Shipman & Goodwin LLP

ERISA Case Update

May 2008

The Second Circuit, the U.S. District Court for the District of Connecticut, and the Connecticut Superior Court have issued the following notable ERISA decisions in the past year:

I. SECOND CIRCUIT DECISIONS:

Krauss v. Oxford Health Plans, 517 F.3d 614 (2d Cir. 2008)

Plaintiff Geri Krauss underwent a double mastectomy and bilateral breast reconstruction surgery, which was performed by two out-of-network providers. After the operation, she received care from private-duty nurses. Oxford, the administrator of plaintiff's health plan, refused payment for one-fourth of the cost of the surgery and all of the costs associated with the private-duty nursing. Krauss and her husband alleged that Oxford's denial violated the Women's Health and Cancer Rights Act ("WHCRA") and various provisions of ERISA. They also alleged that Oxford breached its fiduciary duty under ERISA by failing to make certain required disclosures and by failing to respond to various claims in the manner and time periods set forth under the plan.

The Plan contained a Bilateral Surgery Policy that limited reimbursement to one-and-a-half times the rate for a single procedure. The Second Circuit held that Oxford's payment decision under that policy would be reviewed under an arbitrary and capricious standard. It found two clauses within the Plan's Supplemental Certificate relevant to this determination: one that stated that Oxford "may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Certificate;" and the other which stated that the definition of a "usual, customary and reasonable" ("UCR") charge is either "the amount charged or the amount We determine to be the reasonable charge, whichever is less." The court noted that the insurer had not responded to the claim for reimbursement for private-duty nursing care. In Nichols v. Prudential Life Ins. Co. of America, 406 F.3d 98, 105, 109 (2d Cir. 2005), the Second Circuit held that, under a prior version of the DOL regulations, de novo review was called for under these circumstances. The ERISA regulations have since been amended to provide that, upon a defendant's failure to follow regulatory timeframes, a plaintiff's administrative remedies are deemed to have been exhausted. See 29 C.F.R. § 2560.503-1(1). The court deferred ruling upon the proper standard of review under the new regulations because it concluded that it would deny plaintiffs' claim for compensation for private-duty nursing even under a de novo standard.

The Second Circuit concluded that the WHCRA requires insurers to pay for surgeries in a manner consistent with the policies "established for other benefits under the plan" (29 U.S.C. § 1185b(a)), and did not preclude insurers from imposing cost-sharing mechanisms in addition to deductibles and coinsurance. Accordingly, it held that the statute did not prohibit Oxford's application of UCR limits or the Bilateral Surgery Policy. Similarly, the court held that the WHCRA did not require an insurer to pay for private-duty nurses where such services were not otherwise covered and where other post-operative care could have satisfied the patient's medical needs. Turning to the ERISA claim, the court held that the Bilateral Surgery Policy was supported by the breadth of the Plan's UCR definition and, in particular, the definition of UCR that gave Oxford discretion to employ an amount that it deems "reasonable. . . for a particular Covered Service in the geographical area it is performed." It also found that the Bilateral Surgery Policy comported with Medicare policy. Finally, the court concluded that the Plan contained an explicit and unambiguous exclusion for private or special duty nursing. The fact that Oxford pre-certified plaintiff's surgery knowing that it would require post-operative care did not obligate Oxford "contractually or otherwise, to pay for post-operative care . . . by any and all means – certainly not by a method of care expressly excluded from coverage under the Plan."

The Second Circuit held that plaintiffs were not entitled to any relief based on their claim that Oxford breached its fiduciary duty by failing to disclose certain information, by making false and affirmative misstatements regarding the true reason for denying their claims, and by failing to act in a timely manner. It concluded that plaintiffs could not recovery any money damages and that their claims regarding nondisclosure, misleading statements, and untimely responses were, in essence, claims for which a remand would be the typical remedy but which would be futile because the relevant information had now all been disclosed.

