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Editors' Overview

In this month's edition we explore the arguments asserted by the parties in *US Airways v. McCutchen* as to whether, and under what circumstances, plans may enforce provisions entitling them to reimbursement of previously paid medical benefits where the participant obtains a recovery from another source. The central issue presented by the parties is whether unambiguous written plan provisions may be altered based on the argument that enforcement of these provisions would not constitute ''appropriate equitable relief'' under Section 502(a)(3) of ERISA. The Supreme Court heard oral argument on this important and hotly litigated issue on November 27, 2012, and if history repeats itself, the *McCutchen* opinion could have a much broader impact on ERISA remedies than merely opining as to reimbursement issues presented in the case.

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

Supreme Court Revisits Meaning of 'Appropriate Equitable Relief' in *US Airways v. McCutchen

Contributed by Howard Shapiro

It is a familiar scenario: a health plan participant sustains serious injuries in an accident caused by a tortfeasor. The tortfeasor has limited or no ability to respond in damages. The health plan pays out substantial benefits covering medical costs for the participant's injuries. The language of the health plan requires reimbursement of *all amounts* paid to the participant, so that the plan is made whole for the benefits it paid. But the participant does not receive sufficient money from the tortfeasor to be made whole for both his injuries and the medical costs. Thus, if the participant makes the plan whole for the medical costs, the participant will not obtain a full recovery for his injuries.

Reimbursement claims are asserted by the health plan against the participant and, sometimes, the participant's personal injury counsel, under Employee Retirement Income Security Act Section 502(a)(3),[1] seeking '"other appropriate equitable relief.'" Twice, the Supreme Court has considered the meaning of relief under these circumstances.[2] These past holdings helped shape and define the contours of equitable relief under Section 502(a)(3).

On Nov. 27, 2012, in the case of *US Airways v. McCutchen*,[3] the Supreme Court will hear oral argument again as to what constitutes appropriate equitable relief where a plan asserts a reimbursement claim against a participant and his personal injury counsel. At issue is the meaning of the adjective ''appropriate'' as it applies to equitable relief and equitable defenses. The Third Circuit held that the plan's make-whole relief may not constitute appropriate equitable relief under Section 502(a)(3) because the plan's judgment exceeded the amount of the participant's third-party recovery, net of attorneys' fees. The court reversed and remanded a grant of summary judgment for the plan and held that instead of enforcing the unambiguous written provisions of the plan that compelled such a result, the participant may present traditional equitable defenses to defend against the application of an unambiguous written plan provision.[4]

This issue is an important one. First, a welfare plan's reimbursement right may have an impact on the financial viability of the plan. Second, a participant's ability to assert equitable defenses to override unambiguous plan language may have major repercussions beyond reimbursement claims. Third, the decision may impact the definition of what constitutes ''appropriate equitable relief'' under Section 502(a)(3). Fourth, the issue has been hotly litigated. The Ninth Circuit recently joined the Third Circuit's minority view in *CGI Technologies and Solutions, Inc. v. Rose,* ***[5]*** stating ''We agree with the Third Circuit that under § 502(a)(3), the district court, in granting 'appropriate equitable relief,' may consider traditional equitable defenses notwithstanding express terms disclaiming their application.'' However, construing ''appropriate equitable relief'' under Section 502(a)(3), the Fifth, Seventh, Eighth, and Eleventh Circuits have enforced express plan language, and applied traditional contract principles resulting in full plan reimbursement, precluding a participant's application of equitable defenses.[6]

Facts of the Case

A multi-vehicle car accident occurred; one person was killed, two suffered severe brain injuries, and McCutchen sustained severe and disabling injuries. The plan paid out $66,866 for McCutchen's medical expenses. The tortfeasor was not well insured. Given the serious injuries sustained by the two other survivors and the death of the third motorist, McCutchen settled for $10,000 from the tortfeasor and an additional $100,000 from his underinsured motorist coverage, a gross settlement of $110,000.

The fee paid to McCutchen's personal injury counsel constituted 40 percent of the settlement amount. McCutchen netted $66,000 and his personal injury counsel placed $41,500 in a trust account. The US Airways plan then demanded reimbursement of the entire $66,866 paid out for McCutchen's medical bills. When McCutchen and his counsel refused to pay that amount, the US Airways plan sued under Section 502(a)(3), seeking appropriate equitable relief in the amount of the $41,500 held in trust by personal injury counsel and $25,366 personally from McCutchen.

