ERISA Report

12/30/2019 Volume 14, Issue 3

Committee Leadership

In This Issue

Feature Articles

Case Law

Feature Articles

Despite a Recent Erosion, the Doctrine of Substantial Compliance Vis-à-Vis the 2002 ERISA Regulatory Deadlines Remains Viable

By Scott M. Trager

ERISA practitioners are now well familiar with the recent implementation of the 2018 Department of Labor ("DOL") regulations governing disability procedures. *See* 29 C.F.R. § 2560.503-1. In contrast to the 2002 regulations, the 2018 regulations now require that plans strictly comply with claims procedures or risk losing the benefit of deferential review. *See id*., § 2560.503-1(l)(2). One of the more challenging requirements facing plans under the new regulations is strictly complying with deadlines relating to notifications of benefit determinations on review. *See* 29 C.F.R. § 2560.503-1(f) and (i).

Even though we are now nearly eighteen months past the effective date of the new regulations, plan administrators continue to review and administer disability claims filed *before* April 1, 2018. In that regard, the 2002 regulations remain applicable and late notifications by plan administrators thereunder have frequently been excused under the doctrine of substantial compliance. Under this doctrine, a plan administrator's regulatory violation may be excused if it otherwise substantially complies with the regulation, without the penalty of losing the benefit of deferential review.

However, this is no longer an immutable rule—the federal circuits are now fractured on this issue. While many circuits, explicitly and implicitly, continue to recognize the doctrine of substantial compliance in this context thus preserving discretionary review, two circuits now require strict compliance with the 2002 regulatory deadlines in order to avoid the imposition of *de novo* review. This article provides a survey of how the substantial compliance doctrine is presently treated by the federal circuits vis-à-vis the 2002 ERISA regulatory deadlines. Despite a recent trend rejecting the doctrine and requiring plan administrators to strictly comply with regulatory deadlines in order to preserve the discretionary standard of review, the doctrine is very much alive in a majority of the circuits.

Circuits Rejecting the Doctrine of Substantial Compliance in Favor of Strict Compliance

Although very much the minority view, the Second and Seventh Circuits recently rejected the doctrine of substantial compliance and require strict compliance with the 2002 regulatory deadlines in order to preserve the discretionary standard of review.

Second Circuit

In *Halo v. Yale Health Plan*, 819 F.3d 42 (2d Cir. 2016), the Second Circuit essentially eliminated the doctrine of substantial compliance under the 2002 regulations. *Halo* involved a *pro se* ERISA action brought by a university student insured under a university health plan against the plan administrator alleging it arbitrarily and capriciously denied coverage and violated the DOL regulation governing the timing of notification of benefit determinations. The United States District Court for the District of Connecticut held that, when exercising discretionary authority to deny a claim for benefits, a plan's failure to establish or follow reasonable claims procedures in accordance with the ERISA regulations entitles the claimant to *de novo* review of the claim unless there was substantial compliance therewith, in which case the discretionary standard would apply. *See id*. at 45.

On appeal, the Second Circuit vacated and remanded the district court's decision. *See id*. at 61. It determined the application of the *de novo* standard of review to claim denials failing to comply with ERISA's minimum regulatory requirements comports with trust law as the regulations provide the applicable standard of care, skill, and caution plans must follow when exercising discretion. *See id*. at 52. Under trust law principles, a court may properly "interpose," *i.e.*, review a claim *de novo*, if it finds the trustee's conduct, in exercising a discretionary power, fails to satisfy that standard. *See id*.

The court interpreted the regulation, including its preamble, and held a plan's failure to comport with the regulation entitles a claimant to have his or her claim reviewed *de novo* in federal court. *See id*. at 53. Such a conclusion,

the court reasoned, balances the competing interests of employers and employees and ERISA's dual congressional purposes of encouraging employers to continue voluntarily providing benefits while also protecting employees' interests in those benefits. *See id.* at 55–56.

The court further concluded the doctrine of substantial compliance was flatly inconsistent with the 2002 regulations, particularly 29 C.F.R. § 2560.503-1(l). *See id.* 56. However, the court left the door open for discretionary review in cases where a plan otherwise established procedures in full conformity with the regulation and could demonstrate its failure to comply was inadvertent and harmless. *See id.* at 58. Although the court held there could be no civil penalties for a plan's failure to comply with the regulation, *see id.* at 58–59, good cause to admit additional evidence beyond the administrative record may exist if the plan's failure to comply with the regulation "adversely affected the development of the administrative record." *Id.* at 60.

Seventh Circuit

Most recently, the Seventh Circuit further eroded the substantial compliance doctrine in this context in *Fessenden v. Reliance Std. Life Ins. Co.*, 927 F.3d 998 (7th Cir. 2019). In *Fessenden*, the claimant submitted an administrative appeal following the denial of his claim; however, the plan administrator failed to issue its appeal decision within the timeline mandated by ERISA and the claimant immediately brought suit before the final decision was issued eight days later. *See id.*

In the United States District Court for the Northern District of Indiana, the plaintiff argued that the plan administrator, by virtue of its late final decision, forfeited the benefit of the discretionary standard of review and, instead, the *de novo* standard should apply. *See id.* at 1001. The plan administrator, however, attempted to differentiate a late decision from one that is never rendered and asserted its late decision should be excused under the doctrine of substantial compliance. *See id.* The district court denied plaintiff's motion to determine standard of review, applied the discretionary standard, and subsequently granted summary judgment in favor of the plan administrator. *See* 2018 WL 461105 (N.D. Ind. Jan. 17, 2018); 2016 WL 8968995 (N.D. Ind. Sept. 26, 2016). The case was thereafter appealed to the Seventh Circuit.

In line with *Halo*, the Seventh Circuit found the doctrine inapplicable to ERISA's 2002 regulatory deadlines, held the plan administrator forfeited its grant of discretion by failing to strictly comply with the regulatory deadline for issuing a final decision, and vacated and remanded the decision of the district court. *See id.* at 1006–07. While acknowledging the doctrine of substantial compliance was part of the body of federal common law, the court stated it could not "override regulations that ERISA has authorized the Department of Labor to adopt." *Id.* at 1002. *Fessenden* was decided by the Seventh Circuit on a narrower ground than *Halo* in that it held that even if the substantial compliance doctrine remained valid, it did not apply to the violation of regulatory deadlines. *See id.* at 1003. The court highlighted the 2002 regulation's language that an administrator must review a claim "not later than" a specified period of time – 45 days for disability claims. *See id.* at 1004. Although that time could be extended where "special circumstances" apply, it provides that "in no event shall such extension exceed [the allotted] period," and "when that time is up, it's up." *Id.* The court stated that "[s]ubstantial compliance with a deadline requiring strict compliance is a contradiction in terms. . . . The very point of a deadline is to impose a hard stop. . . . Because the administrator lacks discretion to take longer than the regulations allow, its tardy decision is not entitled to deference." *Id.* (emphasis in original).

Unlike adopting the substantial compliance doctrine to overlook an administrator's failure to strictly comply with the regulations governing the content of letters giving notice of benefit determinations, it "cannot be applied to an untimely decision because there is *nothing* to review at the time that administrative remedies are deemed exhausted" and there is no explanation for a claimant to read and understand. *Id.* at 1005 (emphasis in original). If a claimant files suit before the decision is issued, "there is neither an exercise of discretion to which a court could defer nor anything for the court to use to measure the degree of the administrator's compliance." *Id.* The court found, in the absence of a decision to which the district court could defer, it had no choice but to review the claim *de novo*. *See id.* The court found the plan administrator's position would leave the claimant in an uncertain position and could give it an unfair advantage as "it could sandbag a claimant who sues at the point of exhaustion by issuing a decision tailored to combat her complaint." *Id.*

The court further distinguished the pre-2002 and 2002 regulations and their interplay with the doctrine of substantial compliance. *See id.* at 1006. Specifically, the pre-2002 regulations "allowed courts the flexibility to police . . . gamesmanship and avoid results that would be antithetical to the aims of ERISA." *Id.* (internal quotations omitted). On the other hand, the 2002 regulations included more detailed and balanced provisions on timing and

tolling; therefore, there could be no rationale for applying the substantial compliance doctrine to missed deadlines. *See id.* The Seventh Circuit concluded "that excusing late decisions is both foreclosed by the 2002 regulations and incompatible with the [substantial compliance] doctrine," and was inconsistent with its own precedent. *Id.*; *see also Edwards v. Briggs & Stratton Retirement Plan*, 639 F.3d 355, 361–62 (7th Cir. 2011) (holding that the substantial compliance doctrine did not apply to a claimant's late appeal from a denial of benefits).

