mental Health Parity and Addiction Equity Act of 2008 (the "Parity Act") (29 U.S.C. § 1185a(a)(3)(A)). The Parity Act "requires group health plans and health insurance issuers to ensure that the financial requirements (deductibles, co-pays, etc.) and treatment limitations applied to mental health benefits be no more restrictive than the predominant requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the plan or insurance." *New York State Psychiatric Ass'n, Inc.*, No. 14-20-cv, 2015 WL 4940352 at *1 (citation omitted).

Denbo received "weekly and, later, semiweekly outpatient psychotherapy sessions with an out-of-network psychologist." *Id.* at *2. United granted his claims initially and later terminated his benefits, determining "his treatment plan was not medically necessary." *Id.* Denbo alleged that United improperly administered the plan by treating claims for routine medical and surgical care "more favorably than claims for ongoing, routine, outpatient, out-of-network psychotherapy sessions … in violation of the Parity Act." *Id.* at *2. He also alleged that United violated the terms of the plan itself, which did "not appear to sanction either preauthorization or concurrent review" of "mental health claims for sessions lasting less than fifty minutes …." *Id.* Further, Denbo alleged United violated the terms of the plan and the Parity Act by "conducting a concurrent review of mental health claims based solely on the frequency of mental health office visits …." *Id.*

Regarding Denbo's Section 502(a)(3) claim, the court rejected United's argument that the Parity Act did not apply directly to United because the ERISA plan was self-funded and was therefore not a "group health plan" that offered health insurance coverage to Denbo. *Id.* at *5. The court agreed with Denbo that United's obligation arose not from the Parity Act itself, but through Section 502(a)(3). *Id.* Relying on the Supreme Court's interpretation of Section 502(a)(3) in *Harris Tr. & Sav. Bank*, 530 U.S. 238 (2000), the Second Circuit concluded that "§ 502(a)(3) may impose a fiduciary duty arising indirectly from the Parity Act even if the Parity Act does not directly impose such a duty." *Id.* The court held that "[f]or that reason, and because '§ 502(a)(3) admits of no limit … on the universe of possible defendants' … United is a proper defendant for Denbo's Parity Act claim under § 502(a)(3)." The Second Circuit also found that the dismissal of Denbo's § 502(a)(3) claim was premature because it was not clear whether monetary benefits under § 502(a)(1)(B) alone would provide a sufficient remedy. *Id.* at *6.

The New York State Psychiatric Association ("NYSPA"), which "is a professional organization of psychiatrists practicing in New York State," and Dr. Menolascino, a psychiatrist who treated Denbo, also sued under Sections 502(a)(1)(B) and 502(a)(3) for United's alleged violations of its ERISA fiduciary duties, the terms of the plans United administered, and the Parity Act. The Second Circuit vacated the dismissal

[1] The Second Circuit stated that it need not and did not decide "whether a claims administrator that exercises less than total control over the benefits denial process" was an appropriate defendant under § 502(a)(1)(B). *Id.* at *4 n.5.

of NYSPA's claims, finding that it plausibly alleged its claims did not require individualized proof and, therefore, that NYSPA properly pleaded associational standing. *Id.* at *3 (citations omitted). The court noted, however, that if at summary judgment or trial, NYSPA's claims required significant individual participation or proof, the district court might then dismiss it for lack of standing. *Id.* In addition, the court remanded the case for consideration of whether NYSPA's pleadings satisfied the standards set forth in *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544, 570 (2007). *Id.* The Second Circuit affirmed the dismissal of the Dr. Menolascino's claims because her allegations failed to satisfy *Twombly*.

In any event, the Second Circuit acknowledged that if Denbo succeeds on his claims under both Section 502(a)(1)(B) and 502(a)(3), equitable relief under Section 502(a)(3), in addition to monetary relief under Section 502(a)(1)(B), might be appropriate. *Id.* at *6. Specifically, the court noted that: "[i]f Denbo seeks true equitable relief—such as losses flowing from United's breach of fiduciary duty—the relief sought would 'resemble' the remedy of surcharge, and would therefore be available to him under § 502(a)(3), ERISA's provision for equitable remedies." *Id.* at *7 (quoting *CIGNA Corp. v. Amara*, 563 U.S. 421 (2011)).

This decision serves as a reminder to claims administrators reviewing benefit claims to follow not only ERISA and the terms of employee benefit plans, but also related and applicable statutes, such as the Parity Act. Claims of violations of such statutes, made through Section 502(a)(3), may be able to survive the pleading stage and, ultimately, to expose claims administrators to additional liability and damages in the form of equitable relief under Section 502(a)(3).

If you have any questions about this Client Bulletin, please feel free to contact any of the attorneys listed or the CMN attorney with whom you regularly work.

Chittenden, Murday & Novotny LLC
303 W. Madison St. Suite 1400
Chicago, Illinois 60606
312.281.3600