Deferred Annuities: The Latest Target in Class Action Litigation

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Over the last two years, the insurance industry has faced a rising trend in putative class action litigation attacking the sale of annuities to senior citizens. These complaints often consist of similar accusations: (1) the alleged unfair targeting of senior citizens for the sale of unsuitable annuity products, (2) allegedly deceptive and misleading standardized marketing materials, as well as (3) alleged “twisting” or “churning” schemes. Most of the leading issuers of deferred fixed annuities have been sued in one or more class actions since early 2004.

An example of these types of cases is Migliaccio v. Midland National Life Ins. Co., et al., Case No. C06-1007 CAS (MAN), currently pending in the United States District Court for the Central District of California.

Plaintiffs in Migliaccio filed a class action complaint against Midland National Life Insurance Company alleging claims for RICO violations, elder abuse, breach of fiduciary duty, fraud, negligent misrepresentation and unfair competition in connection with the sale of annuities.

The lawsuit is based on 73-year-old John Migliaccio’s purchase of a deferred annuity issued by Midland National Life Insurance Company. Migliaccio died 17 months after purchasing the annuity, and by the contract terms, Mrs. Migliaccio received the full contract value without surrender charges. The other named plaintiff, Robert Kaiser, a resident of Florida, also purchased a Midland annuity when he was 73 years old.

The Migliaccio complaint asserts that Midland developed a new generation of fixed, deferred annuity products and increasingly targeted senior citizens with its “unsuitable annuity product.” Plaintiffs allege that the
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Editorial Information

Life, Health and Disability News is published quarterly by the DRI’s Life, Health and Disability Committee. Articles and case summaries should be submitted for publication via e-mail to Newsletter Editor Kenton J. Coppage of Carter & Ansley LLP in Atlanta (see p. 2). Submissions are encouraged and welcomed.
FROM THE CHAIR

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This is my last “From the Chair” column, because my term as Chair of the Life, Health and Disability Committee comes to an end at the DRI Annual Meeting in October. I am thankful for the opportunity to serve in this position. During my two years as Chair, I have had much fine help from many committee members and the DRI staff. I would name names, but to do so would invite an omission. Suffice it to say that I am grateful to all of you. You know who you are.

As of October, the Chair position will pass to Sim Rapoport, the current Committee Vice Chair. Sim is not just a bright, enthusiastic, and conscientious individual, he is also a great guy. My guess is that the transition will not be noticed by anyone except that most will find improvement in Committee affairs. Brooks Magratten will take over as Committee Vice Chair. Anyone who has worked with Brooks knows that he is one of those rare people who does an excellent job on any task that is assigned to him. The Committee is in very good hands.

Speaking of the DRI Annual Meeting, attendance at this meeting should be at the top of your list (or at least second, after our Life, Health, Disability and ERISA annual program). This year’s meeting in San Francisco promises to be a real blockbuster with lots of educational and social opportunities. Our Committee business meeting is scheduled for Thursday, October 12, 2006 at 4:30 p.m. Attendance at this meeting has grown dramatically, although it does not yet rival the attendance at the annual program business meeting. We look forward to seeing all of you in October.

Plans are also well underway for another Committee-sponsored teleconference. The topic is “Current and Future ERISA Issues Affecting Defense Lawyers.” We are trying to reach a wider audience, including lawyers who practice outside of the life, health, and disability area. Katherine S. Somervell (Bullivant Houser Bailey in Portland, Oregon) and Simon Manoucherian (Meserve Mumper & Hughes in Los Angeles, California) will join me for discussion of several current issues, including the status of reimbursement actions under ERISA and how they impact personal injury claims; changes in discovery and ERISA judicial review standards; and the nature and structure of self-funded ERISA plans. The teleconference is scheduled for October 24, 2006.

Planning is already well underway for the 2007 Life, Health, Disability and ERISA Conference in Chicago. The program is scheduled for March 28-30, 2007, which is a full month earlier than normal. Please note these dates on your calendars.

Gary Schuman is the 2007 Program Chair and he is doing an excellent job. The House Counsel Advisory Committee has already convened for three telephone conferences to discuss potential topics and speakers. It will be difficult to narrow the very interesting and timely topics to fit into the available time period. However, everyone can be assured that the 2007 conference will be at or above the level that all of us have come to expect.

Let me thank everyone again for a very interesting and fulfilling two years as LHD Committee Chair. Serving as Chair has been a very time consuming task, but it has also been very rewarding. Our Committee has an abundance of talented people. I cherish the friendships that I have made on this Committee and in this area of the law. If our Committee has any weakness, it is that we have more volunteers than positions available. Yes, this is a pleasant problem, but it is a problem that future Committee leaders will need to tackle.

To Sim and Brooks and all others who lead the Life, Health and Disability Committee in the future, I wish you the best. Carry on!
Deferred Annuities, from page 1

products are inherently unsuitable for senior citizens because of the surrender charges purchasers may incur if they withdraw their money early.

Plaintiffs further allege that the insurer's agents were “carefully trained to approach prospective senior citizen annuitants under the guise of offering to provide low-cost estate and/or financial planning services.” According to the complaint, Midland then used the information obtained to “identity senior citizens with available assets to purchase defendants’ annuities.”

The complaint also alleges that defendants engaged in “churning” by causing seniors to borrow against or surrender existing life insurance or annuity policies to purchase a new annuity policy.

Plaintiffs bring these claims on behalf of “all persons who within the applicable limitations period up to the date of the commencement of this action, and while 65 years of age or older, purchased one or more Midland deferred annuities either directly, or through the surrender (in whole or part) of an existing life insurance policy or annuity, or by borrowing against an existing permanent life insurance policy, which annuity had a maturity date beyond the annuitant’s actuarial life expectancy at the time of purchase.”

Midland denies plaintiffs’ claims in Migliaccio. In particular, it asserts that its marketing activities comply with applicable state laws and regulations, that it does not engage in “trust mill” tactics, and that plaintiff’s allegations regarding “maturity dates” mischaracterize the products’ liquidity features. Among other things, the “maturity date” in Midland’s contracts is the last day on which an annuitant may withdraw the contract value, not the earliest date (as alleged in the complaint).

Other Class Actions

Virtually identical allegations have been made by plaintiffs in class actions against other insurers, including Allianz Life Insurance Company of North America, American Equity Investment Life Insurance Company, National Western Life Insurance Company, American Investors Life Insurance Company, AmerUs Life Insurance Company, Conseco Insurance Company, and Fidelity and Guaranty Life Insurance Company. These actions are pending in California and other states, often brought by the same group of plaintiffs’ firms.

The complaints in Negrete v. Fidelity and Guaranty Life Ins. Co., Case No. 2:05-CV-06837 CAS (MAN) and Negrete v. Allianz Life Ins. Co., Case No. 2:05-CV-06838 CAS (MAN), both filed in September 2005 in the United States District Court, Central District of California, assert Civil RICO violations, elder abuse, unlawful, deceptive and misleading advertising, breach of fiduciary duty, aiding and abetting of breach of fiduciary duty, and unjust enrichment and imposition of constructive trust. Plaintiff asserts that Fidelity and Guaranty and Allianz “have increasingly focused and targeted [their] sale of deferred annuities towards senior citizens without complying with the insurance disclosure requirements and consumer protection laws of California.”

The Negrete complaints also allege that the deferred fixed annuity products were unsuitable for seniors, and that agents who sold the products were using standardized marketing and sales materials that were deceptive and misleading. Negrete further asserts that the companies were engaging in “churning” schemes.

Allianz also faces another class action complaint in connection with the sale of annuities in the United States District Court, Southern District of California which focuses on the bonus features of the products. Iorio, et al. v. Asset Marketing Systems, et al., Case No. 05-CV-0633 IEG (blm) (S.D. Cal., filed on Sept. 9, 2005).

American Investors Life Insurance Company is currently a defendant in several actions now pending in three California state courts and several pending in the United States District Court, Eastern District of Pennsylvania. Westcott v. American Investors Life Ins. Co., et al., Case No. BC318323 (Los Angeles Superior Court); Cheves, et al. v. American Investors Life Ins. Co., Inc., et al., Case No. CV031024 (San Luis Obispo Superior Court); California Advocates for Nursing Home Reform, et al. v. American Equity Life Ins. Co., et al., Case No. CGC-04-435933 (San Francisco Superior Court); Stephens, et al. v. American Equity Investment Life Ins. Co., et al., Case No. CV 040965 (San Luis Obispo Superior Court).

A petition to coordinate the federal actions against this defendant in the Eastern District of Pennsylvania was
cases against other petition to coordinate actions pending in California filed an-plaintiffs in the other pending federal defendants (MDL No. 1712).

While that petition was pending, plaintiffs in the other pending federal actions pending in California filed another petition to coordinate all federal cases against all defendant insurers in one district court in California. This petition (MDL No. 1729) was strenuously opposed by the defendants on the grounds that their products and marketing strategies differ substantially and that it would be difficult to protect each company’s competitively sensitive information from disclosure in that context. After the American Investors cases were coordinated in Pennsylvania, the California plaintiffs dropped their petition in MDL No. 1729.


Similar actions are also pending against Liberty Bankers Life Insurance Company, National Western Life Insurance Company and AmerUs Life Insurance Company. See Hicks v. Liberty Bankers Life Ins. Co., et al., Case No. 05-438718 (San Francisco Superior Court, filed on Feb. 16, 2005)(class action complaint alleging Section 17200 and 17500 violations, breach of fiduciary duty, elder abuse and fraud); Camien v. National Western Life Ins. Co., et al., Case No. GIC 842761 (San Diego Superior Court)(class action complaint alleging elder abuse, CLRA and Section 17200 violations and bad faith); Sweeney v. National Western Life Ins. Co., Case No. 05 CV 1018 JM (LS) (S.D. Cal.); Inferrera, et al. v. Amerus Life Ins. Co., Case No. CV05 – 2617 CAS (MANx) (C.D. Cal, filed on Apr. 11, 2005); Stein, et al. v. Amerus Group Co., et al., No. 05-CV-02391 MAM (E.D. Pa., filed on May 19, 2005); Price, et al. v. Amerus Group Co., et al., Case No. 04-CV-00329 MAM (E.D. Pa., filed on July 15, 2004); Miller v. Amerus Group Co., No. 04-CIV-3799 (E.D. Pa., filed on Oct. 22, 2004); Trimble v. Amerus Group Co., No. 05-2101(MAM) (E.D. Pa., filed on May 3, 2005); Gilmour v. Amerus Group Co., No. 04-CV-02535 (E.D. Pa., filed on June 10, 2004); Edwards v. Amerus Group Co., et al., Case No. 05-CV-01590 JDW TBM (M.D. Fla., filed on Aug. 26, 2005).

In one of the California state court cases against American Investors, the court granted plaintiffs’ motion for class certification. The court found that “[w]hile recognizing that thousands of solicitations and/or sales were made by hundreds of different sales agents, resulting in the inevitable departure from the making of uniform representations, the Court finds that there is substantial evidence of a relatively uniform and consistent sales approach and technique” based upon the trust mill allegations. Cheves, Notice of Ruling on Plaintiffs’ Motion for Class Certification and Notice of Hearing, filed on May 12, 2005, at p. 7.

**Class Certification Denied**

When the courts consider certification of a class in a case in which plaintiffs have no evidence of trust mill sales practices, however, the results may well prove different, as shown by the recent decision denying class certification in a federal case against Midland pending in federal court in Hawaii, Letrice Yokoyama, et al. v. Midland National Life Ins. Co., Case No. 05-00303 JMS KSC (D. Haw.).

In Yokoyama, the plaintiffs claimed that deferred annuities are unsuitable for seniors. Midland opposed the motion on the grounds that the determination of whether an annuity is suitable for a particular senior is necessarily an individualized analysis so class certification was not appropriate. The court denied class certification, finding that the plaintiffs’ suitability claims were not appropriate for class relief.

This decision is a major blow to plaintiffs’ attorneys seeking to certify broad classes based upon the suitability theories. In response to their defeat, plaintiffs in Yokoyama are filing an amended complaint that adds claims that allege that Midland’s deferred annuities are inherently unfair and deceptive because they contain “hidden charges” and “undisclosed expenses and risks” and are “overly, unnecessarily complex in the contract terms to the point no reasonable senior citizen could understand the risks and benefits of the [annuities].” Plaintiffs in two cases pending against Allianz Life in federal court in California have recently filed class certifica-
tion motions so additional decisions on class certification are expected soon. Iorio, et al. v. Asset Marketing Systems, et al., Case No. 05-CV-0633 IEG (blm) (S.D. Cal.); Negrete v. Allianz Life Insurance Company of North America, Case No. 05-cv-06838-CAS-MAN (C.D. Cal.).