Circuits Wherein the Doctrine of Substantial Compliance Remains Viable

Despite the recent erosion of the substantial compliance doctrine with regard to the 2002 ERISA regulatory deadlines, it very much remains viable as many federal circuits, to various extents, continue to recognize it in this context and will not strip away a plan administrator's grant of discretion.

First Circuit

The First Circuit has applied the doctrine of substantial compliance to excuse an insurer's failure to precisely comply with ERISA's notice requirements and, in cases involving a plan administrator's regulatory violation, requires the plaintiff to demonstrate that the violation prejudiced him by affecting review of his claim. *See Santana-Diaz v. Metropolitan Life Ins. Co.*, 816 F.3d 172, 182 (1st Cir. 2016); *Niebauer v. Crane & Co., Inc.*, 783 F.3d 914, 927 (1st Cir. 2015). *See also Topalian v. Hartford Life Ins. Co.*, 945 F. Supp. 2d 294, 336–40 (E.D.N.Y. 2013) (finding that plan administrator's allegedly untimely decision on participant's administrative appeal did not require *de novo* review where administrator substantially complied with regulatory deadlines; it regularly communicated with participant, informed him of additional time needed, and rendered a decision before commencement of his federal action). Although the doctrine of substantial compliance has been applied to excuse an *insurer's* failure to comply with ERISA's notice requirements, the First Circuit declined to apply it to late appeals by claimants and an insurer may strictly enforce the 180-day appeal deadline against a plan participant. *See Fortier v. Hartford Life & Acc. Ins. Co.*, 916 F.3d 74 (1st Cir. 2019).

Third Circuit

The Third Circuit, in *Becknell v. Severance Pay Plan of Johnson & Johnson and U.S. Affiliated Cos.*, 644 F. App'x 205 (3d Cir. 2016), explicitly recognized the doctrine of substantial compliance in this context. The plaintiff in *Becknell* contended that his LTD claim was "deemed denied" because of his employer's failure to issue a timely decision to his administrative appeal, as required by the ERISA regulations and the plan, and the *de novo* standard of review should apply. *See id.* at 211. The employer countered that the delayed decision alone did not transform the standard of review from discretionary to *de novo*. *See id.* at 212. The Third Circuit held the plan administrator's actions did not constitute a failure to exercise discretion where the plaintiff's initial claim was timely denied and plaintiff was apprised of the plan administrator's exercise of its discretion well before he brought his action. *See id.* Citing the Supreme Court decisions in *Metropolitan Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008), and *Conkright v. Frommert*, 559 U.S. 506 (2010), the court stated that the late decision to plaintiff's appeal was a "factor" to consider in determining whether the plan administrator abused its discretion. *See* 644 F. App'x at 212. The Third Circuit found that the delay "did not impair the interests *Firestone* deference promotes in fairness and uniformity of plan interpretations." *Id.* at 213. It further stated, "[t]o remove the deference to which this interpretation is afforded by trust principles, the governing documents, and Supreme Court precedent would undermine the balance on which ERISA is founded." *Id.*

Fourth Circuit

In *Donnell v. Metropolitan Life Ins. Co.*, 165 F. App'x 288 (4th Cir. 2006), the claimant specifically raised the issue that the administrator violated ERISA's timing regulations in deciding her appeal, but because she asserted no causal connection between the administrator's noncompliance with the regulations (late appeal decision) and the denial of her claim, the court did not find an abuse of discretion. *See id.* at 297 (citing *Ellis v. Metropolitan Life Ins. Co.*, 126 F.3d 228, 238 (4th Cir. 1997), *abrogated on other grounds by Glenn*, 554 U.S. at 116–17). *See also Price v. Unum Life Ins. Co. of Am.*, 2018 WL 1352965, at *8 (D. Md. Mar. 14, 2018) (holding that, even if a plan administrator did not strictly comply with ERISA's deadlines, such procedural violations would not automatically strip away its discretionary authority to make claim determinations), *aff'd*, 746 F. App'x 231 (4th Cir. 2018).

Fifth Circuit

In the Fifth Circuit, challenges to ERISA procedures are evaluated under the substantial compliance standard and technical compliance therewith will be excused as long

as the purposes of 29 U.S.C. § 1133 have been fulfilled. *See White v. Life Ins. Co. of N. Am.*, 892 F.3d 762, 769 (5th Cir. 2018). It has further declined to alter the standard of review based on procedural irregularities in ERISA benefit determinations, including delays in making a determination. *See Atkins v. Bert Bell/Pete Rozelle NFL Player Retirement Plan*, 694 F.3d 557, 567–68 (5th Cir. 2012) (the discretionary standard of review is not heightened to *de novo* review due to a late final decision absent potential wholesale or flagrant violations that evidence an utter disregard of the underlying purpose of the plan).

Sixth Circuit

The Sixth Circuit recognizes the doctrine of substantial compliance even where technical or procedural defects are present, unless it can be shown they affect the substance of a claimant's claim. *See Tate v. General Motors LLC*, 538 F. App'x 599, 603 (6th Cir. 2013); *Kolpacke v. CSX Pension Plan*, 554 F. Supp. 2d 733, 738–39 (E.D. Mich. 2007) (plan administrator's seventeen (17) day delay in rendering a final decision denying benefits was *de minimis*, and thus discretionary, rather than *de novo*, standard of review applied; delay did not prevent participant from pursuing his rights for an unreasonable period of time).

Eighth Circuit

The Eighth Circuit, which has not directly addressed this issue, stated that courts may apply a less deferential standard of review where procedural irregularities in the administrative process cause a serious breach of the plan administrator's fiduciary duty to the participant, but stopped short of requiring strict compliance. *See Leirer v. Proctor & Gamble Disability Benefit Plan*, 910 F.3d 392, 396 (8th Cir. 2018); *Trustees of Electricians' Salary Deferral Plan v. Wright*, 688 F.3d 922, 927 (8th Cir. 2012) (a heightened *de novo* standard of review of an ERISA plan administrator's decision is only warranted where a procedural irregularity has a connection to the substantive decision reached). However, the Eighth Circuit noted it has not yet decided whether the Supreme Court's decision in *Glenn* abrogated the "procedural irregularity" component created by *Woo v. Deluxe Corp.*, 144 F.3d 1157, 1162 (8th Cir. 1998) (applying the "sliding scale" approach where the evidence supporting the plan administrator's decision must increase in proportion to the seriousness of the . . . procedural irregularity.").

Ninth Circuit

Absent a showing of substantive harm to the claimant, the Ninth Circuit has refused to divest a plan administrator of discretion as a result of its failure to strictly comply with ERISA's regulatory deadlines. In *Dimery v. Reliance Std. Life Ins. Co.*, 597 F. App'x 408 (9th Cir. 2015), the appellant argued the district court should have reviewed the plan administrator's denial of her LTD claim *de novo* because it issued its appeal decision nineteen (19) days after the expiration of the 45-day period required by ERISA. *See id.* at 409. The Ninth Circuit rejected this argument, stating that "ERISA procedural violations do not alter the standard of review unless the violations cause the beneficiary substantive harm." *Id.* Because the appellant failed to specifically identify any substantive harm resulting from the plan administrator's untimely decision, the district court properly reviewed the denial under an abuse of discretion standard. *See id.* at 410.

Tenth Circuit

In *Kellogg v. Metropolitan Life Ins. Co.*, 549 F.3d 818, 827–28 (10th Cir. 2008), the Tenth Circuit left open the question of whether the substantial compliance rule still applies under the 2002 ERISA regulations. However, since then, in the context of untimeliness, it has held a plan administrator is in substantial compliance with an ERISA deadline if the delay is both inconsequential and in the context of an ongoing, good-faith exchange of information between the administrator and the claimant. *See Messick v. McKesson Corp.*, 640 F. App'x 796, 798 (10th Cir. 2016); *Finley v. Hewlett-Packard Co. Employee Benefits Org. Income Protection Plan*, 379 F.3d 1168, 1173–74 (10th Cir. 2004); *see also LaAsmar v. Phelps Dodge Corp. Life, Acc. Death & Dismemberment & Dependent Life Ins. Plan*, 605 F.3d 789, 797-98 (10th Cir. 2010) (precluding deferential review where the plan administrator took 170 days to issue a denial of claimant's appeal); *Rasenack ex rel. Tribolet v. AIG Life Ins. Co.*, 585 F.3d 1311, 1315–18 (10th Cir. 2009) (applying *de novo* standard of review where plan administrator delayed both in initially deciding the claim and subsequent appeal).