Third Circuit Opinion

The court began by analyzing prior Supreme Court precedent: *Great–West Life & Annuity Ins. Co. v. Knudson,* ***[7]*** and *Sereboff v. Mid Atlantic Medical Servs., Inc*.[8] In both cases, plans sought reimbursement from participants. In *Great-West*, the high court held that the fiduciary's right to enforce plan terms was limited to equitable remedies or other ''appropriate equitable relief.'' The court also held that the theory of *equitable restitution* was limited to recovery of a particular *res* or fund found in the participant's possession. Because in *Great-West,* the funds sought by the plan were not in the participant's possession, but were instead placed in a special needs trust under California law, the plan was unable to recover them. In *Sereboff,* the funds were traceable and in the possession and control of the plan participant. Applying the principle of *equitable lien by agreement*, in *Sereboff*, the Supreme Court permitted the plan to seek equitable relief.

In *McCutchen,* the Third Circuit framed the following issue left open by *Sereboff*: ''whether § 502(a)(3)'s requirement that equitable relief be 'appropriate' means that a fiduciary like US Airways is limited in its recovery from a beneficiary like McCutchen by the equitable defenses and principles that were 'typically available in equity.'"[9] The court observed that ''it would be strange for Congress to have intended that relief under § 502(a)(3) be limited to traditional equitable categories, but not limited by other equitable doctrines and defenses typically applicable to those categories.''[10] This observation is the predicate for the court's controlling rationale—namely, that Congress intended that equitable relief includes equitable defenses to unambiguous plan language.

The Third Circuit next considered the uncontested facts that the reimbursement language was unambiguous and that US Airways' conduct was neither fraudulent nor dishonest. Despite these facts, the court relied upon *CIGNA Corp. v. Amara*,[11] for the proposition that while there is an emphatic preference for written plan provisions, that principle is not inviolable. The court noted that *CIGNA Corp.* recognized that plans could be modified by the application of equitable reformation and held that equitable principles could apply even if defendant has not committed a wrong.[12] The court held that the application of the full reimbursement plan provision constituted inappropriate and inequitable relief, because McCutchen would have to pay the plan more than his net recovery from the lawsuit. The court described this event as a windfall for the plan because US Airways did not contribute to the cost of obtaining recovery from the tortfeasor. As to what would constitute appropriate equitable relief and equitable defenses, the court remanded.[13]

The Parties' Supreme Court Briefs

In its brief to the Supreme Court, petitioner US Airways focuses on the language of Section 502(a)(3), the primacy of written plan documents, and scenarios explaining why enforcement of reimbursement provisions are both equitable and promote the expansion of ERISA coverage. US Airways criticizes the Third Circuit's construction as neglecting the entire text of Section 502(a)(3). Instead of asking what is ''appropriate equitable relief,'' US Airways argues that the statute contemplates ''appropriate equitable relief'' to enforce the terms of the plan. This anchors equitable relief to plan language and compels enforcement of an unambiguous plan provision. Petitioner also argues that the Third Circuit's construction of *CIGNA Corp.* errs because reformation is inappropriate where there is neither fraud nor mutual mistake.

US Airways further argues the importance of participant reliance on written plan documents. Noting that what occurred here was an exchange of value – the plan paid benefits in exchange for the participant's commitment to reimburse the plan if there is a tort recovery – petitioner argues that it is neither appropriate nor equitable to permit the participant to rewrite the agreement after the plan makes payments. Petitioner also makes the point that where a participant is relieved of his obligation to reimburse the plan, the cost of these benefits are defrayed by other plan participants in the form of higher premium payments.

US Airways also argues that the Third Circuit conflated the theories of equitable lien by agreement by applying unjust enrichment principles. Relying upon *Sereboff*, US Airways argues that the plan language creates an equitable lien by agreement: it identifies a particular fund from which the plan can seek reimbursement for medical costs that the plan agreed to pay. US Airways claims that, instead of following the language of the plan, the Third Circuit erred by enforcing vague concepts of unjust enrichment or public policy to rewrite an equitable lien by agreement. US Airways argues this is improper because there is nothing equitable about allowing the participant to enjoy the benefit of the bargain while disclaiming the responsibilities set forth in the plan document.