Legislative and Regulatory Actions

These issues raised by these class actions are not only being addressed in the courts, but also in the legislature and by regulators.

The National Association of Insurance Commissioners (“NAIC”) issued a Senior Protection in Annuity Transactions Model Regulation, NAIC 275-1, in September 2003. The purpose of this model regulation, which has been adopted by a few states, “is to set forth standards and procedures for recommendations to senior consumers that result in a transaction involving annuity products so that the insurance needs and financial objectives of senior consumers at the time of the transaction are appropriately addressed.”

The agent or insurance company is to make reasonable efforts to obtain information regarding the senior’s financial and tax status and investment objectives before the purchase. The insurer is also required to design a system to supervise recommendations by maintaining written procedures and conducting periodic review of its records to detect and prevent violations.

In June 2006, the NAIC announced a new model regulation which would apply to all consumers, not just those over the age of 65.

In 2003, the California Legislature passed Senate Bill 620, amending portions of the California Insurance Code to impose additional rules governing the sales of annuities to seniors. The bill, which went into effect on January 1, 2005, imposes a special duty of honesty and good faith on insurers when transacting business with prospective insureds who are 65 years old or older. The bill imposes certain restrictions on, and in some cases prohibits, the sale of annuities to seniors.

The bill also enacts additional restrictions on advertising practices that target seniors and expands the scope of existing restrictions to annuities, including revised disclosure requirements. In addition, the new law now requires eight hours of California specific annuities training and four hours continuing training, for all life agents who sell annuities in California.

Senate Bill 192 is currently pending in the Legislature but has been tabled until the next session. It would require insurers to develop written suitability standards to determine whether the purchase or replacement of an annuity is appropriate for the needs or a senior.

Likewise, the National Association of Securities Dealers (NASD) has raised concerns about equity-indexed annuity products, stating that sellers are inaccurately portraying them as no-risk products, and that they are marketed disproportionately to elderly people. Allison Bell, NASD Head Singles Out EIAs In Speech, NATIONAL UNDERWRITER LIFE AND HEALTH, Vol. 109, No. 44, Nov. 21, 2005. Robert Glauber, chairman of the NASD, added that “equity-indexed annuities ... are subject to utterly ambiguous regulation because it isn't entirely clear to anyone whether they're insurance products or securities.” Id.

Based on these concerns, the NASD has proposed a set of rules which includes requirements for a tailored suitability analysis and approval of any annuity sale by a principal of the selling broker’s firm. Id.; NASD Notice to Members 05-50, Member Responsibilities for Supervising Sales of Unregistered Equity-Indexed Annuities.

The life insurance industry continues to assert that equity-indexed annuities are not governed by the NASD because they are not registered as securities. The political and regulatory battles over the jurisdictional demarcation lines are likely to continue well into 2006. In the meantime, the NASD, in discussions with state insurance regulators, has to seek some degree of harmony in developing rules for broker-dealers. Id.

DEADLINE FOR NEXT ISSUE

The deadline to submit articles and case summaries for the next issue of Life, Health and Disability News is October 1, 2006.
Disability Claims and Lack of Objective Evidence: An Update of the Case Law

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The good news: there is more case law support for benefit denials based on the lack of objective evidence of disability, even if the plan language does not explicitly incorporate an objective evidence requirement.

The bad news: claims administrators can expect that these denials will continue to be challenged when the diagnosis at issue is primarily based on subjective or “self-reported” conditions.


In 1997, the Third Circuit held in Mitchell v. Eastman Kodak Co., 113 F.3d 433 (3d Cir. 1997), that it was unreasonable for an administrator to deny benefits to a claimant with chronic fatigue syndrome (CFS) based on a lack of objective evidence of etiology or cause of the disease. The court essentially reasoned that the claims administrator could not demand what was medically not available.

In addition to relying on this case to support the argument that administrators cannot deny a claim based on the lack of objective evidence of a diagnosis that is not determined by objective medical evidence (i.e., CFS and fibromyalgia), claimants cite to Mitchell as supporting an argument that claims administrators are unable to deny a claim based on the lack of objective evidence of disability. See, e.g., Pralutsky v. Metropolitan Life Ins. Co., 316 F.Supp.2d 840 (D. Minn. 2004) (overruled by the Eighth Circuit as discussed below); Hoover v. Metropolitan Life Ins. Co., 2006 WL 343223 (E.D. Pa. Feb. 14, 2006).

In Hoover, the court found that the plaintiff’s reliance on Mitchell and other decisions that rejected objective evidence requirements for diagnoses was misguided because the administrator agreed with the treating physician’s diagnosis. Therefore, the pertinent issue was whether the diagnosis impacted the plaintiff’s ability to work.

In Mitchell, the court noted that “[t]here are no laboratory tests for the presence or severity of fibromyalgia,” and that “[t]he only symptom that discriminates between it and other syndromes and diseases is multiple tender spots, which we have said were eighteen fixed locations on the body that when pressed firmly cause the patient to flinch.” This court also recognized that the Mayo Clinic in Rochester, Minnesota, has stated that fibromyalgia is not “progressive or crippling.”

In the case of chronic fatigue syndrome, the Eighth Circuit has noted that the illness poses “significant problems for disability plan administrators” because it is difficult for physicians to diagnose and treat, and “apparently it is not always totally disabling.” Wilkins v. Hartford Life & Accident Ins. Co., 299 F.3d 945, 947 n.1 (8th Cir. 2002). This observation applies with equal force to fibromyalgia. See Jordan, 370 F.3d at 873 (noting the symptoms “of fibromyalgia are potentially ‘soft’ and may be subject to examiner interpretation”); Sarchet v. Chater, 78 F.3d 305, 307 (7th Cir. 1996) (“Some people may have such a severe case of fibromyalgia as to be totally disabled from working ... but most do not ....”).

Objective Evidence of Disability

Claims administrators will look for some verification from the medical...
records, functional capacity evaluations, interviews with claimants, or through responses to questionnaires that the claimants have restrictions and limitations in their functional abilities that prevent them from doing their jobs or occupations, or, based on the plan provisions at issue, any job or occupation. While "the diagnoses of chronic fatigue syndrome and fibromyalgia may not lend themselves to objective clinical findings, the physical limitations imposed by the symptoms of such illnesses do lend themselves to objective analysis." Boardman v. Prudential Ins. Co. of Am., 337 F.3d 9, 17 (1st Cir. 2003).

In reviewing the medical records and statements from treating physicians, claims administrators are not bound by what the treating physicians report regarding the patient's symptoms. In Jordan, the Ninth Circuit held that a plan administrator reasonably denied long term disability benefits to a claimant with fibromyalgia based on the opinion of its reviewing medical examiner, even though the plaintiff's treating physicians said she was disabled.

Jordan worked as an administrative secretary. She was treated by several doctors, but no physician responded to the administrator's request for a prognosis on return to work. The district court upheld the administrator's denial of benefits. The Ninth Circuit affirmed, holding that the plan made a reasonable decision in a case where there were conflicting physician reports and, other than the conclusory statements from her doctors, Jordan did not present evidence of a disability that precluded her from working.

The court's decision provides language that assists in distinguishing the Third Circuit's holding in Mitchell - "that a person has a true medical diagnosis does not by itself establish a disability." The court explained that a treating physician is required to accept the self-reported complaints of his patients in order to diagnose and consider treatment alternatives, but if the treating physicians' "ipse dixit" resulted in benefits automatically, then the discretion the plan gives to the administrator would be shifted to the physicians chosen by the applicant.

The Seventh Circuit recognized the Ninth Circuit's assessment as an important reason why claims administrators appropriately require proof in addition to a patient's subjective complaints: "Most of the time, physicians accept at face value what patients tell them about their symptoms; but insurers such as AIG must consider the possibility that applicants are exaggerating in an effort to win benefits (or are sincere hypochondriacs not at serious medical risk)." Leipzig v. AIG Life Ins. Co., 362 F.3d 406, 409 (7th Cir. 2004). In Leipzig, the Seventh Circuit also recognized that while a person may have a medical condition, the diagnosis itself does not mean that the person is necessarily disabled.

Plaintiffs and claims administrators have also used functional capacity evaluations (FCEs), or the lack thereof, as support for their respective positions on whether a person has provided objective evidence of a disability. FCEs are often viewed as "subjective" in nature, but testers will usually provide their opinion as to whether the patient was giving the tests his full effort.

For example, in Brooking v. Hartford Life and Accident Ins. Co., 2006 WL 357881 (6th Cir. Feb. 16, 2006), the FCE was used to demonstrate the plaintiff's inability to work because of pain. The court found that the treating physician's opinion that the plaintiff could sit for no more than one hour at a time, for four hours total per day, was consistent with the FCE, which stated that the plaintiff could sit only occasionally, for two hours and 40 minutes per day.

The FCE also stated that the plaintiff "demonstrated external indicators of pain such as facial grimacing, and deviations in posture and movement patterns" such that the court found this information to present objective evidence of the plaintiff's pain and held that she was entitled to receive disability benefits. See also Liebenguth v. Liberty Life Assurance Co. of Boston, 2006 WL 870618 (W.D. Tex Mar. 22, 2006) (holding that FCE and physical therapy notes demonstrating that the plaintiff had some physical limitations related to her fibromyalgia and CFS did not constitute substantial evidence that plaintiff did not meet the plan's definition of disability).

In Pralutsky v. Metropolitan Life Ins. Co., 435 F.3d 833 (8th Cir. 2006), Pralutsky's counsel argued that MetLife was requiring the impossible by demanding that Pralutsky provide objective evidence of her disability caused by her fibromyalgia and pain. However, during oral argument, counsel acknowledged that MetLife could have requested that Pralutsky submit to a functional test if it wanted to gather more objective evidence about the severity of her condition. The court noted that this suggestion indicated it was not impossible to provide objective evidence to support a disability
based on subjective complaints, and that Pralutsky could have obtained the testing herself. 435 F.3d at 840-41.

In Pralutsky, the medical records documenting Pralutsky's subjective complaints were consistent with a diagnosis of fibromyalgia, but there was no documentation of the typical, multiple tender points used to diagnose the condition. Even though this objective evidence for a diagnosis was missing, MetLife did not dispute the diagnosis. Instead, accepting the diagnosis as true, MetLife denied the claim because Pralutsky failed to demonstrate that she was disabled from performing her sedentary job as a healthcare unit/information coordinator because she did not provide any clinical documentation of a functional impairment caused by her diagnosis.

Pralutsky's evidence supporting her claim included letters from her primary care physician that asserted only conclusive statements and no objective findings of her physical restrictions or limitations, and there was no evidence in the administrative record that the physician providing the letter had seen her for several months.

MetLife interviewed the claimant to determine what activities she could perform, and asked her providers to complete a fibromyalgia questionnaire. Neither of Pralutsky's two treating physicians submitted a completed questionnaire. MetLife also obtained an independent physician consultant to review the claim. The consultant noted that the subjective complaints were consistent with fibromyalgia, but that there was no objective medical documentation to support a disability.

The Eighth Circuit overruled the Minnesota district court's decision that granted Pralutsky's motion for summary judgment. The district court held that the plan language required only "proof" of disability, not "objective proof," and concluded that requiring a level of proof that was not explicitly required by the plan amounted to a procedural irregularity that affected the claim decision reached. It then held that "[w]ithout the requirement of objective medical evidence, '[t]he record contains nothing more than scraps to offset the evidence presented' by Pralutsky." 316 F.Supp.2d at 840.

The Eighth Circuit was not persuaded by the lower court's reasoning on the standard of review or on the merits. The court observed that the plan expressly provided the administrator with discretionary authority to interpret the plan and determine entitlement to benefits. It reiterated that a court could not apply a heightened standard of review based on a serious procedural irregularity unless the administrator "acts dishonestly, or from an improper motive or ... fails to use judgment in reaching a decision ... such that it was the product of an arbitrary decision or the plan administrator's whim." 435 F.3d at 838.

The court provided examples of actions that would constitute a procedural irregularity, such as "fail[ing] to inquire into the relevant circumstances at issue, or never offer[ing] a written decision that can be reviewed, or commit[ting] irregularities so severe that the court has a total lack of faith in the integrity of the decision-making process." Id.

Following Pralutsky, the Eighth Circuit ruled in several other cases upholding a claims administrator's decision to deny benefits based on the lack of objective medical evidence, regardless of whether the plan explicitly contained that requirement. See Johnson v. Metropolitan Life Ins Co., 437 F.3d 809 (8th Cir. 2006) (upholding the Minnesota district court's grant of summary judgment to MetLife under an abuse of discretion standard regarding a claim involving a diagnosis of rheumatoid arthritis and fibromyalgia); Groves v. Metropolitan Life Ins Co., 438 F.3d 872 (8th Cir. 2006) (finding it was not unreasonable to (1) reject the treating physician's opinion in favor of a reviewing physician's opinion, and (2) deny benefits based on a lack of objective evidence of an impairment); Parkman v. Prudential Ins. Co. of Am., 439 F.3d 767 (8th Cir. 2006) (holding that administrator did not abuse discretion in denial based on lack of objective evidence, where claimant's own treating physicians disagreed about the extent of disability).