Strom v. Siegel Fenchel & Peddy P.C. Profit Sharing Plan, et al., 497 F.3d 234 (2d Cir. 2007)

Strom sued her former law firm for benefits under the firm's profit sharing and cash balance pension plans. Before initiating this suit, she submitted a claim for benefits under both plans through the plans' administrative review process. Defendant denied her claim for increased benefits under the profit sharing plan, finding that the plan document excluded her from increased benefits. It also held that she was entitled to no benefit under the cash balance plan because she was ineligible to participate in that plan, and it refused to provide plaintiff with a copy of the cash balance plan. Strom requested and received an administrative hearing on the profit sharing plan decision. In their decision, the defendant plan administrators said that plaintiff had refused to provide necessary information, and tentatively denied plaintiff's claim while declining to reach a final determination. Strom later requested a hearing on the cash balance plan decision, but the defendant said that her request came too long after the benefit denial under that plan, and held that she had waived her administrative remedy. Strom filed a complaint in the United States District Court for the Eastern District of New York, seeking a declaration of her rights under the plans and an award of benefits.

The district court, applying an arbitrary and capricious standard of review to the denial of benefits under the profit sharing plan, dismissed the profit sharing claim on summary judgment. As to the cash balance plan, the court concluded that Strom had waived her claim, and similarly granted summary judgment. On appeal, the Second Circuit held that the district court should have analyzed the administrative decision on the profit sharing plan under a de novo standard of review. Although the plan language gave the plan administrators discretion to interpret plan provisions, the Supreme Court's decision in Firestone Tire & Rubber Co. v. Bruch only entitled their actions to arbitrary and capricious review if they had in fact exercised such discretion. The

court said that their "non-decision" could not be deemed to be an exercise of discretion, and it held that, on remand, the more stringent standard of review should be applied.

On the cash balance plan claim, the Second Circuit stated that a waiver of Strom's right to administrative review would have to be knowingly and voluntarily made. It held that, because defendant denied plaintiff's status as participant and refused to give her plan documents, it could not make the requisite showing of the knowing or voluntary nature of plaintiff's waiver. The court accordingly vacated the district court's holding and remanded for further proceedings.

Caltagirone v. NY Community Bancorp, Inc., No. 06-5700-cv, 2007 U.S. App. LEXIS 29516, 42 Empl. Ben. Cas. (BNA) 1933 (2d Cir. Dec. 20, 2007).

Alleged participants in ERISA savings and Employee Stock Ownership Plans ("ESOP") appealed the denial of their motion for class certification and dismissal of their claims. Plaintiffs alleged that they suffered losses due to NYCB's fiduciary breaches, which consisted of the failure to disclose speculative and risky investment strategies and imprudent stock investments. The Court of Appeals affirmed the holding of the district court that neither plaintiff was a participant or beneficiary of an ERISA plan with standing to sue under ERISA §§ 502(a)(1)(B) or 502(a)(3).

Plaintiff Caltagirone was terminated before he became enrolled in any NYCB plan. Plaintiff Greenblatt's employment terminated before the beginning of the class period. Because she never chose the investment options to purchase shares of defendant's stock, her savings plan never included NYCB shares and she could not claim that she was injured as a result of risky strategies relating to that stock. Although Greenblatt continued to hold her account after she left NYCB, the plaintiffs' theory of fiduciary breaches was inapplicable to the actions of the ESOP administrators, who had no discretion to invest in any stock other than NYCB stock. Citing Hughes Aircraft Co. v. Jacobson, 525 U.S. 432, 443-44 (1999), the court also concluded that a participant cannot sue for fiduciary breaches stemming from the plan's design features, which here limited discretion to choose stock purchases. Finally, because plaintiffs had taken their full distributions before any of the alleged fiduciary breaches, they could not establish that they suffered any losses that would confer standing.

Guilbert v. Gardner, 480 F.3d 140 (2d Cir. 2007)

Guilbert alleged that defendants promised that, if he left his existing employment and joined their company, they would pay him a salary and establish a pension fund for him with an initial deposit of $39,000 (the amount of his accumulated pension at his existing job) and make subsequent annual deposits of $10,000. Guilbert sued, inter alia, under § 502(a) for failure to pay the pension benefits and under § 502(c)(1) and (3) for failure to provide information and notices regarding the plan.