Finally, US Airways argues that the Third Circuit's opinion will increase the expense burden for plans. US Airways contends that reimbursement inures to the benefit of all participants by reducing the costs of the plan. US Airways also challenges the assertion that the reimbursement provision constitutes a windfall to the plan, arguing that enforcing a contractual right cannot be a windfall because the plan is not receiving unearned money. Candidly addressing the logical conclusion of its position, US Airways argues that there is nothing unfair about enforcing a reimbursement provision, even in the case where the result is a negative recovery for the participant.

Respondents, McCutchen and his personal injury firm, focus on very different equitable issues. They argue that McCutchen's actual damages were somewhere between $1 million and $1.75 million; thus, at most, recovery here was 11 percent, and McCutchen was not made whole given these facts. McCutchen then goes on to make the following legal points: there is not a true split in the circuits; *CIGNA Corp.* requires the application of this form of equitable relief; and the principal object of ERISA is to protect plan participants, not to enforce plan terms.

McCutchen argues that no ''true'' split in the circuits exist. The Third Circuit recognized in its opinion that it was reaching a decision that was contrary to the holdings of several other circuits.[14] However, McCutchen argues that because these decisions preceded *CIGNA Corp.*, no actual conflict exists among the circuits. McCutchen reads *CIGNA Corp.* for the proposition that a court sitting in equity is not obligated to enforce categorically plan terms as written, because a court sitting in equity should not enforce a written contract where equity demands a contrary result. McCutchen's position puts squarely at issue the concepts of equitable relief/defenses in the face of an unambiguous written plan provision, where there is neither fraud nor dishonesty. McCutchen complains that US Airways' construction of ''appropriate equitable relief'' requires courts to enforce categorically written plan language. According to McCutchen, this construction reads the words ''appropriate equitable relief'' out of the statute and means US Airways is actually seeking legal, not equitable, relief. McCutchen also points out that ERISA includes a contract-based enforcement provision, ERISA Section 502(a)(1)(B), and contends that US Airways seeks to import this contractual form of relief into Section 502(a)(3).

As to the public policy issue, McCutchen stresses that the purpose of ERISA is to protect people, not plans or plan sponsors. Equitable relief requires that rigid adherence to plan terms must yield when Section 502(a)(3) imposes limitations on strict enforcement of plan terms. As to US Airways' point that reimbursement provisions lower plan costs, McCutchen respondents argues the summary judgment record was devoid of any actual evidence that reimbursement results in lower participant premiums.

Proskauer's Perspective

McCutchen presents serious issues for the Supreme Court's resolution. ''Make whole'' reimbursement provisions have been unpopular with the courts. Generally, courts are sympathetic to participants who have been injured and receive less than full recovery from the tortfeasor. Here, US Airways candidly addresses the logical extension of the reimbursement argument: even if a plan provision causes a loss to the participant, the reimbursement provision must be enforced. Clarity from the Supreme Court as to this point will be helpful to plans.

The central issue presented by the parties is whether unambiguous written plan provisions may be altered by the application of equitable defenses under the guise of ''appropriate equitable relief.'' Generally, defendants rely upon their compliance with unambiguous plan provisions as a ''safe harbor'' demonstrating fiduciaries acted lawfully. Also, defendants prefer to limit plaintiffs to ''appropriate equitable relief'' because that is viewed as a limitation on remedies. If the Supreme Court holds that equitable defenses cannot be asserted to alter unambiguous plan terms, ERISA defendants will view such a development favorably.

The Third Circuit held, and respondents argue to the Supreme Court, that even in the absence of fraud or dishonest conduct, equitable principles permit a court to reform a plan document. Respondents also argue that *CIGNA Corp.* means that a court sitting in equity is not obligated to enforce categorically plan terms as written. Defendants view these positions as an expansion of the Supreme Court's holding in *CIGNA Corp*. A court's power to reform a plan or disregard unambiguous plan terms, without a showing of fraud or dishonest conduct, expands the current reach of equitable principles in ERISA litigation.

Finally, whenever the Court construes Section 502(a)(3) remedies, there is a ripple effect throughout the ERISA litigation environment. Generally, *Mertens v. Hewitt Associates*[15] and *Great-West* are viewed as cases that constrict remedies. *CIGNA Corp.* has been relied upon by plaintiffs as a remedy-friendly case. If past history repeats, the *McCutchen* opinion will impact remedies in a broader manner than merely opining as to reimbursement issues.

