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Feature Articles

When Does an ERISA Service Provider Incur Liability for Breach of Fiduciary Duties?

By H. Sanders Carter, Jr., Co-Editor, ERISA Report

Retirement plans governed by ERISA are required to have at least one named fiduciary with "authority to control and manage the operation and administration of the plan." 29 U.S.C. §1102(a)(1).

A party not named as a fiduciary in a plan document may become a "functional fiduciary" by exercising discretionary authority or control over plan management or the disposition of plan assets, or by providing investment advice for a fee regarding money or property of the plan, or by being given the authority or responsibility to do so. 29 U.S.C. §1002(21)(A).

The same duties of loyalty apply to named fiduciaries and functional fiduciaries. ERISA requires fiduciaries to "discharge [their] duties with respect to a plan solely in the interest of the participants and their beneficiaries," and for the sole purpose of "[i] providing benefits as to participants and their beneficiaries; and [ii] defraying reasonable expenses of administering the plan." 29 U.S.C. §1104(a)(1)(A).

Fiduciaries who breach these duties are personally liable to the plan for losses resulting from the breach. 29 U.S.C. §1109(a). Plan participants and their beneficiaries are authorized to sue breaching fiduciaries for relief. 29 U.S.C. §1132(a)(1).

In two cases decided a year apart, the issue was whether a life insurance company, which was not a named fiduciary, but which provided investment services to a 401(k) retirement plan, could be sued as a plan fiduciary. The cases involved similar facts. Each case was certified as a class action. In each case, the district court granted summary judgment to the insurer. But when the summary judgments were appealed, the outcomes in the Tenth and Eighth Circuit Courts of Appeals were very different.

Teets v. Great-West

In *Teets v. Great-West Life & Annuity Ins. Co.*, 921 F.3d 1200 (10th Cir. 2019), Great-West managed an investment product called the Key Guaranteed Portfolio Fund. The Fund was one of 29 investment options offered by the plan sponsor to its employees. The Fund invested in fixed-income instruments, such as treasury bonds. It "guarantee[d] capital preservation," meaning that plan participants who invested in the Fund could not lose their principal investments or the interest they earned.

Money invested in the Fund earned interest at a fixed rate, known as the "Credited Interest Rate." Under its contract with the plan, Great-West set a new Credited Interest Rate each quarter, which was announced two business days before the start of the quarter.

Plan participants who put money in the Fund could withdraw their principal and accrued interest at any time without penalty, and the plan could terminate its relationship with Great-West based on a change in the Credited Interest Rate. If the plan chose to end the relationship, Great-West had the right – which it had never exercised – to defer payment of the participants' money back to the plan for "not longer than 12 months."

Great-West retained as revenue the difference between the total yield on the Fund's monetary instruments and the Credited Interest Rate – the "margin" or "spread." The Credited Interest Rate dropped from 3.55 percent before 2008 to 1.10 percent in 2016. During that time, the Credited Interest Rate increased only once, and Great-West's margin remained relatively constant.

Teets sued Great-West on behalf of all retirement plan participants who had invested in the Fund since 2008. He alleged that Great-West violated fiduciary duties imposed by ERISA by setting the Credited Interest Rate for its own benefit, rather than for the benefit of plan participants; by setting the Credited Interest Rate artificially low and keeping the difference; and by charging excessive fees.

Teets also alleged that Great-West breached fiduciary duties by engaging in a prohibited transaction – dealing with plan assets "in [its] own interest or for [its] own account," in violation of 29 U.S.C. §1006(b). Finally, Teets alleged that, if Great-West was not a plan fiduciary, it was liable as a non-fiduciary party in interest.

The district court certified a class of 270,000 persons who had invested in the Fund across more than 13,000

ERISA plans. On cross-motions, the court granted summary judgment to Great-West, concluding that in providing investment services it had not acted as a fiduciary of the plan or its participants.

Summary Judgment Affirmed

In a detailed ruling, the Tenth Circuit affirmed, agreeing with the district court that Great-West's contractual authority to set the quarterly Credited Interest Rate did not make it a fiduciary, because plan participants could reject the new rate by withdrawing their money from the plan without penalty. The Tenth Circuit also held that Great-West did not set its own fees, because the amount it earned depended on whether plan participants elected each quarter to keep their money in the Fund.

This decision provides an exhaustive review of the circumstances under which an ERISA service provider, as defined by 29 U.S.C. §1002(14)(B), can become a functional plan fiduciary, and whether Great-West assumed fiduciary status by setting the quarterly Credited Interest Rate, or by retaining the contractual right to impose a 12-month waiting period on plan withdrawal, or by setting its own compensation.

Although the Credited Interest Rate was set unilaterally by Great-West, not as the result of an arms-length negotiation, the court held this did not make Great-West a fiduciary, because each plan participant had the right to reject the rate by withdrawing from the Fund.

The fact that Great-West had the right to impose a 12-month waiting period did not change the result. ERISA "confers fiduciary status on a service provider," the court said, "only to the extent it 'exercises any discretionary authority or discretionary control' over a plan or its assets." While Great-West had the contractual right to impose the waiting period, it had never actually exercised that right. "We are not aware of any case finding fiduciary status under §3(21)(A) of ERISA based on a service provider's unexercised contractual option to restrict or penalize withdrawal," the court said.

The opinion covers multiple other issues, including whether Great-West engaged in prohibited transaction as a non-fiduciary party in interest in violation of 29 U.S.C. §1106(a), and whether Teets was able to make out a claim for "appropriate equitable relief" under 29 U.S.C. §1132(a)(3).

The court concluded:

> Great-West was entitled to summary judgment on both the fiduciary and non-fiduciary claims. Because Mr. Teets has not provided evidence that contractual restrictions on withdrawal from the [Fund] actually constrained plans or participants, Great-West does not act as an ERISA fiduciary when it sets the [Fund's] Credited Rate each quarter. As a result, it also lacks sufficient authority or control over its compensation to render it a fiduciary. As to liability as a party in interest, Great-West was entitled to summary judgment because Mr. Teets failed in the district court to carry his burden of showing that the relief he sought was equitable.

Rozo v. Principal

In *Rozo v. Principal Life Ins.* Co., 949 F.3d 1071 (8th Cir. 2020), the Eighth Circuit came to the opposite conclusion under similar facts.

Principal Life provided investment services to a 401(k) retirement plan. Participants in the plan could invest in the Principal Fixed Income Option, a fund providing a guaranteed rate of return. Principal unilaterally set the fund's interest rate – the Composite Crediting Rate – every six months.

Participants were given notice of each new interest rate a month in advance. A plan sponsor could reject the new rate and withdraw its funds, but unlike the plan in *Teets*, the plan was required to pay a 5 percent surrender charge and wait 12 months. Plan participants could immediately withdraw their funds, but could not reinvest in plans like the one offered by Principal for three months.

Rozo brought a class action, alleging that Principal breached fiduciary duties in setting new interest rates and engaged in prohibited transactions. In granting summary judgment, the district court concluded that Principal was not a fiduciary of the plan, nor liable as a party in interest.

On appeal, the Eighth Circuit agreed that the two-part test followed by the Tenth Circuit in *Teets* provided the correct analysis to determine if Principal acted as a plan fiduciary. According to the court:

> If the [service] provider's actions (1) conform to specific contract terms or (2) a plan and participant can freely reject it, then the provider is not acting with "authority" or "control" respecting the "disposition of [the plan's] assets."

Summary Judgment Reversed

The Eighth Circuit concluded that Principal failed both parts of the test.

Principal contended it acted in accordance with its contract, because it was authorized to set the Composite Crediting Rate. The court disagreed, stating, "Although the contract empowers Principal to set the CCR, the rate is not a 'specific term[ ] of the contract.'"

Rather, when Principal notified plan sponsors of a new Composite Crediting Rate, the sponsors had not agreed to the new rate. Therefore, Principal failed step one of the *Teets* test. "A service provider may be a fiduciary when it exercises discretionary authority," the court said, "even if the contract authorizes it to take the discretionary act."

The court held that Principal also failed step two of the *Teets* test, because plan sponsors did not "have the unimpeded ability to reject the service provider's action or terminate the relationship." Instead, a plan sponsor wishing to reject a new interest rate was required to leave the plan and either pay a 5 percent surrender charge, or have its funds remain in the plan for 12 months. Either option "impedes termination," the court wrote. "Principal, therefore, is a fiduciary exercising control and authority over the CCR."

Principal argued that the surrender charge and the 12-month delay were not impediments, because they were spelled out in its contract with the plan. "Fiduciary status focuses on the act subject to complaint," the court said. "Because the plan sponsors do not have an opportunity to agree to the CCR until it is proposed, the CCR is a new contract term."

The Eighth Circuit rejected Principal's contention that the *Teets* analysis required a finding that it was not a plan fiduciary. "The investment vehicle there, although similar to the one here, differs in one critical respect," the court wrote. "The *Teets* service provider had a 'contractual *option* to impose a 12-month waiting period on plan withdrawal,' but never exercised it. *Teets*, 921 F.3d at 1217 (emphasis added.) Here, Principal imposes the 12-month delay."

Finally, Principal argued that an individual plan participant's ability to freely reject a new interest rate negated fiduciary standing, regardless of the plan sponsor's ability to withdraw from the Fund. Relying on ERISA cases regarding fiduciary status, as summarized in *Teets*, the Eighth Circuit also rejected that argument.

Under *Rozo*, a service provider such as a life insurance company is subject to suit as an ERISA plan fiduciary if either the plan sponsor or a plan participant is impeded from rejecting the service provider's act. "Because the sponsor here is impeded," the court said, "the participant's ability to reject the CCR does not negate Principal's fiduciary status."

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Disability Plan Offsets

Insights for Administering Claims and Defending Disputes

By Charan M. Higbee

ERISA-governed long term disability policies generally contain language allowing the insured's disability benefits to be offset by other income. "Other income" commonly includes state disability benefits, Social Security disability benefits, workers' compensation payments, retirement benefits, and settlements received from third parties.

Despite the long-standing practice of ERISA-governed policies to include these offset provisions, insureds frequently challenge the resulting reduction of their monthly benefits. Since the right to offset other income stems from the policy or plan terms, the insured's most popular argument is that the subject policy provision is ambiguous or simply does not allow for the offset. This tactic is best combatted with clear and specific contract language allowing the offset.

A deferential standard of review and a favorable jurisdiction also can make a significant difference in the plan interpretation and the legal outcome.

Additionally, as discussed below, disputes over applicable offsets sometimes raise public policy issues or the contention that a state law prohibits the reduction. Existing case law provides examples of some of the more unique theories and insight as to how courts may rule.

Disability Policies Are Designed to Replace Income and Not to Provide a Financial Windfall

Federal courts recognize the underlying purpose behind offset provisions, which supports their reasonable enforcement. As explained by a leading insurance treatise:

> Monthly disability benefits are calculated on the basis of an employee's earnings prior to disability and are intended to recompense the insured for the loss in ability to earn a living. It is, therefore, quite common for disability policies to provide for reductions in such benefits for duplicative income replacement benefits from other sources such as workers' compensation, Social Security, and retirement benefits.

12A Couch on Ins. §182:31.

One federal district court noted, "ERISA does not impose on employers an obligation to provide their employees with any benefits at all" and, thus, there is no legal basis under ERISA to question a plan's offset provisions, as long as they are interpreted reasonably. *Day v. AT & T Disability Income Plan,* 733 F. Supp. 2d 1109, 1116 (N.D. Cal. 2010).

In short, an insured may be contractually entitled to a benefit under the policy to compensate for a disability but generally is not allowed a windfall so as to receive more income after a disability than while working.

