In this Issue
SPD May Be the Plan, Despite Reference to a Non-Existent â€œOfficial Plan Documentâ€€
Gorsuch on ERISA: What to Expect From the New Supreme Court Justice
Being Exhausted Matters: ERISAâ€™s Exhaustion Doctrine and the New DOL Claims Regulations
Supreme Court Clarifies ERISAâ€™s Church Plan Exemption, But Questions Remain

Articles of Note

SPD May Be the Plan, Despite Reference to a Non-Existent â€œOfficial Plan Documentâ€€
by H. Sanders Carter, Jr. Co-Editor, ERISA Report


The written instrument, or plan document, must (1) provide a procedure to establish and carry out a funding policy consistent with the plan’s objectives, (2) describe the plan’s procedures to allocate responsibilities for the operation and administration of the plan, (3) provide a procedure to amend the plan, and (4) specify the basis on which payments are made to and from the plan. 29 U.S.C. § 1102(b).

ERISA also requires a plan administrator to provide a summary plan description to each participant and beneficiary of the plan. Id. § 1024(b)(1). The SPD must “reasonably apprise [plan] participants and beneficiaries of their rights and obligations under the plan” and must be “written in a manner calculated to be understood by the average plan participant.” Id. § 1022(a).

Plans typically consist of both documents – the “written instrument,” by which the plan sponsor “creates the basic terms and conditions of the plan,” and a separate summary plan description, by which the plan’s administrator “provides participants with the summary documents that describe the plan (and modifications) in readily understandable form.” Cigna Corp. v. Amara, 563 U.S. 421, 437 (2011).

Plan Document and SPD May Have Contradictory Provisions

While both the plan document and the SPD are required, their provisions are not always consistent, sometimes because they were created at different times or by different entities, and sometimes as the result of careless drafting. When the SPD contradicts, or is otherwise inconsistent with, the plan document, the Supreme Court has made clear that the SPD is not the “written instrument” required by § 1102, and that the plan document, not the SPD, controls. Amara, 563 U.S. at 438 (“the summary documents, important as they are, provide communications about the plan, but … their statements do not themselves constitute the terms of the plan”). (Emphasis by the Court.)

In a number of cases, employees or their beneficiaries have relied on Amara to argue that the requirements of an SPD were enforceable, because those requirements were not also contained in the plan document. Recognizing that an ERISA plan may consist of both the “written instrument” required by § 1102 and the SPD required by § 1024(b)(1), that argument has been rejected when the SPD requirement did not conflict with the plan document. See, e.g., Bd. of Trs. of Natl Elevator Indus. Health Benefit Plan v. Montanile, 563 F. App’x 903, 910 (11th Cir. 2014) (“Amara only precludes courts from enforcing summary plan descriptions … where the terms of that summary conflict with the terms specified in other governing plan documents.”) (Emphasis by the court.); Mull v. Motion Picture Indus. Health Plan, – F.3d –, 2017 WL 3259667, at *3 (9th Cir. Aug. 1, 2017) (“Neither the Trust Agreement nor the SPD meets ERISA’s requirements for constituting a plan. But by clear design … the two documents together constitute a plan. Accordingly, we conclude that the ERISA plan is the Trust Agreement plus the SPD.”) (Emphasis by the court.)

The courts find it easier to reject that argument where the SPD was intended, by its terms, to be part of the plan. Eugene S. v. Horizon Blue Cross Blue Shield of N.J., 663 F.3d 1124, 1131 (10th Cir. 2011) (Where the SPD was identified as a document forming the plan, “the SPD does not conflict with the Plan or present terms unsupported by the Plan; rather, it is the Plan.”) (Emphasis by the court.)

But suppose there is only an SPD and no separate “written instrument”? Not infrequently, the plan sponsor (or the claims administrator) creates an SPD, which is issued to participating employees, but fails to maintain a separate plan document.
In that case, courts have held that the SPD, standing alone, can serve as both the governing plan document and the summary description. (Alday v. Container Corp. of Am., 906 F.2d 660, 666 (11th Cir. 1990) (the SPD "functioned as the plan document" and "unambiguously set out the rights of the parties").

**SPD Stated That Non-Existen Plan Document Would Control**

That was the situation in Rhea v. Alan Ritchey, Inc. Welfare Benefit Plan, 858 F.3d 340 (5th Cir. 2017) – but with an additional twist. An SPD was issued to employees of Alan Ritchey, Inc. Although no separate "written instrument" existed, the SPD stated: "In the event of any discrepancy between this Summary Plan Description and the official Plan Document, the Plan Document shall govern."

Rhea, the wife of an Alan Ritchey employee, suffered injuries from medical malpractice. The plan paid some of her medical expenses. When Rhea settled the malpractice claim, the plan sought reimbursement, relying on this language that appeared in the SPD and nowhere else: "[i]f a third party causes … Injury for which you receive a settlement, … you must use those proceeds to fully return to the Plan 100% of any Benefits you received for that … Injury.”

When Rhea’s attorney asked to see the "official Plan Document," the benefits administrator responded that the SPD "is the Plan document," that it "contains all of the ERISA-required plan provisions," and that it "operates as the Plan’s official plan document."

Rhea sued, seeking a declaratory judgment that she was not required to reimburse the plan. She argued that, in the absence of the "official Plan Document" described in the SPD, no ERISA-compliant written instrument was in place, as a result of which the plan had no enforceable right of reimbursement. The plan filed a counterclaim for equitable relief. On cross-motions for summary judgment, the district court entered judgment against Rhea.

The Fifth Circuit affirmed, rejecting Rhea’s argument that Amara requires a plan’s SPD and written instrument to be separate documents. “To the contrary," the court said, "where a plan has an SPD but no separate written instrument, the SPD can serve as the plan’s written instrument.” Distinguishing the relevant facts from those in Amara, the court wrote:

> We are not grappling with a conflict between an SPD and a written instrument but, instead, are deciding whether an SPD can function as a written instrument in the absence of a separate written instrument.

858 F.3d at 345.

The court held that an SPD can function as the plan document and that, in Rhea’s case, it did. “That is nothing peculiar,” the court said. Id. at 344. “Plan sponsors commonly use a single document to satisfy both requirements, and courts have blessed the practice.” Id. “[W]hen an SPD is a plan’s only plausible written instrument, courts assume that the SPD is the written instrument.” Id. at 346, citing Feifer, 306 F.3d at 1208-10.

In Feifer, a “Program Summary” was the only document describing benefits when certain employees’ claims arose. The Program Summary stated:

> This summary is for information purposes only and is not intended to cover all details of the Plan. The actual provisions of the Plan will govern in settling any questions that may arise.

A group insurance policy was issued later. It provided that disability benefits would be reduced by the receipt of Social Security disability benefits and workers’ compensation benefits; but that offset provision did not appear in the Program Summary.

The employees argued that because the group policy had not been issued when their claims arose, the Program Summary controlled, and their disability benefits could not be reduced. The Second Circuit agreed, holding that “[h]owever slap-dash” it may have been, the Program Summary and an accompanying memorandum “were ‘the plan’ for purposes of the plaintiffs’ actions under § 1132(a)(1)(B),” and they provided disability benefits without offsets for SSDI or workers’ compensation benefits. 306 F.3d at 1209-11.

In the Rhea case, the plaintiff’s fallback argument was that because the SPD referred to an “official Plan Document” that did not exist, the plan sponsor had misrepresented material facts, thereby breaching its duty of loyalty to her as an ERISA plan beneficiary and rendering the SPD unenforceable. The Fifth Circuit acknowledged it had “never addressed this issue,” but rejected the argument. Relying on Feifer, the court concluded that the statement in the Alan Ritchey SPD that discrepancies would be governed by a separate, but non-existent, “official Plan Document” was “sloppy,” but that it did not render unenforceable the plan’s terms set out in the SPD.

H. Sanders Carter, Jr. is a Partner in the Atlanta office of Smith Moore Leatherwood LLP. He leads the firm’s life, health, and disability insurance and ERISA litigation practice. He is the Publications Chair of DRI’s Life, Health and Disability Committee and is the Co-Editor of ERISA Report.

**Gorsuch on ERISA: What to Expect From the New Supreme**
Neil M. Gorsuch was confirmed by the Senate on April 7, 2017, becoming the 113th justice of the Supreme Court of the United States. While the Senate confirmation process focused on all the hot-button constitutional issues (which were never answered), for those of us who read this newsletter, we all know the real question is what does his confirmation mean for ERISA?

In an effort to address this question, this article will examine the ERISA decisions authored by Judge Gorsuch, attempt to discern his views on key ERISA issues, and offer an assessment of his judicial philosophy as it applies to ERISA.

Justice Gorsuch, age 49, is the youngest associate justice appointed to the Supreme Court since Clarence Thomas. His credentials are outstanding, having earned an undergraduate degree from Columbia University, a law degree from Harvard Law School, and a doctoral degree from the University of Oxford. Following law school, he clerked for Judge David Sentelle on the United States Court of Appeals for the District of Columbia Circuit and later served as a law clerk on the Supreme Court for Justices Byron White and Anthony Kennedy.

After working in private practice for ten years, as well as the Justice Department, he was nominated to the United States Court of Appeals for the Tenth Circuit, where he served from 2006 to 2017. Much of what we can learn about Justice Gorsuch’s views on ERISA will come from his years on the court of appeals, but first we will look at his work on the Supreme Court in his first term.

**Clues from the First Term**

On April 17, 2017, ten days after his confirmation, Justice Gorsuch sat for his first oral argument in *Perry v. Merit Systems Protection Board*, 137 S.Ct. 1975 (2017). The case involved a complicated question of statutory interpretation arising under the Civil Service Reform Act of 1978. Justice Gorsuch was highly engaged in the oral argument, but ultimately the case was decided 7-2 with Justice Gorsuch dissenting, joined by Justice Thomas.

The first few lines of the dissent are characteristic of Justice Gorsuch’s writing style and his long-held beliefs about the judiciary’s role in statutory interpretation: “Anthony Perry asks us to tweak a congressional statute—just a little—so that it might (he says) work a bit more efficiently. … Respectfully, I would decline Mr. Perry’s invitation and would instead just follow the words of the statute as written.” *Id.* at 543-44.

