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ERISA LEGALNEWS

SUPREME COURT UPDATE
WHERE PLAN REIMBURSEMENT OR RECOVERY TERMS ARE AMBIGUOUS OR SILENT, EQUITABLE DOCTRINES MAY FILL THE GAPS

by Kimberly J. Ruppel

***US Airways, Inc. v. McCutchen*, 569 U.S. ___ (2013)**

In an opinion delivered by Justice Kagan, the Supreme Court recently clarified when equitable doctrines may apply in subrogation and reimbursement claims brought pursuant to ERISA § 502(a)(3), which authorizes plan administrators to bring suit to obtain appropriate equitable relief to enforce the terms of the plan. Not surprisingly, the High Court held that express terms of an ERISA plan govern. However, the Court expanded on its consideration of equitable defenses in the recent trilogy of cases including *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002); *Sereboff v. Mid Atlantic Medical Services, Inc.*, 547 U.S. 356 (2006); and *Cigna Corp. v. Amara*, 131 S.Ct. 1866 (2011), and found that, although equitable doctrines may not override the terms of a contract, where the terms of a plan leave gaps, courts may properly use equitable rules to construe the contracting parties' intentions.

Cases with facts similar to those here are not unfamiliar to ERISA benefit litigators. US Airways paid $66,866 in medical expenses for injuries suffered by plan participant McCutchen who was involved in a car accident caused by a third party. The plan at issue entitled US Airways to reimbursement if McCutchen later recovered money from a third-party tortfeasor. McCutchen recovered a total of $110,000 from the third party, which was reduced to $66,000 after deduction for his attorney's fees. Accordingly, US Airways filed suit for reimbursement of its payment of medical expenses. McCutchen raised equitable defenses derived from the principles of unjust enrichment, including the double recovery rule and the common fund doctrine. The High Court granted *certiorari* to resolve a Circuit split on whether equitable defenses can override a plan's reimbursement provisions.

Because the plan here provided for reimbursement of "any monies recovered from [the] third party", the Court found that the double recovery rule, which would only allow the plan to recover that portion of a payment to McCutchen representing medical expenses (differentiated from future earnings, or pain and suffering, for example), that equitable doctrine was contrary to the terms of the plan and was not a valid defense.

However, in considering McCutchen's "common fund" defense, the Court found that the plan was silent on the allocation of attorney's fees. According to the Court, the plan's allocation formula could have been interpreted to apply to every dollar received from a third

party. Yet, the Court found the plan could also be interpreted to apply only to the final, true recovery, after all costs of obtaining it were deducted. Finding the plan ambiguous, the Court agreed that McCutchen's equitable defense applied to fill the gap in the express terms of the plan, and US Airways' reimbursement would be limited by its proportional share of McCutchen's attorney's fees incurred in obtaining his third-party payment.

Justice Scalia authored the dissent, joined by Chief Justice Thomas and Justice Alito. The dissenting opinion differed from the majority only with respect to whether the plan terms were ambiguous such that the common fund doctrine should apply, arguing that McCutchen conceded in briefing that the plan allowed for reimbursement without contribution to attorney's fees incurred in obtaining a payment. Accordingly, the dissent found this issue was not properly preserved, or included in the issue presented. The majority addressed this issue by indicating that McCutchen's statement in question was actually a description of US Airways' position in the District Court, and that McCutchen himself argued the same position that the majority adopted.

SELECT CIRCUIT COURT DECISIONS

by Kimberly J. Ruppel

Sixth Circuit - Initial Application Of The Wrong Disability Definition Was Properly Corrected Upon Consideration During The Administrative Appeal

Judge v. Metropolitan. Life Ins. Co., __ F.3d __ (6th Cir. 2013)

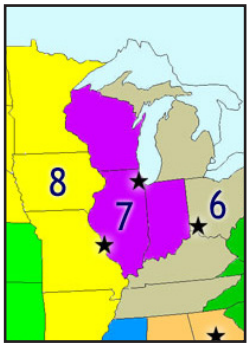
The plan participant, Thomas Judge, was covered by his employer's term life insurance policy which provided for early payment of benefits if an employee became totally and permanently disabled, which was defined by the plan as being unable to do the employee's own job, and any other job for which the employee is fit by education, training or experience. After Judge underwent heart surgery, he applied for benefits under the policy, claiming he was not able to return to any type of work. His treating providers recommended lifting and certain other restrictions, but indicated that he was recovering well with no evidence of complications. Yet, Judge's doctors advised against returning to work.