Rulings, Filings, and Settlements of Interest

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Retiree Benefits

- In *Argay v. Nat'l Grid USA Serv. Co.*, No. 11-3698-cv, 2012 WL 5860518 (2d Cir. Nov. 20, 2012) (by summary order), the Second Circuit Court of Appeals affirmed the district court's ruling in favor of a utility company, holding that retirees' right to participate in a life insurance program was not contractually vested under their former employer's post-retirement life insurance plan, and thus the benefits could be reduced. Several retirees brought a class action lawsuit claiming that in 2002

the company scaled back the post-retirement life insurance benefits available to retirees in violation of ERISA. The district court dismissed the case at the summary judgment stage and the Second Circuit affirmed, finding that the plan contained "language sufficient to reserve Defendants' right to terminate or amend the plan" and, therefore, the plaintiffs' benefits did not contractually vest and the defendants were free to alter the terms of the plan.

- In *Schrieber v. Philips Display Components Co,*, No. 10-1370, 2012 WL 5351279 (6th Cir. Oct 31, 2012), a divided panel of the Sixth Circuit affirmed a ruling that retiree medical benefits were not vested pursuant to the CBA or SPD, and thus could be terminated. In so ruling, the court noted that whereas the CBA vested "non-forfeitable" pension benefits for "as long as you live," it contained no similar language to vest medical benefits. The SPD reserved the company's right to modify or terminate the plan at any time, and provided that medical benefits would end when an employee left the company or otherwise became ineligible for benefits, or when the plan was terminated. The court also upheld the ruling that defendants had no continuing obligation to provide the benefits because its obligations under the CBA were assumed by a successor company that was not its "alter ego." Further, the court held the defendants complied with their fiduciary duties under ERISA by providing adequate notice and information about the successor's acquisition of the benefit obligations, and, in any event, their claims were time-barred by ERISA's three-year limitations period that began to run in 2001, when the plaintiffs were allegedly misinformed. One judge dissented, arguing that based on the jurisprudential presumption of vesting in the Sixth Circuit welfare benefits were vested because they shared certain eligibility requirements with vested pension benefits. That judge would also have held defendant Philips Display liable as a signatory to the CBA because the successor's assumption of liability did not explicitly discharge Philips Display.

Section 510

- In *Gioia v. Forbes Media LLC*, No. 11-4406-cv, 2012 WL 5382256 (2d Cir. Nov. 5, 2012), the Court affirmed summary judgment dismissing ERISA Section 510 and state law discrimination claims, finding no evidence that defendants' proffered reason for plaintiff's termination – cost reduction – was pretextual. The court observed that the supervisory decision-makers had no knowledge of plaintiff's health insurance claims, and that there was no other evidence that the employer acted with specific intent to interfere with plaintiff's benefits. The court affirmed dismissal of the state law claims on similar grounds.

Claim for Benefits

- In *Raybourne v. CIGNA Life Ins. Co. of New York*, Nos. 11-1295, 11-1427, 2012 WL 5870713 (7th Cir. Nov. 21, 2012), the Seventh Circuit held that an insurer with a structural conflict of interest abused its discretion when it terminated a participant's long term disability (LTD) benefits, and affirmed the lower court's award of attorney's fees. The participant applied for LTD benefits under the terms of the plan, insured and administered by Cigna. Cigna hired an external consultant to assist the participant in pursuing a Social Security Administration (SSA) benefits claim. After the first two rounds of the administrative process with the SSA, wherein the SSA denied the participant's claim, the participant appeared before an Administrative Law Judge (ALJ), which held that the participant was, in fact, disabled as defined by the SSA. The ruling benefited the plan because benefits under the plan for the first twenty-four months were offset by any disability benefits paid by SSA. Separate from the administrative process with the SSA, Cigna obtained an independent medical examination (IME) to determine whether the participant was disabled under the standards applied by the plan to periods of disability greater than twenty-four months. Based on the IME, Cigna determined that the participant was not disabled under the terms of the plan. The district court concluded that Cigna arbitrarily denied the LTD benefits for periods of disability greater than twenty-four months because it refused to consider the SSA's final determination of disability and that its decision was influenced by its structural conflict of interest. The Seventh Circuit affirmed and found that Cigna's denial of benefits was not supported by substantial medical evidence but instead was the direct result of their structural conflict of interest. In so holding, the court dismissed the notion of a meaningful distinction between the plan's and SSA's definition of "disability" and criticized Cigna for not explaining its reasons for disagreement with the ALJ's determination and for failing to mention the SSA's favorable determination. The court also faulted Cigna for failing to provide a rational explanation as to why it credited its IME over the substantial medical evidence set forth by the participant's treating physicians and adopted by the ALJ. Finally, the court affirmed the lower court's award of attorneys' fees for the entire litigation reasoning that, although the participant "lost a few skirmishes along the way," "in the end, his victory was complete."