These same textualist concerns also formed the basis of the Court’s decision in *Henson v. Santander Consumer USA Inc.*, 137 S.Ct. 1718 (2017), this time with Justice Gorsuch delivering the unanimous opinion of the Court. The case involved the question of who qualifies as a “debt collector” under the Fair Debt Collection Practices Act. Writing for the Court, Justice Gorsuch again emphasized his views on adhering to the statutory text: “While it is of course our job to apply faithfully the law Congress has written, it is never our job to rewrite a constitutionally valid statutory text under the banner of speculation about what Congress might have done had it faced a question that, on everyone’s account, it never faced.” *Id.* at 184. Rejecting the petitioners’ public policy arguments, the Court narrowly interpreted the definition of “debt collector” based on the plain statutory text.

The Supreme Court’s most recent term also involved an important issue of statutory interpretation regarding the scope of the “church plan” exception under ERISA. See *Advocate Health Care Network v. Stapleton*, 137 S.Ct. 1852 (2017). Oral argument in Stapleton took place just days before Justice Gorsuch was confirmed and, therefore, he took no part in the consideration or decision of that case. Stapleton was decided 8-0 with all of the justices agreeing that a “church plan” need not be originally established by a church to qualify as a “church plan” under the statute.

While it is impossible to know for sure, Justice Gorsuch likely would have sided with the other eight justices as the Court’s decision focused almost exclusively on the relevant statutory text, and only considered “extra-statutory sources” to the extent the respondents attempted to rely on them. See *Id.* at 187 (describing excerpts of committee hearings and scattered floor statements as “the stuff of which we have called ‘among the least illuminating forms of legislative history’”). Of course, Justice Gorsuch probably would not have considered such material at all, but that still would have meant voting with the other eight justices.

**Clues from the Tenth Circuit**

Perhaps the most direct way to discern a judge’s views on key legal issues is to examine the prior written decisions of the judge. There are, however, only a few ERISA decisions authored by Judge Gorsuch during his time on the Tenth Circuit. The decisions that exist, however, are worthy of consideration and tend to show a consistent judicial philosophy involving strict adherence to precedent and judicial restraint.

One example of Judge Gorsuch’s analytical style and adherence to legal precedent is found in *McClenahan v. Metropolitan Life Insurance Co.*, 416 F. App’x 693 (10th Cir. 2011). McClenahan involved three issues: (1) whether a
Colorado statute may operate retroactively to affect the standard of review in an ERISA disability case, (2) whether the insurer abused its discretion in denying disability benefits, and (3) whether the district court erred in refusing to allow the claimant to supplement the administrative record. All three issues were resolved through careful analysis of the law and strict adherence to binding legal precedents.

In McClenahan, the district court granted summary judgment for the insurer, finding no abuse of discretion in the denial of the claimant’s disability claim. On appeal, the court considered whether a recent Colorado statute requiring de novo review in any court having jurisdiction over a disability claim can have retroactive effect. The statute was enacted after the formation of the plan and denial of benefits.

Applying a two-part test for determining the retroactive effect of statutes under Colorado law, Judge Gorsuch looked at the words of the statute itself, and found no evidence suggesting the legislature intended the statute to apply to transactions occurring before the date of enactment. See id. at 696. The court, therefore, held the claimant failed to show the legislature intended the statute to have retroactive effect. See id. Judge Gorsuch further noted neither party argued the statute was preempted by ERISA, and because the court found the statute inapplicable, it would not “pass on the question” as to whether the Colorado statute is preempted by ERISA. See id.

Having determined the district court properly reviewed the insurer’s disability decision under the deferential standard of review, Judge Gorsuch then turned to the argument that the insurer’s decision was an abuse of discretion. The starting point for the analysis was Tenth Circuit legal precedent defining the contours of the abuse of discretion standard.

Judge Gorsuch wrote that the claimant failed to satisfy her burden of proving an abuse of discretion, where the evidence showed the insurer consulted in-house nurses and doctors, as well as independent physicians, and sought out responses from claimant’s own treating providers. See id. at 697. This part of the opinion is notable for its thorough review of the medical evidence, claimant’s arguments about that evidence, and the insurer’s prevailing counterarguments.

Although recognizing that some medical evidence in the record may have supported a different decision, Judge Gorsuch ultimately concluded the district court’s decision was not unreasonable and would be upheld. See id. at 698 (“But neither can we say that its decision was an unreasonable one unsupported by substantial evidence. And more than that our precedent does not require.”).

Finally, the claimant argued the district court erred by refusing to allow her to supplement the administrative record with a medical report created months after the administrative record closed. Once again, adhering to Tenth Circuit precedent, Judge Gorsuch found the district court had “no other possible path,” but to disallow the introduction of new evidence and to limit its review to the administrative record. See id. at 699.

Another case illustrating Judge Gorsuch’s strict adherence to binding precedent and statutory interpretation in the ERISA context is Jensen v. Solvay Chemicals, Inc., 721 F.3d 1180 (10th Cir. 2013). This case involved complicated questions about the remedies available for an employer’s violation of ERISA’s notice requirements as they apply to pension plans. The opening paragraph of the opinion is characteristic of Judge Gorsuch’s ability to engage the reader and make a complicated legal matter easily understandable:

Solvay could never be sure just how much its pension plan would affect its bottom line. Because it promised retirees a defined benefit, the company was on the hook to cover the difference whenever the plan’s performance fell short. In 2000, Solvay didn’t have to contribute anything. But in 2003, it had to meet a $23 million shortfall. Displeased with the volatility of this arrangement—not to mention the cost—Solvay decided to change how it provided retirement benefits.

Id. at 1182.

Federal law did not prohibit the employer from changing its pension plan, but required detailed notice of the changes be given to employees under ERISA § 204(h). The employees complained that the employer’s notice was deficient and filed suit. The district court granted summary judgment for the employer.

In the first appeal, a three-judge panel of the Tenth Circuit, including Judge Gorsuch, reversed the district court, holding that the employer had violated ERISA § 204(h) by failing to adequately describe the early retirement benefits under the old plan. The court then remanded the case to the district court for a determination of remedies.

On remand, the employees “sought the return of their lost early retirement benefits.” Under ERISA § 204(h), a district court can only award such a remedy if the employer’s notice violation is “egregious.” See id. at 1182. The statute defined “egregious” in two ways, which essentially required either (i) intentional conduct by the employer, or (ii) a failure to promptly correct the deficiency when given notice of the violation. See id. The district court found the employer’s violation of the notice requirement was not “egregious” because it was not intentional and the employer never received notice of the violation until the
The employees appealed a second time, and this time the district court was affirmed. Writing for a different three-judge panel, Judge Gorsuch analyzed the meaning of “egregious” based only on the definition provided by the statute. See id. at 1183 (“Happily, the statute defines the term for us….”). He then rejected the argument that the district court’s factual findings were clearly erroneous. Again, applying Tenth Circuit precedent, Judge Gorsuch described the considerable evidence in the record showing the employer intended to make all required disclosures under the law, that its omission was accidental, and that no employee alerted the employer to the deficiency in the notice until the litigation commenced. See id. at 183-84.

The employees further argued they were entitled to “appropriate equitable relief” under § 502(a)(3) because the employer failed to furnish an adequate summary of material modifications in accordance with ERISA § 102(a). Again, looking to controlling precedent, Judge Gorsuch cited Cigna v. Amara, observing that although § 502(a)(3) authorizes forms of relief that were “typically available in equity,” it also imposes whatever requirements “come from the law of equity” for each specific remedy. See id. at 1185. Affirming the district court, Judge Gorsuch concluded the employees could not establish the “remedy of estoppel” because they failed to show that any notice deficiency influenced their conduct having been aware all along of the effect the new plan would have on their early retirement benefits. See id.

Judge Gorsuch allowed that the employees might be entitled to other equitable remedies, but noted they failed to tell the district court what those remedies might be and, therefore, “forfeited any argument that they are eligible for another remedy.” Id. at 1185 (“The employees may secretly harbor a wish for some form of equitable relief not foreclosed by the district court’s findings, but they have yet to identify it to anyone else after six-and-a-half years of litigation and to know that much is to know it is time to call this matter to a close.”).

Two other ERISA decisions authored by Judge Gorsuch involve routine appeals in disability cases. In both cases, Judge Gorsuch wrote opinions affirming the district court and holding the administrators’ claim decisions were supported by substantial evidence. See Lucas v. Liberty Life Assurance Co., 444 F. App’x 243 (10th Cir. 2011) (fact that treating physician held opinion contrary to insurer’s determination did not mean insurer’s decision was unreasonable); Niedens v. Cont’l Cas. Co., 258 F. App’x 216 (10th Cir. 2007) (insurer’s decision to terminate benefits was “supported by substantial evidence &rarr; evidence that, even if not unassailable, is of the sort ‘a reasonable mind could accept as sufficient’”). Neither case involved any novel legal issue.

While on the court of appeals, Judge Gorsuch was known for his criticism of Chevron deference, in which an agency’s reasonable interpretation of an ambiguous statute is often given controlling weight by courts. In his view, Chevron creates numerous “separation of powers” problems and ought to be reconsidered. See Gutierrez-Brizuela v. Lynch, 834 F.3d 1142 (10th Cir. 2016) (Gorsuch, J., concurring). Chevron deference is typically not an issue in the routine ERISA matter, but this may not always be the case. In Black & Decker Disability Plan v. Nord, 538 U.S. 822, 831-32 (2003), the Court acknowledged the potential for Chevron deference in ERISA cases, noting the Secretary of Labor’s regulations had never instructed plan administrators to accord special weight to the opinions of treating physicians. Given the scope of changes in the new ERISA disability regulations, this is perhaps an area that may require closer scrutiny in the not too distant future.

Clues from Judicial Alignment

In his first term on the Supreme Court, Justice Gorsuch has aligned himself with Justice Thomas in 100% of the cases he has considered. See http://www.scotusblog.com/wp-content/uploads/2017/06/Supreme-Court-clues-from-Judicial-Alignment.pdf. Although this is admittedly a small sample size, the trend is not inconsistent with what most commentators had expected. Thus, perhaps the single best predictor as to how Justice Gorsuch will approach ERISA is to look at what Justice Thomas has written.


Notably, Justice Thomas also joined in Justice Scalia’s prescient dissent in Metropolitan Life Insurance Co. v. Glenn, 554 U.S. 105 (2008), which accurately predicted the difficulty lower courts would have attempting to “weigh” the impact of a conflict in reviewing claim decisions for abuse of discretion. These opinions may be the best sources for understanding or predicting how Justice Gorsuch will approach similar ERISA issues that inevitably will arise in the coming years.