Eleventh Circuit

The Eleventh Circuit Court of Appeals has yet to rule on the appropriate standard of review in a case involving a late claim determination under the 2002 regulations. *See Otero v. Unum Life Ins. Co. of Am.*, 226 F. Supp. 3d 1242, 1262–64 (N.D. Ala. 2017) (concluding the Eleventh Circuit has not addressed the standard of review for cases in which the plan administrator had discretion but did not abide by

regulation). However, the United States District Court for the Northern District of Georgia, in *McDowell v. Standard Ins. Co.*, 555 F. Supp. 2d 1361, 1373 (N.D. Ga. 2008), noting the "crucial role" ERISA's regulatory deadlines play in the "meaningful dialogue" required by the regulations as a whole, adopted the view that, "absent substantial compliance with the deadlines, *de novo* review applies on the grounds that inaction is not a valid exercise of discretion and leaves the court without any decision or application of expertise to which to defer." *Id.* (internal quotations omitted).

District of Columbia Circuit

The District of Columbia Circuit has also not squarely addressed whether deferential review should be replaced by *de novo* review in the face of a missed deadline under ERISA. In the context of a plan administrator's failure to timely produce documents pursuant to 29 C.F.R. § 2560.503-1(h)(2)(iii), it observed that although the Supreme Court has never suggested the standard of review applied to ERISA administrators' benefits determinations should change because of procedural irregularities, "[s]ome circuits substitute *de novo* review for deferential review only when the plan administrator committed severe procedural violations." *James v. International Painters & Allied Trades Indus. Pension Plan*, 738 F.3d 282, 283 (D.C. Cir. 2013) (per curiam). The District of Columbia Circuit, while citing *Conkright's* rejection of the "one-strike-and-you're-out approach" to ERISA plan administrator deference, did leave the door open to applying a more stringent standard of review where there are "flagrant" violations as "certain irregularities may call into the doubt the plan administrator's good faith or even competence." *See id.* at 283–84.

Conclusion

The simple timing of a benefit determination can have significant consequences, most notably potentially exposing plans to *de novo* review which directly affects the disposition of cases. Now, more than ever, plan administrators need to ensure they are responding to claimants' claims and appeals in a timely fashion. In those jurisdictions where strict compliance is not required, plans should carefully explain the specific reasons additional time is needed and the date by which it expects to make a decision. If a claim determination is delayed by the need for additional information from the claimant, the claimant should be notified that the determination deadlines have been suspended (tolled). These measures may provide a court with credible grounds for preserving discretionary review.

Given the significant impact of the standard of review in ERISA actions, the stakes are high as a delay of as little as a single day could change the complexion of a claim should it proceed to litigation. With the proliferation of statutory prohibitions of discretionary clauses and the genesis of the new ERISA regulations, plans are already beginning to lose their grip on discretionary review. They don't need, by their own self-inflicted failures to comply with the 2002 regulations, to provide the plaintiff's bar with another argument in favor of *de novo* review. Although safe havens remain for plan administrators that substantially comply with the 2002 regulatory deadlines, the penalty is steep in the Second and Seventh Circuits, where strict compliance is required. Although many federal circuits have yet to squarely reject the doctrine of substantial compliance in this context, plans should be cognizant of their claims handling procedures to ensure compliance with the regulation's timing requirements and, to the extent possible, avoid giving these circuits the opportunity to join the Second and Seventh Circuits in further eroding the doctrine.

Scott M. Trager is a Principal in the law firm of Funk & Bolton, P.A. in Baltimore, Maryland. His practice covers a broad spectrum of civil litigation matters, with a focus on the defense of life, health and disability claims (individual and ERISA) in the state and federal courts of Maryland and the District of Columbia, as well as the Maryland Insurance Administration and Maryland Office of Administrative Hearings. He is currently the Vice-Chair of DRI's Life, Health, and Disability Committee.

ERISA and the Government Plan Exemption

How Not to Lose Subject Matter Jurisdiction

By Michael P. Cunningham

It is well understood that a state court complaint alleging a claim for plan benefits under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§1001 *et seq.*, may be removed to federal court. Indeed, most ERISA practitioners on the plaintiff's side routinely file their cases in federal court, in part, to avoid any delay associated with removal. Still, federal and state courts have concurrent jurisdiction over benefit claims under ERISA and, on occasion, state court complaints are filed alleging claims under ERISA. *See* 29 U.S.C. §1132(e). Such cases are typically removed to federal court. But what if the complaint alleges an ERISA claim under an employee benefit plan exempt from ERISA? Is the action still removable and, if so, will the subsequent filing of a motion to dismiss the ERISA claim prompt the court to remand the matter? This article will address whether the government plan exemption is jurisdictional, discuss how the government plan exemption may impact removal, and consider whether a motion to dismiss an ERISA claim based on an exempt plan should be brought under Rule 12(b)(1) or Rule 12(b)(6).

"[A]ny civil action brought in a State court of which the district courts of the United States have original jurisdiction, may be removed" to federal court. 28 U.S.C. §1441(a). Federal district courts have original jurisdiction over cases raising a federal question, that is, "civil actions arising under the Constitution, laws, or treaties of the United States." 28 U.S.C. §1331. Federal question jurisdiction is invoked by the "well-pleaded complaint rule." Under the well-pleaded complaint rule, "a suit 'arises under' federal law 'only when the plaintiff's statement of [her] own cause of action shows that it is based upon [federal law].'" *Vaden v. Discover Bank*, 556 U.S. 49, 60 (2009) (quoting *Louisville & Nashville R. Co. v. Mottley*, 211 U.S. 149, 152 (1908)); *see also Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 63 (1987) ("It is long settled law that a cause of action arises under federal law only when the plaintiff's well-pleaded complaint raises issues of federal law.").

Although there are exceptions to the well-pleaded complaint rule, such as complete preemption, federal question jurisdiction generally exists when a plaintiff pleads a cause of action created by federal law. *See Grable & Sons Metal Prods., Inc. v. Darue Eng'g & Mfg.*, 545 U.S. 308, 312 (2005); *see also City of Chicago v. Int'l Coll. of Surgeons*, 522 U.S. 156, 163–64 (1997) (state court action properly removed to federal court because plaintiff alleged claims arising under federal law). Accordingly, a state court action alleging a claim for benefits or seeking relief under ERISA, a law of the United States, may be removed to federal court on the basis of federal question jurisdiction. *See, e.g., Bd. of Trustees of Hotel & Rest. Employees Local 25 v. Madison Hotel, Inc.*, 97 F.3d 1479, 1483–84 (D.C. Cir. 1996) (holding district court had federal question subject matter jurisdiction over claims requiring application of ERISA).

Most employee welfare and pension benefit plans established or maintained by private employers are governed by ERISA. Certain employee benefit plans, however, are exempt. *See* 29 U.S.C. §§1003(b)(1)–(5). Employee benefit plans maintained by governmental employers are exempt from ERISA. *See* 29 U.S.C. §§1003(b)(1), 1002(32). Church plans are also exempt. *See* 29 U.S.C. §§1003(b)(2), 1002(33). Although this article will largely focus on government plans, the analysis below applies equally to church plans and other ERISA-exempt plans.

A surprising number of courts have considered whether federal question jurisdiction exists if the plan at issue is a "governmental plan" exempt from ERISA. In fact, a relatively uniform body of case law has developed around this issue in recent years. Based on well-settled Supreme Court precedent, the lack of an employee benefit plan subject to ERISA is not a bar to federal question jurisdiction when the plaintiff is asserting a claim under ERISA. *See, e.g., Dahl v. Charles F. Dahl, M.D., P.C. Defined Ben. Pension Trust*, 744 F.3d 623, 629 (10th Cir. 2014) ("[R]ecent Supreme Court decisions compel the conclusion that the existence of a benefit plan subject to ERISA is not a jurisdictional requirement but an element of a claim under ERISA."); *Daft v. Advest, Inc.*, 658 F.3d 583, 590–91 (6th Cir. 2011) ("[I]n light of *Arbaugh* and its progeny, the existence of an ERISA plan must be considered an element of a plaintiff's claim[,] … not a prerequisite for federal jurisdiction."); *NewPage Wisc. Sys. Inc. v. USW*, 651 F.3d 775, 777 (7th Cir. 2011) ("Whether a claim is good differs from the question whether a district court possesses jurisdiction, a matter of adjudicatory competence. A federal district court is the right forum for a dispute about the meaning of

ERISA…." (citation omitted)); *Carlson v. Principal Fin. Grp.*, 320 F.3d 301, 307 (2d Cir. 2003) (holding that the question of whether a plan is subject to ERISA goes to the issue of whether plaintiff can state a claim under ERISA and "is irrelevant to the question of whether the District Court has subject matter jurisdiction over her complaint").