The plan administrator, MetLife, which was also the insurer of the benefits, initially denied the claim based on a nurse consultant's review of medical records, but mis-stated the applicable definition of disability. Judge requested an administrative appeal, submitting no new medical records or information. Following a second nurse consultant's review of the same medical records, noting the same inconsistencies and lack of objective evidence of disability, the denial was upheld but the correct definition of disability was referenced in the communication to Judge. The Sixth Circuit disagreed with the claimant's argument that the mention of the incorrect definition was arbitrary or capricious because the plan administrator corrected its error following the administrative appeal process. Further, the Court found that a remand to the administrator was unnecessary due to the objective medical evidence demonstrating that the claimant was not disabled under the appropriate definition.

The Court also rejected the argument that a file review conducted by a nurse consultant was insufficient to support the decision which did not involve a credibility assessment or second guessing of the claimant's treating physicians.

Judge also argued that MetLife improperly denied his claim that he could not perform any job without obtaining vocational evidence. However, the Court rejected this argument as well, relying on supporting case law authority from several Circuits, and found that the medical record evidence was sufficient to support a finding that the claimant was not totally and permanently disabled without obtaining vocational evidence in support.

Finally, Judge argued that the financial conflict of interest tainted MetLife's decision to deny benefits. Because the claimant failed to identify anything more than a "general observation that MetLife had a financial incentive to deny the claim", the Court found no need to give the conflict significant weight.



Seventh Circuit - Failure to Adequately Distinguish The Social Security Administration's Disability Finding Resulted From A Conflict of Interest

Raybourne v. CIGNA Life Ins. Co of New York, 700 F.3d 1076 (7th Cir. 2012)

In this second round appeal of a long term disability benefit termination decision, the court considered whether the defendant insurer and plan administrator's decision to deny further payment of benefits was improperly influenced by the structural conflict of interest of both funding benefits and making decisions on claims. CIGNA paid benefits under the 24 month "own occupation" period, based on evidence that pain related to degenerative joint disease prevented the claimant from working as a quality engineer. Benefits were later terminated under the "any occupation" period, based in part on the findings in an independent medical examination ("IME") that the claimant was capable of performing sedentary work, with certain restrictions and limitations.

At the same time, CIGNA engaged a consultant to assist the claimant with his appeal to the Social Security Administration ("SSA"). After a hearing, the Administrative Law Judge determined that the claimant was entitled to benefits. CIGNA then applied the SSA benefit payment amount as an offset against the LTD benefits paid under the Plan, and recovered the resulting overpayment.

The claimant requested an administrative appeal of CIGNA's decision and relied extensively on the ALJ's findings. However, CIGNA did not

mention the ALJ's decision or make any attempt to distinguish its own findings when upholding the LTD benefit termination.

The district court had previously remanded the matter to CIGNA to provide a better explanation of its decision. CIGNA gave four reasons why the court should find that its decision was not influenced by the conflict of interest: (1) the definition of disability under the Plan was not the same as that of the SSA; (2) SSA regulations favoring the opinion of a treating physician and regarding the age of a claimant do not apply under ERISA; (3) at the time when LTD benefits were terminated, the SSA had denied the claim, such that the positions were consistent; and (4) different evidence was considered by CIGNA and the ALJ. The Court rejected each of these explanations in turn.

First, the Court found that the definitions of disability were "functionally equivalent", dismissing any minor language differences. With respect to the regulations cited in the ALJ's findings, the Court found that the ALJ had not relied on the "treating physician rule", and the claimant was younger than 50. Accordingly, the Court reasoned that the cited regulations did not form the basis of the ALJ's finding. The Court found that CIGNA's third reason made no sense because at the time that CIGNA initially approved benefits during the "own occupation", the SSA likewise found that the claimant was not capable of returning to his former work, but that was not sufficient to qualify for SSA benefits at that time. Regarding the evidence considered, the Court was particularly critical of CIGNA's argument that the ALJ did not have access to the IME report disputing disability at the time when CIGNA's consultant was advocating for payment of SSA benefits. The Court found the IME report "became the determinative piece of evidence for CIGNA only when it was financially advantageous to the insurer."