From the perspective of an ERISA defense lawyer, and regardless of one’s
political leanings, the careful and restrained approach demonstrated by Judge Gorsuch in ERISA cases on the court of appeals is precisely the kind of jurist one would hope to have in any ERISA case. This same careful analysis, adherence to legal precedent, and strict statutory construction will most certainly factor into Justice Gorsuch’s decisions going forward, and perhaps we will have more cases like Davila and less like Glenn.

Michael P. Cunningham is a member of Funk & Bolton, P.A. He represents life, health, and disability insurers in federal and state court litigation, as well as in regulatory proceedings, arbitration, and mediation. He is a member of the Maryland and District of Columbia bars. Mr. Cunningham is a member of DRI’s Life, Health and Disability Committee and was named a “Rising Star” in Maryland Super Lawyers.

Being Exhausted Matters: ERISA’s Exhaustion Doctrine and the New DOL Claims Regulations
by Jerel C. Dawson and Michael C. Lamboyeux, Jr.

Running a marathon is exhausting, but it also provides the means with which to test one’s resolve. Unfortunately, the same can be said for reading the new Department of Labor (“DOL”) regulations addressing the claims procedures of employee benefit plans.

Under the Employee Retirement Income Security Act of 1974 (“ERISA”), such plans must provide an appeal process for participants or beneficiaries to obtain full and fair review of an adverse decision. 29 U.S.C. § 1133. In 2000, the DOL implemented this requirement through detailed claims procedure provisions that apply to group health plans, retirement plans, disability plans, and others. 29 C.F.R. § 2560.503-1. These claims procedure regulations were strengthened and enlarged under the Affordable Care Act (“ACA”). See 29 C.F.R. § 2590.715-2719(b)(1)(i)(F).

In the not so distant future â€“ January 1, 2018, to be exact â€“ the new DOL regulations, which are based on the rules already applicable to health claims under the ACA, will further enhance the scope and importance of these “safeguards.” 29 C.F.R. § 2560.503-1 (2018).

Neither the regulations nor ERISA require participants to utilize the review procedures provided by a plan. Courts have, however, uniformly adopted the view that a claimant must exhaust the plan’s appeal and review procedures before filing a lawsuit for benefits pursuant to ERISA. See Vaught v. Scottsdale Healthcare Corp. Health Plan, 546 F.3d 620, 626 (9th Cir. 2008); Fallick v. Nationwide Ins. Co., 162 F.3d 410, 418 (9th Cir. 1998); Kinkead v. Sw. Bell Corp. Sickness & Acc. Disability Benefit Plan, 111 F.3d 67, 68 (8th Cir. 1997); Counts v. Am. Gen. Life & Acc. Ins. Co., 111 F.3d 105, 108 (11th Cir. 1997).

While there are typically consequences of a claimant’s failure to exhaust the claim procedure, the recent evolution of the DOL regulations calls into question the strength of the longstanding exhaustion doctrine. Specifically, the ease with which claims are deemed exhausted, combined with the incentive for a claimant to not exhaust the claims procedure, is concerning. Before explaining how the new regulations undermine the exhaustion doctrine and will increase litigation, a brief overview of the doctrine itself is warranted.

Overview of the Exhaustion Doctrine

The majority of ERISA disputes are benefits claims to which the exhaustion doctrine applies, and those are the claims on which this article will focus. With claims exhaustion, a claimant is required to receive a final decision on a particular claim prior to filing a lawsuit, see DuPerry v. Life Ins. Co. of Am., 632 F.3d 860, 875 (4th Cir. 2011); however, issue or theory exhaustion requires that a plan participant raise all reasons for challenging a denial of benefits during the initial appeal process. Vaught v. Scottsdale Healthcare Corp. Health Plan, 546 F.3d 620, 630 (9th Cir. 2008). Some courts have ruled that ERISA does not require issue or theory exhaustion, but that is a topic for another day. See id.; Wolf v. Nat’l Shopmen Pension Fund, 728 F.2d 182 (3d Cir. 1984).

So why is the claim exhaustion doctrine important? Courts have cited a number of reasons for the judge-made law, which was created in part by the Ninth Circuit’s decision in Amato v. Bernard, 618 F. 2d 559 (9th Cir. 1980), and expanded by subsequent federal circuit courts. In view of the structure and history of ERISA, it has been said that the exhaustion doctrine:

1. Effectuates Congress’ purpose in requiring that benefit plans provide for administrative review procedures by ensuring those internal remedial procedures are utilized;
2. Enables plan administrators to apply their expertise and exercise their discretion to manage the plan’s funds, correct errors, make considered interpretations of plan provisions, and assemble a factual record that will assist the court reviewing the administrators’ actions;
3. Reduces the number of frivolous lawsuits;
4. Promotes the consistent treatment of claims for benefits;
5. Provides a non-adversarial method of claims settlement, and minimizes the cost of claims settlement; and
6. Enables the issues to be more fully developed and refined for judicial review.

The majority of ERISA disputes are benefits claims to which the exhaustion doctrine applies, and those are the claims on which this article will focus. With claims exhaustion, a claimant is required to receive a final decision on a particular claim prior to filing a lawsuit, see DuPerry v. Life Ins. Co. of Am., 632 F.3d 860, 875 (4th Cir. 2011); however, issue or theory exhaustion requires that a plan participant raise all reasons for challenging a denial of benefits during the initial appeal process. Vaught v. Scottsdale Healthcare Corp. Health Plan, 546 F.3d 620, 630 (9th Cir. 2008). Some courts have ruled that ERISA does not require issue or theory exhaustion, but that is a topic for another day. See id.; Wolf v. Nat’l Shopmen Pension Fund, 728 F.2d 182 (3d Cir. 1984).

So why is the claim exhaustion doctrine important? Courts have cited a number of reasons for the judge-made law, which was created in part by the Ninth Circuit’s decision in Amato v. Bernard, 618 F. 2d 559 (9th Cir. 1980), and expanded by subsequent federal circuit courts. In view of the structure and history of ERISA, it has been said that the exhaustion doctrine:

1. Effectuates Congress’ purpose in requiring that benefit plans provide for administrative review procedures by ensuring those internal remedial procedures are utilized;
2. Enables plan administrators to apply their expertise and exercise their discretion to manage the plan’s funds, correct errors, make considered interpretations of plan provisions, and assemble a factual record that will assist the court reviewing the administrators’ actions;
3. Reduces the number of frivolous lawsuits;
4. Promotes the consistent treatment of claims for benefits;
5. Provides a non-adversarial method of claims settlement, and minimizes the cost of claims settlement; and
6. Enables the issues to be more fully developed and refined for judicial review.
Despite the myriad advantages of the exhaustion doctrine, courts have also identified a number of exceptions to the exhaustion requirement. For example, the futility exception applies if a plan’s internal claim procedures would not supply the claimant a meaningful opportunity for review. See Carey v. United of Omaha Life Ins. Co., 633 F. App’x 478, 479 (9th Cir. 2016); Springer v. WalMart Assoc. Group Health Plan, 908 F.2d 897 (11th Cir. 1990). Similarly, a claimant may be excused from the exhaustion requirement if the plan administrator or some decision maker refuses access to the available review procedures. See Schorsch v. Reliance Standard Life Ins. Co., 693 F.3d 734, 736 (7th Cir. 2012); Biesen v. Suburban Trust & Sav. Bank, 642 F. Supp. 1503 (N.D. Ill. 1986).

Additionally, courts do not demand that claimants exhaust claims procedures that are adopted after litigation has commenced. See Eastman Kodak Co. v. STWB, Inc., 452 F.3d 215, 221 (2d Cir. 2006) (noting that “[t]ime-barred ERISA-dispute procedures in place would have the power to force claimants, first, to resort to litigation to obtain their benefits, and then, to abandon their suit at whatever point the plan adopted a claims procedure”). Further, courts are not required to exhaust a claim where a plan and other governing documents do not inform claimants of the requirement to exhaust the administrative procedures prior to filing a lawsuit. See generally Molain v. Trover Sols., Inc., 613 F. App’x 142 (3d Cir. 2015).

By the same token, some circuits have concluded that a plan decision maker’s failure to respond to a claimant’s request for the administrative record and other claims-related documents excuses the claimant’s failure to exhaust. See Brown v. J.B. Hunt Transp. Servs., Inc., 586 F.3d 1079 (8th Cir. 2009); Curvy v. Contract Fabricators Inc. Profit Sharing Plan, 891 F.2d 842 (11th Cir. 1989), abrogated on other grounds by Murphy v. Reliance Standard Life Ins. Co., 247 F.3d 1313 (11th Cir. 2001).

While the above list is not exhaustive, if a claimant fits into one of the above-referenced exceptions, the claimant is typically deemed to have exhausted the administrative remedies available under the plan and is entitled to pursue any available remedies under ERISA § 502(a). See 29 C.F.R. §§ 2560.503-1(m) (2015).

**Consequences of Failure to Exhaust**

When there are no exceptions present, a significant issue in the case law governing claims exhaustion concerns the consequences of a claimant’s failure to exhaust administrative remedies. Courts generally will either dismiss the complaint with or without prejudice, stay the proceedings pending completion of administrative review, or in some circumstances grant a plan’s request for summary judgment.

The most common avenue taken by courts is to dismiss the complaint. See Benaim v. HSBC Bank USA, 23 F. App’x 55, 56 (2d Cir. 2001); Miss v. Unum Grp., 638 F. App’x 347, 351 (5th Cir. 2016); Zhou v. Guardian Life Ins. Co. of Am., 295 F.3d 677, 680 (7th Cir. 2002). In the great majority of cases, when a court refuses to hear a plaintiff’s claim due to failure to exhaust administrative remedies, the court will dismiss the claim without prejudice.

Consequences of Failure to Exhaust (2015).

The court will issue a ruling that pays lip service to the exhaustion doctrine when this route is taken. See Buckley, 461 F.3d at 1329. However, in certain circumstances when the failure to exhaust the plan’s claim procedure has resulted in significant prejudice to the plan, such as the staleness of a claim brought long after relevant events or the allotted time to pursue administrative remedies, the claimant faces a higher risk of a court dismissing the case with prejudice.