Indeed, whether the plan at issue is governed by ERISA goes to the merits of the plaintiff's case, not to the subject matter jurisdiction of the court. *See Saunders v. Davis*, No. 15-2026 (RC), 2016 WL 4921418, at *9 (D.D.C. Sept. 15, 2016) (court not deprived of subject matter jurisdiction based on government plan exemption under ERISA); *see also Smith v. Reg'l Transit Auth.*, 756 F.3d 340, 344–46 (5th Cir. 2014) (government plan exemption did not raise a jurisdictional question; district courts have jurisdiction to decide whether a plan is subject to ERISA); *Graham v. Bd. of Educ. of City of Chicago*, No. 18-4761, 2019 WL 215098, at *2–3 (N.D. Ill. Jan. 16, 2019) (retaining jurisdiction and dismissing ERISA claim under Rule 12(b)(6) based on government plan exemption). In other words, the question of whether the plaintiff can state a claim under ERISA, is itself, a federal question over which the court has subject matter jurisdiction.

A related question is whether the defendant should move to dismiss an ERISA claim seeking benefits under a government plan under Rule 12(b)(1) or Rule 12(b)(6). In *Saunders*, the plaintiff alleged various violations of ERISA. *See* 2016 WL 4921418, at *8. The defendants moved to dismiss for lack of subject matter jurisdiction under Rule 12(b)(1) based on the government plan exemption. *See id.* Rejecting the argument that the court lacked subject matter jurisdiction, the district court explained that in *Arbaugh v. Y&H Corp.*, the Supreme Court held the provision of Title VII stating the law only applied to employers with a certain number of employees related to the adequacy of plaintiff's claims, not to the subject matter jurisdiction of the court. *See id.* at *9 (citing *Arbaugh*, 546 U.S. 500, 516 (2006)). As explained in *Saunders*, "Congress can … craft jurisdictional thresholds as it pleases, but 'when Congress does not rank a statutory limitation on coverage as jurisdictional, courts should treat the restriction as nonjurisdictional in character.'" *See id.* (quoting *Arbaugh*, 546 at 516).

Since the government plan exemption (29 U.S.C. §1003(b)) "makes no reference to the jurisdiction of the federal courts," the applicability of the exemption relates only to the merits of plaintiff's case—not the court's jurisdiction to hear the case. *See Saunders*, 2016 WL 4921418 at *9. The district court, therefore, dismissed the plaintiff's ERISA claims based on the government plan exemption, not for lack of subject matter jurisdiction, but for failure to state a claim under Rule 12(b)(6). *See id.* at *9, 11. It is not always clear whether a plan is exempt from ERISA based on the pleadings; but, if a motion to dismiss is appropriate, the motion should be brought under Rule 12(b)(6) for failure to state a claim.

Most recently, in *Perisic v. Kim*, No. 18-2038, 2019 WL 5459048 (D.D.C. Oct. 24, 2019), an action was filed in the Superior Court of the District of Columbia alleging violations of ERISA and seeking benefits under an alleged ERISA plan. Without conceding whether plaintiff could state a valid claim under ERISA, the defendants removed the action to federal court. The defendants then moved to dismiss the complaint, in part, on grounds that the employee benefit plan is an exempt governmental plan. The motion to dismiss prompted the district court to evaluate the issue of subject matter jurisdiction. In supplemental briefing, the defendants explained the lack of an employee benefit plan subject to ERISA is not a bar to federal question jurisdiction. *See id.* at *8. The court agreed, found the removal proper, and dismissed plaintiff's complaint for failure to state a claim. *See id.* ("The question of whether the plan is governed by ERISA relates to the merits of [plaintiff's] case, and that question has no bearing on the Court's subject-matter jurisdiction.").

There is one caveat to consider. When an action is removed to federal court on the basis of complete ERISA preemption, the government plan exemption may bar the court from retaining jurisdiction. The complete preemption doctrine is an exception to the well-pleaded complaint rule, whereby "[a] complaint purporting to rest on state law … can be recharacterized as one 'arising under' federal law if the law governing the complaint is exclusively federal." *Vaden v. Discover Bank*, 556 U.S. 49, 61 (2009) (citations omitted). Complete preemption is often the vehicle used to remove a state law cause of action for plan benefits when, in reality, the action is based on federal law (*i.e.*, ERISA). *See Aetna Health Inc. v. Davila*, 542 U.S. 200, 207–10 (2004).

In *Burroff v. Hartford Life & Accident Insurance Co.*, No. 13-2595, 2014 WL 2611448 (D. Kan. June 11, 2014), the plaintiff was employed by a hospital affiliated with a state university. The complaint failed to assert an ERISA cause of action or any violation of ERISA. Rather, the plaintiff alleged a breach of contract claim under his employee benefit plan. Believing the plan was subject to ERISA, the defendant removed the action to federal court on grounds of complete preemption.

After removal, the defendant discovered the matter involved only an ERISA-exempt government plan and

conceded removal was improper. *See id.* at *1 ("While defendant initially took the position that ERISA preempted plaintiff's claim, defendant now concedes that the plan under which plaintiff is suing is a governmental plan."). Finding no federal question jurisdiction, the court remanded the matter to state court. *See id.* Thus, when an action is removed to federal court on the basis of complete preemption—not because the complaint expressly states claims arising under ERISA—the matter may be remanded when it is shown the plaintiff never asserted any claim under ERISA.

In conclusion, the governmental plan exemption is not jurisdictional and the lack of an ERISA plan will not deprive a federal court of subject matter jurisdiction if the plaintiff is asserting a claim under ERISA. Accordingly, a motion to dismiss an ERISA claim based on an ERISA-exempt plan, if appropriate, should be brought under Rule 12(b)(6), rather than Rule 12(b)(1). In cases where there is a close question about whether the plan is exempt from ERISA, a motion to dismiss may be inappropriate at the pleadings stage. Moreover, defendants should carefully consider the timing and scope of a motion to dismiss when a complaint contains both federal and state law claims. The exercise of supplemental jurisdiction by federal courts is discretionary and the early dismissal of all federal claims could result in a remand of any remaining state law claims.

Michael P. Cunningham is a principal at Funk & Bolton, P.A. in Baltimore. For more than fifteen years, Mr. Cunningham has defended and prosecuted a broad range of matters involving ERISA, life insurance, disability insurance, health plans, provider contracts, stop loss insurance, annuities, bad faith, and other contract, tort, and statutory claims. Mr. Cunningham is a member of DRI's Life, Health and Disability Committee and is admitted to practice in Maryland and the District of Columbia.

Ninth Circuit Take Another Step Toward Arbitration of ERISA Disputes

By Mark E. Schmidtke and Madeline Chimento Rea


The Ninth Circuit recently denied rehearing in what could become a trend toward arbitration of ERISA disputes. In the second pro-arbitration ruling in the past year, the Ninth Circuit Court of Appeals forced an IRC §401(k) plan participant to abide by the plan's arbitration provision to resolve his claims that the plan included poorly performing investment options and that its investment and administrative fees were too high. The ruling vanquished the plaintiff's efforts to pursue the matter as a class action, resolving an issue left open in an earlier Ninth Circuit ERISA arbitration decision as to whether actions on behalf of a plan under ERISA, Section 502(a)(2) are arbitrable. This article will update a previous discussion of ERISA arbitration that is now getting a lot of attention from litigants, courts, and plan drafters.

