DrinkerBiddle

# Minimizing the Risks of Plan Litigation by Learning from the Mistakes of Others

Chicago – Tuesday, July 17, 2018

Philadelphia – Wednesday, July 25, 2018

# Contact Information

| Chicago | Philadelphia |
|---|---|
| Sarah Bassler Millar, Partner<br>sarah.millar@dbr.com<br>(312) 569-1295 | Mona Ghude, Partner<br>mona.ghude@dbr.com<br>(215) 988-1165 |
| Rick Pearl, Counsel<br>richard.pearl@dbr.com<br>(312) 569-1344 | David Levin, Partner<br>david.Levin@dbr.com<br>(202) 230-5181 |
| | Karen Gelula, Counsel<br>karen.gelula@dbr.com<br>(215) 988-2729 |
| | Allison Crowe, Associate<br>allison.crowe@dbr.com<br>(215) 988-2514 |

**E**very

**R**ule

**I**s

**S**omewhat

**A**mbiguous

# Four Hundred Dollars

# Attorney Fees — ERISA is a fee shifting statute

- ERISA § 502(g)(1) provides that a court in its discretion "may allow a reasonable attorney's fee and costs . . . to either party."
- In *Hardt v. Reliance Standard Life Ins. Co.*, 560 U.S. 242 (2010), the Supreme Court ruled that ERISA has no "prevailing party" standard for an award of attorney fees. Rather, a party must have obtained "some degree of success on the merits."

# Attorney Fees — No Proportionality

Five additional factors in deciding whether to award fees:

1. Degree of opposing parties' culpability or bad faith;
2. Ability of opposing party to pay the fee award;
3. Whether an award of fees would deter other persons from acting under similar circumstances;
4. Whether party seeking fees sought to benefit all plan participants or resolve a significant legal question;
5. Relative merits of the parties' positions.

None of the five factors compares the amount of the claim to the amount of the fees. *See, e.g., Jones v. Metro. Life Ins. Co.*, (9th Cir. 2014) ($191,291 fee award in case seeking $60,000 in benefits).

# Attorney Fees — Catalyst Theory

- A number of courts are now embracing the “catalyst theory” of attorney fee awards in ERISA cases, which allows fee awards for litigants whose judicial action causes another party to settle or otherwise provide them with the requested relief.
- *See, e.g., Templin v. Independence Blue Cross*, 785 F.3d 4493 (3d Cir. 2015); *Boyle v. Teamsters Local 863 Welfare Fund*, 58 EBC 2693 (3d Cir. 2014).

# Establishing, amending, and terminating plans

- Settlor functions, not fiduciary functions
- Who can perform these functions?
- *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 83 (1995)
- *Lockheed Corp. v. Spink*, 517 U.S. 882, 890 (1996) (no ERISA § 406 violation).

**ERISA §402(a) —** Every employee benefit plan shall be established and maintained pursuant to a written instrument.

**ERISA §402(b) —** Every employee benefit plan shall specify the basis on which payments are made to and from the plan.

**ERISA § 404(a)(1)(D) —** Terms of the "documents and instruments governing the plan" control.

ERISA "speaks of 'enforcing' the 'terms of the plan,' not of changing them." *CIGNA Corp. v. Amara*, 563 U.S. 421, 436 (2011).

# Case law emphasizes that plaintiffs must allege facts establishing coverage, including the particular plan provisions under which they claim a right to benefits.

*See, e.g., Mid-Town Surgical Ctr., L.L.P. v. Humana Health Plan of Tx., Inc.*, 2014 WL 1653085, at *6 (S.D. Tex. Apr. 23, 2014) ("[T]o assert a claim for benefits under ERISA, a plaintiff must identify a specific plan term that confers the benefits in question.") (quoting *Innova Hosp. San Antonio, L.P. v. Blue Cross & Blue Shield of Ga., Inc.*, 2014 WL 360349, at *5 (N.D. Tex. Feb. 3, 2014)).

# Appropriate equitable relief and estoppel — Circumventing plan terms to obtain a remedy

- LTD plan participant was entitled to equitable relief under 502(a)(3)—rather than an increase in plan benefits under 502(a)(1)(B)—based on an alleged mismatch between the plan document and the SPD. *See Stiso v. Int'l Steel Grp.*, (6th Cir. 2015).
- The Ninth Circuit holds that an ERISA plaintiff seeking to assert estoppel must allege the four traditional elements of estoppel plus three extra elements. *Gabriel v. Alaska Elec. Pension Fund*, 773 F.3d 945, 957 (9th Cir. 2014).