Clear Policy Language Is the Easiest Way to Defend an Offset

The primary focus of courts reviewing the insurer's right to an offset is on the policy or plan language, including whether the "other income benefits" provision contractually permits the offset and, beyond that, whether the provision logically can be interpreted by the average layperson to include the offset.

In *Thomason v. Metropolitan Life Ins. Co.,* 703 Fed. App'x 247 (5th Cir. 2017), the Fifth Circuit explained, in an unpublished decision, when plan language is insufficient to support an offset.

Joel Thomason participated in two relevant employee benefit programs sponsored by his employer: a long term disability income plan and a pension plan. The claims administrator (MetLife) had discretionary authority to adjudicate disability claims and to interpret the disability plan. The summary plan description explained that certain benefits offset the long term disability benefit, including pension benefits from the employer's pension plan if the employee "elect[s] to receive them."

Thomason became eligible to receive LTD benefits, and he also elected to take all of his pension benefits in a lump sum. He requested a trustee-to-trustee direct rollover from his pension account to his IRA. The IRS regulations explained that such a direct rollover may defer tax penalties because the funds are not considered income until received as a distribution. Thomason believed the offset provision of the disability plan would not apply to the direct rollover because he would not receive the pension benefits until he withdrew them from his IRA. However, MetLife used the pension benefits as an offset against the LTD benefits after a determination that Thomason had "elected to receive" the pension benefits pursuant to the rollover.

After two unsuccessful administrative appeals, Thomason sued his employer and MetLife under the provisions of ERISA. On MetLife's appeal to the Fifth Circuit, the court first examined whether the language of the summary plan description was ambiguous, explaining that, pursuant to Fifth Circuit authority, ambiguities in a plan summary are resolved in favor of the plan beneficiary and a grant of discretion over the plan does not extend to the summary plan description.

The *Thomason* court held the phrase "elect to receive" in the SPD was ambiguous (based on the parties' competing interpretations) and must be construed against MetLife. The Fifth Circuit explained:

> In sum, the Summary Plan Description gave no indication of whether a direct rollover in a trustee-to-trustee transfer constituted a beneficiary "electing to receive" pension benefits from a Verizon pension plan. We do not reach the actual meaning of "elect to receive" under the Plan. Instead, we determine that the Summary Plan Description is ambiguous and thus we construe it in Thomason's favor. Accordingly, we determine that Thomason had not elected to receive the funds when he directly rolled them over from the pension fund to his IRA through a trustee-to-trustee transfer.

703 Fed. App'x at 252 (citation omitted). Thus, the *Thomason* court's ruling centered on a finding that the language of the SPD did not reasonably apprise the plan participant that his direct rollover to an IRA account would constitute an election to "receive" pension benefits.

A different holding was reached in *Day, supra,* 733 F. Supp. 2d 1109, 1114 (N.D. Cal. 2010), where the plan contained specific language allowing the reduction of long term disability benefits by pension benefits if the employee was eligible and applied for the pension benefits and expressly included "a cashout" election. The plan also provided that "other benefits" included "all benefits for which the Employee would be eligible if he applied for them, whether or not he actually receives them." *Id.*

Based on this more detailed plan language, the *Day* court held the claims administrator reasonably offset the pension benefits when the employee elected a direct rollover of his entire accrued pension benefit to an IRA account. As in *Thomason*, the plan participant argued he had not "received" a benefit through the rollover. The *Day* court found in favor of the plan, under an abuse of discretion standard of review, and based on the express plan language referring to a pension cash out.

Not surprisingly, even a detailed and thorough offset provision can lead to litigation. A disability plan participant recently argued, in essence, that the plan's "Other Income Benefits" provision was too lengthy, such that the subpart allowing an offset for Social Security Retirement benefits was buried in the document.

In *Ruppert v. Atlas Air, Inc. Long Term Disability Plan,* 2019 WL 7212305 (D. Alaska Dec. 27, 2019), Thomas Ruppert was a participant in his employer's long term disability plan insured by Hartford Life and Accident Insurance Company. He became disabled on June 1, 2018, and his claim for LTD benefits was approved. Thereafter, Ruppert was advised he was entitled to monthly Social Security Retirement benefits in the amount of $2,461 beginning in July 2018. Hartford informed Ruppert that the Social Security Retirement benefits were "Other Income Benefits" under the plan and his $10,000 monthly LTD benefit would be reduced. A lawsuit followed with the district court reviewing Hartford's determination under the abuse of discretion standard of review.

The plan in *Ruppert* contained a fairly lengthy and detailed definition of "Other Income Benefits" which included two paragraphs, each with numbered subparts. The plan first defined "Other Income Benefits" to include disability benefits received pursuant to any governmental law or program, including disability benefits under the Social Security Act. In subpart 5(a) of the second paragraph, "Other Income Benefits" were defined also to include "retirement benefits under … the United States Social Security Act … that You, Your Spouse and/or children receive because of Your retirement, unless you were receiving them prior to becoming Disabled." *Id.* at *5.

Ruppert argued that "it would not be clear to a person of average intelligence and experience reading the definition of 'Other Income Benefits' that LTD benefits could be reduced by the receipt of Social Security Retirement benefits." *Id.* He additionally asserted that the definition of "Other Income Benefits" which included Social Security Retirement benefits violated 29 C.F.R. §2520.102-2(b), applicable to summary plan descriptions, which states in relevant part, "[a]ny description of exception, limitations, reductions and other restrictions of plan benefits shall not be minimized, rendered obscure or otherwise made to appear unimportant." 2019 WL 7212305, *6.

Thus, Ruppert argued the inclusion of Social Security Retirement benefits as one of the allowable offsets was not clear, plain, and conspicuous enough for a lay person to understand and essentially was buried in the plan's detailed "Other Income Benefits" provision. The district court did not find these arguments persuasive and allowed the offset.

In sum, there is no downside where a policy or plan document contains a detailed provision explaining plan offsets in language easily understood by the average plan participant.

Disputes Arising from Third-Party Settlements Should Be Anticipated

Litigation frequently arises after an insured receives a settlement award from a third party based on the event or conduct which caused the disabling injury and the insurer seeks to offset the settlement payment from the disability benefits due under the plan. In these situations, the insured often already has an attorney who is eager to step in and dispute that the settlement award is an allowable offset. For these reasons, not only must the plan language support offsetting the settlement award, the claims administrator should consider: the nature of the underlying litigation which was settled by the insured; confirm how best to offset the settlement payment (*i.e.,* a lump sum repayment or reductions in future monthly benefits) and ensure the manner of offsetting the award is contractually permitted; and whether the entire settlement award can be used as an offset or it should first be reduced by the amount of attorney's fees incurred by the insured or by amounts attributed in the written release to compensate for damages other than loss of income, such as pain and suffering or medical bills.

In *Murray v. Unum Life Ins. Co. of America,* 2019 WL 7040628 (W.D. Ky. Dec. 20, 2019), Erin Murray was a participant in an employee welfare benefit plan that included long term disability insurance coverage. In March 2012, Murray stopped working due to complications from Meniere's Disease and shortly after, on June 4, 2012, was involved in a car accident. On the claim forms she submitted for disability benefits, she stated her disability stemmed from both Meniere's Disease and intervertebral disc protrusion caused by the car accident. Throughout the disability claim, Murray continued to complain of both cervical injuries and Meniere's Disease.

In August 2012, the insurer approved Murray's claim and began paying her monthly benefits. The approval letter stated the decision was based on Murray's symptoms related to her conditions of Meniere's Disease and the car accident. In a May 15, 2013, letter, the insurer advised Murray it considered the injuries from the car accident as contributing to her ongoing disability. In 2015, Murray reached a $275,000 settlement in her lawsuit arising from the car accident, and the insurer began reducing the LTD benefits to offset the settlement.

The disability policy provided that the insurer "is entitled to offset the LTD benefit by 'deductible sources of income' that stem from the claimed disability, including '[t]he amount that you receive from a third party (after subtracting attorney's fees) by judgment, settlement, or otherwise." *Id.* at *1. In subsequent litigation over the offset, Murray argued the decision to offset her LTD benefits by the amount of her personal injury settlement violated the terms of the policy and the subject provision was unenforceable. The parties stipulated to the "arbitrary and capricious" standard of review, based on a grant of discretion in the policy. Following Sixth Circuit precedent, the district court stated *contra proferentum* does not apply under the arbitrary and capricious standard of review and, even if the terms are ambiguous, the court must defer to the insurer's interpretation as long as it is reasonable.

The *Murray* court found the insurer's interpretation of the offset provision was "not unreasonable." First, the court determined the $275,000 settlement Murray received from the other driver's insurer was an amount received from a third party by judgment, settlement, or otherwise as required by the provision. Second, the court examined the insurer's interpretation of the term "same disability" and noted courts were split as to the correct definition of "same disability" in this context, *i.e.*, whether it refers to the same period of disability or the same disabling condition. However, here, Murray had consistently claimed disability from both her Meniere's Disease and from her neck and back injuries stemming from the car accident.

The court therefore was not required to determine which interpretation of "same disability" was correct, because either definition would be satisfied. Moreover, the insurer had approved Murray's LTD benefits, and paid the benefits, based on both medical conditions throughout the claim period. The administrative record "supports Unum's assertion that it has always paid Murray's LTD benefits based on both conditions, and therefore the car-accident settlement stems from the 'same disability.'" 2019 WL 7040628, *5. Thus, the determination that the car accident settlement was compensation for the "same disability" for which Murray claimed benefits under the policy was not arbitrary and capricious and could not be disturbed.

Two factors appear critical to the holding in *Murray*: (1) both Murray and the insurer consistently took the position her disability was caused by both the Meniere's Disease and the injuries sustained in the accident, and (2) the insurer's conclusion that the car accident contributed to the disability was well supported by the documentation in the administrative record.

The insurer received a less favorable ruling regarding the offset of an insured's settlement award where its opinion as to the medical condition causing the disability changed over the life of the claim *and* there was a lack of medical information in the administrative record to support the insurer's most recent opinion as to the cause of the disabling condition.

In *Rustad-Link v. Providence Health and Services*, 306 F. Supp. 3d 1224 (D. Mont. 2018), Dawn Rustad-Link was a participant in an insured group long-term disability plan provided by her employer. She was diagnosed with multiple sclerosis ("MS") in 1996 and suffered a below-the-knee amputation due to negligent medical care in 2010. Rustad-Link subsequently applied for disability benefits under the plan and based her claim on the amputation, not on the MS. The insurer initially approved her claim without communicating the specific condition or conditions that supported the disability determination. In 2011, the insurer determined that the amputation was the injury causing disability and MS was secondary and so notified Rustad-Link. In 2012, the insurer concluded the injury causing her disability should be updated to MS.

In 2014, the insurer was informed of a third-party settlement obtained by Rustad-Link arising from the medical negligence and that the recovery solely was based on the amputation and not on her MS. The insurer

began assessing whether the settlement would qualify as a deductible source of income, which included an evaluation which determined the injury causing Rustad-Link's disability should be changed to the amputation alone and not the MS. Rustad-Link then was informed her third party settlement resulted in an overpayment in the amount of $46,856.28 and her monthly benefits would be reduced going forward. A lawsuit was filed alleging claims under ERISA and disputing the offset decision.

Applying Washington law, the district court found the claim determination was subject to *de novo* review. The plan defined deductible sources of income to include "[t]he amount that you receive from a third party (after subtracting attorney's fees) by judgment, settlement or otherwise" and stated, with the exception of retirement benefits, the plan "will only subtract deductible sources of income which are payable as a result of the *same disability*." 306 F. Supp. 3d 1224, 1239 (emphasis added). "Same disability" was not a defined term.