The issue of whether ERISA disputes are subject to arbitration finds much of its impetus in the landmark U.S. Supreme Court decision in *Epic Systems v. Lewis*, 138 S.Ct. 1612 (2018). Although *Epic Systems* was not an ERISA decision, it generated much discussion among ERISA plan drafters and litigators about whether lawsuits filed under ERISA's civil enforcement provisions can be subject to mandatory arbitration and class action waiver agreements. There was not much debate that individual ERISA claims (other than health and disability claims) can be arbitrated. The trickier question is whether class action and representative claims under Section 502(a)(2) can be subject to mandatory arbitration. The recent Ninth Circuit decisions shed significant light on the issue and could be game changers in the ERISA litigation arena.

The Decision in *Epic Systems*

The issue in *Epic Systems* was whether an employment agreement that required the employer and employees to arbitrate employment-related disputes through individual arbitration and to waive class and collective actions, was enforceable under the Federal Arbitration Act (FAA) or whether such agreements were prohibited by the National Labor Relations Act (NLRA). The National Labor Relations Board (NLRB) found such agreements prohibited by the NLRA. The Supreme Court disagreed. Citing a liberal federal policy favoring arbitration, the Court held that such agreements are enforceable under the FAA.

The Supreme Court declined to defer to the NLRB. The issue of when and how much deference to give to federal agencies is a hot issue generally. However, the Court held that the question in *Epic Systems* was not whether it should defer to the NLRB's interpretation of the NLRA, but whether it should defer to the NLRB's interpretation of the FAA. The Supreme Court held that because the NLRB had no authority to interpret the FAA, no deference was due.

ERISA's Civil Enforcement Scheme

ERISA incorporates a broad civil enforcement scheme, including several types of actions, some of which are individual in nature and others that are more class-oriented. For example, ERISA, Section 502(a)(1)(B) provides an individual cause of action for an ERISA plan participant or beneficiary to recover benefits that are due under the terms of the plan. Section 502(a)(2) provides a cause of action to remedy breaches by ERISA plan fiduciaries, but such actions can only be brought on behalf of a plan and are therefore more class oriented. *See, e.g., Massachusetts Mut. Life Ins. Co. v. Russell,* 473 U.S. 134 (1985) (actions under Section 502(a)(2) must be brought on behalf of the plan and not for individual relief). Section 502(a)(3) is a hybrid, permitting plan participants, beneficiaries, and fiduciaries to bring suits against fiduciaries and non-fiduciaries to remedy violations of ERISA or an ERISA plan or to enforce ERISA or the terms of an ERISA plan. Actions under Section 502(a)(3) have been brought individually and as class actions.

Impact of *Epic Systems* on ERISA

Courts have long held that ERISA actions for individual relief can be subject to mandatory arbitration. *See, e.g., Prime Health Care Services-Landmark LLC v. United Nurses and Allied Professionals Local 5067*, 848 F.3d 41 (1st Cir. 2017) (ERISA preemption issue was arbitrable). The one potential exception applies to ERISA claims for health and disability benefits. Since at least 2000, ERISA claim procedure regulations promulgated by the U.S. Department of Labor have taken the position that while mandatory arbitration can be required as part of a benefit claim review process and a plan can offer voluntary binding arbitration once the claim process is completed, under no circumstances can a health or disability plan incorporate mandatory binding arbitration. 29 C.F.R. §2560.503-1(b)(4).

There is no mention of arbitration in the ERISA statute. Whether or not the Department of Labor has the authority to limit arbitration options under health and disability plans raises an interesting question. In *Epic Systems,* the Supreme Court declined to defer to the NLRB under similar circumstances when the NLRB attempted to limit arbitration under its authority to regulate federal labor law, reasoning that the NLRB has no authority to regulate the FAA. Likewise, the Department of Labor has no authority to regulate the FAA, so its attempt to limit arbitration options for health and disability plans may likewise be subject to challenge.

The more pressing question is whether class-type actions under ERISA are also subject to mandatory arbitration. Much of the litigation on this issue has occurred in the Ninth Circuit. For example, in *Munro v. Univ. of So. Cal.*, 2017 WL 1654075 (C.D. Cal. 2017), the plaintiffs brought a fiduciary breach action arising out of their 401(k) plan. The plaintiffs had signed mandatory arbitration agreements and class-action waivers as part of their employment. The district court ruled that, while the arbitration agreements were enforceable as to the plaintiffs' individual claims, they were not enforceable to require arbitration for claims brought on behalf of the plan under Section 502(a)(2). On appeal, the Ninth Circuit affirmed, but on a different ground. *Munro v. Univ. So. Cal.*, 896 F.3d 1088 (9th Cir. 2018). The appellate court agreed that the arbitration agreements in that case were not broad enough to require arbitration of the plaintiffs' ERISA claims brought on behalf of the plan. However, the appellate court declined to decide whether Section 502(a)(2) claims are arbitrable generally. In a footnote, the court appeared to suggest that such claims might be subject to arbitration given an appropriately worded agreement or plan provision even though such claims are brought in a representative capacity. The defendant filed a petition for writ of certiorari in the Supreme Court but the Court denied the petition on February 19, 2019.

The most recent arbitration case to get the Ninth Circuit's attention is *Dorman v. Charles Schwab & Co., Inc.*, 934 F.3d 1107 (9th Cir. 2019). Like *Munro,* the *Dorman* case was filed as a breach of fiduciary duty action under ERISA, Section 502(a)(2). *See Dorman v. Charles Schwab & Co., Inc.,* 2018 WL 467357 (N.D. Cal. 2018). The plaintiff signed a mandatory arbitration agreement as part of his employment. Unlike *Munro,* the ERISA plan also contained a provision requiring individual arbitration of disputes arising out of the plan. The district court ruled that the plan fiduciaries could not apply the arbitration agreement to require individual arbitration of a claim brought in a representative capacity under Section 502(a)(2). The district court also held that the plan's arbitration provision did not apply to the plaintiff because the plaintiff ceased to be a participant before the arbitration provision was added to the plan. The

court went on to say that the arbitration provision would not be enforceable in any event because the plan could not require individual participants to waive their right to bring actions on behalf of the plan as authorized by ERISA, Section 502(a)(2).

The defendants appealed to the Ninth Circuit. The court had previously held in *Amaro v. Continental Can Co.*, 724 F.2d 747 (9th Cir. 1984) that ERISA claims were not arbitrable. The Ninth Circuit panel held that *Amaro* had been overruled by intervening Supreme Court jurisprudence holding that "federal statutory claims are generally arbitrable and arbitrators can competently interpret and apply federal statutes." In a concurrently filed unpublished memorandum, the Ninth Circuit addressed defendants' specific arguments and held that the district court erred by denying defendants' motion to compel arbitration. The court noted that the plaintiff and the plan agreed to arbitrate all ERISA claim where, contrary to the finding of the district court, the plaintiff participated in the 401(k) plan for nearly a year after the arbitration provision was added to the plan. The court also held that the plaintiff's claims fell within the scope of the plan's arbitration provision and rejected the district court's reasoning that the arbitration provision was unenforceable because it violated the NLRA and ERISA. Citing *Epic System's* holding that an arbitration agreement containing a class action waiver does not violate the NLRA, the Ninth Circuit also held that ERISA does not prohibit arbitration and enforcing arbitration provisions was not an attempt to insulate fiduciaries from liability. Therefore, "because 'arbitration is a matter of contract,' the [arbitration provision's] waiver of class-wide and collective arbitration must be enforced according to its terms, and the arbitration must be conducted on an individualized basis."

Pros and Cons of Arbitration

For many in the business world, arbitration is the remedy to costly litigation. To be sure, there are advantages to arbitration. If combined with a class waiver, arbitration can be a substantial benefit, although it may result in numerous individual arbitrations over a given issue. Arbitration is also a private forum, which may also be advantageous if publicity is a concern.

Arbitration may or may not be less costly than court litigation. Most arbitrations are conducted under procedural rules established by private arbitration companies. These rules typically limit the amount of discovery and are geared toward a more expeditious process than many court actions, although a particular arbitration proceeding may not always work out that way. Costs too, can be substantial as the parties must pay fees to the arbitration company and to the arbitrator. In many cases, arbitration clauses call for a three-person panel, which triples the cost immediately. In short, arbitration is not always a less expensive alternative to a court action.

Conclusion

Whether courts outside the Ninth Circuit will find arbitration provisions in employment agreements and/or ERISA plans to be enforceable not only in individual actions, but also in class-type actions, remains to be seen. However, the recent Ninth Circuit decisions are already leading plan sponsors to consider adding arbitration provisions with class action waivers to their employee benefit plans. Aside from individual benefit claims, most suits against ERISA plans in the past several years have been filed as class actions. Many of those suits ended in multi-million dollar settlements. At least in the Ninth Circuit, it appears that employers can combat this trend by requiring plan participants to engage in individual arbitration of their ERISA claims.