# Estoppel – Elements

- To be estopped (1) the party must know the facts; (2) he must intend that his conduct shall be acted on or must so act that the party asserting the estoppel has a right to believe it is so intended; (3) the latter must be ignorant of the true facts; and (4) he must rely on the former's conduct to his injury
- To maintain a federal equitable estoppel claim in the ERISA context, the party asserting estoppel must also allege: (1) extraordinary circumstances; (2) that the provisions of the plan at issue were ambiguous such that reasonable persons could disagree as to their meaning or effect; and (3) that the representations made about the plan were an interpretation of the plan, not an amendment or modification of the plan.

# What do your plan and SPD say about . . .

- The standard of review of claims administrator's benefit denial?
- Court reviews denial of benefits under *de novo* standard **unless** plan and SPD provide to the contrary
- If plan and SPD provide for discretionary review, what is the breadth of discretion—facts, plan interpretation, both?

# ERISA §402(b)—Every employee benefit plan shall provide a procedure for . . .

- The allocation of responsibilities for the operation and administration of the plan
- Amending the plan
- Identifying the persons who have authority to amend the plan

# *Metropolitan Life Ins. Co. v. Glenn,* 554 U.S. 105 (2008)

- Dual role conflict of interest (decision maker and payer) does not change standard of review from discretionary to *de novo*
- Supreme Court's active steps to reduce potential bias and promote accuracy (the "vanishing point")
  - Walling off claims administrators from those interested in firm finances
  - Imposing management checks that penalize inaccurate decision making, "irrespective of whom the inaccuracy benefits"
  - Incentives to reward accuracy in claims processing

# No delegation procedure, no delegation.

- *Decovich v. Anthem Life Ins. Co.*, 60 EBC 1075 (9th Cir. 2015)
  - If the plan permits the delegation of authority to decide claims and/or appeals, then there can only be a delegation if the procedure for delegating is followed.
  - If there is no procedure, then there can be no delegation.

# No delegation, no deference.

- *Bilheimer v. FedEx Corp. LTD Plan* (4th Cir. 2015)
  - If the plan does not permit the delegation of authority to decide claims and/or appeals, then there can be no delegation notwithstanding a service agreement stating there has been a delegation.
  - If the plan permits delegation, then the procedure for delegating must be complied with in order to have an effective delegation.
  - Outsourcing the processing of claims is not necessarily the equivalent of an effective delegation.

# ERISA §503 – Every plan shall . . .

- Provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and
- Afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

# What do your plan and SPD say about . . .

- Venue . . . forum selection?
- *Smith v. Aegon Companies Pension Plan*, 769 F. 3d 922 (6th Cir. 2014), *cert. denied*, 136 S.Ct. 791 (2016)
- ERISA § 502(e)(2)
  - Where the plan is administered
  - Where the breach took place, or
  - Where a defendant resides or may be found

# Forum selection provision in plan document and SPD

- “RESTRICTION ON VENUE” – Any action in connection with the plan can only be filed in the federal district court in [insert city and state, either where plan sponsor is headquartered or where plan is administered].

# Class Actions

- Class actions – not a substantive right; not a remedy.
- What do your plan and SPD say about class action waivers?
- *Am. Express Co. v. Italian Colors Restaurant*, 570 U.S. ___, 133 S.Ct. 2304 (2013) ("[T]he fact that it is not worth the expense involved in proving a statutory remedy does not constitute the elimination of the right to pursue that remedy.")

# Arbitration and Class Actions

- What do your plan and SPD say about arbitration?
- What do your plan and SPD say about arbitration and class action waivers.
- *Epic Sys. Corp. v. Lewis,* No. 16-285, 2018 WL 2292444 (U.S. May 21, 2018) (enforcing arbitration contracts barring class actions)
- Be careful what you wish for – *Hunter, Keith Indus. v. Piper Capital Mgmt.*, 575 N.W.2d 850 (Minn. Ct. App. 1998); *Shearson Lehman v. Neurosurgical Assocs.*, 896 F.Supp. 844 (S.D. Ind. 1995) (upholding arbitration awards of punitive damages).

# What do your plan and SPD say about . . .

- Time limitation on timing of filing a lawsuit?
  - No ERISA statute of limitations for benefit claims; use most analogous state law
  - Pick your own . . . What's reasonable? (45 days, 90 days, 2 years, 3 years)
  - *Northlake Regional Medical Center v. Waffle House System Employee Benefit Plan*, 160 F.3d 1301 (11th Cir. 1998) (90 days)
- When does the claim accrue? *Heimeshoff v. Hartford Life Ins. Co.*, 134 S.Ct. 604 (2013)

# Practice Pointers:

1. Include limitation of action provisions in plan document and SPD and make sure that the language is clear so that a participant will be able to read the provision and understand the applicable time limits to bring an action.