In another case decided in 2005, prior to Pralutsky, the Eighth Circuit held that the administrator acted reasonably by denying benefits to a claimant who was diagnosed with Restless Leg Syndrome when the record lacked objective evidence of a disability and there were conflicting physician opinions. Hunt v. Metropolitan Life Ins Co., 425 F.3d 489 (8th Cir. 2005).

Pralutsky's requests for a rehearing or en banc were denied in March 2006. She has recently filed a petition for a writ of certiorari to the United States Supreme Court. Although Pralutsky argued that there is a split in the circuits regarding whether disability plans can require objective evidence of disability when the plan does not explicitly include that requirement, she offered only the Mitchell case, noted above, and two Seventh Circuit cases that essentially said that claims administrators cannot require objective evidence of a disease that cannot be diagnosed objectively.

Although Pralutsky's doctors did not return a completed fibromyalgia questionnaire to MetLife, as it requested, in another case, Speciale v. Blue Cross and Blue Shield Asn., 425 F.Supp.2d 917, 922 (N.D. Ill. 2006), the plaintiff's physicians...
did complete a fibromyalgia functional capacity questionnaire that assisted the plaintiff in proving she was disabled under the plan. This questionnaire demonstrated that the plaintiff met the trigger point criteria for that condition, that she reported pain, and that the doctor observed her limited ability for sitting or standing.

The dissents in the Eighth Circuit’s Hunt and Pralutsky decisions provide important cautionary tips for claims administrators regarding denials based on a lack of objective evidence. Even under the deferential standard of review for abuse of discretion, the claims administrator’s denial of benefits based on the absence of objective evidence may not be upheld where the claimant’s subjective complaints are not contradicted by, or are not inconsistent with, other record evidence. Pralutsky v. Metropolitan Life Ins Co., 435 F.3d 833, 842 (8th Cir. 2006) (Bye, J., dissenting); Hunt v. Metropolitan Life Ins Co., 425 F.3d 489, 492 (8th Cir. 2005) (Bye, J., dissenting).

**Plan Language That Supports Objective Evidence Requirement**

As noted in Pralutsky and other cases referenced above, the plan’s grant of discretion to determine claims and the requirement of “proof” of disability support an administrator’s ability to deny claims when the record lacks objective evidence of disability, even if the plan language does not explicitly use the words “objective evidence.”

Given that ERISA does not require employers to establish employee benefits plans, or mandate the kind of benefits an employer must provide if it chooses to do so, ERISA is best served by “preserving the greatest flexibility possible for ... operating claims processing systems consistent with the prudent administration of a plan.” Black & Decker Disability Plan v. Nord, 538 U.S. 822 (2003) (quoting Department of Labor, Employee Benefits Security Administration, http://www.dol.gov/ebsa/faqs_claims_proc_reg.html, question B-4 (as visited May 6, 2003)).

However, in an attempt to avoid the debate that was central to the district court’s decision in Pralutsky, some ERISA plans have explicitly included the objective evidence of disability requirement in their plan language, or have limited benefits to 24 months when the diagnosis at issue is supported primarily by self-reported complaints. See, e.g., Belcher v. Verizon Wireless Short Term Disability Plan, 2006 WL 1879003, (D.S.C. July 6, 2006) (the benefit plan did not cover “[d]isabilities ... for which the employee cannot provide acceptable objective medical evidence, as determined by MetLife in its sole discretion”); Boone v. Liberty Life Assurance Co. of Boston, 2005 WL 3479835 (6th Cir. Dec. 20, 2005) (plan defined proof as “the provision by the attending Physician of standard diagnosis, chart notes, lab findings, test results, x-rays and/or other forms of objective medical evidence in support of a claim for benefits”).

Troubling for plans including a 24-month limitation for diagnoses based primarily on self-reported complaints is the Eighth Circuit’s holding in Chronister v. Baptist Health, 442 F.3d 648 (8th Cir. 2006). In that case, the court rejected Unum’s decision to deny benefits after 24 months based on the applicable plan limitation for conditions based on self-reported complaints. The claimant’s disability was based on fibromyalgia.

The court noted that because the “trigger point test” provides essentially objective evidence to support the diagnosis of fibromyalgia, relying on its recent decision in Johnson and previous decision in Brosnan v. Barnhart, 336 F.3d 671 (8th Cir. 2003), it was unreasonable for Unum to rely solely on the 24-month limitation for self-reported symptoms in terminating benefits. The court remanded the case to Unum for further review.

**Conclusion**

The Ninth Circuit decision in Jordan and the Eighth Circuit decisions noted above provide valuable assistance to other circuits that may still be coming to terms with distinguishing cases where claim denials are based on the lack of objective evidence of a disease, and those where denials are based on the lack of objective evidence of a disability.

The current trend in the case law supports a position that plan language does not have to explicitly state that claims may be denied based on the lack of objective evidence when the plan language grants the claims administrator discretion to determine a claimant’s eligibility to receive benefits.

However, plans should be cautious when they do alter the plan language in an attempt to limit the exposure on claims that are supported only by a claimant’s subjective complaints or self-reports. Further, when denying claims, administrators should identify in their denials the evidence in the record that contradicts the claimant’s self-reports, if possible, to further support the claim denial.
Seismic Shifts: Is It Time for Long Term Disability Plans to Self-Fund?

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The past three years have seen a dramatic change in the way that disability insurance carriers are being regulated, especially carriers whose policies fund private employee disability benefit programs.

Disability insurers used to be regulated by state insurance statutes and occasional court pronouncements that set guidelines for the interpretation of various plan terms and for the approval of policy forms. But even when these laws challenged carriers' enforcement of insurance contracts, at least the carriers could be consoled by the fact that these laws were created in an environment that observed basic principles of due process in which the carriers were given an opportunity to be heard.

Beginning in early 2004, the environment of insurance regulation entered a new era when the California Insurance Department issued a unilateral announcement that it would no longer approve disability policy forms intended to fund benefits under ERISA plans where the policies contained court-sanctioned discretionary language.

No longer were disability carriers offered an opportunity to be heard, nor were they given even the pretense of due process. No longer was disability insurance regulation subject to administrative rulemaking and adjudication, processes that include protections for all parties, including disability insurance carriers. Instead, insurance commissioners began to regulate by political fiat – heavily assisted by private plaintiffs' lawyers.

In this new unilateral regulatory environment, one has to wonder how long it will be before disability insurance carriers look for ways to escape regulatory blackmail. To be sure, disability insurance policies, including policies that fund employee benefit programs, are subject to state insurance regulation. Even ERISA, the law that regulates private employee benefit programs, carves out a federal preemptive exception for such laws.

However, where an employee benefit plan is self-funded, state insurance laws do not apply, leaving plan sponsors and fiduciaries with much broader discretion in how such plans are structured and in determining what benefits are offered. Insurance policy provisions that may be outlawed by state insurance departments, are untouchable when the disability program is self-funded.

In light of the dramatic changes in the ways insured plans are now being regulated by aggressive state insurance departments, maybe it is time for disability carriers to start discussing creative self-funded disability products.

Seismic Shifts

The aggressive manner in which some state insurance departments are attempting to dictate disability insurance provisions signals two broad ways in which insurance regulation may be changing.

First, there is a change of regulatory forum. Insurance departments appear to be moving away from the legislatures and the courtrooms, forums where insurers are granted an opportunity to be heard and are frequently victorious in defending their rights as contracting parties. Instead, insurance departments are regulating by dictatorial fiat – using politics and an all too willing media to bypass fundamental principles of due process.

The second way in which the insurance regulatory process may be changing lies in the mechanics of regulation. Historically, insurance regulation was the product of the law, either legislative or adjudicatory. These traditional mechanisms have not always been favorable to potential plaintiffs, particularly in the ERISA environment. Accordingly, the plaintiffs' bar has moved away from these mechanisms to an administrative mechanism where the regulator has almost total authority.

Rather than rely on specific laws or regulations that are enacted in accordance with predictable processes, insurance departments appear to be moving toward a mechanism in which
the departments rely on broad and vague statutory powers (e.g., authority to prohibit “misleading” policy provisions) in order to arbitrarily outlaw whatever provisions they choose, regardless of what statutes and court decisions dictate. Indeed, insurance departments are now outlawing policy provisions as “misleading” even though the insurance departments themselves have previously approved those same provisions.

What this leaves for disability insurers is an environment of ever-changing and unpredictable regulation over which insurers have little or no control. Insurers are told to scrap policy forms and contract provisions that have been approved throughout the country and that have been in existence for decades—all without any action by state legislatures or courts of law. Indeed, this is all done without any adherence to even the minimal requirements of administrative rulemaking or adjudicatory processes. All of this signals a seismic shift in the way that insured disability plans are being regulated.

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The ERISA Preemption Triangle

ERISA applies to both employee pension and welfare plans. The terms of pension plans are heavily regulated by federal law; the terms of welfare plans are not. In fact, sponsors of employee welfare benefit plans, including disability plans, are essentially left to their own discretion in designing the terms and funding mechanisms of such plans.

In terms of funding, disability plans can be funded by a trust, an employer’s general assets, or by one or more insurance policies. See, e.g., ERISA, §3(1) (ERISA welfare plans may be funded “through the purchase of insurance or otherwise”).

When an ERISA disability benefit is funded by insurance, the policy funding the plan benefits is subject to state insurance regulation. This is because of the preemption triangle created in ERISA, §514.

In one corner of the triangle is the “preemption clause,” in which ERISA broadly supersedes all state laws that “relate to” an employee benefit plan. Id. at §514(a). In the second corner is the “saving clause” in which there are several exemptions from preemption, including an exemption for state laws that “regulate insurance.” Id. at §514(b)(2)(A). Finally, in the third corner of the triangle is the “deemer clause” in which the statute makes it clear that self-funded plans are not subject to state insurance regulation:

Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts . . . .

Id. at §514(b)(2)(B).

In several early cases, the United States Supreme Court discussed the scope of ERISA’s preemption clause. It was not until Metropolitan Life Ins Co. v. Massachusetts, 471 U.S. 724 (1985), that the Supreme Court directly addressed the preemption and saving clauses.

At issue was a state law that required health insurance policies to include coverage provisions for certain types of health care expenses. The insurer challenged the application of the state law where a health insurance policy funded benefits under an ERISA-regulated employee benefit plan, arguing that the state law was preempted.

The Supreme Court acknowledged that the state law fell within the broad sweep of ERISA’s preemption clause. However, the Court went on to hold that the state law “regulate[d] insurance” and was therefore within the scope of the saving clause. As such, the state mandated benefit law was exempt from preemption under ERISA and health insurance policies were subject to the state insurance requirements, even though the policies funded benefits under ERISA plans.

In FMC Corporation v. Holliday, 498 U.S. 52 (1990), the Supreme Court took the next step to discuss all three corners of the preemption triangle, including the deemer clause. Specifically, the Court was asked to determine whether a state insurance law, otherwise exempt from preemption under the saving clause, could be applied to a self-funded ERISA plan (i.e., a plan in which benefits were not funded by a policy of insurance).

In that case, FMC sponsored an employee health plan that was self-funded, i.e. “it does not purchase an insurance policy from any insurance company in order to satisfy its obligations to its participants.” Among other things, the plan included a subrogation clause by which the participants agreed to reimburse the plan if the participants recovered on a claim for third-party liability.

Ms. Holliday was a beneficiary of the FMC plan. She was injured in an auto accident and settled a tort claim against the other driver. The FMC
plan sought to enforce its subrogation rights in order to obtain reimbursement for medical benefits paid for Ms. Holliday's injuries. Ms. Holliday argued that a state anti-subrogation statute prevented the ERISA plan from enforcing its subrogation rights.

The Supreme Court found that the state law “related to” the plan because the “antisubrogation law prohibits plans from being structured in a manner requiring reimbursement in the event of recovery from a third party.” Thus, the state statute fell squarely within the preemption clause. The Court then noted that it was undisputed that the state anti-subrogation statute “regulate[d] insurance” because it “directly controls the terms of insurance contracts by invalidating any subrogation provisions that they contain.”

Thus, to the extent the state law might be applied to an insurance policy, the Court assumed without directly deciding that the state law would be exempt from preemption under the saving clause. However, the Court went on to hold that the state antisubrogation law was still preempted to the extent the beneficiary sought to enforce the law against FMC’s self-funded ERISA plan by virtue of ERISA’s deemer clause.