- In *Wray v. Am. United Life Ins. Co.*, 2012 WL 5351277, Nos. 10-4297 & 10-4560 (6th Cir. Oct. 31, 2012), the court affirmed a finding that plaintiff was properly designated as one of three beneficiaries of a life insurance policy, but reversed denial of the insurer's request to file a cross-claim to recoup sums already paid to decedent's estate. The underlying issue arose from a beneficiary designation form that the decedent signed and which stated "attached" in the space for naming beneficiaries. On the attached form, the decedent listed three beneficiaries and their addresses, and he assigned one-third of the proceeds of his life insurance

policy to each. Plaintiff, one of the three listed beneficiaries, applied for her share of the insurance proceeds. Her claim was denied, and the proceeds were paid to the decedent's estate, because the decedent failed to sign and date both the official plan designation form and the attachment. The district court overturned the plan's determination, finding that its rationale for denying the claim was erroneous. In so ruling, it excused plaintiff from ERISA's exhaustion requirement, citing the failure to inform plaintiff about her administrative appeal rights, and reviewed the benefit denial *de novo*. On appeal, the Sixth Circuit noted that the official plan form was signed and dated, and that there was no plan requirement for the decedent to also sign and date the attachment. Thus, the panel concluded that the district court did not err in finding that the "attachment" properly signaled that plaintiff was to share in the life insurance proceeds. The Sixth Circuit remanded for additional consideration whether the insurer should be allowed to assert a cross-claim seeking to recoup and pay plaintiff from the funds already paid to the decedent's estate.

Prohibited Transactions

- In *National Security Systems Inc. v. Iola*, Nos. 10-4154 & 10-4155, 2012 WL 5440113 (3d Cir. Nov. 8, 2012), the Third Circuit affirmed a judgment holding a non-fiduciary liable for knowingly participating in prohibited transactions involving a multiple employer welfare plan. The plan was created by Tri-Core and marketed by a financial planner (Barrett) who assured employers that their plan contributions would be tax deductible. The IRS later rejected these deductions and imposed taxes and penalties on contributing employers. Four employers brought suit against Barrett and Tri-Core, asserting prohibited transaction and fiduciary breach claims for misrepresenting the plan's tax status and concealing the commissions Tri-Core received from the plan. The district court held Tri-Core breached its fiduciary duties by engaging in prohibited transactions in receiving commissions for plan purchase of insurance policies. Although Barrett was a non-fiduciary, the court found he could be liable under ERISA Section 502(a)(3) since he actively participated in Tri-Core's breaches. The court ultimately held Barrett liable for disgorgement of his profits. The Third Circuit also vacated certain rulings and remanded certain claims for further proceedings, holding that state-law misrepresentation claims were not preempted by ERISA to the extent they were based on statements made before the plan existed and that the employers' claims were not time-barred by ERISA's three-year limitations period because, although they had actual knowledge that Tri-Core received commissions, they were not aware of Barrett's knowing participation.

Failure to Exhaust Administrative Remedies

- In *Florida Health Sciences Center, Inc. v. Total Plastics, Inc.*, No. 12-11537, 2012 WL 5416539 (11th Cir. Nov. 6, 2012), the Eleventh Circuit affirmed the district court's

decision to grant summary judgment in favor of a self-funded health plan where a participant seeking benefits failed to exhaust administrative remedies under the plan. The participant's son suffered catastrophic and permanent brain damage caused by a third party for which the plan paid the initial medical expenses. Under the terms of the plan, the plan Administrator could require the participant to sign a subrogation agreement acknowledging the plan's entitlement to reimbursement from any settlement to pay for medical costs expended by the plan. The plan terms further stated the plan would be relieved of any obligation to pay medical expenses should the participant fail or refuse to sign the subrogation agreement. After paying medical expenses for two months, the plan Administrator sent the participant a claim denial notice, a subrogation agreement, and a letter informing the participant that the plan could not process the claim for benefits until the participant signed the subrogation agreement. The participant did not respond to the letter nor did the participant respond to the plan Administrator's fifty-four subsequent mailings until the participant's attorney contested the claim denial over a year after the initial letter. The district court found the participant did not contest the benefit denial within the Plan's 180 day period for administrative appeal. The Eleventh Circuit affirmed, finding the plan Administrator provided unambiguous notice of a denial of benefits and that the participant did not appeal within the 180-day window. While the participant argued an unspecified "ambiguity" as to when the benefit was denied, the court reasoned that the forty-eight claim denial notices provided the reasons for the denial, explained how the participant could correct the denial, and described the process for the administrative appeal. The court also rejected the participant's futility argument because the participant never even "attempt[ed] to pursue an administrative remedy" and failed to plead a "clear and positive showing of futility," as required by the Eleventh Circuit.