Rustad-Link argued "same disability" means the same medical condition, and the insurer asserted the term means the same time-period of disability, which therefore would include a settlement payment based on the amputation. The district court found the plain language of the plan to support Rustad-Link's interpretation and noted, even if the definition of "same disability" was a close call, any ambiguity must be construed against the insurer. The district court also agreed that the insurer's "assertion that 'same disability' does not mean same medical condition is undercut by its decision to switch Rustad-Link's injury causing disability from MS back to amputation after it learned of her settlement, due to her amputation …" and this decision was "impermissibly self-serving." *Id.* at 1240.

The district court recognized plaintiff's disability involved both MS and amputation, but the insurer had determined in 2012 that the disabling injury was MS; after learning of the settlement in 2014, the assessment was changed to a determination the disability was based solely on the amputation; and the change in assessment was not based on any new medical information in the administrative record. The district court found these facts did not support a reasonable benefit determination and ultimately ruled in favor of Rustad-Link.

On a different note, one district court recently held the continuing violations theory for statute of limitations purposes does not apply to an insurer's decision to offset monthly disability benefits by a third-party settlement amount, even though the disability payments were ongoing, and the offset applied to each monthly payment.

In *Vizinat v. Unum Life Ins. Co. of America,* 2019 WL 1548653 (W.D. La. April 9, 2019), the group disability insurance policy issued to James Vizinat's employer contained a provision entitled "What Are Deductible Sources of Income?" and included amounts received under a workers' compensation law, an occupational disease law, the Jones Act, and from a third party (after subtracting attorney's fees) by judgment, settlement, or otherwise. Vizinat was injured in a work-related accident on February 1, 1999, and submitted a claim for disability benefits under the Unum policy. In October 1999, the claim was approved.

Subsequently, Unum was informed Vizinat settled a third-party tort claim, alleging he was a Jones Act Seaman and based on the work-related accident, for $850,000 of which he netted $400,000. In 2002, Vizinat was advised the settlement amount was considered a deductible source of income and Unum calculated the applicable offset by dividing the $400,000 received by Vizinat by the number of months left on his disability claim at the time the settlement was signed, which resulted in a monthly offset of $1,646.54 going forward.

Vizinat's attorney disagreed, as stated in correspondence sent in 2002 and 2003, that Unum was entitled to offset the settlement amount. In May 19, 2003, correspondence, Unum provided formal notice of the manner in which it would offset the $400,000 settlement amount, copies of the policy provisions allowing the offset and advising, if Vizinat disagreed with the decision, he was required to submit a written appeal. Vizinat thereafter appealed and a July 7, 2003, letter was sent advising the prior decision was being upheld.

More than eleven years later, on April 2, 2014, Vizinat filed a state court lawsuit alleging Unum was not authorized to offset the amount he received as a settlement, and the action was removed to federal court based on federal question jurisdiction (ERISA). Unum filed a motion for summary judgment on the grounds Vizinat's claim was untimely and accrued, at the latest, when he was notified on July 7, 2003, of the decision to uphold the offset. Unum contended the policy's contractual limitations period ran three years later on July 7, 2006. In response, Vizinat argued Unum was in a continuing state of breach of contract based on the monthly disability payments being paid and his cause of action therefore had not accrued. The district court noted, "[w]hen an ERISA cause of action accrues for limitations purposes is a determination governed by federal law," but the Fifth Circuit had not established a clear rule as to accrual when the allegation is

that benefits have been miscalculated or underpaid. 2019 WL 1548653, *4–5.

Nevertheless, based on the facts of this case, the district court held, "[u]nder any test, it is clear that, no later than July 2003, that Unum had reached a final decision on the calculation of Vizinat's benefits and had rejected or clearly repudiated his calculation. Thus his claim accrued no later than that date." *Id.* at *5. The district court specifically rejected Vizinat's argument "that his cause of action never accrued because each miscalculated or improper payment is a continuing breach of contract." *Id.* The court found this argument fails where, as in this case, a plaintiff's claim is based on a single decision that results in lasting negative effects and is different from the situation where there is repeated decision-making of the same character by the claim fiduciary. Applying the policy's three-year limitations period, Vizinat's claim challenging the offset calculation was held time-barred.

A necessary conclusion is that offsetting third-party settlement awards presents unique contractual and legal issues which are best addressed during the claim administration. As demonstrated by *Murray* and *Vizinat*, the decision letters sent to the insured carry great weight with the court in future litigation and therefore should clearly and consistently apprise the insured of the factual and contractual reasoning behind an offset decision.

New State Laws and Social Issues Provide Insureds with Novel Arguments

In addition to challenging the meaning of contract terms, insureds have asserted broader policy theories to dispute plan offsets and relied on state regulations which arguably prohibit the offset. Many of the public policy issues already have been the subject of litigation and courts tend to follow the existing legal precedent. However, when states enact new laws that may be interpreted as limiting contractual offsets, the legal outcome is harder to predict.

In an unpublished decision, the Second Circuit Court of Appeals affirmed that the offset of Social Security disability payments made to the insured's children did not violate public policy. *See Fortune v. Group Long Term Disability Plan For Employees of Keyspan Corp.*, 391 Fed. App'x 74 (2d Cir. 2010). Plaintiff Diane Fortune was a participant in her employer's long-term disability plan insured by Hartford Life Insurance Company. She filed a lawsuit against the plan and Hartford after her claim for disability benefits was denied and Hartford counterclaimed for reimbursement of benefit overpayments. Fortune also unsuccessfully sought leave in the district court to assert a class action claim based on the plan's offsetting Social Security disability benefits payable to the children of plan participants.

The plan terms allowed Hartford to offset monthly disability benefits by "any benefit for loss of income, provided to you or to your family … as a result of the period of Disability for which you are claiming benefits under this plan," including disability benefits under the Social Security Act "that you, your spouse and children are eligible to receive because of your Disability." *Id.* at 79.

The Second Circuit held the plain language of the plan allowed the offset for Social Security disability benefits paid to dependent children. The court dismissed Fortune's argument that the offset violated public policy, citing to existing authority on the issue, and found the district court acted well within its discretion in denying leave to assert a class action claim. The Second Circuit explained, "[a]pproximately half of the LTD plans adopted by Fortune 500 companies providing for offsets based on social security benefits do so based on benefits paid not only to the claimant but also to the claimant's dependents." 391 Fed. App'x at 80.

The Seventh Circuit similarly affirmed the dismissal of a putative class action lawsuit brought by ERISA plan participants against the plans' insurer based on the reduction of their disability benefits for Social Security disability benefits received by their dependent children pursuant to 42 U.S.C. §402(d). *See Schultz v. Aviall, Inc. Long Term Disability Plan,* 670 F.3d 834 (7th Cir. 2012). The plans both included, as a deductible source of income, the amount the insureds, their spouse, and their children receive as "loss of time disability payments" under the United States Social Security Act because of the insured's disability or based on the insured's work and earnings.

The court conducted a *de novo* review of the plans' decision to offset the Social Security disability benefits received by the insureds' children. The plaintiffs argued the children's Social Security disability benefits did not constitute "loss of time disability" benefits such that the offset violated the plans' terms, and instead "the purpose of Social Security payments to a dependent child of a disabled parent is not to replace the income that the household has lost as a result of the parent's inability to work" but "to provide additional 'support' for the child." *Id.* at 837.

The *Schultz* court disagreed with plaintiffs' contentions and ruled, "[t]he only reasonable interpretation of the applicable language is that when a disabled employee's dependent children receive Social Security payments by

reason of the parent-employee's disability, those benefits are disability benefits based on the employee's 'loss of time'" and the offsets were permitted under the plans. 670 F.3d 834, 838. Moreover, the court stated, "virtually all courts considering this issue have found the dependent children's Social Security benefits were subject to offset under nearly identical policy language" *and* where the policies specifically refer to Social Security benefits paid to children. *Id.* at 838–39. Again, it was critical that the plans' language expressly included Social Security disability benefits paid to the insured's children.

In *Day, supra*, the plaintiff argued it was a violation of the Age Discrimination in Employment Act for the plan to offset his pension benefits. The court was not persuaded by this argument as the insured was not required to involuntarily retire before receiving the pension benefits. 733 F. Supp. 2d at 1116–17. Recently, the First Circuit Court of Appeals disagreed with the plaintiff's contention that the insurer's decision to offset Veterans' Benefits violated the Uniformed Services Employment and Reemployment Rights Act. *See Martinez v. Sun Life Assurance Co. of Canada*, 2020 WL 415145 (1st Cir. Jan. 27, 2020).

However, as demonstrated by the *Arnone* case below, a New York resident successfully argued to the Second Circuit Court of Appeals that a state statute limiting reimbursement and subrogation claims in personal injury and wrongful death actions is a state law regulating insurance, falls within ERISA's saving clause, is not preempted by ERISA, and barred the plan's offset. Section 5-335 of the New York General Obligations Law provides that personal injury settlements "shall be conclusively presumed" not to include "any compensation for the cost of health care services, loss of earnings or other economic loss to the extent those losses or expenses have been or are obligated to be paid or reimbursed by an insurer."

In *Arnone v. Aetna Life Ins. Co.*, 860 F.3d 97 (2d Cir. 2017), plaintiff Salvatore Arnone, a New York resident, was injured while working and was approved for long-term disability benefits under his employer's disability plan insured by Aetna. Arnone also filed a personal injury lawsuit based on the disabling injuries he sustained and settled the lawsuit for $850,000. Aetna thereafter began reducing Arnone's disability benefits based on the plan provision listing other income benefits to include "[d]isability payments which result from the act or omission of any person whose action caused [the Plan participant's] disability." *Id.* at 101. Arnone sued Aetna under the provisions of ERISA to recover the offset amount and asserted Section 5-335 prohibited Aetna from offsetting the personal injury settlement. Aetna maintained this New York statute was preempted by ERISA.

The Second Circuit first held that Section 5-335 would, if applicable to the dispute, prohibit the offset as a matter of law. Next, the court held Section 5-335 is a state law which regulates insurance, falls within ERISA's saving clause, and is not preempted. The statute therefore applied to Aetna, an insurer, and Arnone was entitled to judgment in his favor on his claim seeking payment of his disability benefits without an offset for the personal injury settlement.

As a practical matter, new or unique theories advanced to dispute an offset, which are not based on the meaning of plan terms, often arise only after litigation has been initiated and therefore cannot be anticipated during the claim process. Nevertheless, where such a legal argument is made during the claim process, it certainly should be considered and addressed in the decision letter sent to the insured.

Nationwide Decisions Deliver Guidance for Avoiding Disputes over Offsets

As long as disability policies continue to reduce for other income, insureds will contest offset determinations. Claims administrators and defense attorneys therefore should be prepared to address both the common and more creative arguments asserted by insureds. The cases discussed in this article provide useful guidance for handling offset determinations and, when necessary, addressing the insureds' legal claims.

As with any ERISA benefits determination, a decision to offset a disability benefit first and foremost will be governed by the plan language. Ideally, the plan provisions relating to other income benefits will be plain and unambiguous so as to be reasonably understood by the average insured. However, the particular jurisdiction's rules relating to contract interpretation and how those rules apply under the applicable standard of review can greatly affect a court's decision regarding the policy term's alleged ambiguity. As shown by *Thomason*, the Fifth Circuit held the plan's grant of discretion did not extend to a summary plan description, which ultimately led to a ruling in favor of the insured as to the disputed offset.

The *Murray* and *Rustad-Link* cases illustrate the importance of consistency throughout the claim handling, that the administrative record adequately support an offset determination and avoiding any appearance of bias by the claims administrator. Principles which are recommended for any claim determination.