2. Include the limitation of action provisions in the section of the documents discussing claim and appeal procedures.

3. Include limitation of action provisions in all claim and claim appeal determinations to assure that participants are on notice of the limitations period, if their benefit claim is denied. *See Mirza v. Insurance Administrator of America*, (3d Cir. 2015); *Moyer v. Metro. Life Ins. Co.*, 762 F.3d 503 (6th Cir. 2014) (failure to include plan limitation of action in notice of denial of appeal prevented use of plan limitation period; analogous state law limitation period was used instead).

# Exhaustion

- Discretionary, judicial doctrine
  - Benefit claims only or any claim with respect to a plan—ERISA §§ 502(a)(1), 502(a)(2), 502(a)(3), and 510
- What do your plan and SPD say?

# Exhaustion

- Is there no end to the submission of evidence by a participant?
- *Compare Blair v. Metro. Life Ins. Co.*, 59 EBC 1668 (11th Cir. 2014) (administrator was not under legal obligation to consider later-submitted evidence, where participant submitted additional evidence of disability continuously over two-year period, since) *with Killen v. Reliance Standard Life Ins. Co.*, 776 F. 3d 303 (5th Cir. 2015) (before filing suit, claimant's lawyer can add additional evidence to administrative record simply by submitting it to administrator in a manner that gives administrator a fair opportunity to consider it).

# What do your plan and SPD say about recovery of overpayments?

- The common fund and make-whole doctrines are default rules that apply only in the absence of specific and unambiguous language precluding it. U.S. *Airways, Inc. v. McCutchen*, 538 U.S. 822 (2013) (make whole and common fund doctrines).

# Is enforcement of a reimbursement clause "appropriate equitable relief" under ERISA § 502(a)(3) where the participant has dissipated settlement funds prior to the plan fiduciary's demand for reimbursement?

- **No**. *Montanile v. Bd. of Trs. of the Nat'l Elevator Indus. Health Benefit Plan*, 136 S. Ct. 651 (2016)
- An ERISA fiduciary cannot enforce an equitable lien against a participant's general assets under these circumstances, because it is not "appropriate equitable relief" under ERISA § 502(a)(3).
- Only an equitable lien by agreement against specifically identified funds that remain in the participant's possession or against traceable items that the participant purchased with the funds is permissible.

# Amendments reducing or terminating welfare benefits

- *Hargrave v. Commonwealth General Corporation's Long Term Disability Plan*, 51 EBC 2336 (5th Cir. 2011)
  - ERISA does not statutorily vest welfare plan benefits.
  - Plan sponsor may choose to vest future benefits contractually.
  - Whether plan sponsor can amend plan to reduce or deny welfare plan benefits (retroactively or otherwise) turns on whether the benefits have contractually vested.
  - Plan sponsor vests an ERISA welfare plan benefit "when it intends to confer unalterable and irrevocable benefits on its employees, and it does so by using clear and express language."

# Treating physician rule

- Although the "treating physician rule" does not apply in ERISA cases, plan fiduciaries cannot ignore a claimant's reliable evidence, including the opinions of a treating physician.
- *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 834 (2003).

# Selecting and Monitoring Service Providers – Procedural Prudence

- Establish a prudent process for selecting, monitoring, and eliminating service providers
- Review of fees is only one part of that process
- Determine reasonableness of plan expenses/fees in light of the level and quality of services provided
- Monitor to determine if the fees remain appropriate for the level and quality of services provided
- Monitoring is a continuing process – *Tibble v. Edison Int'l.*, 135 S. Ct. 1823 (2015)

# Responding to requests for documents

- Does your claims procedure state that a claimant shall be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claimant's claim for benefits.
  - What does “relevant” mean?

# A document, record, or other information is “relevant” to a claimant's claim if the document, record, or other information

- Was relied upon in making the benefit determination; or
- Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether the document, record, or other information was relied upon in making the benefit determination; or
- Demonstrates compliance with the administrative processes and safeguards required pursuant to paragraph (b)(5) in making the benefit determination.
  - (b)(5): The claims procedures contain administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants.

# One more note about “relevant” . . .

In a group health plan or a plan providing disability benefits, a document, record, or other information is “relevant” to a claimant's claim if the document, record, or other information constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

# What do your plan and SPD say about out-of-network service providers?

- Are out-of-network charges reimbursed?
  - If so, are the payments made by the plan to the service provider or to the participant?
  - If so, what is the basis for payments — a flat rate schedule, a flat percentage, or something else?
  - If a flat percentage, then a percentage of what—usual, customary and reasonable (UCR) charges; Medicare reimbursement rates; maximum eligible fees established by the TPA; something else?
- When is the last time you reviewed the basis on which out-of-network charges are paid?