Standard of Review

- In *U.S. Foodservice Inc. v. Truck Drivers & Helpers*, No. 12-1108, 2012 U.S. App. LEXIS 24665, (4th Cir. Nov. 30, 2012), the Fourth Circuit reversed the district court's grant of summary judgment to U.S. Foodservice Inc. (USF), finding that the exception to the anti-inurement provision of ERISA Section 403(c) clearly provides the plan administrator – not a reviewing court – with the discretion to determine (1) whether an employer contribution was made by mistake and (2) if so, whether it should be returned to the contributing employer. USF conducted an internal audit of its contributions made to several multiemployer plans and concluded that it mistakenly contributed too much to the health fund and the pension fund. USF notified the funds of the alleged overpayments and requested a refund of the relevant amounts. The plan administrator for the funds formally determined that no overpayments were made, and that USF correctly paid contributions to the funds in accordance with the CBA. USF then filed a lawsuit, seeking recovery of the allegedly

mistaken contributions pursuant to ERISA Section 403 and the federal common law of unjust enrichment. The district court granted USF's motion for summary judgment and denied the funds' cross-motion, holding that the CBA language was clear and unambiguous and that the funds' alternative construction was untenable. On appeal, the court interpreted Section 403(c) to vest the plan administrator with broad discretion in determining when a refund is appropriate: *if* the administrator determines that the contribution was made by mistake, *then* the anti-inurement provision shall not prohibit the return of such contribution. The court also found that an administrator's determination with respect to the requirements of Section 403(c)(2)(A)(ii) is subject to review for an abuse of discretion. Ultimately, the court concluded that the plan administrator acted reasonably when it determined that USF's contributions were not the result of a mistake and reversed the district court's grant of summary judgment to USF.

Preemption

- In *Moon v. BWX Technologies, Inc*., No. 11-1750, 2012 U.S. App. LEXIS 24898 (4th Cir. Dec. 3, 2012), the Fourth Circuit affirmed the lower court's decision that a beneficiary's breach of contract and breach of quasi-contract claims for life insurance benefits were preempted by ERISA and should be dismissed based on the terms of the ERISA plan, but remanded the case to permit the lower court to determine whether, in light of the Supreme Court's decision in *CIGNA Corp. v. Amara*, 131 S. Ct. 1866 (2011), the beneficiary had viable claims for equitable estoppel and breach of fiduciary duty under Section 502(a)(3). At the beginning of 2005, Mr. Moon selected life insurance coverage under an ERISA-covered employee benefit plan while he was an active employee of BWX. In December of 2005, Mr. Moon retired from employment upon a finding by BWX that he was disabled. The life insurance plan provided that an employee loses life insurance coverage when he ceases to be an active employee due to a disability, and further that a disabled employee who wished to continue his life insurance under the plan must covert to an individual plan and arrange to pay the insurance company directly. BWX verified Mr. Moon's life insurance selection two days before Mr. Moon retired; coverage was to become effective January 1, 2006. In early 2006, after Mr. Moon retired, BWX provided Mr. Moon with a second confirmation statement, incorrectly referring to him as an employee. In 2006, Mr. Moon and his family paid some, but not all, of the life insurance premiums to BWX. When Mr. Moon died later in 2006, his widow paid the remaining balance due on Mr. Moon's benefits and made a claim to BWX for the life insurance benefits. BWX denied the claim, finding that Mr. Moon lost this life insurance benefit when he became unable to work in 2005 and failed to convert his policy as required by the plan. Mrs. Moon filed a lawsuit in state court, arguing that BWX made an independent post-employment contract for life insurance by way of