Most sources of other income which are included in offset provisions are customary and well-established, such as Social Security disability benefits and workers' compensation payments, and permitted if clearly set forth in the plan terms. Nevertheless, unanticipated legal arguments may arise based on public policy theories or state regulations. Overall, social policy arguments are less successful than those based on contract interpretation. However, when such a theory is adopted by a court, as in *Arnone*, the legal precedent will be uniformly applied to similar offset decisions in the jurisdiction. In such circumstances, the applicable case law must be considered during the claim administration.

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Litigating the Scope of ERISA's "Catchall Civil Enforcement Provision

By Joseph E Laska, John M. LeBlanc, and Nathaniel A Cohen



In recent ERISA litigation challenging benefit decisions by plan administrators and fiduciaries, litigants have been pleading closely related claims under multiple ERISA statutory civil remedy provisions.

Responding to these attempts, several federal courts of appeals have expanded the types of claims that litigants may bring under ERISA's "catchall" equitable remedy provision, 29 U.S.C. §1132(a)(3). This expansion has drawn scrutiny due to issues related to the appropriate standard of review and the availability and scope of discovery for certain ERISA claims. Future decisions clarifying the law on these issues would be a welcome development.

Background: Section 1132(a)(3), *Varity*, and Subsequent Appellate Decisions

29 U.S.C. §1132 provides the exclusive means of civil enforcement of ERISA. Subsection 1132(a) generally sets forth a list of 11 different actions that ERISA plaintiffs (and in some cases states or the Secretary of Labor) may bring. Among these, 29 U S C. §1132(a)(3) permits a participant, beneficiary, or fiduciary to bring a civil action to:

- Enjoin "any act or practice" that violates "any provision" of ERISA Subchapter I or the plan; or
- Obtain "other appropriate equitable relief" to redress such violations or to enforce "any provisions" of ERISA Subchapter I or the plan.

This language is broad and seemingly invites civil actions of any type to enforce ERISA requirements. But this statute has a more complex relationship with other, more specific causes of action in Section 1132(a)—such as Section 1132(a)(1)(B), which authorizes civil actions by a participant or beneficiary "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan[ ]."

In *Varity Corp. v. Howe*, the Supreme Court characterized Section 1132(a)(3) as a "catchall" safety net, "offering appropriate equitable relief for injuries caused by violations that [Section 1132] does not elsewhere adequately remedy." 516 U.S. 489, 512 (1996). But, when addressing the interaction between Section 1132(a)(3) and other provisions of Section 1132(a) that *do* provide commonly invoked remedies—such as the recovery of plan benefits available under Section 1132(a)(1)(B)—the Court expressed doubt that a plaintiff could simultaneously invoke both statutes. "[W]e should expect that where Congress elsewhere provided adequate relief for a beneficiary's injury, there will likely be no need for further equitable relief, in which case such relief normally would not be 'appropriate." *Varity,* 516 U.S. at 515.

The Supreme Court later revisited Section 1132(a)(3) in *CIGNA Corp v. Amara,* 563 U. S. 421 (2011), in which it upheld a district court's "reformation" of the terms of a plan

through Section 1132(a)(3) and reaffirmed prior holdings that Section 1132(a)(3) provided a vehicle for a variety of remedies that, "traditionally speaking[,]" were typically available in the old courts of equity. *See id.* at 438–41.

In the wake of *Varity,* district courts often dismissed claims brought under Section 1132(a)(3) when they were satisfied that another, more specific ERISA civil remedy was available to redress the claimed injuries, such as in the context of disputes over access to plan benefits under Section 1132(a)(1)(B). More recently, however, the Second, Eighth, and Ninth Circuits have issued decisions permitting plaintiffs to proceed *simultaneously* under Sections 1132(a)(1)(B) and 1132(a)(3) in some circumstances, at least at the pleading stage, under alternative theories of liability. *See New York State Psychiatric Ass'n Inc. v. UnitedHealth Group,* 798 F.3d 125, 134–35 (2d Cir. 2015); *Silva v. Metro Life Ins. Co.*, 762 F.3d 711, 726–27 (8th Cir. 2014); *Moyle v. Liberty Mut. Ret. Benefit Plan,* 823 F.3d 948, 960–61 (9th Cir. 2016).

The Fifth and Sixth Circuits reached a different conclusion, however, holding that a plaintiff may not plead a duplicative or redundant remedy under Section 1132(a)(3) where another section, such as Section 1132(a)(1)(B), provides an adequate remedy. *See Rochow v. Life Ins. Co. of N. Am.,* 780 F.3d 364, 371 (6th Cir. 2015) *(en banc); Tolson v. Avondale Indus. Inc ,* 141 F.3d 604, 610 (5th Cir. 1998). This has led one district court to characterize current law as "murky and inconclusive" on the issue of "whether a plaintiff may simultaneously plead claims under Section [1132(a)(1)(B)] and Section [1132(a)(3)] and proceed past a motion to dismiss[ ]." *Christine S. v. Blue Cross Blue Shield of N.M.,* 2019 WL 6974772, at *11 (D. Utah Dec. 19, 2019).

Most recently, the Second Circuit addressed the scope of Section 1132(a)(3) in its December 23, 2019, opinion in *Laurent v. PricewaterhouseCoopers LLP,* 945 F.3d 739 (2d Cir. 2019). In *Laurent,* a putative class action, the plaintiffs sought relief under Section 1132(a)(3) in the form of contract reformation of pension plan terms that they contended were necessary under ERISA and IRS pension benefit calculation requirements, and they also sought enforcement of the terms of the plan as reformed under Section 1132(a)(1)(B) in the same case. 945 F.3d at 742–43. In an apparent matter of first impression, the Second Circuit held that this "two-step" remedy under both sections is available under ERISA, reversing the district court's grant of judgment on the pleadings. *Id.* at 745–47. On February 12, 2020, the Second Circuit denied the *Laurent* defendants' petition for panel rehearing or, in the alternative, for rehearing *en banc.*

Recent District Court Cases Reveal Practical Issues

Recent ERISA benefits denial cases show that allowing more types of Section 1132(a)(3) claims past the pleading stage has consequences, not all of which may have been intended—particularly where those claims are closely related to, or in some cases duplicative of, Section 1132(a)(1)(B) claims advanced in the same case.

The Proper Standard of Review

For example, one potential consequence is the prospect of having to litigate closely related ERISA claims under separate standards of review in a single case. It is well established that ERISA plans may grant administrators discretion to determine benefit eligibility and construe plan terms. *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101, 115 (1989). (While some states have sought to ban or curtail the use of "discretionary clauses" in plans governed by ERISA, many others have not, leaving the deferential *Firestone Tire* standard of review in place.)

Where the plan does so, courts review the administrator's decisions for an abuse of discretion. *Id.* Yet under this new line of circuit court opinions, this could lead to a situation where an ERISA litigant could, at least theoretically, plead around the discretionary authority provisions in the ERISA plan terms in an attempt to avoid the highly deferential standard articulated in *Firestone Tire,* simply by pleading equitable claims that are indistinguishable from claims for benefits.

Supporting the *Varity* petitioners, several *amici* brought this potential consequence to the Supreme Court's attention. *See Varity,* 516 U.S. at 513–14; *see also Christine S.,* 2019 WL 6974772, at *11 ("The *Varity* Court was concerned that if a plaintiff could repackage a denial of benefits claim as a breach of fiduciary duty claim, she could avoid the deferential arbitrary and capricious standard of review applied to denial of benefits claims under *Firestone Tire* and instead avail herself to the rigid level of conduct expected of fiduciaries.") (Internal quotation marks omitted.)

District courts have responded in various ways. Some courts have held that "the same arbitrary and capricious standard" applies whether a plaintiff chooses to articulate a claim under Section 1132(a)(1)(B) or Section 1132(a)(3). *See Lees v. Munich Reinsurance Am. Inc.,* 2016 WL 164611, at *4 (D.N.J. Jan. 13, 2016) (citing *Varity).* Other courts, however, have held that a *de novo* standard of review should apply to Section 1132(a)(3) claims, even where the claim challenges

a denial of benefits, if the plaintiff challenges the administrator's decision by reference to alleged breaches of fiduciary duties imposed by ERISA rather than by invoking Section 1132(a)(1)(B). *See Galante v. Fin. Indus. Regulatory Auth., Inc.,* 2018 WL 2063748, at *1, 5 n.8 (E.D. Pa. May 2, 2018).

Still other courts have applied different standards of review to closely related claims under Section 1132(a)(1)(B) and Section 1132(a)(3), finding liability under one cause of action but not the other. *See Snitselaar v. Unum Life Ins.* Co. *of Am.,* 2019 WL 279995, at 3–10 (N.D. Iowa Jan. 22, 2019). Other courts have sidestepped the issue completely, finding it unnecessary to determine the applicable standard of review for a Section 1132(a)(3) claim and holding the plan administrator's "rejection of [the] claim for benefits erroneous under any standard of review[ ]." *See Berman v. Microchip Technology Inc.,* 2019 WL 1318550, at *9 (N.D. Cal. Mar. 22, 2019).

And still other courts have taken a different approach. For example, in *Clark v. Ford Motor Co.*, 2019 WL 7212692 (E.D. Mich. Dec. 26, 2019), the court analyzed issues that arise from parallel ERISA claims in the context of Section 1132(a)(2) and permitted actions to remedy breaches of fiduciary duties specifically, rather than under catchall Section 1132(a)(3). Referring to *Varity* and its progeny in discussing the practical effects of permitting both claims to continue, the court quoted Chief Justice Roberts' concurring opinion in *Larue v. DeWolff, Boberg & Assocs. Inc.,* 552 U.S 248, 258–59 (2009), for the proposition that "the significance of the distinction … is not merely a matter of picking the right provision to cite in the complaint. Allowing a … claim to be recast … might permit plaintiffs to circumvent safeguards for plan administrators that have developed under [Section 1132(a)(1)(B)]," such as the discretionary standard of review under *Firestone Tire. See Clark,* 2019 WL 7212692, at *6–9. The *Clark* court dismissed the Section 1132(a)(2) claim as duplicative of the plaintiff's Section 1132(a)(1)(B) claim. *Id.* at *9.

Availability and Scope of Discovery

A second area of concern stemming from these circuit court rulings involves discovery. The law in many jurisdictions is that when reviewing an ERISA benefits denial claim under the abuse of discretion standard, a court is generally limited to considering the materials that were available to the administrator when making the challenged benefits determination—*i.e.*, the administrative record. *Abatie v. Alta Health & Life Ins Co ,* 458 F.3d 955, 970 (9th Cir. 2006); *Urbania v. Cent. States, Se. & Sw. Areas Pension Fund,* 421 F.3d 580, 586 (7th Cir. 2005); *Kosiba v. Merck &* Co. 384 F.3d 58, 67 n.5 (3d Cir. 2004).

But how should courts approach cases where a plaintiff advances a separate cause of action under Section 1132(a)(3), premised on essentially the same facts concerning denial of benefits but seeking equitable remedies? Some ERISA litigants have argued that ERISA's goal of providing an orderly methodology for the disposition of claims forbids wide-ranging and burdensome discovery. *See Meidi v. Aetna, Inc.,* 346 F. Supp. 3d 223, 234–37 (D. Conn. 2018). Others argue that limiting review of a Section 1132(a)(3) claim to the administrative record would be inappropriate, because the claim may allege statutory or plan violations that are not limited to a single, identifiable decision by an administrator. *See Milby v. Liberty Life Assurance* Co. *of Boston,* 2016 WL 4599919, at *4–5 (W.D. Ky. Sept. 2, 2016). Courts have ruled both ways. *Compare Berman,* 2019 WL 1318550, at *6–8 (ruling on administrative record), *with Cotton v. Altice USA, Inc.,* 2020 WL 32433, at *3–4 (E.D.N.Y. Jan. 2, 2020) (permitting limited discovery).