For example in Bird v. GTX, Inc., 2010 WL 883738 (W.D. Tenn. Mar. 5, 2010), the undisputed evidence showed that the plaintiff filed the lawsuit prior to completing her internal appeals. However, the period to pursue administrative remedies had expired, so the court reasoned that a dismissal with prejudice was appropriate. Id. at 4.

When clarifying the distinction between a dismissal with prejudice versus without prejudice, the Fourth Circuit came to a similar conclusion in Gayle v. United Parcel Service, 401 F.3d 222 (4th Cir. 2005). The court noted that a dismissal without prejudice was appropriate whenever a claim can still be brought, but that dismissal with prejudice was required where the claimant’s plan remedies were time-barred. Id. at 230. In dismissing the case with prejudice, the court specifically expressed that “[a]ny remaining dispute must be resolved between the plaintiff and her lawyers.” Id.

circumstances, the exhaustion doctrine has been an invaluable tool for plans during claims disputes.

In line with the above referenced cases, courts have also granted summary judgment in favor of the plan when a claimant fails to exhaust administrative remedies. See Counts v. Am. Gen. Life & Acc. Ins. Co., 111 F.3d 105 (11th Cir. 1997) (affirming summary judgment in favor of the plan where claimant failed to file an administrative appeal prior to filing suit and court did not find administrative remedies would be futile); Harding v. Provident Life & Acc. Ins. Co., 809 F. Supp. 2d 403, 421 (W.D. Pa. 2011) (summary judgment in favor of plan where claimant failed to file an administrative appeal from the denial of benefits within the time period set forth in the denial letter); Tindell v. Tree of Life, Inc., 672 F. Supp. 2d 1300, 1312 (MD. Fla. 2009) (summary judgment in favor of plan where claimant chose to file suit instead of seeking administrative review).

Despite the teeth the exhaustion doctrine appears to have, under appropriate circumstances, the court will stay the case, rather than dismiss it, to allow a plaintiff the opportunity to exhaust his or her administrative remedies and return to the court for review of the decision, if necessary. See Lindemann v. Mboil Oil Corp., 79 F.3d 647, 651 (7th Cir. 1996) (noting that a district court has discretion to dismiss or stay a case pending completion of administrative review); see also Weaver v. Phoenix Home Life Mut. Ins. Co., 990 F.2d 154, 159 (4th Cir. 1993); Brown v. Babcock & Wilcox Co., 589 F. Supp. 64, 71-72 (S.D. Ga. 1984).

Effects the New DOL Regulations Have on the Previous Consequences

Consequences in life prevent us from making mistakes and guide us to do the right thing, theoretically. However, it appears the new DOL regulations set to take effect will significantly curb the already flexible consequences of a claimant’s failure to exhaust administrative remedies. The regulations make it easier for claimants to file suit under ERISA and serve to protect claimants who erroneously file suit without exhausting administrative remedies.

The section of the new regulations that will have the largest effect on the exhaustion doctrine provides as follows:

(i) In the case of a claim for disability benefits, if the plan fails to strictly adhere to all the requirements of this section with respect to a claim, the claimant is deemed to have exhausted the administrative remedies available under the plan, except as provided in paragraph (1)(2)(ii) of this section. Accordingly, the claimant is entitled to pursue any available remedies under section 502(a) of the Act on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. If a claimant chooses to pursue remedies under section 502(a) of the Act under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

(ii) Notwithstanding paragraph (1)(2)(i) of this section, the administrative remedies available under a plan with respect to claims for disability benefits will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the claimant so long as the plan demonstrates that the violation was for good cause or due to matters beyond the control of the plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the plan and the claimant. This exception is not available if the violation is part of a pattern or practice of violations by the plan. The claimant may request a written explanation of the violation from the plan, and the plan must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the administrative remedies available under the plan to be deemed exhausted. If a court rejects the claimant’s request for immediate review under paragraph (1)(2)(i) of this section on the basis that the plan met the standards for the exception under this paragraph (1)(2)(ii), the claim shall be considered as re-filed on appeal upon the plan’s receipt of the decision of the court. Within a reasonable time after the receipt of the decision, the plan shall provide the claimant with notice of the resubmission.


Of that section, the two italicized segments should give pause to all plan administrators governed by U.S. law. The first section is troubling for several reasons. At the onset, it unambiguously puts the final nail in the coffin for the “substantial compliance” doctrine.

The substantial compliance doctrine, which was already on the ropes in various circuits, see Halo v. Yale Health Plan, Dir. of Benefits & Records Yale Univ., 819 F.3d 42 (2d Cir. 2016), previously provided that the plan administrator who has violated a technical rule under ERISA such as regulations governing the content of letters denying claims for benefits may be excused for the violations if the administrator has substantially complied with the provisions of ERISA. See generally Phoenix Mut. Life Ins. Co. v. Adams, 30 F.3d 554, 563 (4th Cir. 1994).
The new regulations quickly bury any hope of a comeback on the part of the substantial compliance doctrine by expressly stating that strict adherence to the regulations is required. See 29 C.F.R. § 2560.503-1(l)(2)(ii) (2018).

In addition, the regulations put the onus on the plan to prove that the violations were de minimis and were due to good cause or matters beyond the control of the plan in order to avoid the “deemed exhausted” moniker. Id. This segment alone will incentivize claimants to challenge the exhaustion requirement. If found to be correct, the claim or appeal is deemed denied on review and is not entitled to deference; however, it gets even worse. See 29 C.F.R. § 2560.503-1(l)(2)(ii) (2018).

Read plainly, the second segment appears to remove any and all potential consequences of the new regulations: Per the new regulations, the court reject a claimant’s position that the administrative remedies should be deemed exhausted, the claim is simply “re-filed on appeal.” See 29 C.F.R. § 2560.503-1(l)(2)(ii) (2018). This is disturbing for several reasons â€“ especially in jurisdictions where discretionary clauses are not banned.

First, claimants now have every motivation to file lawsuits before exhausting the administrative remedies. Should a claimant be wrong, there is no skin off their nose and they go back to being on administrative appeal. However, should they be right they will be entitled to sue under a de novo standard of review, which as everyone reading this knows, can significantly alter the outcome of a case. The proverb “no risk, no reward” is thus dispelled in this instance.

Second, the plain language of the regulation does not appear to allow any sort of dismissal â€“ with or without prejudice. Simply put, the claim “shall be considered as re-filed on appeal” if the court determines the deemed exhaustion doctrine does not apply. See 29 C.F.R. § 2560.503-1(l)(2)(ii) (2018) (emphasis added). On its face, it appears that even if the period to file administrative remedies has expired, the claim would be put back on administrative appeal. Such an outcome would be a very harsh reality for plan fiduciaries, so it will be important to follow the case law that will undoubtedly develop in this area once the new regulations are implemented.

Third, the regulation provides that it is a plan’s burden to prove that a de minimis violation was for good cause or for matters beyond the control of the plan. See 29 C.F.R. § 2560.503-1(l)(2)(ii) (2018). This will undoubtedly open the flood gates for claimants to seek discovery related to internal procedures and practices when the issues of claims exhaustion are advanced.

Given that the de minimis “exception is not available if the violation is part of a pattern or practice,” the main potential avenue for discovery would appear to be an allegation of “pattern or practice” violations. Courts have generally been reluctant to allow for such extensive discovery in the ERISA context. See, e.g., Sernien v. Life Ins. Co. of N. Am., 436 F.3d 805 (7th Cir. 2006); Denmark v. Liberty Life Assur. Co. of Boston, 566 F.3d 1 (1st Cir. 2009); Blake v. Union Camp Int’l Paper, 622 F. App’x 853, 855 (11th Cir. 2015).

However, the new regulation appears to put a plan’s prior patterns and practices at issue when a plaintiff files a “deemed exhaustion” case and this has been any perceptible violation. This will leave plan administrators with two undesirable choices â€“ (1) decline to contest that the claim is deemed exhausted, thus avoiding pattern/practice discovery but allowing the claimant to potentially receive a more favorable standard of review; or (2) assert that the violation was de minimis, which may open the door for pattern/practice discovery and potentially force plans to defend other administrative decisions involving non-party claimants.

Such options undoubtedly weaken the exhaustion doctrine by incentivizing plans to acquiesce to deemed exhaustion arguments. Ultimately, this will shift judicial attention away from the core issue of whether the claimant is disabled and put the spotlight on the plan to make sure it crossed the t’s and dotted the i’s in accordance with the new regulations.

Finally, the DOL regulations specify that if a claimant believes there is a violation, the claimant may request a written explanation, to which the plan has 10 days to respond. See 29 C.F.R. § 2560.503-1(l)(2)(ii) (2018). The request isn’t required, so it is puzzling why the plaintiff would voluntarily make one. Additionally, the regulations do not define what happens if the plan does not respond within the allotted ten-day period. That said, at the very least, it puts another burden on the plans that will increase costs in administering and defending these ERISA claims.

Conclusion

The exhaustion doctrine has been uniformly imposed in the context of plan benefit terminations or denials under ERISA for the better part of 30 years. The rationale behind the application of the doctrine in the context of ERISA claims is based principally on the assumption that Congress intended plan participants to utilize the internal administrative remedies mandated by the statute. The doctrine has thus been a crucial tool to keep the primary responsibility for processing and reviewing claims in the hands of the plan fiduciaries.

Now that the doctrine is under an apparent attack, its usefulness will continue to wane unless the federal courts intervene and resurrect its significance. In the meantime, it is imperative that plan administrators, third party
administrators, and their counsel ensure the claim handling procedures are in compliance with the new regulations’ requirements. The spotlight will be brighter than ever on administrators’ claim handling procedures, and thanks to the DOL, it appears that the plan fiduciaries’ jobs just got a whole lot more exhausting.

Jere C. Dawson is a partner in the Miami office of Shutts & Bowen LLP, where he is a member of the Insurance Practice Group. Jere practices primarily in the areas of life, health, and disability insurance defense, with particular focus on federal ERISA litigation and appeals. Since 2003, he has prepared 49 successful summary judgment motions on behalf of insurers in federal ERISA actions.

Michael C. Larmoyeux, Jr. is an associate in the Miami office of Shutts & Bowen LLP, where he is a member of the Insurance Practice Group. Michael focuses his practice on cases involving life, health and disability insurance. He represents securities brokers and dealers, corporations and other business entities on claims under ERISA and other federal and state laws in all aspects of ERISA litigation, with a particular focus in complex commercial insurance and bad faith litigation.