The Second Circuit affirmed, in part, the district court's grant of summary judgment to defendants. The court held that no reasonable fact-finder could conclude that defendants "established or maintained" a pension plan under ERISA, pursuant to 29 U.S.C. § 1003(a)(1), based on alleged oral promises. Citing Donovan v. Dillingham, 688 F.2d 1367, 1373 (11th Cir. 198) (en banc), the Second Circuit stated that it was the "reality of a plan, fund or program and not the decision to extend certain benefits that is determinative." However, the court reversed the grant of summary judgment based on the six-year statute of limitation with regard to Guilbert's claim that defendants entered into an employment agreement to make annual $10,000

contributions to his pension fund. The breach of contract claim was allowed to proceed to the extent it encompassed breaches with the six-year limitations period.

LaScala v. Scrufari, 479 F.3d 213 (2d Cir. 2007)

Plaintiff trustees alleged that Scrufari, the Plan Manager of union welfare and pension funds, breached his fiduciary duties under ERISA by unilaterally increasing his and his son's compensation without trustee approval. The trustees claimed that these actions violated Scrufari's fiduciary duty of loyalty and care under § 404(a)(1), 29 U.S.C. § 1104(a)(1), and his fiduciary duty to avoid self-dealing under § 406(b)(1), 29 U.S.C. 1106(b)(1). The Second Circuit held that the "prudent person" standard employed by Section 404(a)(1) imposes fiduciary obligations on the trustees of an ERISA plan equivalent to "the highest known to the law." Reversing the district court, the Second Circuit held that the question of whether Scrufari breached his fiduciary duties did not turn on whether the trustees knew or should have known of his actions, but rather on whether Scrufari himself acted in accordance with the duties imposed by ERISA and the provisions of the documents and instruments governing the plan. Because those documents did not give the Plan Manager the authority to increase his compensation unilaterally, but instead provided that only the trustees could increase his salary by a majority vote, the court concluded that Scrufari's actions in increasing his own compensation and that of his son violated ERISA.

II. CONNECTICUT DISTRICT COURT DECISIONS:

Amara, et al. v. CIGNA Corporation and CIGNA Pension Plan, 534 F. Supp. 2d 288 (D. Conn. 2008)

In a 90 page opinion, Judge Kravitz rejected the claim of a class of current and former CIGNA employees that CIGNA's cash balance plan was age discriminatory, but in strong language held that CIGNA had failed to provide its employees with appropriate notices and other disclosures required by ERISA regarding the impact of the cash balance plan. The court followed the growing weight of authority (excluding Judge Hall's decision in Richards v. FleetBoston Fin. Corp., 427 F. Supp. 2d 150 (D. Conn. 2006)) by holding that a cash balance plan did not discriminate against older workers. Judge Kravitz concluded that the fact that a younger employee's pay credits are eventually worth more than those paid to an older employee results not from discrimination but from the fact that the younger employee has had more time to accumulate interest.

Significantly, however, the court found that CIGNA was aware that its employees suffered from a lack of accurate information about the effect of the cash balance plan but "sought to negate the risk of backlash by producing affirmatively and materially misleading notices" about the plan. Judge Kravitz held that the ERISA § 204(h) notice "misled plan participants into believing that significant reductions in the rate of future benefit accrual were not a component or possible result" of the new plan, and that the disclosures contained in the Summaries of Material Modifications and Summary Plan Descriptions were also inadequate. It found that the evidence established that CIGNA was aware that benefit "wear away" was a significant factor for some employees but failed to inform participants of this effect. As an example, the court cited a statement in a Retirement Kit that, as of the conversion date, employees would "begin earning retirement benefits under the new plan," which was incorrect for some employees. The court also found the disclosures inadequate regarding which benefits under the old defined benefit plan would be preserved in opening account balances or as part of the minimum benefit established under the new plan. Judge Kravitz concluded that the defective notices and disclosures "likely harm[ed]" plaintiffs pursuant to the standard set by Burke v. Kodak Retirement Income Plan, 336 F.2d 1103 (2d Cir. 2003), and that prejudice would be presumed. He directed the parties to submit additional briefing regarding appropriate, available remedies.