The recent increase in Section 1132(a)(3) claims that advance past the pleading stage has led to an increase in litigation of discovery issues, and the law is in flux. ERISA litigants can continue to expect uncertainty until the issue is resolved.

Conclusion

At some point, the Supreme Court may be required to revisit Section 1132(a)(3) and assess how lower courts have interpreted *Varity* and *Amara.* Until that time, ERISA practitioners should be aware of the practical concerns that may arise in litigating ERISA health plan claims simultaneously under multiple ERISA civil remedy provisions, including evidentiary issues and the possible application of differing standards of review for parallel claims.

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Foreign Employee Benefit Claims: Does ERISA Apply?

By Kenton J. Coppage

Attorneys in the United States are generally well-versed in the application of ERISA to claims for employee benefits provided by private industry employers. When such claims arise beyond the borders of the United States, however, the applicability of ERISA may be a source of contention, even where the plan on its face appears to be an ERISA-governed plan.

In addition to considerations of the extent to which ERISA may have extra-territorial effect, the issue may also be impacted by an express exemption in ERISA for plans "maintained outside of the United States primarily for the benefit of persons substantially all of whom are nonresident aliens ...." 29 U.S.C. §1003(b)(4).

As a very general proposition, where the issue is directly raised, courts have tended to find ERISA inapplicable to claims of foreign nationals arising overseas. The cases discussed below illustrate that general approach.

Maurais v. Snyder

In 1998, Snyder was involved in a speed boat racing accident in Canada and was treated in Montreal by Dr. Maurais. Snyder was a participant in an ERISA plan for which medical benefits were provided by Guardian Life Insurance Company. Dr. Maurais forwarded a bill to Guardian for $75,750 for certain surgical procedures performed on Snyder. Guardian sent a check to Snyder for $38,000 for the treatment rendered by Dr. Maurais, and Snyder deposited it into his own account.

Dr. Maurais brought state law claims in Pennsylvania against Snyder and also against Guardian, which argued that the claims were preempted by ERISA. The court, however, concluded that there was a threshold issue – whether "ERISA applies to the facts of this case at all," and specifically "whether ERISA has extraterritorial application." *Maurais v. Snyder*, 2000 WL 1368024, at *2 (E.D. Pa. Sept. 14, 2000).

The court turned to the Supreme Court's decision in *EEOC v. Arabian American Oil Co.,* 499 U.S. 244, 248 (1991), in which the Court recognized the principle that "legislation of Congress, unless a contrary intent appears, is meant to apply only within the territorial jurisdiction of the United States." The district court in *Maurais* found "absolutely no language in ERISA which evinces a clearly expressed intent on behalf of Congress to legislate extraterritorially." 2000 WL 1368024, at *2. The court thus denied Guardian's motion to dismiss the plaintiff's state law claims. *Id.* at *4.

The court's decision in *Maurais* is interesting, since the party which incurred medical expenses was a U.S. citizen and indisputably a participant in an ERISA plan. The party seeking the benefits in the litigation (the medical provider), however, was Canadian. It is unclear whether the court would have ruled otherwise had Snyder, the ERISA plan participant, been the plaintiff, rather than the Canadian doctor. If a medical benefits plan provided coverage for expenses incurred overseas, as the plan insured by Guardian apparently did, one would ordinarily expect a lawsuit to recover those benefits brought in the United States to be governed by ERISA.

Chong v. InFocus Corp.

Christopher Chong was a citizen of Singapore and worked in that nation for InFocus Corporation, which maintained a pension plan "for all employees of InFocus and its subsidiaries ...." In 2001, Chong took a position with an indirect subsidiary called InFocus Systems Asia, Pte. Ltd.

in Singapore, where he worked until he was terminated in 2004. Thereafter, the company denied his 2006 claim for pension benefits.

Chong brought suit against InFocus Corporation in federal district court in Oregon. InFocus challenged subject matter jurisdiction on the grounds that ERISA did not extend extraterritorially to foreign nationals working beyond the borders of the United States. Chong argued that the location of employees was irrelevant, because the plan was administered in the United States. The court framed the issue as "whether ERISA's protections are available to a foreign national working abroad who claims benefits under a plan administered in the United States by a United States company." *Chong v. InFocus Corp.*, 2008 WL 5205968, at *2 (D. Ore. Oct. 24, 2008).

InFocus first cited the doctrine of extraterritoriality set forth in *Arabian American Oil. Id.* at *3. The court agreed that extraterritoriality was absent, given the lack of language in ERISA extending its reach to foreign corporations controlled by U.S. corporations.

Chong sought to distinguish *Maurais* on the grounds that facts relevant to his claim occurred within the United States, including that the plan was administered in the United States, the decision to deny benefits was made here, and benefits would be payable from the United States. The court dismissed that argument, noting that other acts occurred overseas, including Chong's performance of services for the company and the decision to terminate his employment.

The court also rejected policy arguments, including those based on ERISA's goal of uniformity. While "the globalization of the world's marketplace" gave rise to policy arguments for extraterritorial reach, the court wrote, such arguments were "better addressed to Congress, than to the courts." The court dismissed the case for lack of subject matter jurisdiction.

In reality, the facts cited by Chong as distinguishing would appear to be equally true in *Maurais.* There too the plan was administered in the United States, the decision regarding benefits was made in the United States, and benefits would have been payable from the United States (and indeed were paid to Snyder, the plan participant in the United States).

The court's decision in *Chong* is less surprising, however, given that the participant was a citizen of another country and worked overseas where all the employment decisions were made.

Caldwell v. Transocean International Long Term Disability Plan & Transocean International Life Insurance Plan

As noted above, ERISA exempts a plan that "is maintained outside of the United States primarily for the benefit of persons substantially all of whom are nonresident aliens ...." 29 U.S.C. §1003(b)(4). Addressing that exemption and the doctrine of extraterritoriality generally, the court in *Caldwell v. Transocean International Long Term Disability Plan & Transocean International Life Insurance Plan*, 2009 WL 10711821 (S.D. Tex. Aug. 21, 2009), described the range of situations that have been addressed by the courts:

> On one end, ERISA applies to qualified plans if the beneficiaries are primarily United States citizens in the United States, the employer is a United States company, and the plan is administered in the United States. On the other end, ERISA does not apply when the beneficiaries are foreign nationals who live and work for a foreign company and seek benefits under a foreign plan. In between those two poles are several combinations of factors that affect ERISA's application. The factors include whether the beneficiaries are foreign nationals, whether the beneficiaries are in or outside the United States, whether the employer is a foreign or a United States company, and whether the plan is "maintained" in or outside the United States.

2009 WL 10711821, at * 7. The court summarized the conclusions of the courts as follows:

> The cases show that when the employer, the plan, and substantially all the beneficiaries are foreign, ERISA does not apply even if the plaintiff is a United States citizen who lived and worked inside the United States. ERISA does apply if, although the employer and plan are foreign, the plan does not benefit primarily nonresident aliens but instead United States citizens. If the plan is administered in the United States to benefit foreign nationals who are working in the United States, the ERISA foreign-plan exclusion does not apply. Finally, *Maurais* and *Chong* represent the variation in which the plan is administered in the United States but the beneficiaries are foreign nationals, working for a foreign company, outside the United States, and the basis for the benefits claim occurred outside the United States. In these cases, ERISA did not apply.

2009 WL 10711821, at *8. Again, the description of *Maurais* seems somewhat questionable since the plan participant in fact was a U.S. citizen covered under a plan that likely covered primarily fellow citizens.

The plaintiff in *Caldwell* was a Scottish citizen who worked outside the United States for various Transocean entities, including Cayman Island and British Virgin Islands corporations. The disability plan in which he participated

excluded "[e]mployees who are non-U.S. citizens hired in the United States to work in the United States." All of the plan's beneficiaries lived and worked outside of the United States. The plan administrator was a committee based in Houston, and the claims administrator/insurer was Cigna. The decisions concerning the disability claim at issue were made in the United States. Caldwell sued in Texas state court, and the defendants removed the case to federal court based on ERISA preemption.

The Transocean defendants asserted that the courts in *Chong* and *Maurais* had erred by overlooking the language of the ERISA exemption providing that the plan "is maintained outside of the United States." According to the defendants, that requirement must be met before the plan is exempted from ERISA. The court, however, rejected the conclusion that the plan was maintained in the United States, noting that the location of the plan administrator and documents are "relevant factors but do not determine where a plan is 'maintained.'" 2009 WL 10711821, at *8.

The factors favoring the conclusion that the plan was maintained outside of the United States included that the sponsor was a foreign corporation, all of its operations were outside of the United States, the employees covered by the plan were all outside of the United States, and the plaintiff himself worked outside of the United States. The court determined that that the plan was "maintained" outside of the United States.

"[T]o find that the Plan is 'maintained' in the United States … on this record would make ERISA apply to a benefit plan established by a foreign employer for the sole benefit of its foreign employees who did not work or live in the United States," the court reasoned. 2009 WL 10711821, at *8. "This application," the court concluded, "would indeed raise concerns about the extraterritorial application of ERISA in the absence of any explicit extension by Congress." *Id.*

Barjami v. Reliance Standard Life Ins. Co.; In re: Reliance Standard Life Ins. Co

More recently, a federal district court in Pennsylvania declined to apply ERISA to disability claims brought by Kosovo nationals living and working overseas. *See Barjami v. Reliance Standard Life Ins. Co.*, 334 F. Supp. 3d 659 (E.D. Pa. 2018); *In re: Reliance Standard Life Ins. Co.*, 386 F. Supp. 3d 505 (E.D. Pa. 2019).

Barjami, who was assigned to Afghanistan by his Cayman Islands employer, asserted a disability claim and filed suit against the insurer in a Pennsylvania state court after his claim was denied. Reliance removed the case to federal court, and Barjami moved to remand, asserting that foreign nationals are excluded from ERISA due to the extraterritoriality doctrine.

The court noted that "no court of appeals has determined whether a foreign national working outside of the United States can bring a claim under ERISA." 334 F. Supp. 3d at 663. Finding *Maurais* and *Chong* persuasive, however, the court concluded that ERISA did not apply to Barjami's claims.

"The events that underlie the denial of benefits," the court wrote, "stem from his employment and health conditions abroad." *Id.* at 664. "Even though the plan is administered in the United States and the decision to deny the claim allegedly occurred domestically, as in *Chong*, whether the disability benefits plan was properly denied greatly depends on issues arising outside of the United States," the court continued. *Id.* "Barjami's employment was wholly within Afghanistan, his offer of disability insurance coverage was made in Afghanistan to be performed outside the territorial limits of the United States, and his physical examinations and medical diagnoses were conducted abroad," the court concluded. *Id.* The court also found "no language within the exemption providing that foreign nationals can bring claims under ERISA." *Id.*

The same court reiterated its conclusion nearly a year later in *In re Reliance Standard,* 386 F. Supp. 3d 505, with respect to similarly situated Kosovars who had disability claims arising in Afghanistan. In that case, the court addressed in more detail the argument that the foreign plan exemption under ERISA demonstrated the intent of Congress to extend ERISA's reach overseas.