Supreme Court Clarifies ERISA’s Church Plan Exemption, But Questions Remain
by Bryan M. Shay and Jeffrey M. Brenner

One of the developments in ERISA litigation over the past few years has been an increased focus on the provision in the statute that exempts so-called “church plans” from ERISA’s control.

On June 5, 2017, the Supreme Court decided the consolidated matter of Advocate Health Care Network v. Stapleton, 198 L. Ed. 2d 96 (2017), in which it was asked to clarify what qualified as a “church plan” under ERISA. In a unanimous decision, the Court held that employee benefit plans maintained by a “principal-purpose organization” can qualify as a “church plan” for purposes of ERISA, even if the plans were not originally established by a church. In so holding, the Supreme Court reversed decisions of the Third, Seventh, and Ninth Circuit Courts of Appeals, but its decision left open several questions that will necessarily have to be further litigated in the lower courts.

Exceptions For “Church Plans”

Congress enacted the Employee Retirement Income Security Act of 1974 (“ERISA”) to remedy “the lack of employee information and adequate safeguards” and the “inadequacy of current minimum standards” for pension (and welfare) plans. 29 U.S.C. § 1001(a). Generally, ERISA requires comprehensive regulation of employee benefit plans, and it mandates that private employers offering employee benefit plans must comply with a wide variety of rules regarding plan solvency, safeguards, reporting, and notification.

One of the main purposes of ERISA was to “ensure that employees will not be left empty-handed once employers have guaranteed them certain benefits.” Lockheed Corp. v. Spink, 517 U.S. 882, 887 (1996). From the beginning, however, Congress created certain exemptions from the sometimes onerous requirements of ERISA. Among those few exceptions were employee benefit plans that qualified as “church plans.” See 29 U.S.C. § 1003(b)(2). The purpose of this exemption, according to one of the parties to the Stapleton matter, was “to avoid government examination of confidential church books and records.” Stapleton Respondent Brief at p.1.

Originally, Congress defined a “church plan” as “a plan established and maintained ... by a church.” 29 U.S.C. § 1002(33)(A). However, this definition led to some difficulty for the courts and the federal agencies tasked with enforcing ERISA’s regulations.

One example of this confusion cited by the parties and the Court in Stapleton related to the pension plans established by orders of Catholic Sisters to benefit their hospitals’ employees. Stapleton, 198 L. Ed 2d at 107. In 1977, the general counsel of the IRS opined that these pension plans did not qualify as “church plans” under ERISA’s original definition because the Catholic Sisters were “not carrying out [the Church’s] religious functions.” Id. This decision and others enforcing a strict definition of “church plan” were protested by religious groups, which claimed that the IRS and other federal organizations were improperly inserting themselves into the question of what the mission of a church is or how that mission should be carried out. See id. (quoting 125 Cong. Rec. 10054 (1979)).

As part of the Multiemployer Pension Plan Amendments Act of 1980, Congress amended the definition of “church plan” that was included in ERISA. It did so by adding subpart (C)(i) to the definition, which reads as follows: “A plan established and maintained for its employees (or their beneficiaries) by a church or by a convention or association of churches includes a plan maintained by an organization ... the principal purpose or function of which is the administration or funding of [such] plan or program for the provision of retirement benefits or welfare benefits, or both, for the employees of a church or a convention or association of churches, if such organization is controlled by or associated with a church or a convention or association of churches.” 29 U.S.C. § 1002(33)(C)(i). In its holding in Stapleton, the Supreme Court referred to the organizations referenced in the amended definition as “principal-purpose organizations.” Stapleton, 198 L. Ed. 2d at 102.

Exceptions for “Church Plans”
Although the Congressional record is not a model of clarity with regard to Congress’ intention in amending the definition of “church plan,” there are some—including the hospitals involved in the consolidated Stapleton matter—that have argued the amendment was intended to address the concerns raised about the IRS’ narrow interpretation of the term. See id. at 107.

In light of the 1980 amendment of the definition of “church plan,” the federal agencies responsible for administering ERISA began interpreting the term “church plan” in a much broader manner, such that it was deemed “to include any plan maintained by a principal-purpose organization, regardless of whether a church initially established the plan.” Id. at 102. The IRS, for example, determined that “internal benefits committee of a church-affiliated nonprofit counts as such an organization.” Id. (citing IRS General Counsel Memorandum No. 39007 (Nov. 2, 1982)). In fact, from 1982 onward the IRS issued several hundred private letter rulings endorsing this view. Id.

The Underlying “Church Plan” Litigation

The Stapleton case decided by the Supreme Court was actually three separate cases that were consolidated on appeal. These cases were Stapleton v. Advocate Healthcare System, 817 F.3d 517 (7th Cir. 2016); Kaplan v. St. Peter’s Healthcare Systems, 810 F.3d 175 (3d Cir. 2015); and Rollins v. Dignity Health, 830 F.3d 900 (9th Cir. 2016).

According to the Supreme Court, the consideration of these three cases by the Court was the culmination of what the Court called “a recent wave of litigation challenging the [federal] agencies’ view regarding what qualified as a “church plan” under ERISA. Stapleton, 198 L. Ed. 2d at 102. Indeed, in the several years preceding the Court’s decision in Stapleton, the federal district and appeals courts found themselves split as to how narrowly the term should be applied. See, e.g., Jeffrey A. Herman, Resolving ERISA’s “Church Plan” Problem, 31 ABA J. Labor & Empl. Law 231, 234-238 (2016) (collecting cases reflecting the “split” between a narrow and broad interpretation of the “church plan” exemption).

Although the cases consolidated on appeal to the Supreme Court originated in different Circuit Courts of Appeals, the parties in each case were similar. For example, the petitioners in each case were three church-affiliated nonprofit organizations that ran health care facilities and offered pension plans to their employees. Id. at 101.

Petitioner Advocate HealthCare Network, for example, was described as operating “12 hospitals and some 250 other healthcare facilities in Illinois, and is associated with the Evangelical Lutheran Church in America and the United Church of Christ.” Id. at 101 n.1.

Petitioner Saint Peter’s Healthcare System ran “a teaching hospital and several other medical facilities in New Jersey, and is both owned and controlled by a Roman Catholic diocese there.” Id.

Petitioner Dignity Health was described as running “an extensive network of community hospitals throughout the country, and maintaining ties to the Catholic religious orders that initially sponsored some of its facilities.” Id.

The three cases also had in common the critical fact that the pension plans at issue in each case were established by the health care facilities, not churches, and the plans were managed by internal employee-benefits committees. Id. at 101.

The respondents in the consolidated Stapleton cases were current and former employees of the health care facilities, each of whom had participated in their employer’s pension plan. These parties argued that the pension plans at issue did not qualify as “church plans,” and therefore were required to comply with ERISA’s requirements. Id. at 102.

For example, the underlying complaint filed by respondents in the Stapleton case alleged that Advocate’s plan (referred to as the “Plan”) “imposed an improperly long five-year vesting period,” and that “petitioners failed to follow ERISA’s reporting and disclosure requirements and failed to insure and adequately fund the Plan.” Resps.’ Br. at pp.4-5.

The respondents maintained that these plans were required to comply with ERISA, and that they were not exempt based on the “church plan” exemption because the plans were not established by a church. Stapleton, 198 L. Ed. 2d at 102-03. Indeed, it was respondents’ belief that “hundreds of church-associated hospital conglomerates, often at the urging of “gotcha” benefit consultants, have in recent decades exploited a misreading of ERISA to lower their costs by claiming church-plan status for plans that had been operated—correctly—as ERISA plans.” Resps.’ Br. at p.19 (internal citations omitted).

In the litigation in the lower courts, the petitioners argued that the 1980 amendment to the definition of a “church plan” negated any need for the plan to be established by a church in order to qualify as a “church plan.” Stapleton, 198 L. Ed. 2d at 102. Rather, the petitioners argued, all that was required was that the plan be established or maintained by a principal-purpose organization.

The respondents argued that all “church plans” must originate from, and be “established” by, a church. Id. Notably, both the petitioners and the respondents agreed that a “church plan” need not be maintained by a church—
that is, it could be maintained by a principal-purpose organization. Id. at 103.

The district courts in the three cases agreed with the respondents’ position, and held that the petitioners’ plans must comply with ERISA because the plans were not “established” by a church. The Third Circuit was the first to address the issue on appeal, and it affirmed the trial court’s holding that ERISA’s plain text required that a pension plan be established by a church in order to qualify for the “church plan” exemption. Kaplan, 810 F. 3d 175, 177 (3d Cir. 2015). The Seventh and Ninth Circuit Courts of Appeals reached similar conclusions in Stapleton, 817 F. 3d at 523; and Rollins, 830 F. 3d at 906.

Appeals of each of the circuit courts’ decisions followed, and the Supreme Court consolidated the three cases for review. During the briefing in the Supreme Court, various groups submitted amicus briefs in support of the hospitals, including the Church Alliance, the Thomas More Society, the Catholic Health Association of the United States, the Alliance Defending Freedom, the Becket Fund for Religious Liberty, and other religious organizations.

These parties argued (among other things) that the circuit courts’ decisions contradicted the previous rulings of the IRS and the Department of Labor, thus creating confusion and a lack of uniformity for church-affiliated organizations that provided employee benefit plans. Several of the amicus in favor of the hospitals also raised the issue of whether the First Amendment permitted the government agencies and courts tasked with enforcing ERISA to second-guess the mission of a church and whether an affiliated organization—like a hospital—fit within that mission.

Several other parties filed amicus briefs in favor of the employees. These parties—which included the Employment Lawyers Association, Americans United for the Separation of Church and State, the ACLU, People for the American Way, the Pension Rights Center, and AARP—argued that a narrow reading of the “church plan” exemption was in keeping with the goal of ERISA and would most serve to protect the rights of employees. Some of the amicus in support of the respondents also argued that expanding the “church plan” exemption to religiously-affiliated institutions would create an impermissible preference for religion in the application and enforcement of ERISA.