Although the potential downside to provisions requiring individual arbitration could result in multiple arbitrations regarding the same issues, such provisions could also discourage such claims in the first place. The prospect of arbitrating multiple individual claims requires litigants to face significant costs to prosecute claims that may not involve much money for each individual participant. In other words, the decisions in *Munro* and *Dorman* cannot be good news for the plaintiffs' ERISA bar. Plan drafters, on the other hand, see little to lose by including a mandatory individual arbitration provision in their plan documents. For the most part, the worst that will happen is that a court will decline to enforce such a provision.

Mark E. Schmidtke is a shareholder in Ogletree, Deakins, Nash, Smoak & Stewart, P.C., an international employment/labor/employee benefit law firm. In a career that has spanned nearly 40 years, he has represented employee benefit plan sponsors, insurers, administrators, and fiduciaries in litigation matters in every state in the U.S. He is a frequent speaker at national seminars, has authored numerous books and articles on employee benefit topics, is a Fellow in the American College of Employee Benefits Counsel, and is a former chair of the U.S. Department of Labor Advisory Council on Welfare and Pension Employee Benefit Plans. Madeline Chimento Rea is marketing counsel in the New Orleans office of Ogletree Deakins.

A Review of Recent Decisions Addressing Mental Health Coverage in the ERISA Context

By Nathaniel A. Cohen

Mental healthcare coverage issues, particularly those related to federal and state mental health parity statutes, feature prominently in recent litigation arising under the Employee Retirement Income Security Act ("ERISA"). This article discusses several district court decisions from 2019 that involve mental health treatment claims, including recent cases addressing the interaction between ERISA and mental health parity statutes.

Emch v. Community Insurance Company

In *Emch v. Community Insurance Company d/b/a Anthem Blue Cross and Blue Shield*, No. 1:17-CV-00856, 2019 WL 5538196 (S.D. Ohio Oct. 25, 2019), the plaintiff filed a putative class action alleging that an employer-sponsored health insurance plan improperly denied claims for residential mental health services for the plaintiff's minor son. Notably, the plaintiff alleged that Ohio Rev. Code §3923.281 (the "Ohio Parity Act"), a mental health parity statute in Ohio state law, was incorporated into the terms of the plan through a "Conformity with Law" clause, empowering him to seek relief through ERISA for alleged violations of the Ohio Parity Act.

The court denied the defendant's motion to dismiss the complaint, holding that the plaintiff had stated plausible claims for relief under 29 U.S.C. §1132(a)(1)(B) and 29 U.S.C. §1132(a)(3) because the plan incorporated the Ohio Parity Act's requirement that plans cover the "diagnosis and treatment of biologically based mental illnesses on the same terms and conditions as, and … provide benefits no less extensive than, those provided under the policy of sickness and accident insurance for the treatment and diagnosis of all other physical diseases and disorders …." Ohio Rev. Code §3923.281(B); *see Emch*, 2019 WL 5538196, at *3.

The court analyzed two prior district court cases where plaintiffs had argued that state mental health parity laws were incorporated into their plans: *Bushell v. Unitedhealth Group, Inc.*, No. 17-CV-2021, 2018 WL 1578167 (S.D.N.Y. Mar. 27, 2018), and *A.F. ex rel. Legaard v. Providence Health Plan*, 35 F. Supp. 3d 1298 (D. Or. 2014). The defense urged the court to follow the reasoning in *Bushell* that rejected a similar claim and cautioned that it would improperly expand the scope of relief available under ERISA. *See Bushell*, 2018 WL 1578167 at *4 (holding that the plaintiff "cannot enforce" a New York mental health parity law "under the guise of an ERISA claim" and noting that a contrary conclusion "would mean that this one provision allows suit for violation of any state or federal law"). But the court followed the reasoning in *Legaard* that a plaintiff has standing to enforce provisions of state statutes incorporated into her plan through ERISA. *See Legaard*, 35 F. Supp. 3d at 1305 (holding that plaintiff had stated a cause of action under 29 U.S.C. §1132(a)(3) for violation of the Oregon mental health parity statute, and that "ERISA provides courts with the power to enjoin violations of state law regulating insurance that have become part of the terms of the plan"). The *Emch* litigation continues following the court's denial of the motion to dismiss.

Kerry W. v. Anthem Blue Cross and Blue Shield

In *Kerry W. v. Anthem Blue Cross and Blue Shield*, No. 2:19-CV-67, 2019 WL 2393802 (D. Utah June 5, 2019), a parent and minor child alleged that the defendant improperly denied claims for a portion of the child's lengthy treatment at a residential center serving adolescents with mental health, behavioral, and substance abuse issues. In addition to a claim for recovery of plan benefits under 29 U.S.C. §1132(a)(1)(B), the plaintiffs advanced a second claim under 29 U.S.C. §1132(a)(3) alleging violations of the federal mental health parity statute, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"). The plaintiffs invoked provisions of MHPAEA that require health plans providing "both medical and surgical benefits and mental health or substance abuse disorder benefits" to ensure that "the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive that the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage)" and that "there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits." *See* 29 U.S.C. §1185a(a)(3)(A).

In granting the defendant's motion to dismiss, the court held that the plaintiffs' MHPAEA allegations were fatally

deficient due to their failure to tie their allegations to any analogous treatment in the medical or surgical setting. The court found that, while the plaintiffs had alleged flaws in the defendant's claims handling, they had not sufficiently alleged there was any illegal disparity in the way that the defendant had handled, processed, or evaluated the claim in comparison to the defendant's disposition of claims for allegedly analogous medical treatment, such as treatment at a skilled nursing facility. *Kerry W.*, 2019 WL 2393802, at *4–5.

Halberg v. United Behavioral Health

In *Halberg v. United Behavioral Health*, No. 16-CV-6622, 2019 WL 4784571 (E.D.N.Y. Nov. 5, 2019), a case challenging a denial of benefits for nearly 18 months of residential mental health treatment for the plaintiff's minor child, the district court adopted the magistrate judge's Report and Recommendations granting the defendant's motion for summary judgment. Finding that the plan in question granted discretionary authority to the defendant to interpret the plan and determine eligibility for benefits, the court held that the defendant's denial should be examined under a "highly deferential" arbitrary and capricious standard of review. *See id.* at *16–17.

Applying this standard, the court agreed with the defendant that further residential treatment beyond an initial period of several months was not medically necessary under the terms of the plan. Record evidence showed that, while the child had indisputably suffered a mental health crisis in the later part of 2011, by January 2012 her immediate crisis had passed, and substantial evidence supported the defendant's conclusion that residential treatment was no longer medically necessary. Medical records revealed that she presented as cheerful and goal-oriented, was planning for the future, responded to medication, socialized well with others, left the facility on day passes, and was able to work and go to school. *See id.* *19. The court also noted that an independent and external reviewer had upheld the defendant's decision, further demonstrating that the defendant had acted reasonably.

Rejecting arguments that the defendant should have afforded more deference to the opinions of the child's treating providers, the court explained that while it was sympathetic to the plaintiffs' arguments, they had "not demonstrated that under the applicable deferential standard, Defendant's denials were unsupported by evidence that a reasonable mind might accept as adequate to support the conclusion reached by the administrator." *See id.* at *20 (citation omitted).

S.B. v. Oxford Health Insurance, Inc.

In *S.B. v. Oxford Health Insurance, Inc.*, No. 3:17-CV-1485, 2019 WL 5726901 (D. Conn. Nov. 5, 2019), by contrast, the court held that the defendant had improperly denied claims for residential mental health treatment for the plaintiff's eating disorder, even when applying a deferential arbitrary and capricious standard of review.

The plaintiff, a minor at the time of the treatment at issue, had suffered from an eating disorder since 2013. She had undergone substantial treatment at the outpatient and intensive outpatient levels from 2013 until her admission to a residential treatment center on February 11, 2015. The defendant initially denied, and then agreed to cover, the first weeks of residential treatment. The defendant then denied coverage from February 27, 2015 forward and upheld its decision through two levels of administrative appeal on the basis that the plaintiff had not shown that continued residential treatment was medically necessary.