According to the court, Reliance Standard argued that "the exemption alludes to the fact that ERISA 'must apply to all plans maintained in the United States primarily for the benefit of persons who are residents,' which then inferentially may include some foreign nationals." *Id.* at 510. The court considered that argument to "begin[] with the mistaken premise that extraterritoriality can be implied, when the Supreme Court has directed that 'unless there is an affirmative intention of Congress clearly expressed' to give a statute extraterritorial reach, '[courts] must presume it is primarily concerned with domestic conditions.'" *Id.*, quoting *Morrison v. Nat'l Australia Bank Ltd.*, 561 U.S. 247, 255 (2010).

Conclusion

The more recent cases addressing ERISA applicability to claims of foreign nationals appear to be confined to the lower courts. Appellate review is hampered by the context in which the issue arises, often on motion to remand. Nonetheless, there is room for modification in the case law if a decision on the issue makes it to the appellate courts.

Moreover, with the possible exception of *Maurais*, which was brought by a medical provider, none of these decisions cuts strongly against the application of ERISA to the claim of a foreign national who is both employed by a United States company and covered under an ERISA plan which primarily benefits United States citizens.

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Case Law

ERISA Update

By Joseph M. Hamilton, ERISA Update Editor

First Circuit

Denial of Accidental Death Benefits Upheld

In *Arruda v. Zurich American Ins. Co.*, 2020 WL 880548 (1st Cir. 2020), the First Circuit reversed a decision by the U.S. District Court of Massachusetts and held Zurich's decision to deny accidental death benefits was not arbitrary and capricious.

Arruda was a participant in an employee benefit plan provided by his employer that included accidental death coverage. The coverage was funded by a policy issued by Zurich.

Arruda had a history of heart disease. In 2014, he had a defibrillator implanted in his chest. In May 2014, while driving, Arruda's car crossed a highway median into oncoming traffic and struck another car causing Arruda's car to hit a curb and flip multiple times. Arruda was pronounced dead on the scene. Arruda's widow filed a claim for accidental death benefits. After a lengthy investigation, Zurich denied the benefits. Suit followed.

The policy provided the benefit if the death was the result of a covered injury. A covered injury was defined as an injury directly caused by accidental means, which is independent of all other causes and results from a covered accident. A covered accident was defined as an accident that results in a covered loss. The policy also contained an exclusion that a loss would not be a covered loss if it was caused by, contributed to by, or resulted from illness or disease.

In its decision, Zurich relied on an opinion from a Dr. Bell that Arruda's death was caused by his heart disease. A similar opinion was rendered by a Dr. Angell. The autopsy report also concluded that the cause of death was hypertensive heart disease. Similarly, a Massachusetts State Police report and an EMS report attributed the death to a medical episode while driving and cardiac arrest. Finally, a Dr. Taff found that Arruda's accident was caused by several pre-existing illness or diseases. He also concluded that Arruda died from accidental bodily injuries.

Arruda's widow submitted a report from a former medical examiner, Dr. Laposata, that concluded Arruda's death resulted from injuries sustained in the auto accident. While Dr. Laposata could not explain what caused Arruda to travel across traffic lanes and hit another vehicle, she found no evidence that he experienced incapacitation by heart disease. The widow also submitted a log book report which tracked Arruda's defibrillator. The log showed no measured "events" prior to the accident.

The district court held that Zurich's decision was arbitrary and capricious. Zurich appealed.

The First Circuit held that Zurich's determination that Arruda's death was caused or contributed to by pre-existing medical conditions was supported by substantial evidence and was not arbitrary and capricious. The court found that the record before Zurich of the causes that contributed to Arruda's death were all consistent that the crash was caused, at least in part, or was contributed to by, his pre-existing medical conditions. Taking all of those materials and medical opinions as a whole, the court held that Zurich's conclusion was not undermined because the opinion of Arruda's expert, Dr. Laposata, differed.

As the court noted, in the First Circuit "the existence of contradictory evidence does not, in itself, make the administrator's decision arbitrary." The court seemed to be particularly convinced that the third-party reviewer used by Zurich on appeal, Dr. Taff, could be relied upon by Zurich because he carefully ruled out other possible causes of Arruda's accident, gave a detailed account of the Arruda's medical history, acknowledged potentially conflicting evidence, and came to a reasoned conclusion. The court also noted that a reviewing court should not find an insurer's decision to be arbitrary when the insurer relies on several independent experts

There was a dissent to the decision.

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Court Upholds Reduction of LTD Benefits Based on Receipt of Veterans Benefit

In *Martinez v. Sun Life Assurance Co. of Canada*, 948 F.3d 62 (1st Cir. 2020), the First Circuit upheld a decision by the U.S. District Court of Massachusetts that Sun Life properly determined Martinez's disability benefit from the Veterans Administration was an offset from his LTD benefit.

Martinez was covered by an employee benefit plan provided by his employer that was funded by a group policy issued by Sun Life. Martinez filed a claim for LTD benefits due to multiple sclerosis and began receiving benefits. Several years later, Martinez's claim for VA disability benefits based on the multiple sclerosis was approved. After Sun Life learned of the VA award, it informed Martinez it would offset his VA benefit from the LTD benefit as "Other Income Benefits" under the plan. Martinez challenged this determination and ultimately filed suit.

The district court denied Martinez's claims and entered judgment in favor of Sun Life. Martinez appealed.

On appeal, Martinez first argued that Sun Life failed to clearly disclose in its letters to him that it relied upon the provision of "Other Income Benefits" that addressed "Compulsory Benefit Act or Law." The court held that Sun Life adequately disclosed its rationale to Martinez and, even if it did not, Martinez had a full opportunity to present his arguments on the construction of the plan. Thus, there was no prejudice to Martinez.

The court went on to find that the meaning of "Compulsory Benefit Act or Law" included veterans disability benefits, because the Veterans Administration was required by law to provide that benefit to Martinez once it determined he was eligible. Therefore, Sun Life was correct in offsetting the benefit.

Finally, the court upheld the district court's determination that Sun Life's offset of the veterans benefits did not discrimination against employees who had served in the armed forces.

The court affirmed the decision by the district court.

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Second Circuit

Court Can Reform ERISA Plan Without Proof of Fraud, Mistake, or Other Inequitable Conduct

In *Laurent v. PriceWaterhouseCoopers LLP*, 945 F.3d 739 (2d Cir. 2019), the Second Circuit ruled, in a matter of first impression, that reformation of a plan under 29 U.S.C. §1132(a)(3) is an available remedy when plan language violates ERISA, even when there is no fraud, mistake, or inequitable conduct.

The case involved a retirement plan's definition of "normal retirement age" for purposes of calculating lump-sum early retirement benefits. (In order to accurately calculate an early lump-sum payment, a plan must project earnings forward to normal retirement age, and then discount that value back to the present; this is known as a "whipsaw" calculation, and "normal retirement age" is a key variable). In a lengthy history prior to this decision, several district courts and the Second Circuit had concluded the PWC plan used a definition of normal retirement age that violated ERISA and IRS guidelines.

After the Second Circuit ruled in 2015 that the plan language violated ERISA, it remanded to determine the proper remedy. On remand, PWC moved for judgment on the pleadings, arguing that plaintiffs had no remedy under ERISA. The district court agreed, holding that *Cigna Corp. v. Amara*, 563 U.S. 421 (2011), precluded use of §1132(a)(1)(B) to reform the plan, and that there was no "appropriate equitable relief" available under §1132(a)(3). In particular, the district court held that the plan administrator was not acting in a fiduciary capacity when distributing benefits in accordance with plan language; ERISA did not authorize equitable reformation of the plan absent fraud, mistake, or inequitable conduct; and plaintiffs therefore were asserting a legal claim for money damages.

On appeal, the Second Circuit considered what it described as an issue of first impression – is reformation available when plan language violates ERISA, but not as a result of any improper or inequitable conduct by the plan sponsor. The court noted that §1132(a)(3) permits equitable relief "to enforce any provisions of this subchapter or the terms of the plan." It held the PWC plan's definition of normal retirement age violated a "provision[] of [the] subchapter" – *i.e.*, §1002(24) – making equitable reformation appropriate relief.

The court rejected the district court's narrower reading of *Amara* and earlier Supreme Court cases as limiting the scope of equitable remedies under §1132(a)(3) to those typically available in equity courts. Rather, the court noted, *Amara* explained that, in construing §1132(a)(3), "courts are to be guided by 'equitable principles, as modified by the obligations and injuries identified by ERISA itself.'"

The court also held that, to conclude plan participants can have no remedy, even if they prove a violation of ERISA, is inconsistent with the maxim that "equity suffers not a right to be without a remedy." Following reformation of the plan, a court can then compel compliance with the reformed plan under §1132(a)(1)(B).

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Third Circuit

Court Nixes Claims Related to Enforcement of Subrogation Right

What began as a purported class action ended with no relief for the only plaintiff left standing in *Minerley v. Aetna, Inc.*, 2020 U.S. App. LEXIS 4626 (3d Cir. 2020). Minerly participated in the Weiss-Aug Co. benefit plan, which included medical benefits under health insurance policies issued by Aetna. Minerly was injured in a motorcycle accident for which Aetna paid $3,152.82 in emergency services.

After Minerly recovered damages from the third-party tortfeasor, a vendor on behalf of Aetna notified him that the plan insurer had a lien and asked for payment. Minerly repaid the full amount he received from Aetna but then filed suit, claiming Aetna violated a New Jersey regulation against subrogation/reimbursement. The lawsuit was removed to federal court based on ERISA. Minerly then amended the complaint to assert claims against Aetna under §§502(a)(1)(B) for benefits due under the terms of the plan and §502(a)(3) for breach of fiduciary duty.

The district court held, and the Third Circuit affirmed, that the claim under §502(a)(1)(B) failed because Minerly never exhausted his administrative remedies as required. Minerly argued that exhaustion was not required because the Aetna policy was not a plan document and he never received a copy of the policy. The court disagreed with both arguments.

The Third Circuit recognized that it is not necessary to have a single document identified as the "plan." In fact, a plan can be comprised of several different documents. And following decisions from several sister circuits, the Third Circuit agreed that an insurance policy can serve as a plan document. The court also rejected Minerly's argument that exhaustion should be waived because he did not receive a copy of the policy in response to a request. The ERISA regulation he relied on provided that it is the duty of the plan administrator to produce plan documents. And since Aetna was not the plan administrator, it owed no such duty.

Finally, the Third Circuit rejected Minerly's arguments that Aetna breached fiduciary duties owed to him. His first argument, based on his employer's failure to provide a copy of the policy to him, was rejected, because there was no evidence that the employer was Aetna's agent, and the policy specifically said that it was not.

As his second argument, Minerly claimed it was a breach of fiduciary duty to seek reimbursement, contrary to his interest as a beneficiary. But since this would be contrary to the language in the plan, it was rejected.

As his final argument, he claimed that offering different policies to employees depending on their residency was contrary to *Conkright v. Frommert*, 559 U.S. 506 (2010). But as the court recognized, *Conkright* discussed conflicting

judicial interpretations of a single ERISA plan, an entirely different issue.

Accordingly, the district court's grant of summary judgment in favor of Aetna on all claims was affirmed.

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A Single "Internally Inconsistent" Report from One Doctor Does Not Make a Decision Arbitrary and Capricious

In *Reichard v. United of Omaha Life Ins. Co.*, 2020 U.S. App. LEXIS 5548 (3d Cir. 2020), prior to claiming disability, the plaintiff worked as a nurse in a hospital. Her claim was based on headaches, Crohn's disease, and fibromyalgia. The claim was accepted and paid for two years. But after two years, the plaintiff had to prove that she was precluded "from doing any job," and the claim was denied.

A nurse reviewed updated records and concluded the plaintiff still had work capacity. And during the appeal, United of Omaha submitted the records to an in-house doctor, who concluded she could perform light or sedentary work. The doctor also wrote to four of the plaintiff's doctors to see whether they agreed. Only one doctor responded, and he did not object to the in-house doctor's conclusion.