The Court discussed the relation between the saving clause and the deemer clause as follows:

We read the deemer clause to exempt self-funded ERISA plans from state laws that “regulate insurance” within the meaning of the saving clause. By forbidding States to deem employee benefit plans “to be an insurance company or other insurer . . . or to be engaged in the business of insurance,” the deemer clause relieves plans from state laws “purporting to regulate insurance.” As a result, self-funded ERISA plans are exempt from state regulation insofar as that regulation “relate[s] to” the plans. State laws directed toward the plans are preempted because they relate to an employee benefit plan but are not “saved” because they do not regulate insurance. State laws that directly regulate insurance are “saved” but do not reach self-funded employee benefit plans because the plans may not be deemed to be insurance companies, other insurers, or engaged in the business of insurance for purposes of such state laws. On the other hand, employee benefit plans that are insured are subject to indirect state insurance regulation. An insurance company that insures a plan remains an insurer for purposes of state laws “purporting to regulate insurance” after application of the deemer clause. The insurance company is therefore not relieved from state insurance regulation. The ERISA plan is consequently bound by state insurance regulations insofar as they apply to the plan’s insurer.

In short, although insurance policies that fund ERISA plan benefits are subject to state insurance regulation by virtue of the saving clause, self-funded plans are not subject to state insurance regulation by virtue of the deemer clause. In FMC, because the health plan was self-funded, the Supreme Court held that the state anti-subrogation statute was preempted as it applied to the health plan, regardless of whether the state law was “saved” as a state law that regulates insurance.

Self-Funding Mechanism - Plan Entities

As is the case with insured ERISA plans, self-funded ERISA plans can involve multiple entities, each with its own unique responsibilities:

Plan Sponsor: In order to be governed by ERISA, there must be a plan sponsor and the plan sponsor must be an employer, an employee organization, or both.

Plan Administrator: There must be an entity with overall administrative responsibility for operation of the plan. Under ERISA, this entity is the plan sponsor by default. However, another entity other than the sponsor can be designated as the plan administrator and that entity can in turn delegate its various duties to other entities.

Claim Administrator: In the insured context, the insurance policy provides not only a funding mechanism (i.e. insured benefits), but also claim administration services. In a self-funded plan, benefits are not insured, so the plan sponsor or administrator must arrange for a separate funding mechanism. The sponsor or administrator must also process benefit claims or hire another entity to perform this service. This entity is variously described as the “claim administrator” or the “third party administrator.”

Trustee: When a self-funded plan is funded through a trust, the trust is controlled by a trustee. In most cases involving welfare
plans, the trustee is primarily a passive entity, that holds the plan funds and distributes the funds at the instruction of other entities (e.g., the plan administrator or the claim administrator).

Stop-Loss/Excess Risk Insurer: Many self-funded plans arrange for reinsurance to cover catastrophic benefit costs. In order for the plan to remain truly self-funded, and not unlike other reinsurance contexts, the excess risk insurer reimburses the plan sponsor for benefit costs that exceed a certain trigger point. The trigger point in this case operates as a “deductible” or self-insured retention. Excess risk insurers do not have direct responsibility for paying benefits to or on behalf of plan participants and beneficiaries. Rather, the excess risk insurer’s obligation is to reimburse the plan sponsor once the plan pays benefits that exceed the trigger point. In most cases, the excess risk contract contains an individual trigger point, applicable to benefits paid to an individual participant or beneficiary in a given time period, as well as an aggregate trigger point, applicable when all benefits paid to all participants and beneficiaries in the plan exceed the trigger point during the given time period.

**Self-Funded Plan Documents**

Self-funded plans involve several types of documents, not all of which apply to an insured benefit plan:

**Master Plan:** Like all ERISA plans, there must be a master plan document that spells out the plan benefits, limitations, and exclusions, as well as the procedures for filing benefit claims.

**Summary Plan Description:** Also like insured ERISA plans, there must be a plan summary, the purpose of which is to summarize the terms of the master plan document. ERISA requires the plan summaries to be distributed to each plan participant and beneficiary.

**Administrative Services Agreement:** This is the document that governs the relationship between the plan sponsor or administrator, on the one hand, and the claim administrator or third party administrator, on the other hand. Among other things, the administrative services agreement dictates the services that will be provided to the plan by the claim administrator. It also frequently includes certain indemnity provisions.

**Trust Agreement:** If the plan is funded through a trust, there will be a trust agreement that dictates the terms of the trust and the duties of the trustee. In the self-funded welfare plan context, trusts are frequently established as an alternative to benefit payments being paid from the plan sponsor’s general assets. One purpose of a trust is to allow the plan to accumulate funds over time. Funds accumulated during periods when benefit costs are lower are then available during periods when benefit costs are higher. This helps to avoid cash flow inconsistencies for plan sponsors that might occur if the sponsor pays benefits out of its general assets.

**Stop-Loss/Excess Risk Insurance Policy:** This is the document that reinsures the plan for benefit costs that exceed the agreed individual and/or aggregate trigger points. Typically, the excess risk policy offers reimbursement for benefits that are paid and payable in accordance with the terms of the underlying benefit plan. However, many excess risk policies also include other substantive terms that may otherwise limit the insurer’s reimbursement obligations. For example, in the health insurance context, it is not unusual for both the underlying plan document and the excess risk policy to include exclusions for medical costs that arise out of medical treatment that is considered experimental or investigational. Moreover, the exclusionary terms of the underlying plan may or may not be consistent with the exclusionary terms of the excess risk policy, leaving open the possibility that certain benefits may be payable under the terms of the benefit plan, but not reimbursable under the terms of the excess risk policy.

**The Fiduciary Question**

One of the key questions in establishing a self-funded plan is the identifi-
cation of fiduciaries and their duties. ERISA incorporates a functional definition of “fiduciary,” meaning that a person is a fiduciary, not necessarily based on that person’s title, but based on that person’s duties in connection with the ERISA benefit plan. Indeed, there is case law holding that a person can be a fiduciary even where the plan document specifically denies fiduciary status. See, e.g., IT Corp. v. General Am. Life Ins. Co., 107 F.3d 1415 (9th Cir. 1997).

Under ERISA, fiduciary status is defined by two general sets of responsibilities: (1) discretionary authority in administering an ERISA plan; and (2) authority over plan assets. ERISA, §3(21)(A). In the context of a self-funded welfare benefit plan, fiduciary status is most often at issue when it impacts the processing of benefit claims. Specifically, the question that must be resolved is whether the entity with final decision-making authority over benefit claims is a fiduciary under ERISA.

Frequently, final decision making authority over the payment of benefits follows the person or entity that is responsible for funding the benefits. In other words, the entity whose money is funding the plan is most often the entity with final decision making authority over participants’ benefit claims. For this reason, many claim administrators carry out their claim processing duties in a non-fiduciary capacity, i.e., the claim administrator’s benefit decisions are subject to review by the plan’s sponsor or other entity that funds benefits. This is in part due to the fact that the claim administrator’s money is not at risk in paying out benefits. It is also in part due to what appears to be an irrational, and possibly mistaken, position on the part of many professional claim administrators that it is better to be a non-fiduciary than a fiduciary.

Fiduciary status does carry with it certain duties and responsibilities (e.g., the duty to pay benefits in accordance with plan terms, etc.). However, in the ERISA context, fiduciary status also carries with it the protections of the remedial limitations of ERISA’s civil enforcement section, limitations that are not always applicable under state law. Thus, in many cases, being a fiduciary under ERISA may not be a bad thing.

The Health Plan Template

There are self-funded long term disability plans already in existence, but most of these plans are sponsored by very large employers. Self-funding is more common in short term disability plans, but these plans offer limited benefits. The type of ERISA plan with the most experience in overall self-funding of benefits is the health plan.

At one time, most health plans were fully insured. Over time, particularly in the past ten years, it has become more common to see self-funded health plans, even among smaller employers. Typically, these plans are created to save money because they are cheaper to administer than many fully insured arrangements. Self-funded health plans are also utilized because they are not obligated to offer state mandated health benefits, giving the employer/plan sponsor broader discretion in deciding what types of benefits to offer to its employees.

A self-funded health plan must include a master plan document, a plan summary, and a third party service agreement. It may also include a trust document and an excess liability insurance policy.

As benefit claims are processed and approved by the claim administrator (also known as the third party administrator or “TPA”), the plan sponsor pays the medical bills. Sometimes the claim administrator is given check writing authority and will pay the medical bills directly from an account that is funded by the plan sponsor. The claim administrator then reports benefit expenses to the plan sponsor on a periodic basis in order to keep the checking account fully funded. When and if benefit costs reach an agreed trigger point, the claim administrator contacts the excess risk insurer and applies for reimbursement.

In many ways, and certainly from the perspective of most participants and beneficiaries, the self-funded health plan operates no differently than a fully insured plan. The key difference is that the self-funded plan is not subject to state insurance regulation.

Application of Self-Funding to Disability Plans

As noted, many employers sponsor self-funded short term disability programs, also known as salary or wage continuance programs. Such programs are relatively easy to fund because of the limited benefits available. In fact, many such plans are funded out of the sponsor’s general assets and, in such cases, may not even be governed by ERISA when they are stand-alone programs. See 29 C.F.R. §2510.3-1(b) (exempting from
ERISA regulation various employer “payroll practices”).

Self-funded long term disability plans are less common, primarily because they require more funding over a longer period of time. The claim process is functionally no different between self-funded and insured disability plans: in either case, an entity is hired to process and determine benefit claims. However, the key hurdle that must be cleared in order to self-fund a long term disability plan is the funding of that plan.

Many smaller employers may be willing to self-fund a health plan and pay medical bills up to their excess risk insurance trigger point, but these same employers may be less likely to commit to paying disability benefits over many years to an ex-employee under a long term disability plan.

At one time, many employers were reluctant to self-fund their health plans. Health insurers solved the funding problem by creating excess risk insurance in order to reimburse plan sponsors for catastrophic health plan expenses. This made self-funding of health plans more attractive to employers because employers were able to cap their health plan costs, making them more predictable. Self-funding options on the health plan side became more available to smaller and smaller employers.

Disability insurers are certainly capable of following the lead of health insurers and developing creative excess risk insurance options, packaged with claim processing services, in order to make self-funding of long term disability plans more widely available.

One possibility is to create excess risk policies that reimburse plan sponsors for monthly benefit amounts that exceed a certain trigger point, so that employers can better predict their potential liability. Another option is for such policies to reimburse plan sponsors after benefits have been paid for a certain period. Again, this makes long term disability plan costs more predictable to employers. Certainly, other options are available.

Conclusion

If current trends continue, insurance department regulations will become more and more onerous for long term disability insurance carriers. Maybe today insurance departments only want to outlaw discretionary language clauses, but what clauses will they want to outlaw tomorrow? Already, some departments are moving to prohibit other disability policy clauses.

Maybe today insurers are willing to play along, figuring that if the entire disability insurance industry is in the same boat, it will make no difference anyway. However, at some point, it would seem that disability insurers will start looking at products other than the traditional fully insured long term disability policy and will ask the question: is it time to start self-funding ERISA-governed long term disability benefit programs?
Language of Discretion – Which Version of the Plan Determines the Authority of the Administrator?

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Following the Supreme Court’s decision in Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101 (1989), plan sponsors increasingly included language granting discretionary authority to plan administrators. Amendments of existing plan documents to add such language invariably have given rise to disputes concerning which version of the documents controls.

A specific issue that arises with some frequency, and that was addressed earlier this year by the Second Circuit, is: “When reviewing the administrator’s denial of benefits under an ERISA-governed long-term disability plan, to which version of the summary plan description should the District Court refer when determining the applicable standard of review: the version in effect at the time the claim is denied or the one in effect when the beneficiary became disabled?” Gibbs ex rel. Estate of Gibbs v. CIGNA Corp., 440 F.3d 571, 572 (2d Cir. 2006). The answer, according to the court, depends on whether and when such benefits have vested.

Gibbs was a long-time employee of Connecticut General Life Insurance Company who became disabled in October 1995 and began receiving long-term disability benefits on May 1, 1996. In late 1996, Gibbs contended that the amount of his benefit was calculated incorrectly because it was not based on his actual “eligible earnings.” The difference in the parties’ positions stemmed from an issue regarding whether some of Gibbs’s prior compensation was intended to constitute a “salary” or a guaranteed draw against commissions earned.

A final letter from CIGNA denying Gibbs’s claim for additional benefits was issued in March 1998. Gibbs filed suit on February 27, 2001.

