

DROP THE KNIFE! CUTTING-EDGE DEVELOPMENTS IN ERISA LITIGATION

32nd Annual Labor & Employment Conference

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QU'EST-CE QUE C'EST?



WHAT IS ERISA & WHY AM I HERE (OR, WHO CARES!)?

- E
- R
- I
- S
- A

**Pension and “welfare” benefits*

READY FOR COURT?



"Apparently, you have very little respect for our judicial system, sauntering in here with only one lawyer."

CN
COLLECTION

WHO CAN SUE, AND FOR WHAT?

29 U.S.C. § 1132 – The Civil Enforcement Section of ERISA

- **For penalties** for not providing requested plan documents [502 (a)(1)(A)]
(By a participant or beneficiary)

- **Claims “for” benefits** [502 (a)(1)(B)]

“By a **participant** or **beneficiary**... To **recover benefits** due to him **under the terms of his plan**, to enforce his rights under the terms of the plan, **or to clarify** his rights to future benefits under the terms of the plan

WHO CAN SUE, AND FOR WHAT? (CONT.)

In claims for benefits, the plaintiff bears the burden. See *Amin v. Bank of Am. Pension Plan*, 57 Employee Benefits Cas. (BNA) 1307, 2013 U.S. Dist. LEXIS 82247, at **14-15 (E.D. Mich. June 12, 2013)

Court: “Plaintiff’s challenge rests upon an impermissible attempt to shift a burden that the law places squarely on Plaintiff — namely, the burden to prove that she is entitled to pension benefits under the Plan”



"The burden I can bear, but the constant rotation makes me dizzy."

WHO CAN SUE, AND FOR WHAT? (CONT.)

- Breach of fiduciary duty [502 (a)(2)]
- Equitable claims
 - “A civil action may be brought— . . . (3) by a participant, beneficiary, **or fiduciary** (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan.” [502(a)(3)]

MAJOR AREAS OF CLAIMS LITIGATION

- Section 502(a)(1)(B)
 - Group Medical
 - Group Disability
 - Group Life
 - Pension

THE LAW ON OUR SIDE (IN CLAIMS LITIGATION)?

- Pros for ERISA for plans/plan sponsors in claims litigation:
 - Opportunity for federal court, even if filed in state court (preemption)
 - No jury trial
 - No punitive damages (but possible prejudgment interest and fees), for now. *Rochow v. Life Ins. Co. of N. Am.*, 780 F.3d 364 (6th Cir. 2015) (vacating award for disgorgement of profits on wrongful LTD denial)
 - The arbitrary and capricious standard
 - Possible second try, with discretion, on remand (*Conkright v. Frommert* -- 2010); but be aware of fee awards (*Hardt v Reliance Standard Life Ins. Co.* - 2010)

THE ARBITRARY AND CAPRICIOUS STANDARD

- Among the highest in the law

Summary by Court:

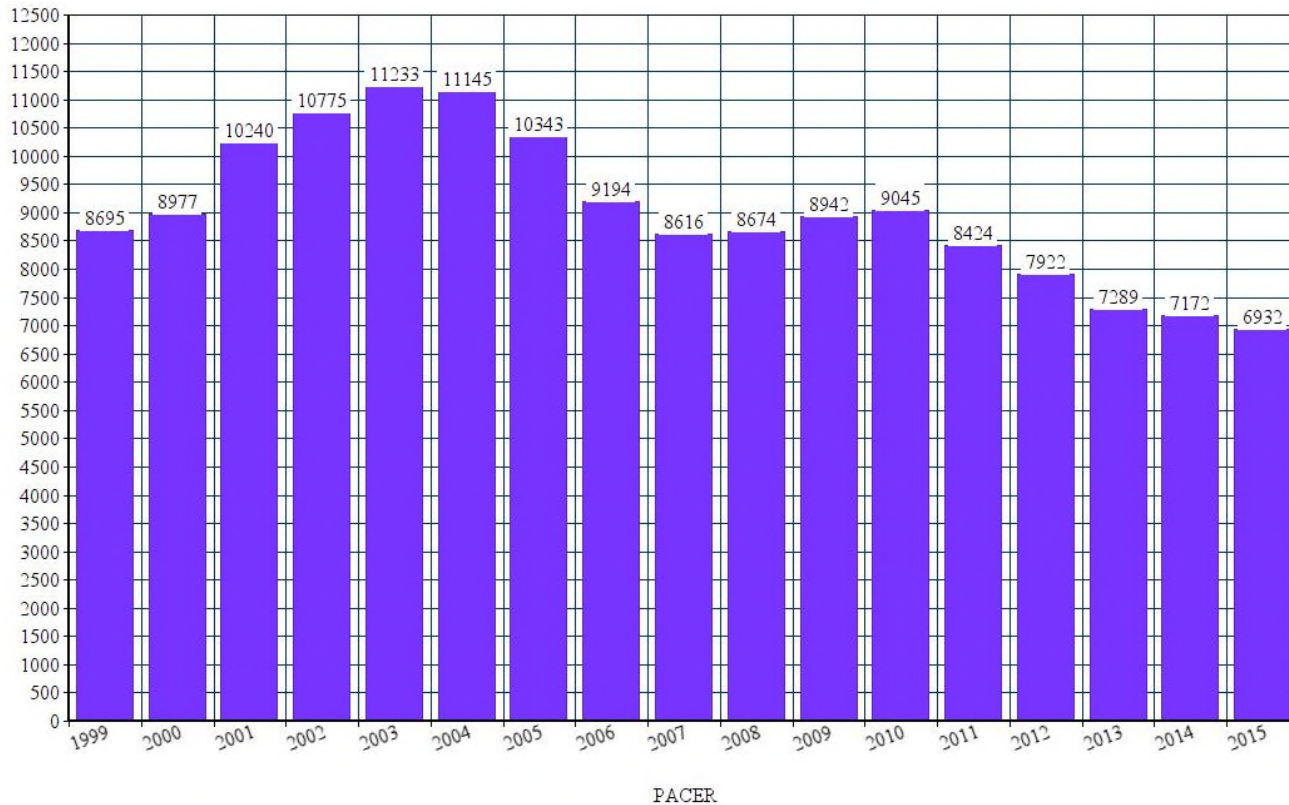
- Though the arbitrary and capricious standard is not without some teeth, it is not all teeth. An **extremely deferential review**, to be true to its purpose, must actually honor an extreme level of deference to the administrative decision.
- A decision reviewed according to the arbitrary and capricious standard **must** be upheld if it results from a **deliberate principled reasoning process** and is supported by **substantial evidence**. When it is **possible** to offer a reasoned explanation, based on the evidence, for a particular outcome, that outcome is not arbitrary or capricious.
- *McClain v. Eaton Corp. Disability Plan*, 740 F.3d 1059, 1064-65 (6th Cir. 2014)

MAJOR AREAS OF OTHER LITIGATION

- Fees by service providers (fiduciary duties)
 - Medical (claims by plan sponsors)
 - 401(k) (claims by participants)
- Company stock litigation (aka “stock drop” cases) (fiduciary duties)
- Church plan litigation (many are regarding under-funded pensions)

THE LAST 17 YEARS – FILINGS IN FEDERAL COURT

ERISA Cases Filed By Year (U.S. Courts)



I WOULD LIKE A LIST OF NUMBERS, PLEASE

Year	Cases filed (US)	Year	Cases filed (US)
1999	8,695	2009	8,942
2000	8,977	2010	9,045
2001	10,240	2011	8,424
2002	10,775	2012	7,922
2003	11,233	2013	7,289
2004	11,145	2014	7,172
2005	10,343	2015	6,932
2006	9,194	2016	2,238 (4/26/16); 6,800 projected
2007	8,616	2017	?
2008	8,674		

TOP FIVE ISSUES OF THE PAST YEAR

1. Subrogation/reimbursement rights
2. New disability claims procedures
3. Retiree medical
4. Discretionary clauses
5. Risks under section 510 due to ACA

ARE YOU SELF-INSURED FOR ONE OR MORE OF YOUR ERISA PLANS OR COMPONENTS OF THEM?

- A. Yes
- B. No
- C. I have no idea

1. CATCH ME IF YOU CAN!

In late 2008, just after out-running Special Agent Tom Hanks, Raphael DeCaprio was badly injured in a car accident. Mr. DeCaprio was covered by an employee welfare benefit plan administered by the Board of Trustees of the National Airlines Health Benefit Plan (Plan). After DeCaprio's accident, the Plan paid over \$120,000 of DeCaprio's medical expenses. DeCaprio later sued the driver of the other car involved in the accident, and that suit settled for \$500,000. Under powers granted by the Plan terms, the Plan then requested DeCaprio reimburse the \$120,000 already paid. DeCaprio and the Plan failed to reach an agreement, and the Plan sued DeCaprio.