The Third Circuit first addressed the district court's denial of the plaintiff's request to conduct discovery of the in-house doctor, who also served as a senior vice president of United of Omaha. Specifically, the plaintiff sought "batting average" information on the doctor's reviews. As the court recognized, even if there was a low reversal rate based on the doctor's opinions, a "mini trial" on each case would be needed to determine whether those denials were unreasonable. Based on the high cost of producing evidence on other reviews and the minimal value of this evidence, the court concluded the discovery was not proportional to the needs of the case.

On the merits, the Third Circuit affirmed the district court's conclusion that the denial of additional benefits was not arbitrary and capricious. The court recognized that "multiple doctors," including some of the plaintiff's own, believed she could perform sedentary or light duty work. Only one doctor affirmatively supported the claim, and the reviewing doctor noted that this doctor's opinion was inconsistent with his own statements elsewhere. According to the court, this one doctor's opinion did not make the denial of benefits unreasonable.

Finally, the plaintiff relied on a favorable Social Security decision issued after the final claim decision. According to the plaintiff, the Social Security decision should still be considered related to the conflict of interest because she was referred to the Advocator Group to represent her in her pursuit of Social Security benefits by United of Omaha. The court rejected the argument because United of Omaha had no reason to foresee that the Social Security claim would be approved.

In the end, the court concluded that, while United of Omaha's "procedures may have been imperfect, its ultimate decision was not unreasonable." Therefore, the judgment in favor of United of Omaha was affirmed.

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Fifth Circuit

Defendants Prevail on Attorney's Fee Arguments in Two Fifth Circuit Cases

In *Cluck v. MetroCare Servs. - Austin, L.P.*, 785 Fed. App'x 244 (5th Cir. 2019), the Fifth Circuit upheld an award of attorney's fees against an unsuccessful plaintiff. The defendant had removed the case to federal court because some of plaintiff's claims implicated ERISA. The district court granted summary judgment to the defendant on the ERISA claims, and remanded the case to state court for a resolution of the remaining state law claim.

The defendant filed a motion for attorney's fees under ERISA's fee-shifting provision, 29 U.S.C. §1132(g)(1), which grants the court discretion to allow a reasonable attorney's fee and cost award to either party. Under Supreme Court case law, a district court has discretion to award attorney's fees "as long as the fee claimant has received 'some degree of success on the merits.'" *Cluck* at *2.

Since the defendant obtained dismissal of the ERISA claims, there was no dispute that the defendant had achieved some degree of success on the merits. Instead, plaintiff argued that the district court's award violated due process by ordering her to pay attorney's fees without first determining her wherewithal to pay.

The court observed that *Cluck* relied on non-Fifth Circuit case law pertaining to the imposition of sanctions. The court

observed that "an award of attorney's fees under ERISA is not a sanction. Such an award is possible whenever one party achieves 'some degree of success on the merits,' and the availability of fees does not depend on the other side's 'culpability or bad faith.'" *Cluck* at *4 (citations omitted). The Fifth Circuit thus rejected the plaintiff's argument that her financial wherewithal should have been considered as a factor in the decision to award attorney's fees.

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Procedural Victory on Standard of Review Does Not Authorize Award of Attorney's Fees

In *Ariana M. v. Humana Health Plan of Texas, Inc.*, 2019 WL 5866677 (5th Cir. 2019), the Fifth Circuit issued a ruling in a case that had been before it previously on a different issue. In its prior opinion in 2018, the Fifth Circuit held the proper standard of review was *de novo*, rather than the deferential standard that had been found by the district court, and remanded the case.

On remand, applying the *de novo* standard, the district court nonetheless upheld the denial of partial hospitalization benefits, and went on to deny the plaintiff's claim for attorney's fees. On appeal, the Fifth Circuit upheld the benefit denial, and addressed the claim for attorney's fees as the more challenging aspect of the appeal.

The court observed that plaintiff had achieved some degree of success in connection with the prior appeal, as she had succeeded in her argument that the proper standard of review was a *de novo* standard. The court observed that securing a change in the standard of review is "certainly a procedural success, but it's not success on the merits of Ariana's benefits claim." *Ariana M.* at *5. The court expressed no opinion on a First Circuit ruling in *Gross v. Sun Life Assurance Co. of Canada*, 763 F.3d 71 (1st Cir. 2014), where a divided panel held the plaintiff had indeed achieved "some success on the merits" when she won a remand order favorably changing the standard of review.

Thus, the Fifth Circuit refused to find that the district court had abused its discretion when it refused to award attorney's fees to a party who had won a procedural victory that did not result in success on the merits.

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Sixth Circuit

Court Reverses Denial of Benefits Where Claimant Was Under "Regular Attendance of a Physician"

Reversing the district court, the Sixth Circuit held in *Bruton v. America United Life Ins. Corp.*, 2020 WL 398539 (6th Cir. 2020), that the plaintiff was entitled to LTD benefits.

Bruton was an information technology manager who developed severe back and leg pain. The plan in which he was a participant required that, to be "totally disabled," an insured must be unable to perform the material and substantial duties of his "Regular Occupation" (meaning a "person's occupation as it is recognized in the general workplace and according to industry standards," rather than "the specific job tasks he does"), and that he be "under the Regular Attendance of a Physician" for his disabling condition.

The plan defined "Regular Attendance" to mean the insured "1) personally visits a Physician as medically required according to standard medial practice, to effectively manage and treat his Disability; 2) is receiving the most appropriate treatment and care that will maximize his medical improvement and aid in his return to work; and 3) is receiving care by a Physician whose specialty or clinical experience is appropriate for the Disability."

The district court affirmed the administrator's denial of benefits under *de novo* review, finding that Bruton failed to follow standard medical practice to manage his pain, because he received increasingly large doses of opiates, despite normal clinical findings; he failed to undergo an MRI his physician recommended; he failed to pursue aquatic therapy his physical therapist recommended; and he failed to follow up with a referral to a rehabilitation specialist.

The Sixth Circuit reversed, holding that the "Regular Attendance" requirement "does not empower an administrator to micromanage a claimant's medical care – instead, it exists merely to prevent malingering and fraud." It characterized the administrator's argument as being "the failure to pursue *any* treatment recommended by *any* medical professional with *any* level of confidence that the treatment would lead to medical improvement puts the applicant outside the realm of 'total disability' – even in circumstances when a patient declined treatment that is prohibitively expensive, or experimental, or risky, or painful."

The Sixth Circuit's own "march through the [administrative] record reveal[ed] that he received extensive treatment from medical professionals," including "over a dozen

visits with his primary care provider and multiple visits with specialists." The court discounted Bruton's failure to follow up with the recommended medical options, because "the record offers little evidence that Bruton would have improved his health outcome had he pursued them."

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Seventh Circuit

In De Novo Case, Plaintiff Has Burdon to Develop the Record

In *Dorris v. Unum Life Ins. Co. of Am.*, 2020 WL 524726 (7th Cir. 2020), the Seventh Circuit discussed plaintiff's burden of proof and obligation to provide relevant evidence in *de novo* cases, upholding judgment for the insurer where the record lacked sufficient information.

The plaintiff worked as the president of a company until medical complications prevented her from continuing. She received own occupation disability benefits and then any occupation benefits for several years. After benefits were terminated, the plaintiff brought suit in district court.

During the course of the matter, the plaintiff was denied certain depositions regarding matters that were covered by evidence in the claim file. However, the judge noted the ruling did not prevent her from conducting other discovery. Ultimately, the defendant prevailed in the case.

While the district court found the plaintiff could not perform the duties of her regular occupation, it found a lack of evidence regarding an inability to perform the duties of any occupation. The district court acknowledged the plaintiff's criticism of the defendant's lack of vocational evidence, but highlighted that the plaintiff could have produced such documentation herself during the litigation.

Following the ruling, the plaintiff moved to amend the judgment. She claimed the district court overlooked certain information and alternatively, asked to reopen discovery. The motion was denied and the plaintiff appealed.

The Seventh Circuit upheld the district court's ruling and made three main findings. First, the Court observed that the record was underdeveloped as to the any occupation test. In assessing which party this impacts, the court highlighted the nature of *de novo* cases and how extra-record evidence was permitted. Since the plaintiff bore the burden of proof to show she was entitled to benefits, any gap in the record undermined her claims. As such, she was obliged to build the record. The court explained that in a *de novo* case, the district court was not tasked with reviewing the record. Rather, it had to determine whether the plaintiff was entitled to benefits. If there was no evidence to this point, judgment in the defendant's favor was appropriate.

The court pointed out that the plaintiff never offered—and the district court never rejected—relevant extra-record evidence. She had the opportunity to seek evidence, but failed to do so. There was no obligation for the district court to reopen discovery, and it did not err in declining to do so. The Seventh Circuit concluded that lack of vocational evidence was construed against the plaintiff, not the defendant, as she bore the burden of proving entitlement to benefits. Accordingly, judgment for the defendant was affirmed.

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Eighth Circuit

No Abuse of Discretion in Applying Mental Illness Limitation

In *Miller v. Hartford Life & Accident Ins. Co.*, 944 F.3d 1006 (8th Cir. 2019), the Eighth Circuit affirmed the district court's decision to grant judgment in favor of Hartford and to dismiss Miller's complaint with prejudice. On appeal, Miller argued the district court had erred because (1) there was insufficient evidence of improvement in her condition, and (2) Hartford failed to consider potential medication side effects and risk of future psychotic episodes.

Miller stopped working in April 2012 and initiated her claim for long-term disability benefits from the plan based on depression and psychosis. In November 2013, Hartford approved Miller's claim with an effective date of November 11, 2012, but limited benefits to the 12-month mental illness maximum under the policy. Miller disputed this decision in May 2014, contending her mental illness was secondary to physical impairment and she was entitled to benefits. After additional review, Hartford approved the claim and paid benefits for physical impairment.

Hartford learned a year later that Miller was only treating with a psychiatrist. Upon Hartford's request, Miller submitted information from the psychiatrist, stating she was unable to work due to mental illness, but noting the source of her condition was unknown. Hartford obtained an IME

that confirmed Miller's depression and psychosis but found no physical impairment precluding her from returning to full-time work. The IME physician noted there was a possible link between thyroid disorders and psychotic episodes. Hartford sought more clarity by obtaining a psychiatric review from a board-certified psychiatrist, Dr. Sharma. After speaking to Miller's psychiatrist and reviewing the records, Dr. Sharma did not find mental illness requiring restriction from full-time work.

Based on this and a vocational report identifying jobs available to Miller, Hartford closed the claim and notified Miller she had exhausted the mental illness benefits and she did not meet the definition for physical disability.

Miller appealed, arguing her anti-psychotic medications caused physical side effects and her psychotic episodes rendered her unable to work for several weeks. She did not dispute the lack of evidence to support a physical impairment. Hartford obtained another review from Dr. Sharma, who affirmed her earlier opinion that Miller's mental status did not prevent her from working. Hartford upheld its decision on appeal, and litigation followed.

The Eighth Circuit reviewed the district court's decision under an abuse of discretion standard. The court determined Miller's arguments failed because the medical records did not support a finding of physical disability. Dr. Sharma's opinion only related to Miller's mental illness. Although Miller claimed her psychotic episodes were linked to an autoimmune thyroid disorder, the record showed no record of treatment for this condition since 2015.

The court found it was not an abuse of discretion for Hartford to rely on the opinions of the reviewing physician over the treating physician. Miller also argued Hartford did not comply with the plan language because there was insufficient evidence that she could work at the required level. But the court confirmed that there was substantial evidence for this determination.