The Court then relied on the Supreme Court's holding in *Metropolitan Life v. Glenn*, that a structural conflict of interest may be used as a tie breaker in a case where it may have affected the benefit decision. Because CIGNA did not provide a rational explanation for crediting the IME report over the opinions of the claimant's treating physician or the credibility finding of the ALJ, both of which were supported by medical evidence documenting the source of pain, the Court concluded that the denial of benefits was the result of a structural conflict of interest and affirmed judgment in favor of the claimant.

In addition, the claimant sought recovery of his legal fees under ERISA section 1132(g)(1) and the Supreme Court's holding *Hardt v. Reliance Standard Life Ins. Co.*, 130 S. Ct. 2149. The Court declined to opine on whether the previous test used to award attorney fees survived *Hardt,* and found that the district court erroneously disregarded one of the factors. Nonetheless, the Court found that error meaningless given the district court's discussion of the other four factors, all of which supported an award of fees. Finally, although CIGNA argued that fees should be limited to the last phase of litigation in which the claimant finally prevailed, the Court found that the claimant achieved complete success on his claim and affirmed the award of fees for the entire litigation.

Certification of Class Under 23(b)(2) Involving Claims For Monetary, Injunctive and Declaratory Relief

Johnson v. Meriter Health Svcs. Employee Retirement Plan, 702 F.3d 364 (7th Cir. 2012)

This case involved the appeal of a certification of an ERISA pension plan dispute as a class action under Federal Rule 23(b)(2). The plan at issue was a defined benefit plan which entitled participants, upon reaching normal retirement age, to receive a pension benefit either as an annuity or as a lump sum. The class consisted of over 4,000 plan participants who alleged that they were not credited with all the benefits to which the plan entitled them. Although class members differed as to whether they had received benefits already, or were current or former plan participants, and as to which amendment of the plan applied, the district court certified 10 sub-classes according to those variations. Each subclass sought a declaration of rights, and an injunction directing that the plan's records be reformed to reflect those rights.

The Circuit Court rejected the plan's argument that class certification was inappropriate because the subclasses asserted so many different claims. Instead, the Court found that the Rule 23(b)(2) requirement that the defendant has acted on grounds that apply generally to the class applies to subclasses as if each subclass represented a separate class action rather than to the larger class as a whole, and that requirement was satisfied here.

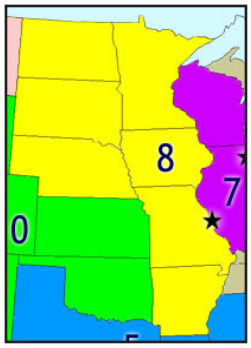
The Court also rejected the plan's argument that class members who are no longer participants in the plan are not entitled to declaratory or injunctive relief because such relief is prospective and because they want retrospective relief in the forms of money damages, as "silly". The Court found that all class members, whether they were current or former plan participants, sought reformation of the plan as a basis for claiming additional pension benefits. These benefits, reasoned the Court, were not damages but instead were the automatic consequence of a judicial order revising the plan in the participants' favor.

The plan also argued that Supreme Court precedent precluded a Rule 23(b)(2) class action in which monetary as well as declaratory or injunctive relief is sought.

In 2011, the Supreme Court held in *Wal-Mart v Dukes* that claims for damages in the form of backpay related to employment discrimination allegations were not properly certified as a class action under Rule 23(b)(2) because class certification under Rule 23(b)(2) is only appropriate when a single, indivisible remedy would provide relief to each class member. *Wal-Mart v. Dukes*, 131 S.Ct. 2541 (2011). The high Court found that the claims for monetary relief were not incidental to claims for declaratory or injunctive relief, but declined to hold that monetary claims can never be certified under Rule 23(b)(2).