1. CATCH ME IF YOU CAN! (CONT.)

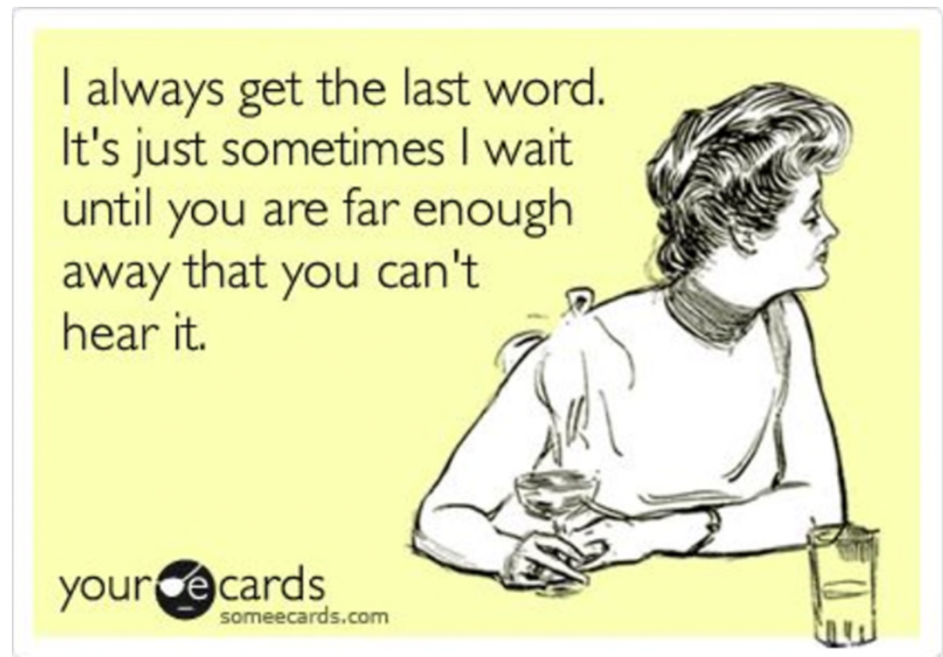
- Holding
 - When an ERISA-plan participant
 - Wholly dissipates
 - A third-party settlement
 - On non traceable items ...
- The plan fiduciary **may not** bring suit to attach the participant's separate assets under Section 502(a)(3) of ERISA, which authorizes plan fiduciaries to file suit "to obtain... appropriate equitable relief," because the plan is not seeking equitable relief when it seeks to recover such general funds
- *Montanile v. Bd. of Trs. of the Nat'l Elevator Indus. Health Benefit Plan*, 136 S. Ct. 651 (U.S. Jan. 21, 2016)

LESSONS FROM *MONTANILE*

- 8-1 decision; Clarence Thomas authoring Opinion of the Court; Ginsburg, dissenting
- When do we demand reimbursement or assert subrogation liens, and to whom?
 - Who should sign a reimbursement agreement?
 - Who is pursuing potential claims for us, what are they doing, and at what cost to us?
- When can we sue?
 - Is the claim “ripe”?
 - Will it be too late?
- Whom should we sue?
- Changes to plan language?

2. WHY DO YOU ALWAYS GET THE LAST WORD?!?

- Claims Procedure for Plans Providing Disability Benefits
- New Rule proposed by the Employee Benefits Security Administration on 11/18/2015; comments to the DOL were due 1/19/2016
- 145 comments are posted
- Final Rule – later this year?



THE PROPOSED NEW CLAIMS PROCEDURES

- **Limits on contracts/vendors:** Can't contract with a medical expert based on "outcomes" in contested cases
- **It's all in the details:** Adverse benefit determinations need to discuss the decision, any basis for disagreeing with the SSA or treating physician; must include the internal rules, guidelines and protocols used in denying the claim
- **The last word:** Added right of claimant to review and respond to new information before the final decision

THE PROPOSED NEW CLAIMS PROCEDURES (CONT.)

- **Deemed exhausted:** Where the plan fails to adhere to all the procedural requirements (except for “minor” errors), claimant can sue, and the court should give no “special deference to the plan’s decision”
- **Rescission of coverage:** By a plan may trigger procedural rights (as an adverse benefit determination) even if one is not receiving benefits
- **Bottom line:** More lawsuits, not fewer; higher expenses to adjudicate and litigate claims; higher costs of providing policies/higher costs of contracts; possibly less deference

3. RETIREE MEDICAL



- When collective-bargaining agreements create pension or welfare benefits plans, those plans are subject to rules established in ERISA
- Weird rule existed for decades in the Sixth Circuit (which covers Michigan, Ohio, Kentucky and Tennessee) covering union contracts, favoring lifetime vesting of retiree medical benefits when ambiguous or a close call. *UAW v. Yard-Man, Inc.*, 716 F.2d 1476 (6th Cir. 1983)
- Supreme Court finally said – Cut it out! *M&G Polymers USA, LLC v. Tackett*, 135 S. Ct. 926 (U.S. Jan. 26, 2015) (no special inferences in favor of vesting)

RETIREE MEDICAL (CONT.)