A Plan Need Not Be Established By a Church to Qualify For the Church Plan Exemption

Writing for a unanimous Court (Justice Gorsuch did not participate), Justice Kagan started, and ended, with the plain language of the statute. The Court noted that the term “church plan” originally meant only “a plan established and maintained ... by a church.” However, the amended language in subparagraph (C)(i) that was added in 1980 provided that the original definition of “church plan” now includes “a plan maintained by [a principal-purpose] organization.” Stapleton, 198 L.Ed. 2d. at 103. According to the Court, the use of the word “include” signified Congress’ intent “that a different type of plan should receive the same treatment (i.e., an exemption) as the type described in the old definition”:

“In effect, Congress provided that the new phrase can stand in for the old one as follows: The term “church plan” means a plan established and maintained by a church. A plan established and maintained by a church includes a plan maintained by a principal-purpose organization. The church-establishment condition thus drops out of the picture.

Id. at 104. Or, as the Court illustrated:

Premise 1: A plan established and maintained by a church is an exempt church plan.

Premise 2: A plan established and maintained by a church includes a plan maintained by a principal-purpose organization.

Deduction: A plan maintained by a principal-purpose organization is an exempt church plan.

Id. As the Court explained, “[h]ad Congress wanted, as the employees contend, to alter only the maintenance requirement, it had an easy way to do so—differing by only two words from the language it chose, but with an altogether different meaning.” Id. Thus, according to the Court:

ERISA provides (1) that a ‘church plan’ means a ‘plan established and maintained ... by a church’ and (2) that a ‘plan established and maintained ... by a church’ is to ‘include[] a plan maintained by a principal-purpose organization.’ Under the best reading of the statute, a plan maintained by a principal-purpose organization therefore qualifies as a ‘church plan,’ regardless of who established it.

Id. at 108; see also id. at 104 (“Because Congress deemed the category of plans ‘established and maintained by a church’ to ‘include’ plans ‘maintained by principal purpose organizations, those plans—and all those plans—are exempt from ERISA’s requirements.’”).

Writing a concurring opinion, Justice Sotomayor agreed with the logical framework and conclusion of the unanimous majority opinion, noting that she “join[ed] the Court’s opinion because [she was] persuaded that it correctly
interprets the relevant statutory text.” Id. However, Justice Sotomayor did note
the relatively sparse legislative history of Subsection (C)(i), and expressed
concern about the practical implications the Court’s holding might have on
future cases, competitors, and society at large:

The decision to exempt plans neither established nor
maintained by a church could have the kind of broad effect that is
usually thoroughly debated during the legislative process and
thus recorded in the legislative record. And to the extent that
Congress acted to exempt plans established by orders of
Catholic Sisters, it is not at all clear that Congress would take
the same action today with respect to some of the largest health-
care providers in the country. Despite their relationship to
churches, organizations such as petitioners operate for-profit
subsidiaries, employ thousands of employees, earn billions of
dollars in revenue, and compete in the secular market with
companies that must bear the cost of complying with ERISA.
These organizations thus bear little resemblance to those
Congress considered when enacting the 1980 amendment to
the church plan definition.

Id. at 109.

The Supreme Court Leaves Many Church Plan Questions Unanswered

Following Stapleton, it is clear that a “church plan” for the purposes of ERISA
includes a plan maintained by a principal-purpose organization, even if the plan
was not established by a church. It goes without saying that the implications of
this decision will likely have a huge impact on thousands, if not millions, of
employees who work for nonprofit religious organizations like hospital systems,
schools, and charity organizations. For these employees, a mere showing that
their employer is affiliated with a church and maintains an employee benefit
plan would remove that plan from the protections afforded by ERISA.

However, these plans would still likely be regulated by other federal and state
laws. And although exemption of their employee benefit plans from ERISA will
afford these employers greater freedom in the design and implementation of
their benefit plans, they obtain this benefit at the expense of foregoing the
protections of ERISA-preemption of state law causes of action and the
differential standard of review for claim denials. Thus, the Stapleton decision
alters both the rights and the protections of both employers and employees of
church-affiliated organizations.

Perhaps more interesting than what the Supreme Court did decide in Stapleton,
however, may be the issues it did not decide. For example, although it
acknowledged that a “principal-purpose organization” is defined in ERISA as “a
church-associated organization whose chief purpose or function is to fund or
administer a benefits plan for the employees of either a church or a church-
affiliated nonprofit,” it expressly did not opine as to whether or not the petitioner
medical facilities’ internal benefits committees actually qualified as “principal-
purpose organizations” under ERISA. Id. at 109 n.3. In other words, Stapleton
did not set out criteria for determining when an organization would be
considered a “principal-purpose organization.” Addressing this issue, Karen
Ferguson, Director of the Pension Rights Center, stated:

The Court merely ruled that a religiously-affiliated entity can
establish a “church plan” that is exempt from federal pension
law. However, the Court noted that its ruling did not address a
second requirement of the law, that an exempt church plan be
maintained by an ‘organization’ that has administration of the
plan as its principal purpose.

* * *

In its opinion, the Court pointed out that this issue and a second
issue were not before it, and nothing said in the opinion
“expresses a view of how they should be resolved.” The
retirement security of hundreds of thousands of current and
former employees of religiously-affiliated hospitals, schools, and
social services agencies remains in limbo until these issues are
addressed.

Pension Rights Center, U.S. Supreme Court’s “church plan” decision leaves
key issue undecided (June 5, 2017),
http://www.pensionrights.org/newsroom/releases/us-supreme-
court%E2%80%99s-%E2%80%9Dchurch-plan%E2%80%9D-decision-leaves-
key-issue-undecided

Relatedly, the Court expressly did not address what it meant for an organization
to be “controlled by or associated with” a church or a convention or association
of churches. Several of the amicus parties raised this issue, as well as a
related issue: that is, the constitutionality of the “church plan” exemption.
Indeed, the amicus parties each seemed to find something in the
Establishment Clause that supported their position.

For example, the ACLU and Americans United for the Separation of Church and
State suggested that the Court should not extend the “church plan” exemption to
organizations like hospitals, which are regulated by the government in other
areas. As they stated in their brief, “The issues presented by this case are
whether religiously affiliated entities are the legal equivalent of churches (they aren’t) and whether courts are capable of differentiating between the two (they are).” \textit{Amicus Br. of ACLU, et al., at 7-8 and n.2.}

Groups like the Becket Fund for Religious Liberty found support in the First Amendment for the exact opposite conclusion: that the courts and the governmental agencies tasked with enforcing ERISA should not be in the business of deciding what degree of connection is necessary between a church and its affiliate organization, especially in an era in which “there is no single template for how religious groups organize themselves.” \textit{Amicus Br. of The Becket Fund for Religious Liberty, at 2-3. Indeed, as the Becket Fund stated, “A law that bases exemptions on questions of obedience to church doctrine is a clear violation of the Establishment Clause. And forcing government officials or courts to decide the relative zeal of religious organizations is both unconstitutional and unwise.” Thus, although the Court’s decision was—in its view—based on the plain language of the “church plan” exemption, it would seem that the full scope of the exemption remains to be tested.}

\textbf{Conclusion}

In reaching its unanimous conclusion in \textit{Stapleton} that an employee benefit plan maintained by a church-affiliated organization is exempt from ERISA, the Court may have addressed the “recent wave” of litigation regarding the scope of the “church plan” exemption. However, it appears that several waves may be following this one, as the Court’s opinion appears to invite further litigation on several issues.

These issues include what organizations qualify as “principal-purpose organizations” (including the question of what degree of connection is necessary between the church and the organization); and, as discussed in the amicus briefs, what it means for this organization to be “controlled by or associated with” a church (which may well bring the First Amendment into the discussion regarding ERISA).

This further litigation—as well as any action by Congress as suggested in Justice Sotomayor’s concurrence—will have a significant impact on the rights and obligations of both church-affiliated organizations like hospitals and schools and their numerous employees.

\textbf{* * *}

\textit{Bryan M. Shay} is a Principal in the Philadelphia and New-Jersey offices of Post & Schell P.C. He is a member of the firm’s Insurance Law Department, and he represents national and regional insurers in various coverage and bad faith matters, including matters involving life, health, and disability insurance. He has litigated matters involving a variety of issues under ERISA, including cases involving ERISA preemption; fiduciary misrepresentation and breach of fiduciary duty claims; and challenges to health plans and benefits determinations.

\textit{Jeffrey M. Brenner} is an Associate at the Philadelphia office of Post & Schell, P.C. where he represents national and regional insurers in life and disability insurance in the ERISA context as well as novel annuity and structured settlement disputes. His ERISA litigation practice focuses on defending matters involving sophisticated preemption issues; fiduciary issues; fiduciary misrepresentation claims; prohibited transactions; Section 510 cases; benefit claims and challenges to health plans.

\textbf{ERISA Update}

by \textit{Joseph M. Hamilton, ERISA Update Editor}

\textbf{First Circuit}

\textit{Named Beneficiary of Annuities Deemed to Be a Required Party In Suit Challenging Benefit Payment}

In \textit{Maldonado-Vinas v. National Western Life Ins. Co.}, 2017 WL 2855661 (1st Cir. 2017), the First Circuit reversed a decision by the District Court of Puerto Rico that the recipient of annuity payments was not a required party to the action and that joinder of Francisco was not feasible because he resided in Spain. Reviewing the requirements of Fed. R. Civ. P. 19(a), the district court denied National Western’s motion. After the plaintiffs prevailed on a motion for summary judgment, National Western

Francisco Iglesias was named as a beneficiary of two annuities purchased by his brother, Carlos. After Carlos’ death, National Western paid the annuity payments to Francisco.

Approximately two years later, Carlos’ widow and two sons sued National Western seeking return of the premiums paid for the annuities on the grounds that the application for the first annuity was signed by a person claiming to be a licensed agent in Puerto Rico, but who was not licensed; that the second annuity was void because Francisco, as the owner of the annuity, never signed the application; and because both annuities were purchased with money from the conjugal partnership between Carlos and the widow.

National Western moved to dismiss the complaint on the grounds that Francisco was a required party to the action and that joinder of Francisco was not feasible because he resided in Spain. Reviewing the requirements of Fed. R. Civ. P. 19(a), the district court denied National Western’s motion. After the plaintiffs prevailed on a motion for summary judgment, National Western
appealed.

The First Circuit found that Francisco was a required party to the case. The primary rationale for the court’s decision was that without Francisco, National Western would be in the position of possibly having to pay the annuities twice. The court noted that it is an object of courts to prevent the payment of any debt twice.