The SPD in effect in 1995, when Gibbs’s disability claim arose, contained no grant of discretion, according to the court’s opinion. The 1997 SPD, in effect when Gibbs’s claim for additional benefits was denied, granted “sole discretion” to the plan administrator “to determine whether [a participant is] eligible for benefits ... and the amount of any benefit ....” Siding with Gibbs on the threshold issue, the court concluded that the grant of discretionary authority in the 1997 SPD did not apply to Gibbs’s claim, “because his right to disability benefits vested prior to CIGNA’s amendment of the Plan.”

First, the court noted that disability plans are “treated somewhat differently than other welfare plans for purposes of vesting.” The Second Circuit had held in an earlier decision, Feifer v. Prudential Ins. Co. of Am., 306 F.3d 1202, 1212 (2d Cir. 2002), that “absent explicit language to the contrary, a plan document providing for disability benefits promises that these benefits vest with respect to an employee no later than the time that the employee becomes disabled.” The 1995 SPD contained no such explicit language, the court determined.

Rather, the court emphasized, the “SPD states quite the contrary: ‘Any modification or termination will not affect your right to benefits from a covered disability that occurred before the termination or modification.’” The court held: “Without an explicit reservation of CIGNA’s right to alter disability benefits after a beneficiary became disabled, Gibbs’s right to benefits vested when he became disabled.” As a result, the later grant of discretion was “ineffective with respect to Gibbs’s benefits.”

Other Circuits Reach Different Result

As the Second Circuit acknowledged,
when the plaintiff’s claim was denied. To the terms of the revised plan in effect per petuity.” As a result, the court looked to the employee to invoke that plan’s provisions in her case. Nothing in the plan at issue in Grosz-Salomon “assured employees that their rights were vested.” To the contrary, the court wrote, “the policy provided that Paul Revere could change the group policy upon written request from the policyholder and that the insured’s consent was not needed to make a policy change.”

Far from according disability plans special treatment, the Ninth Circuit noted that the fact that the plaintiff “became permanently disabled and filed her disability claim while the first policy was in effect is irrelevant; it does not entitle her to invoke that plan’s provisions in perpetuity.” As a result, the court looked to the terms of the revised plan in effect when the plaintiff’s claim was denied.

Finding Grosz-Salomon persuasive, the Third Circuit followed suit in Smathers v. Multi-Tool, Inc./Multi-Plastics, Inc. Employee Health and Welfare Plan, 298 F.3d 191 (3d Cir. 2002), which involved a claim for medical expenses resulting from a motorcycle accident. The plan language was changed to include a grant of discretion after the date of the accident and after the medical claims were submitted, but before the date of the administrator’s decision.

Important to the Third Circuit’s decision was the conclusion that the grant of discretion “did not change the coverage under the plan or substance of [the plaintiff’s] benefits or his entitlement to them.” Rather, the court reasoned, “[a]ll that changed was the scope of the administrator’s discretion and authority.” The court wrote: “Procedural provisions of a plan such as this, containing a grant of discretionary authority to the administrators, are not implicated until the administrator actually exercises that authority.”

Finally, the Seventh Circuit in Hackett v. Xerox Corp. Long-Term Disability Income Plan, 315 F.3d 771 (7th Cir. 2003), also applied the language of the plan in effect on the date of the denial, despite a provision in the earlier plan which stated that the plan could not be amended so as to “diminish any rights accrued for the benefit of the participants prior to the effective date of the amendment.” This provision, the court concluded, “only says that no amendment shall require [the plaintiff] to return benefits he has already received or alter benefits for which the payments have become due.”

Without much analysis, the court in Gibbs distinguished these decisions, essentially by pointing out that they were contrary, that is, they held that the plaintiffs “were not vested in their right to benefits.”

Addressing Smathers more directly, however, the court added that it disagreed with the Third Circuit’s basic premise in that case “that granting the Plan Administrator sole discretion to determine benefits – thus altering the District Court’s standard of review – does not ‘affect’ the substance of Gibbs’s benefits.” According to the Second Circuit, there was “no doubt” that “a right that may be denied by an administrator’s incorrect, but not arbitrary, interpretation of the plan is substantively diminished as compared with one not subject to erroneous decisions.”

The court did not elaborate on that statement, and the equating of a court’s standard of review with the notion of substantive rights under the plan seems at least questionable. The level of ultimate judicial review has no bearing in fact on a participant’s “right” to benefits under the terms of the plan.

The provision of a grant of discretion, for example, is not equivalent to the inclusion of language imposing a new limitation of benefits for a particular illness or injury after onset. Yet, even such substantive alterations have been permitted in the context of welfare plans. See, e.g., McGann v. H & H Music Co., 946 F.2d 401 (5th Cir. 1991); Owens v. Storehouse, Inc., 984 F.2d 394 (11th Cir. 1993).

Conclusion

The Second Circuit’s decision in Gibbs likely will find limited application on a national scale, and most courts will apply language of discretion appearing in plan documents on the date of claim denial. (The only decision outside the Second Circuit to cite Gibbs to date, Agn v. Liberty Life Assurance Co. of Boston, 2006 WL 1722228 (W.D. Mich. June 21, 2006), declined to follow it, finding the decision “at odds with Sixth Circuit law, which holds a plan administrator may modify a welfare plan at any time ....”) Still, the decision emphasizes the link between this issue and ERISA’s vesting principles and highlights the need for clear language regarding the plan sponsor’s right to alter the terms of the plan.
Massachusetts

Limitation Period for Misrepresentation Claims Is a Statute of Repose

In Passatempo v. McMenimen, 20 Mass. L. Rptr. No. 26,593 (Mass. Super. 2006), a trial court held that Massachusetts General Law, Chapter 175, Section 181, which establishes a two-year limitation period for claims against a life insurer for misrepresentations concerning life insurance policies, constitutes a statute of repose, not a statute of limitations. However, the court also held that the barrier does not apply to claims against an insurance agent.

Plaintiff sued Nationwide Provident and the insurance agent, McMenimen. Plaintiff claimed that defendants induced the purchase of a life insurance policy that was worth less than it was represented using misleading analyses, reports and illustrations.

Chapter 175, Section 181, prohibits insurance companies and their officers and agents from making misrepresentations regarding the terms of any policy of insurance. The statute states that any insured under a policy of life insurance induced to procure it by any action or violation of the statute may recover all premiums paid on the policy in an action brought within two years after the policy is issued. The agent sought to dismiss the claims against him on the grounds that the action was filed more than two years after the date of issuance.

The court held that the first issue it must decide was whether the statute was one of repose or a statute of limitations. The court noted that there was no appellate level decision in Massachusetts addressing the issue.

The court held that if a statute of repose, the statute would place an absolute limit on the liability of those within its protection, and would abolish the cause of action thereafter, even if the injury did not occur, or was not discovered until after the statute's time expired. The court also noted that statutes of repose are not subject to any form of equitable tolling.

While the court noted that there had been a number of trial court decisions in which the courts have referred to the statute as one of limitations, the court stated that a reading of each of those cases revealed that the argument that §181 is a statute of repose had not been made to the court. Reviewing the plain language of the statute, the court concluded that §181 was a statute of repose. However, this was not the end of the court's analysis.

The court held the language of the statute only protected the insurer, not the agent. Noting that a statute of repose can have harsh results and impose a great hardship on aggrieved parties, the court stated it would not expand the reach of the statute beyond that set forth in the clear language from the legislature. Thus, the court held that the repose portion of §181 did not reach beyond claims against the insurer and denied the agent's motion to dismiss.

Michigan

ERISA Does Not Preempt Waiver of Right to Benefits

In Sweebe v. Sweebe, 712 N.W.2d 708 (Mich. 2006), the court held that ERISA does not preclude a named beneficiary from waiving her right to life insurance proceeds as part of a divorce judgment. Sweebe conflicts with a Sixth Circuit opinion on the same issue. Metropolitan Life Ins. Co. v. Pressley, 82 F.3d 126, 130 (6th Cir. 1996).

Marilyn Sweebe and Herbert Sweebe were divorced in 1986. As part of their divorce judgment, they each agreed to give up any interest either had in any life insurance policy of the other. Mr. Sweebe, however, neglected to change the designated beneficiary on his ERISA-governed life insurance policy. When Mr. Sweebe died, therefore, the plan administrator paid the plan proceeds to Marilyn, because she was listed as the named beneficiary.

Mr. Sweebe's estate filed an action to enforce the waiver in the divorce judgment. The circuit court held that ERISA preempted the divorce judgment and that the life insurance proceeds had to be paid to Marilyn, the ex-wife. The Michigan Court of Appeals reversed, holding that the divorce judgment was not preempted by ERISA. The Michigan Supreme Court granted leave.

The Michigan Supreme Court held...
that, although ERISA required the plan administrator to pay the life insurance proceeds to Marilyn, ERISA did not prevent the ex-wife from contractually waiving her rights to the proceeds. Thus, the court analyzed the issue solely on grounds of waiver and not on ERISA preemption. The court held that the divorce judgment was a contractual waiver of the ex-wife's right to the life insurance proceeds.

In holding that a named beneficiary can contractually waive her right to ERISA-governed benefits through a divorce judgment, the Michigan Supreme Court joined the majority of federal circuit courts that have addressed the issue. See Sweebe, 712 N.W.2d at 712. The Michigan Supreme Court rejected the minority rule, which has been adopted by the Sixth Circuit. See Pressley; McMillan v. Parrott, 913 F.2d 310, 312 (6th Cir. 1990).

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New York

Workers' Compensation Benefits Can Be Recouped to Prevent Double-Dipping
In Meeks v. Verizon New York, Inc., 814 N.Y.S.2d 310 (3d Dept Apr. 20, 2006), a New York appellate court held that a self-insured employer's disability benefit plan was authorized to seek credit or reimbursement from another benefit plan on account of its advanced payments to the plaintiff-employee.

The Verizon employee had injured his left shoulder in a work-related injury. During the almost nine weeks that he was disabled, Verizon paid him his full weekly wages, more than half of which were workers' compensation benefits, the remainder coming from Verizon's ERISA disability plan.

Plaintiff thereafter made a claim for a workers' compensation schedule loss of use award, at which time Verizon filed a request for reimbursement of the workers' compensation benefits previously paid, pursuant to New York Workers' Compensation Law § 25(4)(c). The administrative law judge found that Workers' Compensation Law § 25 was not preempted by ERISA and awarded Verizon full reimbursement for the benefits paid to plaintiff that had been attributable to his workers' compensation coverage.

On appeal, plaintiff conceded his preemption argument but maintained that because the plan did not explicitly mention workers' compensation benefits as a collateral source, Verizon's claim for reimbursement should have been rejected. In response, Verizon emphasized that Workers' Compensation Law § 25(4)(c) authorized it to seek credit or reimbursement for advanced payments to an employee pursuant to any benefit plan.

The court agreed, concluding that Verizon's plan was intended to achieve the socially-beneficial goal of providing immediate income to injured employees, while also permitting the subsequent recovery of benefits paid from a collateral source under "any law" to the extent that they were duplicate benefits. The court found that such reimbursement not only was permissible, but it was necessary to protect the integrity of the fund by preventing double recoveries at the possible expense of future beneficiaries.

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Second Circuit

Benefits for Mental Syndrome Limited Despite Physical Cause
In Fuller v. J.P. Morgan Chase & Co., 423 F.3d 104 (2d Cir. 2005), the court held that it was neither arbitrary nor capricious for an insurer to limit plaintiff's benefits based upon a mental syndrome, even if the disorder had a physical cause.

Plaintiff became disabled by bipolar disorder while working for the defendant bank. She collected long-term disability benefits from J.P. Morgan's Long Term Disability Plan. Under the terms of the plan, defendant covered employees with long-term physical disabilities until the age of 65, while employees with long-term disabilities arising from mental or emotional disorders only received benefits for 18 months. Plaintiff's bipolar disorder was classified by the plan's administrator as a mental disorder, and her benefits were discontinued after 18 months.

Plaintiff initially challenged the plan administrator's decision as a disparate treatment ADA claim, which was dismissed by the district court. At the same time, however, the district court liberally construed her complaint to make out an arbitrary and capricious claim under ERISA.

The district court inferred that plaintiff was arguing that because bi-
polar disorder is chemically-caused like diabetes, it should be treated like any other physical illness, entitling her to benefits until age 65. Even with this liberal inference, the district court granted defendant's motion for summary judgment.

Upon review, the Second Circuit held that the plan's terms entitled the administrator to interpret any and all provisions of the plan. The administrator was authorized to determine whether plaintiff's disability was physically- or mentally-based and had exercised this authority in a reasonable manner by demonstrating reliance on an objective authority on the subject of mental disorders (the DSM-IV) in making its determination.