Dobson v. Hartford Life & Accident Ins. Co., 518 F. Supp. 2d 365 (D. Conn. 2007)

Plaintiff Dobson brought this lawsuit under ERISA §§ 502(a)(1)(B) and 502(a)(3) on behalf of a putative class of participants in long-term disability plans insured by Hartford Life, who were denied interest on benefits that were allegedly unreasonably denied and then retroactively paid. After several earlier decisions by the district court, and an appeal to the Second Circuit, the remaining issue was Dobson's claim under § 502(a)(1)(B) for interest on LTD benefits that were withheld for 13 months and then retroactively paid. Dobson argued that, even though the benefit plan contained no explicit provision for interest on withheld or delayed benefits, such a provision could be implied as part of the "benefit" provided by the Plan. In 2002, the district court granted Hartford Life's motion for summary judgment on Dobson's § 502(a)(1)(B) claim. The Second Circuit vacated this ruling and directed the trial court, on remand, to consider whether the Plan permitted Hartford Life to delay payment of benefits past their due date without interest.

Judge Arterton held that, because the issue of whether to imply a provision for payment of interest calls for a legal determination, a de novo standard of review applied. She also held that Dobson's claim was not rendered moot by the fact that the court had already required Hartford Life to disgorge profits from the withheld payments under § 502(a)(3). The court concluded that recovery of interest on unreasonably withheld benefits payments was an implicit "benefit" under the Plan. It reasoned that, although Massachusetts Mutual Life Insurance Co. v. Russell, 473 U.S. 134 (1985), bars "implied statutory rights," it does not bar enforcement of "implied contractual rights." The court found that Dunnigan v. Metropolitan Life Ins. Co., 277 F.3d 223 (2d Cir. 2002) and Babcock ex rel. Computer Management Sciences, Inc. v. Computer Assocs. Int'l, Inc., 186 F. Supp. 2d 253, 260 (E.D.N.Y. 2002), suggested in dicta that such an implication was permissible under ERISA. Further, the Hartford Life Plan provided, in its "Time Payment of Claims" section that "accrued benefits *will be paid* at the end of each month that you are Disabled." The court concluded that the "mandatory language of the provision for the monthly payment of benefits makes clear that the payment of such benefits *at the time provided* is the 'benefit' accorded a beneficiary under the Plan." Accordingly, the court held that a beneficiary "is entitled to the value of his or her benefits at the time they are due and thus, in recognition of the time value of money, if those benefits are not paid when they are due, but are instead unreasonably delayed and paid later, the value of those benefits must include accrued interest to replace their otherwise diminished value to the plaintiff." Id. at 374. The court concluded that the only way to "incentivize" timely payments to beneficiaries, "is to regard the time value of this monthly benefit as the full value of the 'benefit' promised under the Plan, absent any express provision to the contrary."

In re: Xerox Corp. ERISA Litig., 483 F. Supp. 2d 206 (D. Conn. 2007)

Plaintiffs, a group of participants in Xerox's 401(k) plans who directed the purchase of Xerox stock for their plan accounts from 1997 to 2002, brought suit against Xerox Corporation and some of its directors, officers and employees. They alleged breach of fiduciary duty based on, among other things, the imprudent investment of plan assets and the failure to avoid conflicts of interest, which resulted in losses to the plan. The claims arose out of a series of incomplete SEC disclosures that resulted in Xerox's agreement to settle SEC accounting fraud charges and restate its earnings from 1997 to 2001. Defendants moved to dismiss all claims.

Defendants claimed that they could not be held liable for the imprudent investment of plan assets in the Xerox Stock Fund because the choice to offer Xerox stock was made in the company's settlor, non-fiduciary capacity. The court refused to dismiss the claim on that basis, holding that whether one functioned as a fiduciary is a fact-intensive inquiry not appropriately decided on a motion to dismiss. Defendants also argued that, because investments in the plan were participant-directed, they had no control with respect

to investments in Xerox stock. The court again declined to dismiss the claim, noting that participants do not exercise control within the meaning of ERISA unless their plan fiduciaries have given them complete information about the investments. The court also said that, while ERISA does not compel plan fiduciaries to violate insider trading rules, it does require them to disseminate truthful information to plan participants, including in SEC filings.