The First Circuit remanded the case to the district court because it had not exercised its discretion as to whether it was feasible to add Francisco. If not, the district court would then be required to determine whether the action should proceed among the existing parties or be dismissed.

Joseph M. Hamilton
Mirick O'Connell
Worcester, MA
jhamilton@mirickoconnell.com

Third Circuit

Promise of “Continuing Benefits” Does Not Guaranty Lifetime Health Benefits When Employer Has the Right to Amend

In Grove v. Johnson Controls, Inc., 2017 U.S. App. LEXIS 10615 (3d Cir. June 15, 2017), two classes of retired employees claimed that they were entitled to vested lifetime health insurance benefits under ERISA.

Under ERISA, welfare benefits do not automatically vest (unlike pension benefits). While retiree health benefits were included in collective bargaining agreements spanning over 30 years, each agreement included an expiration date. In 2009, the plan imposed a lifetime cap of $50,000 for retirees over age 65. Those who exceeded the amount would still be eligible to receive Medicare.

The retirees argued that the district court’s decision in favor of the plan was contrary to the Supreme Court’s decision in M&G Polymers USA, LLC v. Tackett, 135 S. Ct. 926 (2015). Tackett abrogated an earlier Third Circuit decision which held that a plan’s commitment to provide lifetime health benefits must be “stated in clear and express language.” Under Tackett, the question of whether lifetime benefits vested must be answered based on “ordinary principles of contract law,” including reading the agreement “as a harmonious whole.”

For the first class of retirees, this meant the promise of “continuing benefits” must be read in conjunction with the CBA’s expiration dates. When read together, the agreement promised continuing health benefits only through the end of the agreement. The second class of retirees relied on language which stated that coverage would continue until the person’s death. Based on this language, the retirees argued that the promise was durational.

The Third Circuit disagreed, again relying on the surrounding language. The death language referred to when a dependent’s coverage would terminate. Finally, the court noted that the plan reserved its right to “amend or terminate the benefits program or any portion of it at any time.” Therefore, using ordinary principles of contract law, the court held that the parties to the CBA did not intend to provide vested lifetime health benefits.

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

Rehabilitation Earnings Paid to Plaintiff’s Medical Practice to Reduce Debt Were Still “Received” and a Reduction


While still disabled under the plan, the plaintiff, a doctor, returned to limited work. Under the terms of the plan, her monthly benefit was reduced by 50% of her earnings from work. The claimant argued, however, that she did not “receive” earnings as required under the plan because the money was applied to her share of the practice group’s overhead.

The Third Circuit concluded that the plan’s interpretation was reasonable under deferential review. First, the court recognized that the claimant received the benefit of her earnings by having them applied to her debt. Second, there was nothing in the partnership agreement which required the practice to use her earnings to pay off her debt.

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

Former Employees Not Entitled to Severance Benefit When They Suffered No Financial Hardship

Eligibility for severance benefits by former Sunoco employees was at issue in Felker v. USW Local 10-901, 2017 U.S. App. LEXIS 10982 (3d Cir. June 21,
After Sunoco “idled” its refinery in Marcus Hook, maintenance employees were reassigned to a different refinery, and if laid off, they would receive a limited severance. The stated purpose of the severance plan was to “alleviate financial hardship” from idling the refinery.

Sunoco subsequently sold the refinery, causing the workers to be terminated by Sunoco. However, on the same day, the former Sunoco employees were hired by the new company.

The court held that the goal of the plan was to “alleviate financial hardship” experienced by employees resulting from the idling of the refinery. Denial of severance benefits to the former employees who suffered no financial hardship was consistent with the terms of the plan and ERISA. Therefore, the judgment in favor of the plan was affirmed.

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

**Fourth Circuit**

**NFL Plan Mishandles CTE-Related Disability Claim by Insisting on Contemporaneous Medical Evidence**

In *Solomon v. Bell*, 2017 U.S. App. LEXIS 11197 (4th Cir. June 23, 2017), the Fourth Circuit affirmed a district court’s judgment that the plan administrator for the Bert Bell/Pete Rozelle NFL Retirement Plan and NFL Player Supplemental Disability Plan (“the Plan”) abused its discretion in denying disability benefits to former NFL linebacker Jesse Solomon.

Solomon played professional football in the NFL for nine seasons before retiring in 1995. During his career, he sustained more than 69,000 full-speed contact hits resulting in symptoms associated with chronic traumatic encephalopathy (“CTE”), a degenerative brain condition caused by repeated head trauma. In 2007, Solomon was forced to resign from his post-NFL career as a high school teacher and football coach due to his football related injuries.

The Plan provides disability benefits to retired players who become disabled as a result of their football career, and provides a larger benefit to players who become disabled within 15 years of their NFL retirement. The district court found the administrator abused its discretion when it concluded Solomon became disabled more than 15 years after his retirement. On appeal, the administrator argued, among other things, that Solomon presented no “contemporaneous evidence,” predating the 15-year cutoff, demonstrating he was disabled due to brain injuries.

Rejecting this contention, the Fourth Circuit concluded the administrator abused its discretion by ignoring unanimous relevant evidence postdating the 15-year cutoff merely because it was generated after the cutoff. In fact, Solomon had presented multiple expert reports dated within months after the 15-year cutoff that described serious neurological impairments traceable to his “decades-old” football career. And, the administrator’s own neutral expert concluded almost a year after the cutoff that Solomon’s brain injuries had worsened “over a period of 5-10 years.” Absent the administrator’s arbitrary restriction on evidence, the Fourth Circuit held the administrator had no evidence to sustain its benefits denial and, therefore, affirmed the judgment of the district court.

Michael P. Cunningham
Funk & Bolton, P.A.
Baltimore, MD
mcunningham@fblaw.com

**Sixth Circuit**

**Rejection of “Objective Evidence” of Disability as Defined by The Plan Was Arbitrary and Capricious**

In *Corey v Sedgwick Claims Management Services, Inc.*, 858 F.3d 1024 (6th Cir. 2017), the plaintiff worked as a factory machine operator and suffered from “cluster headaches,” described as extremely painful attacks which occurred several times per day for weeks on end. After a series of such cluster headaches forced the plaintiff to miss work, he applied for short-term disability benefits. Although initially approved, benefits were eventually discontinued for failure to provide objective findings of disability.

The Plan included a fairly standard definition of disability: “illness or injury [that] prevents [the employee] from performing the essential duties of [the employee’s] regular position with the Company or the duties of any suitable alternative positions with the Company.”

In support of a claim, the Plan required objective medical documentation of a disability. “Objective findings of a disability are necessary to substantiate ... your disability. ... Objective findings include: ... medications and/or treatment plan.”

The plaintiff submitted medical records in support of his claim, including
records of his prescribed medications, supplemental oxygen usage, and occipital nerve treatment. Nonetheless, the claim administrator determined the plaintiff was not disabled because the headaches did not “result in any neurological, physical exam abnormalities,” and the claim was denied due to a lack of “objective findings.” After an administrative appeal, the denial was upheld without further explanation or analysis.

Although the plan conferred discretionary authority on the claim administrator, the court found fault with the analysis of the evidence provided by the plaintiff and the application of the express plan terms. The defendant explained the plan’s inclusion of medications as objective evidence of disability related to whether side effects of a medication caused the disability or that a medication or treatment plan objectively confirmed a claimant’s inability to work. The court criticized that interpretation as unsupported by the plan. Because the plaintiff supplied evidence of his treatment and medications, which were defined as “objective evidence” by the plan, the court held the defendant’s denial due to a lack of objective findings without explanation was arbitrary and capricious.

Kimberly J. Ruppel
Dickinson Wright PLLC
Troy, MI
KRuppel@dickinsonwright.com

Seventh Circuit

Opinion of IME Physician Discounted, Based on Data from American College of Rheumatology

In Kennedy v. Lilly Extended Disability Plan, 856 F.3d 1136 (7th Cir. 2017), the Seventh Circuit upheld the lower court’s award of retroactive long-term disability benefits of $537,843.81 and reinstatement in the plan. Plaintiff was initially paid long-term disability benefits under the self-funded plan after she stopped working in 2008. The plan terminated benefits approximately three years later on the grounds that plaintiff’s fibromyalgia was not disabling from any occupation.

In reviewing the evidence, the Seventh Circuit discounted the IME physician’s opinion. The majority opinion referred to quotations from the American College of Rheumatology as a basis for disagreeing with the IME physician’s contention that the American College of Rheumatology does not consider fibromyalgia to be disabling on a long term basis. The court favored the opinions of the treating physicians and rejected findings of several other medical reviewers relied upon by the plan. The vocational evidence and alleged lack of identification of an appropriate occupation was also criticized.

A dissenting opinion focused on the deferential review standard and the discretion owed to the plan’s decision. The dissenting opinion found that the termination of benefits met the reasonableness test based on the available evidence. It was also noted that the majority opinion failed to recognize the negative Social Security Administration decision that was consistent with the plan’s termination of benefits.

Eric P. Mathisen
Ogletree, Deakins, Nash, Smoak & Stewart, P.C.
Valparaiso, IN and Chicago, IL
eric.mathisen@ogletree.com

Eighth Circuit

Reliance on Record Reviews By In-House Doctor and Nurse Not an Abuse of Discretion


On appeal, Cooper argued that MetLife’s role as both the evaluator and payor of the benefit claims created an inherent conflict of interest, requiring a less deferential application of the abuse of discretion standard of review and arguing in the alternative that MetLife abused its discretion.

On appeal, Cooper argued that MetLife’s role as both the evaluator and payor of the benefit claims created an inherent conflict of interest, requiring a less deferential application of the abuse of discretion standard of review and arguing in the alternative that MetLife abused its discretion.

The court then considered whether MetLife abused its discretion. Cooper challenged MetLife’s medical analysis in three ways. First, she asserted that MetLife’s reliance on a reviewing physician was unreasonable because his opinions were premised on “a lack of objective indicia of disability to the exclusion of subjective indicia.”

The court of appeals rejected the argument and noted the reviewing physician practiced the same specialty as Cooper’s attending physician, the attending physician was given an opportunity to respond to the reviewing physician’s report, the information sought by MetLife was for the purpose of substantiating the extent of her disability, rather than “to question the diagnosis,” and “it was not unreasonable for a plan administrator to deny benefits upon a lack of objective evidence.”
Apart from the foregoing, Cooper also challenged the reviewing physician because his opinions were contrary to those of her attending physician. The court disagreed, reasoning that the reviewing physician had considered all of Cooper’s medical records and, unlike the attending physician, was “tasked with interpreting ‘disability’ as defined in the Plan.”