The court also drew a distinction between the terms “disability” and “disorder” as they were used in the plan. In so doing, it emphasized that the legal issue was whether plaintiff's disability arose from a mental disorder rather than whether the disorder itself had a physical cause. Because it was reasonable to rely on the DSM-IV to determine that plaintiff's disability was based on a mental syndrome rather than a physical disorder, defendant's decision to terminate benefits after 18 months was not arbitrary or capricious.

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Court Clarifies Effect of Exhaustion Defense in ERISA Cases
Recognizing that it had been less than clear in previous rulings, and paying heed to the Supreme Court's recent admonition that the courts should be more precise when ruling on claims-processing defenses, the Second Circuit confirmed in Paese v. Hartford Life & Accident Ins. Co., 449 F.3d 435 (2d Cir. 2006) that an insured's failure to exhaust administrative remedies does not destroy subject matter jurisdiction. Instead, the court wrote, it properly is viewed as an affirmative defense, subject to attack by the equitable doctrines of waiver, estoppel, and futility.

Noting the admonition of Eberhart v. United States that “[c]larity would be facilitated . . . if courts and litigants used the label ‘jurisdictional’ only for prescriptions delineating the classes of cases (subject-matter jurisdiction) and the persons (personal jurisdiction) falling within a court’s adjudicatory authority,” the court examined Hartford's defense that plaintiff had failed to exhaust his administrative remedies in order to determine if it was a subject-matter jurisdiction bar. Paese, 449 F.3d at 443-44 (quoting Eberhart, 126 S. Ct. 403, 405 (2005) (internal quotation marks omitted)). Along the way, it twice recognized its own “firmly established . . . policy favoring exhaustion of administrative remedies in ERISA cases.” Id. (citing Kennedy v. Empire Blue Cross & Blue Shield, 989 F.2d 588, 594 (2d Cir. 1993)).

For guidance, the court looked to analogous failure-to-exhaust analyses under other statutes, including the Individuals With Disabilities Education Act; Financial Institution Reform, Recovery, and Enforcement Act; Labor Management Relations Act; and Prison Litigation Reform Act. It described the primary reasons for compelling exhaustion of administrative remedies in ERISA cases, including allowing the ERISA administrator an opportunity to decide the issue, ensuring that the administrative record is well-developed, and avoiding unnecessary litigation, and reasoned that none of these salutary goals had much to do with the existence of a claim or with ripeness. The court therefore concluded that, unless a litigant's failure to exhaust administrative remedies destroys the existence of an Article III case or controversy, the failure must properly be treated only as an affirmative defense, not as a jurisdictional bar.

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Plan Fiduciaries' Actions Justified Their Removal and Required Remuneration
In Chao v. Malkani, 452 F.3d 290 (4th Cir. 2006), defendants, Information Systems and Networks Corporation ("ISN") and Roma Malkani, established an ERISA-governed employee pension plan. They provided annual contributions to the plan from 1982 to 1994; however, they made no contributions in 1995. After 1995, defendants provided only one contribution to the plan despite admonitions from the third-party administrators that contributions were due.

On November 28, 2000, the Secretary of Labor filed suit against Malkani, alleging that she breached her fiduciary duties by failing to collect the required plan contributions for 1995 and 1996. The Secretary
later amended the complaint to encompass ISN’s failure to contribute through 2003.

Defendants subsequently ordered one of the third-party administrators (“TPA”) to pay ISN an additional $706,264.54 in plan assets (even more than they had previously requested) for administrative expenses. Upon the TPA’s refusal to make such payment, ISN cancelled its contract with it and hired a new TPA, and Malkani appointed herself trustee of the plan, thus equipping herself with the ability to withdraw plan funds.

The Secretary then filed a motion for a temporary restraining order to enjoin defendants from transferring any additional plan assets to ISN for administrative expenses. The Secretary also amended the complaint, adding ISN as a defendant, and alleged that Malkani and ISN breached their fiduciary duties by seeking plan assets for administrative expenses and for separate conduct in which they interpreted the plan’s vesting provisions to divest employees of their nonforfeitable rights.

Notwithstanding, defendants continued to pursue retroactive reimbursement for their so-called administrative expenses even after the TPA repeatedly expressed its concern that reimbursement might violate ERISA.

Thereafter, defendants once again attempted to acquire plan assets on the grounds that the plan was overfunded, directing the TPA to place approximately $1.86 million of the plan’s funds into an ISN corporate account.

Both parties moved for summary judgment, and the district court granted the Secretary’s motion and denied defendants’ request, holding that defendants breached their ERISA fiduciary duties, and ordered ISN to return $62,888.05 in administrative expenses it had received from the TPA. The district court also removed defendants as the plan’s fiduciaries, and barred them from ever serving again in that capacity for an employee benefit plan. See Chao v. Malkani, 216 F.Supp.2d 505 (D. Md. 2002).

The Fourth Circuit, affirming the district court’s judgment in its entirety, found that defendants’ repeated efforts to plunder the plan’s assets and minimize their own liabilities demonstrated that they were administering the plan neither for the sole benefit of plan participants and beneficiaries, nor with the skill and care of a prudent person in like circumstances. Although the court acknowledged that while one of the defendants’ actions standing alone may have made the extraordinary remedy of removal a “closer call,” when considered in the aggregate, it became evident that defendants abdicated their fiduciary obligations and had to be removed.

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Plan Insurer Cannot Recover Class Action Defense Costs

In Perdue Farms, Inc. v. Travelers Cas. & Sur. Co. of Am., 448 F.3d 252 (4th Cir. 2006), Travelers issued to Perdue Farms a policy that covered claims based on ERISA violations but did not apply to claims for violations of state wage and hour laws.

Travelers defended Perdue Farms in a class action seeking relief under both ERISA and wage and hour statutes, but refused to indemnify Perdue for the subsequent $10 million settlement. Travelers contended that the settlement was based predominantly, if not completely, on non-covered wage and hour claims.

In the ensuing coverage suit, the district court held that Perdue was entitled to indemnification for the entire settlement, and that Travelers could not obtain a partial reimbursement of defense costs.

The Fourth Circuit affirmed in part and reversed in part, holding that the district court properly denied Travelers claim for reimbursement for defense costs, but ordering a remand on the settlement indemnification issue because the district court conflated the duty to defend and the duty to indemnify under Maryland law. The Fourth Circuit ordered the district court to determine how apportionment between covered ERISA claims and non-covered wage and hour claims should be applied.

The Fourth Circuit first provided a brief discussion of the duty to defend and the duty to indemnify under Maryland law, stating that while an insurer must frequently defend both potentially covered claims and claims that are not covered under its policy, it is only required to indemnify covered claims for which liability is incurred.

In rejecting Travelers’ contention that it was entitled to a partial reimbursement of defense costs for those funds allocated to the defense of non-covered wage and hour claims, the Fourth Circuit found that, under Maryland’s comprehensive duty to defend, if an insurance policy potentially covers any claim in an underlying complaint, the insurer must typically...
defend the entire suit, including non-covered claims.

The court stated that a partial right to reimbursement of defense costs would “tip the scales in favor of the insurer” by eroding Maryland’s long-held view that the duty to defend is broader than the duty to indemnify, and by undermining the policy language that provides that the insurer has both the “duty” and the “right” to defend its insured.

The court then addressed the issue of Travelers’ duty to indemnify the settlement and held that the “potentiality” and “reasonably related” rules apply only to the duty to defend, and do not govern the duty to indemnify because an insurer has no obligation to remunerate its insured for claims not covered under its policy.

Finally, the Fourth Circuit found that the district court was incorrect to award nearly full indemnification to Perdue Farms under a policy that covered only ERISA-based claims in view of the fact that the employer violations of wage and hour laws and employer violations of ERISA were different.

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Sixth Circuit

ERISA Preempts State Law Regarding Pension Payments to Prisoners

In DaimlerChrysler Corp. v. Cox, 447 F.3d 967 (6th Cir. 2006), the court held that ERISA preempts a Michigan state law that requires a prisoner to direct a plan administrator to send the prisoner’s pension payments to the prisoner’s institutional account, where they can be garnished by the state. This Sixth Circuit opinion conflicts with a Michigan Supreme Court opinion on the same issue. See State Treasurer v. Abbott, 660 N.W.2d 714, 719 (Mich. 2003).

Under Michigan law, a prisoner is required to keep all of his assets in his institutional account. Further, the Michigan State Correctional Facility Reimbursement Act (SCFRA) allows the state to garnish up to 90% of a prisoner’s assets to pay for the cost of incarceration. SCFRA also requires Michigan prisoners to direct the plan administrator of any pension plan to send all benefit payments to the prisoner at the prison. If the prisoner refuses to comply, the warden of the prison is required to notify the plan administrator of the prisoner’s institutional address and to direct the plan administrator to make any payments to the prisoner’s institutional account.

The Sixth Circuit held that the anti-alienation provision of ERISA preempts SCFRA’s notice requirements, and that a plan administrator therefore is not required to comply with SCFRA notices. The court reasoned that, if the SCFRA notices were enforceable, they would operate to divert funds from a prisoner against his wishes before the benefits were paid to the prisoner.

The court acknowledged that, once benefit payments have been disbursed to a beneficiary, creditors may encumber the proceeds. The court noted that the SCFRA notices, however, operated before any payment was made. The court further held that the state could attempt to impose a constructive trust on any pension payments, but only after they were paid to the plan beneficiary.

The Sixth Circuit disagreed with the Michigan Supreme Court’s analysis of the same issue. See State Treasurer v. Abbott, 660 N.W.2d 714, 719 (Mich. 2003). In Abbott, the Michigan Supreme Court had held that, because the SCFRA notices merely required pension payments to be made to a prisoner’s institutional account, no pre-distribution alienation of the benefits occurred. The Sixth Circuit stated that this distinction was formalistic, noting that Michigan law strictly controls how a prisoner’s bank account is used and that, once the proceeds are deposited into a bank account against the prisoner’s will, the state would effectively own 90% of the payments.

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Seventh Circuit

Court Endorses Reliance on Medical Records Reviews by In-House Physicians

Increasingly, courts have refused to give deference to an insurer’s benefit decision (or have diminished the degree of deference) based on the insurer’s dual role as payor of benefits and adjudicator of claims eligibility. These courts essentially presume that the insurer has a thumb on the scale in favor of benefit denial.

The court’s recent decision in Davis v. Unum Life Ins. Co. of Am., 444 F.3d 569 (7th Cir. 2006) exposes the fundamental flaws of this judicially created conflict presumption. Davis firmly establishes that (i) an
administrator’s reliance on the opinions of in-house physicians does not manifest a conflict of interest; (ii) an administrator properly may choose to rely on the medical opinions of in-house physicians who have performed a “paper review;” and (iii) a plaintiff’s treating physicians can lose their objectivity and credibility by acting as disability advocates.

Plaintiff initially claimed to be disabled due to a psychiatric illness, namely, depression and depressive pseudo-dementia. Unum approved the claim pursuant to the plan’s mental illness coverage, which capped benefits at 24 months. The plan provided benefits to age 65, however, for non-psychiatric disability.

After receiving disability payments for one year, plaintiff claimed to be disabled due to multiple physical conditions. Unum consulted with four in-house physicians, who opined that plaintiff failed to establish a debilitating physical, as opposed to a psychiatric, condition. Based on the opinions of its in-house physicians, Unum determined that plaintiff’s litany of claimed physical conditions were minor, well-controlled, or had been blatantly misdiagnosed. Unum, therefore, declined plaintiff’s physical disability claim.

The district court found that Unum’s decision was arbitrary and capricious, because the in-house physicians (i) inherently lacked objectivity, (ii) failed to explain the basis for their medical opinions and (iii) performed a “mere” paper review.

The Seventh Circuit reversed and ordered the district court to enter summary judgment in favor of Unum. The Seventh Circuit held that “the district court went beyond the bounds of arbitrary and capricious review” by improperly “penalizing Unum for relying on in-house doctors.” “Unum’s in-house doctors were every bit as capable as outside doctors to evaluate the medical information in the file and provide independent medical opinions.”

The court also recognized the propriety of relying on the medical opinions of physicians who have performed a paper review: “In such file reviews, doctors are fully able to evaluate medical information, balance the objective data against the subjective opinions of the treating physicians, and render an expert opinion without direct consultations.”

Indeed, it is reasonable “for an administrator to rely on its doctors’ assessments of the file and to save the plan the financial burden of conducting repetitive tests and examinations.” The Seventh Circuit held that the district court improperly penalized Unum for utilizing the expertise of its in-house physicians in conjunction with an efficient and cost-effective management of the Plan.

The court also rejected the district court’s finding that Unum’s in-house physicians failed to explain the basis for their opinions: “Contrary to the district court’s view, there is nothing in ERISA or our precedent requiring doctors to write like lawyers or plan administrators. Were we to arrive at such a decision today, we would unnecessarily and unwisely drive up the administrative costs of benefit plans, the negative affects of which would ultimately be borne by workers. Finally, the court determined that the opinions of plaintiff’s treating physician were unreliable, because he acted “more as an advocate than a doctor rendering objective opinions.”