As to plaintiffs' claim that defendants breached their duty to avoid conflicts of interest, the court held that a fiduciary's duty is not to avoid conflict, but rather to be loyal to the plan and its participants and beneficiaries, when faced with a conflict. The court accordingly dismissed plaintiffs' claim, with leave to replead. Finally, defendants argued that plaintiffs' complaint sought money damages for individual participants, rather than recovery for the plan as a whole, as required by the Supreme Court's decision in Massachusetts Mutual Life Ins. Co. v. Russell. The court declined to hold that the "plan as a whole" means all participants in the plan, and instead found that a subclass of plan participants may sue for breach of fiduciary duty.

Kosswig v. The Timken Co., No. 3:06cv499 (CFD), 2007 U.S. Dist. LEXIS 58718 (D. Conn. Aug. 10, 2007).

Plaintiffs were employees of Ingersoll-Rand when the facility where they worked was sold to the Timken Company and later to RBC Aircraft Products, Inc. ("RBC"). Through both of these transactions, plaintiffs remained employed at the same location with equal or higher pay. Although they had never applied for severance benefits under the plan, plaintiffs brought suit to enforce their rights under the Timken Company's severance plan and recover benefits due to them. Plaintiffs argued that it would have been futile for them to apply for benefits, as either they did not know of, or the plan did not have, any claims procedure for evaluating their applications.

On the defendants' motion for summary judgment, the court first found that plaintiffs were not eligible for severance benefits under the plan's terms because they were offered and accepted equivalent employment with RBC. The court noted that, even if it credited plaintiffs' argument that the plan terms were not clear, plaintiffs would still be ineligible for severance benefits under Second Circuit case law, which generally holds that employees rehired by purchasing companies do not qualify for severance benefits because they were not laid-off or terminated.

The court further held that, even if plaintiffs had been eligible for severance benefits, they would still be barred from recovering them in this action because they did not meet ERISA's exhaustion requirement. The court found that the plan had a claim procedure and that ignorance of that procedure does not support a futility defense.

Merrill v. Hartford Life & Accident Ins. Co., 503 F. Supp. 2d 531 (D. Conn. 2007)

Plaintiff Merrill, Quinnipiac University's Assistant Director of Intramurals, stopped working due to a painful back condition. His treating physician concluded that Merrill was not capable of any gainful employment as a result of lumbar spine disease. Hartford Life denied Merrill's application for LTD benefits based on a review of his medical records. Its outside medical examiner never spoke directly to Merrill or personally examined him, but concluded that the records did "not provide information that would contradict [plaintiff's] ability to perform full time sedentary work at a seated level."

At the summary judgment stage, Judge Underhill found that Hartford Life acted under a structural conflict because it was responsible for both evaluating Merrill's claim and paying benefits. The court also found that

the conflict affected the reasonableness of Hartford Life's decision and that its denial was therefore subject to de novo review. The court concluded that Hartford Life had failed to present sufficient evidence to support its denial. It found that the outside examiner's opinion was not probative because (1) he failed to examine Merrill, (2) his opinion was "reserved and qualified" whereas the treating physician's opinion was "strong and unequivocal;" (3) he failed to address Merrill's complaints of severe pain, (4) he relied on plaintiff's failure to seek treatment without offering evidence that his condition was treatable, and (5) Hartford Life failed to present any affirmative evidence that Merrill was capable of performing the duties of his occupation. The court concluded that, by contrast, plaintiff's treating physician, through his observations and opinions after personal examination, provided reliable evidence that plaintiff was not capable of performing the duties of his occupation.

The court remanded the denial to the administrator for further consideration, with instructions that, if Hartford Life again denied Merrill's claims, it must present affirmative medical evidence that plaintiff did not suffer from a disabling back condition, that Merrill's condition was treatable, or that he could perform the duties of his occupation in his current state.