The court ordered the denial decision remanded for the defendant to reconsider the evidence and apply what the court considered to be the appropriate definition of "medical necessity" as stated in the plan. The court held that the defendant strayed beyond its discretion under the terms of the plan by applying admission criteria in the UBH 2015 Level of Care Guidelines ("UBH Guidelines") that conflicted with the plan's definition of medical necessity. Relying in part on the American Psychiatric Association Practice Guidelines for the Treatment of Patients with Eating Disorders, submitted into the record by the plaintiff, the court found that the defendant had improperly weighed "why now" factors in the UBH Guidelines, such as "changes in the member's signs and symptoms, psychosocial and environmental factors, or level of functioning" that "precipitated admission." *See id.* at *12. The court found that the definition of medical necessity in the plan focused the inquiry instead on the treatment necessary to address a patient's underlying mental health condition, rather than their acute symptoms. *Id.* at *13. The court explained that, on remand, the defendant's coverage decision and rationale "must be rationally related to whether residential treatment was necessary to treat Plaintiff's *eating disorder*, and not just manage her acute symptoms." *Id.* at *17 (emphasis in original).

Conclusion

These recent decisions illustrate legal issues that courts are confronting as they continue to address mental health coverage litigation in the ERISA context. They add to a

growing body of law addressing the interaction between ERISA, MHPAEA, and state mental health parity statutes, as well as the proper level of scrutiny to apply under deferential standards of review.

Nathaniel Cohen is an associate in the healthcare litigation practice at Manatt, Phelps & Phillips, LLP, and is based in the firm's San Francisco office. Before joining Manatt, Nathaniel worked as a senior attorney for the information law team in the Office of the General Counsel at the U.S. Department of Health and Human Services. Nathaniel has also worked as a Special Assistant U.S. Attorney in the U.S. Attorney's Office for the District of Maryland.

Case Law

ERISA Update

By Joseph M. Hamilton, ERISA Update Editor

First Circuit

Pre-Existing Condition Determination by ERISA Plan Arbitrary and Capricious

In *Lavery v. Restoration Hardware Long Term Disability Benefits Plan*, 937 F.3d 71 (1st Cir. 2019), the First Circuit affirmed an award of LTD benefits to Lavery.

Lavery was covered under a disability plan provided by his employer, Restoration Hardware. The plan was funded by a group policy issued by Aetna Life Insurance Company ("Aetna"). Aetna also administered claims.

Lavery filed a claim for disability benefits after he was diagnosed with malignant melanoma. The issue in the case was whether Lavery's claim was barred by the pre-existing condition provision of the plan.

The First Circuit upheld the district court's determination that the claim was not a pre-existing condition. The court first noted that the pre-existing condition clause was ambiguous. However, because the plan granted Aetna discretionary authority to interpret it, the court was required to defer to Aetna's interpretation unless Aetna's decision to deny the claim was arbitrary and capricious. In deciding whether Aetna's decision was arbitrary and capricious, the court examined whether Aetna conducted itself as a true fiduciary, attempting to fairly decide the claim. The court found that Aetna's behavior in handling the claim suggested that its structural conflict of interest played a role in its handling of the claim. The court cited to Aetna's benefits managers twice overruling the decisions of the claim representatives as to whether the condition was pre-existing. The court also found that Aetna incorrectly interpreted the pre-existing condition provision.

Therefore, applying contra proferentum, the court held that it read the plan just as Aetna's front line claim representatives and technicians did: Lavery was not treated for melanoma, provided services for it, prescribed or recommended a drug for it, or diagnosed with it during the look-back period.

Aetna's second argument was that, based on a retroactive change in plan provisions, Lavery's coverage did not come into force until later than originally believed. If so, there was no dispute that the pre-existing condition exclusion applied, because Lavery's appointment with the dermatologist was within the look-back period.

Lavery argued, and the court agreed, that Aetna violated ERISA and caused Lavery prejudice by failing to give him an opportunity to respond to Aetna's reliance on the corrected look-back period. It was not until Aetna's final decision that Aetna first told Lavery that there was a corrected look-back period upon which Aetna relied as an alternative basis for denial. The court held this was a procedural violation of the Department of Labor claims regulations.

Moreover, the court found that this violation prejudiced Lavery by failing to give him the opportunity to contest whether he was still eligible for coverage earlier than Aetna had calculated.

The court next addressed the relief to be given Lavery. It ordered retroactive reinstatement of benefits up until the time of the court's decision. While Aetna argued that the case should be remanded to determine whether Lavery was disabled under the any occupation standard, the court rejected that, finding that there was adequate information in the record to demonstrate that Lavery's condition was worsening and because Aetna had repeatedly referred to

Lavery as disabled in its communications with him. The court noted that to the extent Lavery was seeking any further disability benefits he would need to proceed pursuant to the any occupation standard.

Joseph M. Hamilton
Mirick, O'Connell, DeMallie & Lougee, LLP
Worcester, MA
jhamilton@mirickoconnell.com

Third Circuit

No Liability for Reduction in Pension Plan Contributions

***Caesars Entertainment Corp. v. Int'l Un. of Op. Eng, Local 68 Pension Fund*, 932 F.3d 91 (3d Cir. 2019).**

In its heyday, Caesar's Entertainment operated four casinos in Atlantic City, NJ. It bargained with the International Union of Operating Engineers for engineering work at all four casinos through collective bargaining agreements. As part of these agreements, each casino was required to contribute to the Union's multi-employer pension fund. But in 2014, one casino closed and Caesar's contributions were reduced by 17 percent. This 17 percent reduction was below the statute's threshold of 70 percent for automatic liability for partial withdrawal liability. But the Union argued that there was still liability under the Multiemployer Pension Plan Amendments Act of 1980, which amended ERISA.

Under the MPAA, there is liability for an employer who stops paying contributions for less than all collective bargaining agreements but continues to perform work in that jurisdiction "of the type for which contributions were previously required." In deciding whether this provision applied, the Third Circuit looked to the plain language in the statute and guidance from the Pension Benefits Guaranty Corporation. Focusing on the word "previously," the court stated that it means "no longer required." Therefore, there can be no withdrawal liability for "bargaining out" when an employer closes one facility and shifts the work to another location where contributions under a collective bargaining agreement are still required. Since those contributions are still required, they could not be considered "previously required." Therefore, the court affirmed the decision of the district court in favor of Caesars.

Joshua Bachrach
Wilson Elser Moskowitz Edelman & Dicker LLP
Philadelphia, PA 19103
joshua.bachrach@wilsonelser.com

Fourth Circuit

ERISA Plan Must Provide Plan Beneficiary Reasonable Access to Information Relevant to a Claim as Part of a Full and Fair Review

In *Odle v. UMWA 1974 Pension Plan*, 777 F. App'x 646 (4th Cir. 2019), the Fourth Circuit addressed the importance of affording an ERISA plan participant whose claim for benefits has been denied a "reasonable opportunity . . . for a full and fair review" of the decision under 29 U.S.C. §1133(2), and held a failure to do so constitutes an abuse of discretion.

Veda Odle challenged the amount of a survivor's annuity benefit awarded to her under the provisions of the United Mine Workers of America 1974 Pension Plan (the "Plan"). Her late husband, Ray Odle, who died in 2010 from black lung disease, worked in the coal mining industry from 1973 to 2002 in both union and non-union jobs. In August 2010, the Plan notified Ms. Odle that it had awarded her a survivor's annuity based on Mr. Odle's service from 1973 through 1988. She challenged the Plan's decision not to award additional service time and requested a hearing, claiming that Mr. Odle had worked nearly fourteen additional years of credited service. The Plan upheld its denial of Ms. Odle's claim in August 2014. In upholding its decision, the Plan relied on, inter alia, a 1995 audit of Mr. Odle's employer, Dale Coal, but did not provide a copy of the audit to Ms. Odle.

Ms. Odle filed a complaint in the United States District Court for the Western District of Virginia, and the case was referred to a magistrate judge who, focusing specifically on the Plan's failure to provide Ms. Odle with a copy of the audit, concluded that the Plan failed to provide a full and fair review of Ms. Odle's claim and acted unreasonably by failing to award additional years of credited service. The district court, however, rejected the magistrate judge's findings and granted summary judgment in favor of the Plan. The court noted that, while the Plan did not strictly comply with ERISA's procedural requirements, there was no credible indication that providing the audit during the review process would have made any difference. Ms. Odle then appealed the case to the Fourth Circuit and contended the Plan abused its discretion by failing to provide her with a copy of the audit and denying her claim.