Finally, Miller argued she was not afforded a full and fair review of her claim because Harford communicated with her treater without notifying her. The court dismissed this claim, finding that even if it were true, it did not deprive Miller of the necessary information to adequately prepare for further administrative review or appeal to the courts.

In closing, the court held Miller was essentially asking the court to substitute its judgment for Hartford's, an inconsistent and improper role. The Eighth Circuit upheld the district court's decision that Hartford did not abuse its discretion in terminating benefits.

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Tenth Circuit

Court Upholds Determination That Plaintiff's Claims Under ERISA Would Be Time-Barred

In *AGI Consulting L.L.C. v. American National Ins. Co.*, 2020 WL 104339 (10th Cir. 2020), the Tenth Circuit held that AGI's Rule 59(e) request to amend its complaint to add ERISA breach of fiduciary duty claims was properly denied, because the proposed claims would be time-barred under ERISA's statute of repose, 29 U.S.C. §1113.

AGI had purchased a defined benefit plan for its employees that ANICO was to administer in accordance with agreed terms. AGI alleged that, without AGI's knowledge, ANICO had altered the terms of the plan and had failed to resolve its disputes with AGI regarding ANICO's calculation of the census (the list of eligible employees).

Section 1113 states:

> No action may be commenced under this subchapter with respect to a fiduciary's breach of any responsibility, duty, or obligation under this part, or with respect to a violation of this part, after the earlier of—
>
> (1) six years after (A) the date of the last action which constituted a part of the breach or violation, or (B) in the case of an omission the latest date on which the fiduciary could have cured the breach or violation, or
>
> (2) three years after the earliest date on which the plaintiff had actual knowledge of the breach or violation;
>
> except that in the case of fraud or concealment, such action may be commenced not later than six years after the date of discovery of such breach or violation.

With regard to the first allegation that AGI breached its fiduciary obligations when it altered the terms of the plan without AGI's knowledge, AGI conceded it had received a copy of the altered terms on March 14, 2012, but claimed it did not have actual knowledge of the terms of the document containing the altered terms until much later.

The court held AGI's suit was untimely under §1113(1) because it was filed on March 21, 2018, more than six years after March 14, 2012, and there was no dispute that, by

then, ANICO had begun administering the plan under the altered terms.

The court also rejected AGI's argument that the "fraud or concealment" exception would apply, explaining that this provision, unlike the three-year limitation period in §1113(2), did not require "actual knowledge" of the breach, but merely "discovery." Therefore, constructive knowledge would suffice, and the period would begin to run when the plaintiff, by exercising diligence, should have discovered the breach. The court explained the exception would not apply because AGI conceded it had constructive knowledge of the altered terms by March 14, 2012.

As to the second allegation that ANICO breached its fiduciary obligations when it failed to resolve disputes with AGI regarding the inclusion of ineligible employees in the census which increased AGI's costs, the court found this claim was also time barred. AGI argued this claim was not time-barred because AGI lacked actual knowledge that ANICO was operating under the altered plan, which was what it alleged caused ANICO to include the ineligible employees.

However, the court of appeals agreed with the district court's determination that the existence of the altered plan was not a material fact underlying this claim, as the reason why the employees had been included in the census was not material to the claim. Because it was clear from AGI's filings that it had actual knowledge of an unresolved census dispute after ANICO included allegedly ineligible employees in the census, the court affirmed the decision that this claim was time-barred under §1113(2).

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Eleventh Circuit

Decision That Medical Treatment Was Experimental, Investigational, or Unproven Not Arbitrary or Capricious

In, *Pierce v. Wyndham Worldwide Operations, Inc.*, 791 Fed. App'x 45 (11th Cir. 2019), plaintiff sued Cigna under ERISA, 19 U.S.C. §1132(a)(1)(B). She sought coverage under the healthcare plan her former employer, Wyndham Worldwide Operations, Inc., provided. Cigna was the plan administrator. Plaintiff sought coverage for two-level spinal fusion surgery to treat her multi-level lumbar degenerative disc disease.

Two neurosurgeons with whom plaintiff treated recommended she undergo the two-level spinal fusion. One noted it would give her "a reasonable chance of recovery back to her baseline." He requested prior authorization to perform the surgery, which Cigna denied.

Plaintiff's healthcare plan excluded coverage for expenses "for or in connection with experimental, investigational or unproven services." The plan defined those terms to mean procedures "that are determined by the utilization Physician to be … not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective" for treating the condition. Cigna's medical coverage policy stated, "Cigna does not cover ANY of the following because each is considered experimental, investigational or unproven: Lumbar fusion for treatment of multiple-level … degenerative disc disease." The policy referred to and explained medical literature supporting that conclusion.

The district court entered summary judgment for Cigna, stating its denial of benefits had not been arbitrary or capricious. On appeal, the Eleventh Circuit discussed its standard of review, the reasonableness of the coverage decision, and whether Cigna labored under a conflict of interest.

The court applied the six-part test for determining the appropriate standard of review articulated in *Blankenship v. Metro. Life Ins. Co.*, 644 F.3d 1350, 1355 (11th Cir. 2011). Under the first three steps, even when the administrator's decision is *de novo* wrong, the court applies a deferential arbitrary and capricious standard if the plan vests the administrator with discretion to review claims. However, the court noted that, under its precedent, it was permitted to assume the administrator's decision was *de novo* wrong, and skipped to step two to determine whether the administrator had discretion.

There was no dispute that Cigna had discretion to make medical necessity determinations, and thus the arbitrary and capricious, or abuse of discretion, standard applied. To determine whether the coverage denial was arbitrary and capricious, the court looked to whether reasonable grounds supported it. The court repeated that plan administrators need not accord extra respect to the opinions of a claimant's treating physicians. They may, so long as there is a reasonable basis in the record to do so assign different weight to certain physicians' opinions without acting arbitrarily and capriciously. In the Eleventh Circuit the plan administrator's decision must be upheld as not being arbitrary and capricious, even if there is evidence

to support a contrary conclusion, so long as a reasonable basis in the record supports the decision.

The court of appeals rejected the claimant's contention that the "experimental, investigational or unproven" language of the plan exclusion was ambiguous. The Cigna plan expressly defined that language and specified who would make the determination. Even if the term was ambiguous, under the arbitrary and capricious standard, the administrator need only reasonably interpret it.

The court observed that Cigna reasonably concluded a two-level spinal fusion falls under the "experimental, investigational or unproven" exclusion, noting that the claimant had not identified a single piece of medical literature to counter Cigna's conclusion. She relied only upon her physicians' opinions that the procedure was medically necessary. In fact, those opinions established only that she had degenerative disc disease, were not peer-reviewed, evidence-based, scientific literature, and were not evidence the proposed fusion was not experimental, investigational, or unproven. Last, the court noted that accepting the claimant's argument would read out the "experimental, investigational or unproven" exclusion from the plan.

Having determined a reasonable basis in the record supported the plan administrator's decision, the court addressed whether Cigna operated under a conflict of interest. Claimant submitted a conflict of interest existed because Cigna, as the claims administrator, had a financial interest in "pleasing Wyndham." Wyndham, claimant's employer, however, self-funded the plan benefits; Cigna did not pay them from its own funds, and Cigna and Wyndham are separate entities. For these reasons, the court concluded there was no structural conflict of interest and affirmed summary judgment in favor of Wyndham.

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Disability Decision Was Arbitrary and Capricious Where Court Finds Evidence Was "Cherry-Picked"

In, *Kaviani v. Reliance Standard Life Ins. Co.*, 2020 WL 506551 (11th Cir. 2020), an insured dentist, Kaviani, sued the administrator of his ERISA-governed disability plan. He alleged the administrator acted unreasonably when it denied his claim for long-term disability benefits. The Eleventh Circuit affirmed summary judgment in his favor.

In April 2012, the automobile Kaviani was driving was hit from behind by another vehicle. He sought treatment two days later for neck and back pain; he was diagnosed with cervical neck pain. He treated over the next three years with an orthopedic surgeon and a neurologist for neck pain radiating to his shoulder, arms, hands, and fingers, weakness, numbness, tingling, headaches, and neck and back pain.

Kaviani continued to practice dentistry notwithstanding continued pain, headaches, and other effects of the accident. He had a second MRI in June 2015 and told his orthopedic surgeon that pain was making it difficult to practice without dropping his tools. Results of a muscle strength test and a neurological examination were normal. Even so, the orthopedic surgeon recommended that Kaviani change occupations. Kaviani resigned from his dental practice, but worked through August 7, 2015.

On August 14, 2015, Kaviani submitted a claim for long-term disability benefits. To qualify under the policy, he had to be unable to perform the material duties of his regular occupation for 180 consecutive days.

A physician who examined him as part of the claim review noted Kaviani's pain was self-reported and subjective, and that the June 2015 MRI was essentially normal. The plan's physician also noted Kaviani had trouble grasping, had a reduced range of neck motion, and that there could be patient safety issues if he continued as a dentist. The physician wrote that Kaviani had no objective neurological deficits and his MRI was benign. Thus, he concluded, there was no basis for Kaviani to be out of work. The plan administrator denied Kaviani's claim.

Kaviani appealed the claim denial. He submitted additional records documenting continued neck and arm pain, with and without pain medication, cervical spasms, and upper extremity numbness and tingling, as well as "grip strength that showed his inability to safely perform his essential job functions."

A physician performing a paper review of Kaviani's file stated it was difficult to say whether Kaviani could do "his full work." The medical reviewer also stated Kaviani was capable of sedentary or light work on a fulltime basis because of the "dearth of objective impairments." The reviewer also wrote that Kaviani's contention he could not work because of neck pain was not supported because he would have pain "[w]hether he sits at home or whether he works." The plan administrator denied the internal appeal.

The district court entered summary judgment in favor of Kaviani, holding it was unreasonable for the administrator to have denied the claim on the basis that Kaviani failed to present objective evidence of disability. The district

court rejected the administrator's contention that Kaviani was not entitled to benefits because he had continued to work and had not submitted a claim for three years after the automobile accident. It considered the administrator to have cherry-picked favorable evidence while ignoring plentiful unfavorable medical evidence, stating this was arbitrary and capricious. The district court also rejected as contrary to the evidence, the conclusions that "pain cannot be the basis of … disability because [Kaviani] will be in pain whether he is working or not."

The Eleventh Circuit applied its six-part test, established in *Blankenship v. Metro.Life Ins. Co.*, 644 F.3d 1350, 1354 (11th Cir. 2011), for reviewing an ERISA plan administrator's benefits decision. Since the administrator was vested with discretion to interpret the plan and insurance policy, the question was whether the denial was arbitrary and capricious, *i.e.*, an abuse of discretion. Specifically, the question was whether the record reasonably supported the administrator's decision.

The plan administrator made several arguments on appeal, which the Eleventh Circuit did not accept. The court rejected the notion that Kaviani was not disabled because he did not seek benefits for three years after the accident, had not received treatment from the orthopedic surgeon for 18 months before his June 2015 visit, and had continued to work for 30 days after giving notice of his resignation. The court noted its prior cases holding that disability is not disproved by the fact that a claimant continues to work, and stated that these time-related arguments were insufficient to overcome Kaviani's showing that his condition became progressively worse and that he was "likely practicing dentistry in an unsafe manner."

The court also concluded the plan administrator had ignored an IME report that concluded Kaviani's chronic pain syndrome rendered him unable to perform his work obligations safely, even with further treatment. The court wrote, "[t]he objective medical evidence here proves Kaviani was disabled," and that the administrator acted arbitrarily and capriciously when it ignored the unfavorable findings of disability in the record.

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