the second confirmation statement and acceptance of life insurance premiums. BWX timely removed the action, asserting that Mrs. Moon's claims were preempted by ERISA. The district court denied Mrs. Moon's motion to remand and dismissed her suit. Mrs. Moon appealed, arguing that her state law claims sought a one-time recovery from BWX based on an alleged independent contract for benefits and thus did not fall under ERISA. The Fourth Circuit disagreed, finding that Mrs. Moon's claims for breach of contract and breach of implied or quasi-contract were essentially mislabeled federal claims that fell within the broad scope of ERISA Section 502(a). More specifically, the court found that the record made clear that if Mrs. Moon were eligible for coverage at all, it would be according to the terms of the ERISA plan. The court also concluded that the district court was correct in deciding that the life insurance plan language at issue unambiguously barred Mrs. Moon's claim for benefits on its terms. The court, however, remanded Mrs. Moon's claims for equitable estoppel and breach of fiduciary duty claims, directing the court to determine whether such remedies were available to Mrs. Moon under Section 502(a)(3) since the district court decision with regard to these claims was based on a now-superseded opinion from the Fourth Circuit, and without the benefit of the *Amara*.

- In *Baker v. Allied Chemical Corp.*, No. 11-8110, 2012 WL 5951613 (10th Cir. Nov. 29, 2012), the Tenth Circuit held that an employer was not a proper defendant in a suit for benefits under a life insurance policy, as it had no decision making authority for the payment of benefits, and ERISA preempted the beneficiary's multiple state law claims. Plaintiff, heir and beneficiary to her husband's group life insurance policy issued by two insurance companies, sought to collect benefits upon her husband's death. One insurer issued a partial payment and the second insurer denied her claim. Plaintiff then filed suit against the insurers, her husband's former employer, Allied Chemical, and Honeywell, the predecessor corporation to Allied Chemical, alleging ERISA claims and multiple state law claims, including theft, conversion, misappropriation and breach of contract. Honeywell filed a motion to dismiss claiming that (1) they were not a proper party under ERISA as they were not the administrator or decision maker regarding the life insurance plan and (2) ERISA preempted plaintiff's state law claims. The district court granted Honeywell's motion to dismiss, reasoning that (1) Honeywell was not a proper defendant because it was an employer or sponsor of the plan and not the plan itself or an entity possessing decision making authority and (2) that ERISA preempted plaintiff's state law claims as the participant sought benefits under an insurance policy. The Tenth Circuit agreed with the reasoning of the district court and affirmed its decision to grant Honeywell's motion to dismiss.

Class Actions

- In *Johnson v. Meriter Health Services Employee Retirement Plan*, No. 12-2216, 2012 WL 6013457 (7th Cir. Dec. 4, 2012), the Seventh Circuit affirmed class certification of over 4,000 current or former Meriter pension plan participants who challenged various features of the plan, including the effects of its conversion in 2003 to a "cash balance" formula and its unwritten practice of using an index rate not provided by the plan to calculate lump-sum benefits. The district court certified the class pursuant to Rule 23(b)(2) (requiring that the defendant "acted . . . on grounds that apply generally to the class"), and created ten subclasses to address the multiple circumstances involved in the claims (including different dates of participation, early or normal retirement, and payment of benefits as an annuity or a lump sum). The Seventh Circuit granted interlocutory review of the certification pursuant to Federal Rule of Civil Procedure 23(f). In affirming, the court made several significant rulings and findings: First, it rejected the defense's contentions that the various subclasses and claims made the class unsuitable for Rule 23(b)(2) certification, noting that "every member of [each] subclass wants the same relief" and, further, that understanding the plan and its history was necessary to all claims. Second, the court found certification appropriate in spite of a statute of limitations defense. In reaching this conclusion, the court determined that there was no need for individualized statute of limitations determinations because the proof put forward was that the communications at issue went to all plan participants. Third, the court acknowledged that the class claim challenging the plan's unwritten practice in calculating lump sums could later be decertified if it turned out that participants had different expectations about whether the practice would continue. Fourth, the court found that the individualized claims for relief in the form of benefits did not preclude certification under Rule 23(b)(2) if the relief sought "would be the automatic consequence" of the requested declaratory and injunctive relief, and would be "incidental" to that relief as required by Rule 23(b)(2), because their calculation would require only reference to (1) the plan, as reformed, and (2) each individual's employment and benefit records. To the extent the calculation would be more than mechanical, the court noted that the class members should be notified and permitted to opt out, or the case should be bifurcated into a trial on liability, followed by additional trial(s) on damages. Finally, the court found that alleged conflicts among class members (who might want different index rates or dates for the 2003 conversion to become effective) were "hypothetical" but, if proven, could be addressed by forming additional subclasses.