The Fourth Circuit, applying the discretionary standard of review and factoring in the Plan's structural conflict of interest, reversed the decision of the district court and remanded the case for further proceedings to provide Ms. Odle another chance to contest the Plan's denial of her claim. It found the

Plan procedurally erred by denying Ms. Odle the opportunity to review the audit during the administrative process, which prejudiced her. The court, citing 29 U.S.C. §1133(2), held that ERISA requires that any plan participant whose claim for benefits has been denied be given a "reasonable opportunity . . . for a full and fair review" of the decision. As part of this "full and fair review," the claimant must be given reasonable access to documents relevant to the claim. Information is considered "relevant" to a claim if it "[w] as relied upon" or "submitted, considered, or generated in the course of making the benefit determination." 29 C.F.R. §2560.503-1(m)(8).

In that regard, the court found the Plan was obligated to provide Ms. Odle a copy of the audit it explicitly relied on in denying her claim and, by failing to disclose it during the administrative process, it denied her a "full and fair review" of her claim. The court further determined that a causal connection existed between the procedural defect and the denial of Ms. Odle's claim because the Plan's failure to disclose the audit prevented her from pursuing further investigation and arguments in support of her claim. The court concluded it was unreasonable for the Plan to rely on an audit that documented potentially fraudulent underreporting of union hours without disclosing it to Ms. Odle and she was prejudiced. The court ordered, on remand, that Ms. Odle be given an opportunity to contest the Plan's denial based on a full disclosure of the documents and evidence relevant to her claim as the right to a full and fair review is at the foundation of ERISA. The court stated its decision was consistent with ERISA's purpose to promote the interests of employees and their beneficiaries in employee benefit plans, and to protect contractually defined benefits.

Scott M. Trager
Funk & Bolton, P.A.
Baltimore, MD
strager@fblaw.com

Seventh Circuit

Court Holds Retirees Entitled to Lifetime Health Coverage Where Health Benefit Coverage Provision Ran Beyond Agreement Termination

In affirming the district court's permanent injunction, the Seventh Circuit held that union-represented retired steelworkers from a defunct packaging plant were entitled to lifetime health coverage from successor Signode Industrial Group LLC based on the contractual language of the relevant health insurance agreements in *Stone v. Signode Indus. Grp. LLC*, 2019 WL 6139680 (7th Cir. 2019).

The lawsuit involved the health benefits for approximately 140 retirees, who claimed that their health benefits were vested for life under the terms of their collective bargaining agreements. After the company exercised its right to terminate the underlying benefits agreement, it also ceased paying benefits to the retirees. The retirees initiated a class action under both ERISA and the Labor-Management Relations Act and argued that certain promised benefits under the plan were vested and thus could not be terminated with the agreement.

The Seventh Circuit acknowledged that ERISA does not require that retiree health-care benefits be vested and that the vesting of health-care benefits is determined according to ordinary principles of contract law. *M & G Polymers USA, LLC v. Tackett*, 135 S. Ct. 926, 933 (2015). The Court found the following language dispositive in finding for the retirees, "[retirees] shall not have such coverage terminated or reduced (except as provided in this Program) ... notwithstanding the expiration of this Agreement, except as the Company and the Union may otherwise agree."

The Company argued that the "Term provision" provided an exception to the promise that coverage would persist "notwithstanding expiration" of the 2002 Agreement and that the obligation to provide health-care benefits was extinguished upon termination of the Agreement. Specifically, the Term Provision provided that the agreement "shall remain in effect until February 29, 2004, thereafter subject to the right of either party on one hundred and twenty (120) days written notice served on or after November 1, 2003 to terminate the 'Pensioners' and Surviving Spouses' Health Insurance Agreement'" and thus transformed the right to terminate the Agreement itself and nullified the provision that benefits would survive expiration of the Agreement. The Court rejected that argument, finding that the cited provision only applied to the underlying health insurance agreement, not to the agreement's overriding promise of continued coverage.

Even if the agreement language was ambiguous, the Court stated that industry usage and the behavior of the parties provided enough evidence to support vesting such that resolution of any ambiguity in favor of the retirees would still be correct. The Court ultimately determined that the agreement said "as plainly as possible" that coverage would continue beyond the expiration of the agreement. The retirees' bargaining agreement with the company's

predecessor "unambiguously provided retirees with vested lifetime health-care benefits."

Eric Mathisen and Rebecca Bryant
Ogletree, Deakins, Nash, Smoak & Stewart, P.C.
Chicago, IL
eric.mathisen@ogletree.com
rebecca.bryant@ogletree.com

Ninth Circuit

Court Holds Pension Plan Arbitration Clause Enforceable

In *Dorman v. Charles Schwab Corp.*, 934 F.3d 1107 (9th Cir. 2019), the Ninth Circuit held that a Plan's arbitration provision must be enforced to resolve plaintiff's ERISA claims for pension benefits under 29 U.S.C. §1132(a)(2) and breach of fiduciary duty under §1132(a)(3). The Court overturned prior precedent holding that ERISA cases are not arbitrable.

Dorman participated in his employer's defined contribution Plan, which mandated arbitration of any claim, dispute, or breach. Under the provision, participants also waived their right to be part of a class action. Dorman's compensation agreement also contained an arbitration clause relating to his employment and to any claim arising under federal, state, or local law. Dorman left employment, and one year later withdrew his full account balance. On behalf of himself and the class of Plan participants and beneficiaries, Dorman sued his employer, its board of directors, and plan fiduciaries for breach of fiduciary duties and prohibited transactions. In part, Dorman alleged Schwab included its own poorly performing funds in the investment options solely to generate fees for itself. The district court denied Schwab's motion to compel arbitration, and Schwab appealed the interlocutory order.

The Ninth Circuit reversed and remanded in light of the intervening Supreme Court decision of *American Express Co. v. Italian Colors Restaurant*, 570 U.S. 228, (2013). In *American Express*, the Supreme Court ruled that arbitrators were competent to interpret and apply federal statutes. Prior to *American Express*, the Ninth Circuit followed the principle that ERISA cases are not arbitrable. *Amaro v. Continental Can Co.*, 724 F.2d 747 (9th Cir. 1984). In *Amaro*, the Court determined arbitral proceedings could not satisfy the "minimum standards [for] assuring the equitable character" of ERISA plans. *Amaro* relied on the assumption that arbitrators, "many of whom are not lawyers," would generally lack "competence… to interpret and apply the statutes as Congress intended." Five years after the Supreme Court decided *American Express*, the Ninth Circuit, in *Munro v. Univ. of S. Cal.*, 896 F.3d 1088(9th Cir. 2018), noted there is "'considerable force' to the argument that *Amaro* had been overruled."

In *Dorman*, the Court explained the procedural authority to overturn *Amaro*. Generally, a three-judge panel, rather than the Court sitting en banc, may not overrule a prior decision. But, such a panel can overturn existing precedent, if an intervening Supreme Court decision undermines the precedent, and both cases are closely on point. The test is "whether the higher court 'undercut the theory or reasoning underlying the prior circuit precedent in such a way that the cases are clearly irreconcilable.'" The Ninth Circuit is then bound to follow the reasoning of the higher court. The Court held that, "The holding in *American Express Co*. that federal statutory claims are generally arbitrable and arbitrators can competently interpret and apply federal statues…constitutes intervening Supreme Court authority that is irreconcilable with *Amaro*. *Amaro*, therefore, is no longer binding precedent." The Court remanded the case for the lower court to enforce the Plan's arbitration clause. Another district court recently recognized the overruling of *Amaro* in *Trustees of the Operating Engineers Pension Trust v. Smith-Emery Co.*, 2019 WL 5595047 (C.D. Cal. 2019).

Nancy Jerian Marr
Burke, Williams & Sorensen, LLP
Los Angeles, CA
NMarr@bwslaw.com

Joseph M. Hamilton is a partner at Mirick O'Connell and chair of the firm's Life, Health, Disability and ERISA Litigation Group. He concentrates his practice in life, health and disability insurance defense, and ERISA. Mr. Hamilton serves as counsel for numerous life, health, and disability insurers and self-insureds at all levels of the state and federal courts. Mr. Hamilton is a past chair of the ABA's Life Insurance Law Committee; and a vice-chair of the ABA's Health and Disability Law Committee. Mr. Hamilton received his B.S. and J.D. from Boston College.