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Court Disregards Language of Policy Not Included in Administrative Record

In Barham v. Reliance Standard Life Ins. Co., 441 F.3d 581 (8th Cir. 2005), the court held that the district court erred in applying an abuse of discretion standard of review to the decision of Reliance to terminate long term disability benefits. The court found that a de novo standard of review applied after finding that the policy initially submitted to the district court with an affidavit and the claim file did not give Reliance discretionary authority to determine benefit claims.

Barham involved a claim by a machine operator who had worked for Arquest, Inc. in a disposable diaper factory. Plaintiff had a long history of back problems, and, in 1999, was diagnosed as permanently and completely disabled. Her long-term disability policy, administered by Reliance, provided benefits for the first 24 months if the claimant was disabled from her own job, and additional benefits after this period if the claimant could not perform any job.

After approving benefits for 24 months, Reliance reviewed plaintiff’s claim, had her complete a Functional Capacity Evaluation, and based upon the results of that evaluation, deter-
Plaintiff appealed this decision internally. The physician who completed a paper review at Reliance's request determined that plaintiff could perform sedentary work, although he thought it would be helpful to obtain all of plaintiff's records from both her primary and mental health providers. After Reliance upheld its decision to terminate plaintiff's benefits, plaintiff brought suit against Reliance.

The district court required the parties to submit a copy of the administrative record and to file briefs addressing the appropriate standard of review. In February 2004, Reliance filed an affidavit with the district court, attaching the claim file and a policy that did not grant Reliance discretion to interpret the plan or to determine eligibility for benefits. A few months later, Reliance filed its brief arguing that the court should apply the abuse of discretion standard of review and attach a different policy than the one contained in the administrative record. This second policy did grant Reliance discretionary authority to determine eligibility for benefits.

Based on the policy attached to Reliance's brief, the district court concluded that the ERISA plan gave Reliance discretionary authority to determine eligibility for benefits, applied an abuse of discretion standard, and determined that Reliance's decision was sufficiently supported by the evidence. Plaintiff appealed, contending that the district court applied the wrong standard of review.

The Eighth Circuit reversed and remanded the case to the district court with instructions for the court to apply a de novo standard of review to determine plaintiff's ongoing disability claim. The court disregarded the policy attached to Reliance's brief because the policy was never verified as authentic and accurate, as was the policy Reliance submitted with the administrative record.

One judge dissented, stating that although he agreed with the majority's decision to remand, he disagreed with remand instructions that the district court should apply a de novo standard of review. The dissenting judge did not believe that the policy containing the provision granting Reliance discretionary authority to determine eligibility for benefits had to be contained in the administrative record.

The district court, applying an abuse of discretion standard, determined that Unum's denial of benefits was not supported by substantial evidence, and remanded the case to Unum to make a new determination of the claim. Both parties' requests to the district court to alter or amend its judgment were denied.

In Chronister v. Baptist Health, 442 F.3d 648 (8th Cir. 2006), the Eighth Circuit adopted the Fourth Circuit's three-part Lown test to determine whether an organization shares sufficient common bonds and convictions with a church so as to meet ERISA's "church plan" exception. It also determined that plaintiff's disability based on fibromyalgia was not subject to the plan's 24-month limitation for diagnoses based on self-reported symptoms.

Plaintiff worked as a registered nurse for Baptist Health, an Arkansas nonprofit organization. In 1997, plaintiff filed a claim for long-term disability benefits as a result of injuries sustained in a car accident two years earlier.

In 1998, Unum, the insurer of Baptist Health's plan, approved her claim. Plaintiff received disability benefits until December 2001, when Unum discontinued her benefits based on a "self-reported symptoms limitation" contained in the policy.

After exhausting her administrative remedies, plaintiff brought suit in state court, and Unum removed the case to federal district court based on federal question jurisdiction under ERISA. Plaintiff brought a remand motion, asserting that the plan was exempted from ERISA, and was denied. Unum filed its motion for judgment on the ERISA record.

The district court, applying an abuse of discretion standard, determined that Unum's denial of benefits on the self-reported symptoms limitation was unsupported by substantial evidence, and remanded the case to Unum to make a new determination of the claim. Both parties' requests to the district court to alter or amend its judgment were denied.
On appeal, the court upheld the determination that the district court had jurisdiction over plaintiff’s claim because the Baptist Health Employee Benefit plan was not a “church plan” as defined under 29 U.S.C.A. § 1002 (2005), and therefore the plan was not exempt from ERISA.

In order to evaluate whether Baptist Health was “associated with” the Baptist church because it “shares common religious bonds and convictions,” the court applied the Fourth Circuit’s non-exclusive three-part test set forth in Lown v. Continental Cas. Co., 238 F.3d 543 (4th Cir. 2001). This test directs courts to consider: (1) whether the religious institution plays an official role in the governance of the organization, (2) whether the organization receives assistance from the religious institution, and (3) whether a denominational requirement exists for any employee or patient/customer of the organization.” Id. at 548.

Applying the Lown factors to Baptist Health’s long-term disability benefits plan, the court noted that the Arkansas Baptist State Convention did not provide Baptist Health with financial support or play a role in its governance. The court also pointed out that Baptist Health’s denominational requirement did not reach all of its employees or patients. Based on these facts, the court determined that the plan was an ERISA plan and not an exempted “church plan.”

The court also affirmed the district court’s finding that Unum abused its discretion in denying benefits based only on the self-reported symptoms limitation, holding that the 18-point test for diagnosing fibromyalgia, although based on a patient’s self-reports, had been deemed to “more or less” be an objective test. The case was remanded to Unum for further claim analysis.

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Plan Administrator Must Consider Claimant’s Non-Medical Affidavits

In Rekstad v. U.S. Bancorp, 451 F.3d 1114 (10th Cir. 2006), the court held that it was arbitrary and capricious for the claim administrator not to consider non-medical affidavits submitted by the claimant’s relatives. The court remanded the case to the claim administrator to reconsider the claim, including the affidavits.

Plaintiff was employed by U.S. Bancorp as a loan originator. She became disabled by an ankle injury in 1993, and received short- and long-term disability benefits. In 1995, plaintiff’s physician opined that she was able to return to work. However, before she could return to work, plaintiff claimed that she was disabled by injuries suffered in an automobile accident. Based upon this new development, plaintiff continued to receive long-term disability benefits through February 1996, when the claim administrator determined that she was no longer disabled within the meaning of the employer’s plan. Plaintiff appealed the decision, claiming to be disabled by continuing chronic pain, but the denial was affirmed.

In April 1996, U.S. Bancorp sold its mortgage operations to another company. Plaintiff applied for work with the buyer, representing that she was ready and able to work. The successor company declined to hire her, however.

In June 1996, plaintiff’s psychologist opined that she was able to work part-time. However, the physician indicated that, in addition to chronic pain, plaintiff would have residual deficits, including memory problems, difficulty with concentration, and confusion.

Notwithstanding these limitations, plaintiff sought and obtained employment. She worked as a commissioned loan originator from August 1996 through February 1997, but was terminated. She worked for another employer for another three months, then was again terminated. She obtained a third position, with Chase Manhattan, and worked for over one year, earning $58,000.00.

Simultaneously, plaintiff enrolled in a master’s degree program. She took a leave of absence from Chase, and was eventually awarded long-term disability benefits by Chase’s disability insurer.

In 2001, plaintiff was found to be disabled by the Social Security Administration as of July 10, 1998 (over two years after she had worked for U.S. Bancorp).

Plaintiff filed an action against U.S. Bancorp in June 1997, while she was working for another employer. In 1999, the district court found that U.S. Bancorp’s denial of benefits, beginning in 1996, was arbitrary and capricious, and remanded to the claim administrator for reconsideration.

After collecting extensive medical information, U.S. Bancorp denied any further benefits. Plaintiff appealed, submitting not only additional medical information, but also affidavits...
from herself, her husband, and her sister regarding the difficulties she faced in her post-accident employment. U.S. Bancorp retained a consultant to help it determine the claim; the consultant in turn hired an independent medical reviewer, who refused to consider the non-medical affidavits, and found plaintiff not to be disabled. U.S. Bancorp relied upon the reviewer’s opinion in affirming the denial of plaintiff’s claim. It also considered and relied upon the fact that plaintiff had held three jobs after submitting her disability claim.

Plaintiff reopened her previous lawsuit, and moved for summary judgment, arguing that U.S. Bancorp’s denial of her claim as of January 31, 1996 was arbitrary and capricious. In April 2004, the district court granted summary judgment in favor of plaintiff. The district court subsequently ruled that not only was plaintiff entitled to benefits, but that benefits payable by U.S. Bancorp should not be reduced by the amount of benefits that plaintiff had received from the Chase long-term disability plan. U.S. Bancorp appealed.

The Tenth Circuit held that “[i]t was arbitrary for U.S. Bancorp to make its decision to deny disability benefits without giving full and fair consideration to the affidavits submitted by [plaintiff] and her relatives.” The court noted that U.S. Bancorp had looked at other non-medical information—the post-claim employment history of plaintiff. Thus, U.S. Bancorp’s consideration of non-medical evidence was “impermissibly one-sided.” The court stated that:

While [plaintiff’s] ability to pursue and attain employment and attend post-graduate level courses may support a determination that she is not totally disabled, her inability to hold that employment or finish her course work because of problems associated with her physical and cognitive impairments may support a contrary conclusion. ... Evidence regarding the latter need not have been furnished by a medical professional to warrant its consideration.

The court then remanded the claim to U.S. Bancorp, because “[t]his is not a case where it is so clear-cut that it was unreasonable ... to deny benefits.” The court stated that “we are not convinced that U.S. Bancorp would arrive at its previous conclusion once full and thorough consideration is given to all relevant evidence. And we will not substitute our judgment for that of U.S. Bancorp.”

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Insurer’s Interpretation of Recurrent Disability Provision is Reasonable
In DeGrado v. Jefferson Pilot Fin. Ins. Co., 451 F.3d 1161 (10th Cir. 2006), the court reversed a judgment in favor of the claimant, and remanded the case for further fact-finding by the claims administrator. The district court had found that Jefferson Pilot unreasonably applied a recurrent disability provision so as to limit plaintiff’s monthly benefit for a second period of disability to the monthly benefit he had received for the first period, based on the language of the controlling policy, because it found that plaintiff had not returned to full time work for at least six months between the two disability periods.

The Tenth Circuit reversed, finding that Jefferson Pilot’s interpretation of the recurrent disability provision was reasonable. However, it found Jefferson Pilot’s factual findings with regard to plaintiff’s return to full-time work to be insufficient, requiring remand.

Plaintiff, who suffered from Crohn’s disease, was employed as a sales manager. He stopped working from April through September 1999 because of the effects of his illness. Jefferson Pilot paid him long term disability benefits for most of this period. Plaintiff returned to work in September 1999 and worked for about 14 months, but ceased work again in November 2000. He applied again for disability benefits.

Jefferson Pilot first determined that plaintiff was not disabled. He appealed, and in the process submitted evidence (including his own statements) that he had been unable to work full time during the 14 month interval between his two periods of disability. After considering further evidence, Jefferson Pilot determined that plaintiff was disabled, and further found that his disability was “recurrent” for purposes of the controlling policy, because he had not returned to full-time work for at least six months.

During his 14 month return to work, plaintiff’s earnings had increased dramatically (based largely on receipt of commissions for sales that he had initiated prior to his first period of disability). Jefferson Pilot interpreted the policy’s recurrent disability provision to require that plaintiff’s monthly benefit for the second period of disability would be the same as under the first period, notwithstanding the increase in plaintiff’s earnings in the interim.
The district court had held that Jefferson Pilot’s interpretation of the recurrent disability provision was unreasonable, and that the recurrent disability provision operated only to relieve the need for satisfaction of a new elimination period for the second period of disability. The Tenth Circuit reversed this finding, expressly finding Jefferson Pilot’s contrary interpretation to be reasonable.

The district court had also found Jefferson Pilot’s factual findings to be unreasonable and not supported by substantial evidence. In reaching this conclusion, the district court had considered, over the objection of Jefferson Pilot, extra-record evidence including plaintiff’s post-claim affidavit and deposition testimony of Jefferson Pilot employees. The Tenth Circuit also reversed the district court’s conclusion on this issue, but found that Jefferson Pilot’s factual findings were insufficiently explained to fully evaluate whether they were supported by substantial evidence. The appellate court therefore remanded to Jefferson Pilot for more complete factual findings and directed that plaintiff be allowed to submit new factual information. Remand, according to the court, was the proper remedy where a claims decisionmaker “fail[s] to make adequate findings or to explain adequately the grounds of its decision.”