Trustees of the Teamsters Local Union No. 443 Health Servs. & Ins. Plan v. Papero, 485 F. Supp. 2d 67 (D. Conn. 2007)

Plaintiffs, trustees of a multi-employer welfare benefit plan, brought suit against a plan participant and his attorneys, requesting the imposition of a constructive trust on funds that the participant received in settlement of a tort claim, as well as transfer of the funds from the trust to the plan in reimbursement of claims paid by the plan on the participant's behalf. Although the plan specifically excluded from coverage claims that related to the negligence of a third party, it also gave plaintiffs the discretion to pay such claims if the participant agreed to reimburse the plan in full from the proceeds of any settlement or judgment he received. The participant was in an accident and the plan paid for his medical claims. In exchange, he and one of his attorneys agreed not only to reimburse the plan, but also to hold in trust the proceeds received from the tort claim until such reimbursement occurred. The participant subsequently received a settlement that was greater than the amount of claims paid on his behalf.

Plaintiffs alleged, in part, that the two attorneys who represented the participant in his tort action breached their fiduciary duties when they failed to place the settlement proceeds in trust and reimburse the plan. The attorneys moved to dismiss the claims on the basis that they were never fiduciaries of the plan. The court noted that, to the extent the attorneys were fiduciaries, they could be liable to the plan for any of the settlement proceeds they had retained. Stating that whether an individual is a fiduciary is a mixed question of law and fact, the court held that it could not determine the attorneys' fiduciary status on a motion to dismiss, and it consequently denied the attorneys' motions.

III. CONNECTICUT STATE COURT DECISIONS:

Ceste v. Anthem Health Plans, Inc., No. CV066000188, 2007 Conn. Super. LEXIS 1671 (Conn. Super. Ct. June 22, 2007)

Plaintiff, a participant in a health insurance plan administered by defendant, brought claims for breach of contract, fraud and violation of the Connecticut Unfair Trade Practices Act ("CUTPA"), arising out of defendant's refusal to cover certain prescription medications. In its motion to dismiss, defendant argued that the claims were preempted under 29 U.S.C. § 1144(a).

The court distinguished between ERISA preemption under 29 U.S.C. § 1132(a), which allows for the removal of certain claims to federal court, and preemption under 29 U.S.C. § 1144(a), which requires dismissal of state law claims. The court noted that the plaintiff arguably could have brought an action to enforce his rights under § 1132(a), rather than a breach of contract claim. However, finding a distinction between "claims which specifically invoke ERISA and thereby give state courts concurrent jurisdiction and those which state breach of contract claims," the court held that it did not have concurrent jurisdiction over the breach of contract claim. Furthermore, the court held that all three claims were completely pre-empted under § 1144(a) because, in order to decide them, it would be required to scrutinize the plan's administration and to determine the nature and amount of benefits to which plaintiff was entitled.

Preston v. Select Energy, Inc., HHBCV065002524, 2007 Conn. Super. LEXIS 976 (Apr. 13, 2007)

Preston brought claims against his employer relating to benefits under an enhanced severance package. The employer moved to dismiss and/or strike these claims on the basis of ERISA preemption. The court denied the motion on the grounds that the severance package involved little managerial discretion or ongoing administration. In particular, the court found that determining the amount of the benefits involved an arithmetic calculation based on the employee's length of service and prior salary. Although some discretion was involved in determining whether the employee was offered a substantially similar total compensation package and reasonable work location so as to decide whether a new position offered was a "comparable job" under the package, that determination was essentially based on objective, quantifiable factors. Further, the severance package did not make any ongoing commitments to provide benefits or require the employer to analyze the circumstances of each employee's termination. Finally, the court found "none of the usual earmarks" of an ERISA plan, such as references to a plan administrator, a claims procedure, appeal rights or ERISA itself. For all these reasons, the court held that plaintiff's claim was not subject to ERISA.

QUESTIONS OR ASSISTANCE?

If you have any questions about this ERISA update, please contact Vaughan Finn at (860) 251-5505 or vfinn@goodwin.com or Kelly Smith Hathorn at (860) 251-5868 or khathorn@goodwin.com.

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