# Responding to requests for documents

- Who is making the request?
  - A participant, a beneficiary, an authorized representative?
- What are your plan procedures for determining whether a requester is an authorized representative?
- How readily can the plan administrator provide documents — ERISA 104(b) requests, administrative record requests?

# Differentiating between an authorized representative and an assignee

- Plans are prohibited from "preclud[ing] an authorized representative of a claimant from acting on behalf of such claimant in pursuing a benefit claim or appeal of an adverse benefit determination." 29 C.F.R. §2560.503-1(b)(4).
- Whether an assignment gives plaintiffs the right to submit a claim and pursue an appeal on a patient's behalf is a separate issue entirely from whether plaintiffs have the right to sue under ERISA. *See, e.g., Rojas v. Cigna Health & Life Ins. Co.*, 793 F.3d 253 (2d Cir. 2015).
- Anti-assignment provisions are valid and enforceable, and an unambiguous anti-assignment clause in an ERISA plan voids any purported assignment. *See, e.g., Spinedex Physical Therapy USA Inc. v. United Healthcare of Ariz., Inc.*, 770 F.3d 1282, 1289 (9th Cir. 2014).

# Assignments

- No consensus among courts as to whether language providing for direct payment of benefits constitutes an assignment for purposes of ERISA.
- A number of courts rule that a patient's authorization for a plan or insurer to make payment directly to a provider, without more, does not constitute an assignment. *See, e.g., Am. Chiropractic Ass'n v. Am. Specialty Health Inc.*, 14 F. Supp. 3d 619 (E.D. Pa. 2014).
- Assignment must be “express and knowing.” *See e.g. Advanced Women's Health Ctr., Inc. v. Anthem Blue Cross Life & Health Ins. Co.*, 2014 WL 3689284 (E.D. Cal. July 23, 2014).
- A key factor in deciding whether there is a valid assignment is whether the alleged assignee agreed to take on the risk of nonperformance along with the right to enforce performance — Does the assignee acknowledge that it would have no recourse against the patient if the plan did not pay?

# More about assignments

- If there is a valid assignment, what rights were assigned?
- A number of courts have ruled that assignments of contract rights (like the right to receive benefits under an ERISA plan) do not include an assignment of the right to raise claims for breach of fiduciary duty under ERISA §§ 502(a)(2) or (a)(3). *See, e.g., Romano Woods Dialysis Center v. Admiral Linen Service, Inc.*, 2014 WL 3533479 (S.D. Tex. July 15, 2014).

# Even more about assignments

- Assignee is often an out-of-network provider
  - challenging the plan's reimbursement rate as unfair
  - claiming that the reimbursement is not as much as what the provider was "promised" by some anonymous person who works for the plan
  - challenging a plan limitation on the benefit (e.g., failed to obtain pre-authorization or only covered if provided in-network)
  - claiming that payment should have been made directly to the provider, not to the participant

# When the government knocks . . .

- IRS audits, DOL investigates, PBGC audits and investigates
- Agency oversight is broad, but not without limits
  - Verbal requests versus written requests
  - On site audits/subpoena power
  - FOIA protection, but only if you ask
- Limit the scope of any request for additional response time. Do you really need more time to produce plan documents, service provider agreements, and audits?

# Don’t forget: those who write history win

- You have to document
  - what you are going to do,
  - what you are doing, and
  - what you have done.
- Who maintains the administrative record of a denial of a benefit appeal?
- Who maintains the record of service provider hiring?
- Who maintains the record of service provider monitoring?

# How do you monitor ERISA litigation (1) to avoid making the same mistakes that others make and (2) to learn how to improve the provisions of your plan and SPD?

# If you have any questions, please ask.

## Thank you.

# Contact Information

| Chicago | Philadelphia |
| --- | --- |
| Sarah Bassler Millar, Partner<br>sarah.millar@dbr.com<br>(312) 569-1295 | Mona Ghude, Partner<br>mona.ghude@dbr.com<br>(215) 988-1165 |
| Rick Pearl, Counsel<br>richard.pearl@dbr.com<br>(312) 569-1344 | David Levin, Partner<br>david.Levin@dbr.com<br>(202) 230-5181 |
| | Karen Gelula, Counsel<br>karen.gelula@dbr.com<br>(215) 988-2729 |
| | Allison Crowe, Associate<br>allison.crowe@dbr.com<br>(215) 988-2514 |