In remanding the case, the court suggested that “full time” status for purposes of the recurrent disability provision would be satisfied by working 30 hours per week, the minimum number of hours required under the relevant policy’s eligibility provision. Jefferson Pilot had argued that full-time status should be determined by reference to the employer’s expectations, not a policy provision limited by its terms simply to coverage eligibility.

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Iowa District Court

Fiduciaries Cannot Obtain Indemnity for Amount Paid to Settle Alleged Violations

In Travelers Cas. and Sur. Co. of Am. v. IADA Serv., Inc., No. 4:05-cv-212-RAW (S.D. Iowa May 26, 2006), the court held that ERISA fiduciaries do not have a right of indemnity or contribution against a party in interest for amounts paid to settle alleged violations of duties governed by ERISA.

In the underlying case, the Department of Labor alleged that the trustees of an ERISA plan had authorized the payment of fees for services provided to the plan that exceeded the direct costs of those services, in violation of various sections of 29 U.S.C. §§1101, et seq. The DOL claimed that the amount of those fees could not exceed direct costs because many of the plan’s trustees also were directors of IADA, which was the party in interest that provided the services to the plan.

Travelers insured the trustees of the plan and paid a settlement to resolve the DOL’s prohibited transaction claims. Travelers then filed a subrogation action for indemnity, contribution, and restitution to recover those amounts from IADA, which had received the fees.

In the subrogation action, Travelers made three types of claims as subrogee of the trustees. Travelers made a claim under 29 U.S.C. §1132(a)(3)(B) for “appropriate equitable relief.” Travelers also made both federal and state common law claims for indemnity, contribution, and restitution. Travelers’ allegations against IADA mirrored those made earlier by the DOL and were based on violations of the fiduciary responsibility part of ERISA, 29 U.S.C. §§1101, et seq.

IADA moved for summary judgment to dismiss all of Travelers’ claims on the grounds that the relief sought was not “appropriate equitable relief” under 29 U.S.C. §1132(a)(3)(B); that there was no federal common law right of contribution or indemnity by an ERISA fiduciary against a co-fiduciary or party in interest; and that the state common law claims were preempted by ERISA. IADA also argued that Travelers’ section (a)(3) claim was time-barred by 29 U.S.C. §1113, but the court disposed of the case on other grounds and did not reach that issue.

IADA defended against the section (a)(3) claim on the ground that, even though indemnity and contribution are based on equitable principles, Travelers merely sought legal relief for the recovery of damages. IADA also claimed that section (a)(3) does not allow for individual relief by a fiduciary and, consequently, the claim for indemnity or contribution was not “appropriate” relief.

The court concluded that Great West Life & Annuity Ins. Co. v. Knudson, 534 U.S. 204 (2002), was controlling and dismissed Travelers’ section (a)(3) claim on the ground that Travelers sought damages, not equitable relief. The court did not reach the issue of whether a fiduciary could
seek individual relief through a section (a)(3) claim.

The court then noted a split among courts in different circuits on the issue of whether fiduciaries had a federal common law right of indemnity or contribution. See In re Enron Corp. Sec., 228 F.R.D. 541, 546-52 (S.D. Tex. 2005) (reviewing the court decisions that have split on the issue). The court acknowledged that federal common law rights and obligations could be judicially developed for ERISA-regulated plans. However, the court held that this rule did not extend to creating remedies which are simply not in ERISA, particularly remedies for those such as fiduciaries who are not members of the class for whose benefit ERISA was enacted.

The court recognized that the Eighth Circuit has rejected other types of common law claims because of the exclusivity of the statutory remedies in ERISA. For these reasons, it concluded that ERISA does not afford fiduciaries, through supplementation by federal common law, the remedies of contribution, indemnity or restitution in this case.

Finally, IADA raised both types of preemption: statutory “relates to” preemption and conflicts preemption. The court concluded that Travelers' state common law claims had a “connection with” a plan and therefore were preempted by statute. The court held that for Travelers to obtain relief under any of its theories, Travelers would have to prove violations of various provisions of ERISA as alleged in its amended complaint. Consequently, those claims were premised on the ERISA plan, and state law claims were preempted by statute.

The court observed that it reached its conclusion with “considerable reluctance.” Assuming the merits of Travelers' claims, the result would be that IADA gets to keep the fees it acquired allegedly in breach of its statutory duties. Nevertheless, the court concluded: “What the Supreme Court said with respect to the Equal Pay Act and Title 7 applies to ERISA as well: ‘[A] favorable reaction to the equitable consideration supporting [a] contribution claim is not a sufficient reason for enlarging on the remedial provisions contained in [this] carefully considered statute[.]’” (citing Northwest Airlines, Inc. v. Transport Workers Union, 451 U.S. 77, 98 (1991)).

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Massachusetts District Court

Video Surveillance Performed During Litigation Must be Produced

In Papadakis v. CSX Transp., Inc., 233 F.R.D. 227 (D. Mass. 2006), a magistrate court ruled that video surveillance tapes that were taken at the direction of defendant's attorney must be produced in discovery, but that the written reports of the investigator to the attorney were protected as work product.

The defendant, CSX, sought an order protecting from discovery surveillance materials its attorney obtained in this regard.
concerning plaintiff. Plaintiff’s physical condition, as well as the nature and extent of his alleged disability, were in controversy.

The court held that federal and state courts have “fairly uniformly held” that video surveillance tapes, even if work product, must be provided in discovery and prior to trial. The court indicated that production of the videotape was also warranted because plaintiff had already been deposed, citing an Eastern District of North Carolina case which held that allowing discovery or surveillance materials after the deposition of the plaintiff, but before trial, best meets the ends of justice and the spirit of the discovery rules to avoid surprise at trial. Thus, the court ordered the surveillance videotapes to be produced immediately.

The court refused to order the production of the written surveillance reports prepared for defendant’s counsel by the investigators, absent a showing by plaintiff of substantial need and an inability to obtain the substantial equivalent without undue hardship. Because the court held that the work product protection did not extend to the observations of the investigators or the mechanics of the surveillance, the court ordered defendant to disclose the names and addresses of the investigators so plaintiff could take their deposition.

While this case supports the view that surveillance video must be produced, it also supports the proposition that it need not be produced prior to taking the plaintiff’s deposition.

Lee v. Fortis Benefits Ins. Co., 2006 WL 777224 (D. Minn. Mar. 27, 2006), the court applied an abuse of discretion standard in affirming the insurer’s findings that there was insufficient evidence to demonstrate that plaintiff was immunosuppressed, that plaintiff did not sufficiently establish a link between lymphoma and exposure to anesthetic gases, and that plaintiff did not adequately demonstrate that her pain, fatigue, and decreased concentration were disabling.

Plaintiff, a Certified Registered Nurse Anesthetist, was diagnosed in May of 2000 with non-Hodgkin’s lymphoma. She ceased working and commenced chemotherapy shortly after her diagnosis. In June of 2000, plaintiff applied for and was granted disability benefits. Later that year, her cancer went into remission.

In March 2001, an independent physician reviewed plaintiff’s file and concluded that there was no evidence to support the presence of permanent physical limitations as a result of her lymphoma. Fortis then terminated benefits and plaintiff appealed, claiming that she was unable to perform her duties because her lymphoma and chemotherapy rendered her immunosuppressed, that there may be a link between lymphoma and exposure to anesthetic gases, and that she was suffering from fatigue, weakness, burning eyes, pain, and an inability to concentrate. After consulting with an independent physician certified in internal medicine, occupational and preventive medicine, Fortis upheld its decision on appeal.

In accordance with plan procedures, plaintiff appealed for a second time and Fortis again upheld its benefit termination. The second rejection was based on a Functional Capacity Evaluation that demonstrated that plaintiff was capable of working eight hours a day as a nurse anesthetist, and the review of an oncologist who reported that there was no direct relationship between lymphoma and exposure to anesthetic gases. Plaintiff then filed suit against Fortis to recover benefits.

Fortis argued that an abuse of discretion standard of review was proper because the plan had explicit language conveying discretion to Fortis to determine what evidence was sufficient to establish liability. The court agreed and stated that it would uphold Fortis’ decision as long as it was “reasonable” or supported by “substantial evidence.”

The court went on to reject each of plaintiff’s grounds for claiming she was entitled to disability. First, the court determined that plaintiff’s contention that she was immunosuppressed was not supported by sufficient evidence in the record. The court noted that plaintiff had not provided Fortis with laboratory tests showing a disorder of her immune system, and that there was no evidence that plaintiff was in any greater danger of infection because of her work as a nurse anesthetist. Further, plaintiff’s physician had authorized her to return to work part-time in August 2001.

With regard to plaintiff’s claims of pain, fatigue, and decreased concentration, the court found that Fortis’ use of the description of nurse anesthetist contained in the Department
of Labor’s Dictionary of Occupational Titles (DOT) was proper, although it was possible that plaintiff’s particular job might require more strength and stamina than that depicted in the DOT description. The court also found that although plaintiff might suffer from pain, fatigue, and impaired concentration, her self-evaluation submitted to Fortis declared that it was “not difficult at all” to do her work, even with her alleged symptoms. Finally, the court found plaintiff’s argument that there was a causal link between exposure to anesthetic gases and lymphoma was not sufficiently supported by the medical literature and testimony of the physicians involved in the case.

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Texas District Court

Death by Self-Inflicted Gunshot Wound is Excluded as Suicide

In Needleman v. John Hancock Life Ins. Co., 2006 WL 842370 (N.D. Tex. Mar. 31, 2006), the court found that benefits were properly denied under the life insurance policy’s exclusion for “suicide, while sane or insane.”

The insured, covered under a $4,000,000 policy, died of a self-inflicted gunshot wound. The insured, depressed over business problems, began taking antidepressent drugs. One evening his wife returned home to find her husband sitting in a bathtub, holding a gun to his head. He told his wife “I wanted to do this before you got home.” He attempted to talk him into putting down the gun, but after 45 minutes he pulled the trigger, causing fatal injuries.

The police and medical examiner ruled the death a suicide. Accordingly, benefits were denied.

The beneficiary argued that in order to establish suicide the insurer must prove the insured actually had intended to take his own life. Specifically, the beneficiary’s theory was that the death had been induced by antidepressents and the insured’s pulling of the trigger was an accident.

However, the court, granting the insurer’s motion for summary judgment, held that under such a policy provision, it was not necessary for the insured to have realized the consequences of his act or to have had a conscious purpose to take his life. His state of mind at the time of the act was irrelevant. If the act was one that would be regarded as suicide in a sane person, then it falls within the suicide exclusion.

A sane person’s actions of pointing a gun at his chest and pulling the trigger would be regarded as a suicide. The insurer need only establish that the insured had the intent to commit the acts which caused his death, which was well supported by the record before the court.

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West Virginia District Court

Court Denies Equitable Relief to Insurer under § 502(a)(3)


Beginning in March 2001, PMA paid benefits to plaintiff, a participant in an employee welfare benefit plan, until February 2003, based upon a 24 month limited pay period for mental conditions. The policy provided that the gross amount of disability benefits would be reduced by payments made to plaintiff under the United States Social Security Act.

In July 2002, plaintiff executed an LTD Payment Option form, whereby he opted to receive the disability benefits without a reduction for SSDI benefits pending the Social Security Administration’s decision on his claim. Pursuant to the Payment Option Form, plaintiff agreed to repay any overpayment.

After the disability payments were terminated, plaintiff was approved for SSDI benefits of $1,123.40 per month retroactive to July 2001. The award created an overpayment by PMA of $23,133.80. After plaintiff filed suit concerning the termination of benefits, PMA counterclaimed, seeking to impose a constructive trust or equitable lien on future SSDI payments equal to the amount of the overpayment.

The parties based their arguments on the counterclaim upon the Supreme Court’s holding in Great-West Life & Annuity Ins. Co. v. Knudson, 534 U.S. 204 (2002), and the Fourth Circuit’s holding in Mid-Atlantic Med. Serv., Inc. v. Sereboff, 407 F.3d 212 (4th Cir. 2005). After the briefing and prior to the district court’s decision, the Supreme Court issued its opinion in Sereboff, 126 S.Ct. 1869 (2006). The district court considered
the arguments briefed by the parties as well as the Supreme Court’s analysis in Sereboff.

However, the court entered summary judgment for plaintiff on the plan’s counterclaim based on the Anti-Alienation Clause of the Social Security Act, 42 U.S.C. §407, which prohibits, inter alia, the transfer or assignment at law or equity of any person’s right to future payment under the Social Security Act. Nevertheless, the court acknowledged that plans may enforce offset provisions which require the reduction of current plan benefits by the amount of Social Security benefits received by a plan beneficiary.

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