- *Gallo v. Moen Inc.*, 813 F.3d 265 (6th Cir. Feb. 8, 2016), *reh'g en banc denied*, 2016 U.S. App. LEXIS 5557 (6th Cir., Mar. 16, 2016) (finding under that set of contracts, no vesting occurred)
 - Nothing in the CBAs stated the employer committed to provide unalterable health care benefits to retirees and their spouses for life
 - **Everything** the CBAs said about this topic were **contained** in a **three-year agreement**
 - The agreements contained **reservation of rights clauses** that evidenced an intent not to vest and that applied to employees and retirees
 - Phrases “continued” and “will be covered” and “will be provided” did *guarantee* benefits; but *only* until the agreement expires, nothing more

4. DISCRETIONARY CLAUSES

- Attacks on the arbitrary and capricious standard
- Mich. Admin. Code R. 500.2202 (On and after June 1, 2007, an “insurer shall not issue ... or deliver to any person in [Michigan] a policy ... that contains a discretionary clause. This does not apply to a contract document in use before that date, but does apply to any such document revised in any respect on or after that date”; same “is void and of no effect.”)
- The rule is not preempted by ERISA . *Am. Council of Life Insurers v. Ross*, 558 F.3d 600 (6th Cir. 2000)
- Thus, ERISA plans in Michigan with fully-insured policies are typically subject (for those policies) to Michigan’s rules regarding discretionary clauses

4. DISCRETIONARY CLAUSES (CONT.)

Not preempted, but...

- Doesn't apply to policies **issued before June 1, 2007** and never revised thereafter in any respect. *Mendelblatt v. Aetna Life Ins. Co.*, No. 14-cv-12140, 2016 U.S. Dist. LEXIS 21400 (E.D. Mich. Feb. 22, 2016)
- Doesn't bar grants of discretion in **an SPD or plan document?** *Rose v. Liberty Life Assur. Co.*, No. 3:15-cv-28, 2016 U.S. Dist. LEXIS 37433 (W.D. Ky. Mar. 23, 2016) (granting "Motion for Application of the Arbitrary and Capricious Standard of Review"); *Hess v. Metro. Life Ins. Co.*, 91 F. Supp. 3d 895 (E.D. Mich. Feb. 17, 2015)
 - Will these cases breathe new life into the debate?
 - Does or will it depend on who makes the final decision?

Practical advice: consult with employee benefits counsel to maximize discretion covering all components of your plans

5. “LET’S GET THAT FULL-TIME STAFF NUMBER DOWN!”

Nuts & Clusters, LLC, an organic packaged foods company in June 2013, in response to the enactment of the ACA in March of 2010, had its main store managers tell employees that compliance with the ACA would cost as much as two million dollars; and that, to avoid the costs, the company’s main location planned to reduce its full-time employees at that store from more than 100 to 40. Many full-time employees were reduced to 10-25 hours per week and notified in writing they now had part-time status and their company-provided coverage would end in a few weeks.

NUTS & CLUSTERS, LLC

Result?

- A. Employer receives a local award of the year (great foresight & management & cost containment)
- B. No lawsuit – coverage available on the exchanges – no lawyer would take the case
- C. Lawsuit – thrown out as nonsense
- D. Lawsuit – court won't throw out

NUTS & CLUSTERS, LLC (CONT.)

- Plaintiff sufficiently claimed employer intended to interfere with welfare plan benefits – to deprive employees of continued participation in a company-sponsored group health plan
 - Violation of ERISA Section 510
- ACA: Employers with 50 or more full-time and/or full-time equivalent employees must offer “affordable” and “minimum value” health care coverage to full-time employees and their dependent children or face penalties
 - (30 hours per week / 130 hours per month)
- Specific intent to deprive = bad; can run afoul of ERISA Section 510
- *Marin v. Dave & Buster’s, Inc.*, 15 Civ. 3608, 2016 U.S. Dist. LEXIS 18086 (S.D.N.Y. Feb. 8, 2016) (order denying defendants’ motion to dismiss)

OTHER LITIGATION AND PLAN RISK ISSUES

- Venue provisions – why not?
- Limitations on time period to file suit; re-state the limit in the appropriate denial letter(s)
- *Gobeille v. Liberty Mut. Ins. Co.*, 2016 U.S. LEXIS 1612 (U.S. Mar. 1, 2016) (ERISA preempts state law (VT) that required Blue Cross (TPA) to report the payment detail and other information it possessed about the self-funded/self-insured Plan's members in Vermont, for compilation in state database for ACA)

QUESTIONS?



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THANK YOU

Legal Disclaimer: This document is not intended to give legal advice. It is comprised of general information. Employers facing specific issues should seek the assistance of an attorney.

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