Judge Posner explained in this case that the *Dukes* opinion referred to individualized awards of monetary damages, requiring presentation of evidence specific to each class member. Because the class members here sought reformation of the plan, a declaration of rights under the plan, and an injunction ordering the plan to conform to said declaration, then an award of monetary relief here would be merely "incidental" to the declaratory and injunctive relief. As a result, monetary relief could be determined by simply matching each class member's employment records to the reformed plan terms and calculating the proper benefit amount. Nonetheless, the Court acknowledged that individualized evidentiary hearings might be required for some class members and suggested that either bifurcation (divided certification) or notice and an opt out period might be appropriate. The Court indicated that this finding comported with the Dukes holding despite contrary authority in the Ninth Circuit in *Ellis v. Costco Wholesale Corp.*, 657 F.3d 970 (9th Cir. 2011).

Finally, the Court rejected the plan's argument that conflicts of interest among class members precluded certification. The Court noted that the plan did not identify a single class member who might be harmed by class treatment, agreeing with the district court that any conflict of interest was purely hypothetical.



Eighth Circuit - Income Related To Sale Of Business Properly Excluded From Calculation Of Earnings

Govrik v. Unum Life Ins. Co., 702 F.3d 1103 (8th Cir. 2013)

This case involved a dispute over the calculation of monthly earnings used to determine the long-term disability benefit ("LTD") payment. By way of background, in 1991, the claimant founded a home health care service company which also had a subsidiary company. At first, the claimant was the sole shareholder of both companies. He eventually transferred his shares in the parent company to his sister and then to a Trust in 1996. In 2000, the claimant sold his interest in the subsidiary to the parent company. At all times, the claimant was the president of the parent company.

In 2004, the parent company purchased a long-term disability policy from Unum. In 2005, the claimant, who was a partial quadriplegic, reduced his hours due to his worsening medical conditions. He eventually stopped working completely and filed a claim for LTD benefits in March 2006.

Initially, Unum approved payment of benefits. The claimant was also receiving disability payments from the Social Security Administration ("SSA") which were considered offsetting income under the LTD policy. In 2007, the SSA informed the claimant that his benefits should have terminated as of 2005, resulting in an overpayment that had to be repaid. The claimant notified Unum of this change, which led to a review of the LTD benefit payment amount. First, Unum discovered a mathematical error in its calculation and the resulting correction dramatically reduced the monthly payment amount. Next, Unum reviewed the information provided by the claimant purporting to demonstrate his "earnings" which included large sums that the claimant argued should be considered either bonus or commission earnings. Unum also reviewed sworn testimony and information provided to the SSA during the claimant's challenge of the SSA overpayment decision. That information included a promissory note by the parent company to the claimant for payment of the sale price of the subsidiary company, and an amortization schedule of payments which corresponded with the large payments that the claimant argued were bonus or commission earnings. Unum determined that the large payments were not earnings as defined by the policy and removed those figures from its calculation of pre-disability income. As a result, the claimant's pre-disability and post-disability income were roughly the same. Unum discontinued payment of benefits and responded to the claimant's lawsuit with a counterclaim to recover the allegedly overpaid benefits.

The Circuit Court found that it was reasonable for Unum to rely on the information and sworn testimony presented to the SSA during the claimant's request for reconsideration by the SSA over the contrary financial information later provided by the claimant in connection with Unum's review of his LTD benefit amount. The Court was influenced in part by the claimant's shifting position on how his income should be characterized, and because the claimant's position – that he received nothing for the sale of the business while instead receiving bonus or commission payments corresponding with the promissory note terms and amortization schedule payment amounts – was simply not credible. As a result, the Court remanded the case for consideration of Unum's counterclaim.

ERISA LITIGATION & EMPLOYEE BENEFITS COUNSELING

Practice Area Overviews

ERISA Litigation

Dickinson Wright's ERISA litigators are well versed in every aspect of ERISA litigation. This federal statute gives rise to suits brought by plan participants and others bringing claims ranging from challenges to the denial of life, disability or health benefits to allegations of breach of fiduciary duties by benefit or pension plan administrators. We have represented insurers, employers and other plan fiduciaries in numerous contexts, by defending benefit decisions and procedural challenges, counseling and defending clients regarding fiduciary obligations and plan administration, resolving coordination of overlapping policies and conflicting beneficiary claims, and interpreting the intricacies of the statutory framework. Our experience in the trial and appellate courts, as well as in the mediation arena, serves our clients effectively and efficiently.

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We regularly represent national and multinational clients in employee benefits, executive compensation, and ERISA matters. Our broad capabilities and solid experience allow us to create workable plans, provide implementation strategies, counsel employers on

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