Statutory Penalties

- In *Mondry v. American Family Mutual Ins. Co.*, Nos. 10-3409, 11-1750, 2012 WL 5938681 (7th Cir. Nov. 28, 2012), the Seventh Circuit affirmed the district court's decision to assess statutory penalties against a plan administrator for failing to timely produce plan documents. Plaintiff participated in a self-funded group health

plan and sought coverage for her son's speech therapy. Cigna, the claim administrator, denied the participant-beneficiary's claims as not medically necessary, relying on Cigna's internally created Benefit Interpretation Resource Tool for Speech Therapy (BIRT) and Clinical Resource Tool for Speech Therapy (CRT). Neither of these documents set forth the terms of the plan and both were inconsistent with the governing plan documents. Cigna realized this error and belatedly granted the claim for benefits. Plaintiff sued Cigna and American Family for failing to timely produce copies of the BIRT and CRT under ERISA Sections 1024(b)(4) and 404(a)(1). In a prior decision, the Seventh Circuit determined that Cigna's express reliance on the BIRT and CRT rendered the two documents plan documents because they governed the operation of the plan and therefore subject to ERISA's disclosure requirement. The court, however, held that only American Family, as the plan administrator, had the duty to produce the two documents under Section 1024(b)(4). In its most recent decision, the Seventh Circuit upheld the district court's determination of statutory penalties of $30 per day, as opposed to the statutory maximum of $110 per day, for American Family's failure to timely produce the CRT and BIRT. Plaintiff argued that the full statutory penalty should apply to each document request and that document requests made before the Seventh Circuit's prior decision encompassed the CRT and BIRT. The court rejected plaintiff's argument and held that a request for "plan documents" is too vague to encompass interpretative tools such as the CRT and BIRT and that the earliest American Family would have been on notice to provide the CRT and BIRT was after the Seventh Circuit's prior opinion. The court further rejected plaintiff's claim that American Family could be held vicariously liable for Cigna's failure to produce the requested documents as Cigna was American Family's agent only with respect to claims administration. Finding no evidence of bad faith on the part of American Family, the court reasoned that American Family was "at most guilty of negligence" for not timely producing the CRT and BIRT and upheld the reduced statutory penalty.

[1] 29 U.S.C. § 1132(a)(3).

[2] *Great–West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 27 EBC 1065 (2002); *Sereboff v. Mid Atlantic Medical Servs., Inc.*, 547 U.S. 356, 37 EBC 1929 (2006).

[3] 663 F.3d 671, 52 EBC 2143 (3rd Cir. 2011), *cert. granted*, 80 U.S.L.W. 3707 (June 25, 2012).

[4] *McCutchen*, 663 F.3d at 676.

[5] 683 F.3d 1113, 1123 (9th Cir. 2012).

[6] *See, e.g., Zurich Am. Ins. Co. v. O'Hara*, 604 F.3d 1232, 1238, 49 EBC 1018 (11th Cir. 2010); *Administrative Comm. of Wal-Mart Stores, Inc. Assocs.' Health & Welfare Plan v. Shank*, 500 F.3d 834, 839, 41 EBC 1681 (8th Cir. 2007); *Administrative Committee of Wal-Mart Stores, Inc. Assocs.' Health & Welfare Plan v. Varco*, 338 F.3d 680, 691–92, 30 EBC 2409 (7th Cir. 2003); *Bombardier Aerospace Employee Welfare Benefits; Plan v. Ferrer, Poirot and Wansbrough*, 354 F.3d 348, 361, 31 EBC 2505 (5th Cir. 2003); *Wal-Mart Stores, Inc. Assocs.' Health & Welfare Plan v. Wells*, 213 F.3d 398, 402, 24 EBC 1673 (7th Cir. 2000).

[7] 534 U.S. 204, 27 EBC 1065 (2002).

[8] 547 U.S. 356, 37 EBC 1929 (2006).

[9] *McCutchen*, 663 F.3d at 675-76.

[10] *Id.* at 676.

[11] 131 S. Ct. 1866, 50 EBC 2569 (2011).

[12] *McCutchen*, 663 F.3d at 678-79.

[13] *Id.* at 679-80.

[14] *See* note 6, *supra*.

[15] 15 508 U.S. 248, 16 EBC 2169 (1993).

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