Finally, Cooper argued that MetLife’s reliance on its appeals nurse consultant violated the requirements of 29 C.F.R. § 2560.503-1(h)(3)(iii). In particular, Cooper asserted that because the nurse’s background was unspecified in the administrative record, she lacked “appropriate training and experience in the field of medicine involved in the medical judgment” when deciding an appeal of any adverse benefits determination this is based in whole or in part on medical judgment.”

The court rejected this argument, reasoning that it would follow the “substantial compliance” rule as recognized by other circuits rather than the “technical compliance” rule, and that in any case, there was no evidence that a physician’s review of the same evidence would have changed the result.

Terrance J. Wagener  
Messerli & Kramer P.A.  
Minneapolis, MN  
twagener@messerlikramer.com

**Ninth Circuit**

**Ninth Circuit Gives Effect To Clear Communications with Plan Participants in Disability Cases**

The Ninth Circuit heard two disability benefit cases, *Gonda v. Permanente Medical Group, Inc.*, 2017 WL 2231824 (9th Cir. 2017), and *Colman v. American Int’l Group, Inc.*, 2017 WL 2533411 (9th Cir. 2017), and affirmed district court decisions in favor of the plans.

*Gonda* addressed whether a broad settlement agreement and release of claims relating to a wrongful termination action barred the insured from bringing an action for disability benefits under the employer’s plan. In settlement of his wrongful termination action, Gonda, a physician and former employee, agreed to release his “right to bring any and all claims and causes of action arising under ERISA against TPMG [his employer] and its related persons and entities.”

Gonda then brought an action against TPMG and the plan, administered by Life Insurance Company of North America, for wrongful termination of benefits. The Ninth Circuit found the settlement agreement “clearly and expressly waived” ERISA claims against the employer and plan.

The joint stipulation to stay district court proceedings pending administrative review did not negate the waiver or estop defendants from asserting the settlement agreement terms as a defense to the ERISA benefit claims. The court found the settlement agreement enforceable, based on Gonda’s knowing and voluntary consent, representation by counsel, and opportunity to review terms.

Under a tempered standard of discretionary review, the Ninth Circuit in *Colman* declined to apply contra proferentum and affirmed the insurer’s “but-for” interpretation of a 24-month mental condition limitation in a case where it found “a continuing good faith exchange of information” between the plaintiff and the insurer, Hartford Life and Accident Insurance Company, during the claim review process. As to the standard of review, the Ninth Circuit determined the insurer’s conflict of interest was taken into account, and the tempered level of discretion was proper “to account for several minor procedural errors, but those errors did not justify de novo review.”

Next, the court considered plaintiff’s argument that the mental condition limitation was ambiguous, and that the district should have applied the principle of contra proferentum to find in favor of continued coverage. The court rejected the argument because the plan gave Hartford Life discretion to interpret the plan.

Instead, it considered whether Hartford Life’s application of the limitation was reasonable. It found, “Hartford’s determination that the limitation applied to claims in which mental illness is a ‘but-for cause’ of the disability was reasonable,” and its “determination that Colman had not demonstrated that she was disabled as a result of her physical ailments was overwhelmingly supported by the medical evidence.”

Nancy Jerian Marr  
Burke, Williams & Sorenson, LLP  
Los Angeles, CA  
njmarr@marr.law

**ERISA Does Not Preempt California Statute Banning Discretionary Review Clauses**

In *Orzechowski v. Boeing Co. Non-Union Long-Term Disability Plan, Plan No. 625, 856 F.3d 686 (9th Cir. 2017)*, the Ninth Circuit upheld California Insurance Code § 10110.6 which voids discretionary review clauses. Finding that § 10110.6 regulates insurance and is saved from preemption, the court reversed and remanded under de novo review.
Orzechowski claimed disability benefits due to fibromyalgia and chronic fatigue syndrome. The plan documents contained discretionary review language. The district court applied an abuse of discretion standard and upheld Aetna’s denial on a two-year limitation and finding of light work capacity. Plaintiff appealed.

The significant issue on appeal was whether the district court properly applied the abuse of discretion standard of review, or whether § 10110.6 voided the plan’s discretionary language and restored de novo review. The Ninth Circuit cited “inappropriate claims practices” and using discretionary clauses as “a shield to deny valid claims” to explain why some states have adopted similar laws.

The court’s saving clause analysis used the two-part test of Kentucky Ass’n of Health Plans v. Miller, 538 U.S. 329, 342 (2003), determining if the law is “specifically directed toward entities engaged in insurance,” and whether it “must substantially affect the risk pooling arrangement between the insurer and the insured.”

As to the first part, the court broadly construed “entities engaged in insurance” to include employers and their plans, reasoning that § 10110.6 regulates “entities engaged in insurance...even if they are not insurance companies,” and is “directed at insurance and not insurers.” The court found no difference between “a law directed at insurance companies and a law directed at ERISA plans and procedures.” Standard Ins. Co. v. Morrison, 584 F.3d 837 (9th Cir. 2009).

The court found § 10110.6 “substantially affects risk-pooling,” “by narrowing the scope of permissible bargains between insurers and insureds,” and “dictating to the insurance company the conditions under which it must pay for the risk it has assumed.” Citing Fontaine v. Metropolitan Life Ins. Co., 800 F.3d 883 (7th Cir. 2015), the court stated in practical terms, the ban “will lead to greater number of claims being paid. More losses will thus be covered, increasing the benefit of risk pooling for consumers.”

The court rejected Boeing’s arguments that § 10110.6 did not apply because it postdated the plan’s effective date, and that the discretionary clause in the master plan survived. Interpreting the discretionary ban broadly, the court found the effective date of the plan did not matter, because the plan renewed annually as required by § 10110.6(b), and that the master plan document was subsumed in § 10110.6(a)’s reference to “contracts, certificates, or agreements” that “fund” the disability coverage. Section 10110.6 applied to both the master plan and summary plan description. The court thus held de novo review applied, and remanded with a weighted instruction to reconsider plaintiff’s claims without requiring objective evidence of diagnoses.

Orzechowski’s saving clause discussion assumed the broad application of § 10110.6’s discretion ban is constitutional, and that Kentucky Association’s test applies equally broadly. What is absent from the court’s decision is detailed Supremacy Clause analysis of whether states can wholly legislate de novo review by passing discretionary review bans arguably contrary to ERISA policy, a possible topic for future review.

Nancy Jerian Marr
Burke, Williams & Sorenson, LLP
Los Angeles, CA
njmarr@marr.law

Eleventh Circuit

Anti-Assignment Provision In ERISA-Governed Benefit Plan is Enforceable

In Griffin v. Coca-Cola Enterprises, Inc., 2017 WL 1505308 (11th Cir. April 27, 2017), the court noted that two categories of persons have statutory standing to maintain an action under ERISA: plan beneficiaries and plan participants. Healthcare providers lacking independent standing may obtain derivative standing through a written assignment from a beneficiary or participant.

Dr. Griffin sued Coca-Cola Enterprises (“CCE”) seeking payment of ERISA benefits and penalties. CCE’s welfare benefit plan provided that “Members cannot legally transfer the coverage. Benefits under [the plan] are not assignable by any member without obtaining written permission” from the claim’s agent.

Dr. Griffin did not allege that she had such written permission, although she did allege possession of assignments from the plan beneficiary. The district court dismissed her complaint for lack of standing under ERISA.

The Eleventh Circuit affirmed, stating “an unambiguous anti-assignment Provision in an ERISA-governed welfare benefit plan is valid and enforceable, and will operate to void [an] assignment.”

Joshua D. Lerner
Rumberger Kirk & Caldwell
Miami, FL
jlerner@rumberger.com

Case Remanded to Trial Court to Determine Whether Claimant Reasonably Relied on Typographical Error in Uphold Letter

involved whether a suit was timely filed within an ERISA policy’s contractual limitation period.

Because of a typographical error in the plan administrator’s uphold letter denying the administrative appeal, the court of appeals reversed summary judgment in favor of the insurer for a factual determination whether the claimant reasonably relied on the administrator’s statement that “further review will be conducted” when the administrator meant to say “no further review will be conducted.”

Plaintiff sought benefits under her husband’s basic and optional life and accidental death insurance, provided through his employer. The administrator determined that it would pay the basic life insurance benefit but not the optional life insurance benefits or the accidental death benefit because claimant’s husband’s death had been ruled a suicide.

Upon administrative review, the plan administrator upheld its decision. Its uphold letter dated June 23, 2014, stated, however, that “[a]t this time, the appeal process has been exhausted and further review will be conducted by Liberty.”

On May 5, 2015, plaintiff’s attorney wrote the administrator inquiring about the “further review” and providing additional evidence to support claimant’s position that the death was not a suicide. On May 15, 2015, the administrator responded, thanking the attorney for pointing out the typographical error in the uphold letter, and stating it had meant no further review would be conducted. Plaintiff filed suit on June 12, 2015.

The court of appeals concluded plaintiff had filed suit after the lapse of the contractual limitations period set forth in the policy and next considered whether the limitations period was unreasonable and fundamentally unfair. Noting it has not established a clear test for whether an ERISA contractual limitations period is reasonable, the court of appeals looked to instructive factors, i.e., (1) whether there was any subterfuge to prevent lawsuits; (2) whether the limitations period was commensurate with other provisions in the plan that are designed to process claims with dispatch; and (3) whether an ERISA-required internal appeals process was completed. In connection with the second factor, the court emphasized the importance of the plan provider completing administrative review with ample time left for the claimant to file suit.

Based upon the foregoing reasoning, the court concluded the contractual limitations period would be unreasonable if the claimant reasonably relied on the administrator’s written statement that it was conducting further review. It stated that if an objectively reasonable person in claimant’s position would have believed the administrative review process was incomplete based on the statement in the uphold letter, the limitations period would be unreasonable because plaintiff could not have brought suit until the administrative review process was over. The court remanded to the trial court for a determination whether plaintiff reasonably relied on the typographical error.

Joshua D. Lerner
Rumberger Kirk & Caldwell
Miami, FL
jlermer@rumberger.com