ERISA
LEGALNEWS

SUPREME COURT'S DECISION ON HEALTHCARE REFORM – WHAT DOES THIS MEAN TO ERISA WELFARE BENEFIT PLANS?

by: Kimberly J. Ruppel

National healthcare has been the subject of political discussion since former President Theodore Roosevelt's campaign in the 1912 election (which he lost to Woodrow Wilson). The Patient Protection and Affordable Care Act (the "ACA") is the most significant revision of the national healthcare system since the creation of Medicare in the 1960s. Last month's Supreme Court ruling upholding the individual mandate of the ACA (among other findings) is the latest on this important and divisive topic, but is not the final word by any measure.

Now that the Court has decided that the ACA will remain effective (in large part), employers and plan sponsors should focus on compliance efforts such as drafting and providing uniform benefit summary disclosures for coverage options, and updating payroll deductions to increase the hospital insurance tax and Medicare withholding tax to executives with income greater than $200,000. Further, beginning next year, employee flexible spending accounts will be limited to $2,500, which is generally lower than many plans currently allow. Also, as of next year, employers can no longer offer additional benefits only to highly compensated employees. Although larger employers may have already begun to implement some of these ACA provisions, smaller employers with less administrative resources may only now be focusing on these mandates.

Some benefits consultants predict that in order to help control rising health care costs and still comply with the ACA, employers may consider moving away from traditional defined benefit plans and toward defined contribution plans instead, to offer employees a fixed amount of money to use toward health care costs.

The Court's ruling regarding expansion of Medicaid will affect multi-state employers with insured health benefit plans whose participants may have a range of options depending on the exchange offered in their respective state. Yet, those employers may also realize health care cost savings due to some employees dropping out of the employer provided plan and qualifying for Medicaid, lower insurance rates due to increased competition for state exchange coverage, or lower agent or broker commission rates.

The recent ruling is surely not the final word on this topic. While employers and plan sponsors may be immune from some of the insurance-related requirements, much of the law's requirements affect self-funded plans as well. The results of the election this Fall will likely also bring further changes to healthcare reform. However, in order to comply with deadlines set by the ACA, employers and plan sponsors are advised to begin to act now.

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SELECT CASE SUMMARIES

by: Julie H. Johnston and Kimberly J. Ruppel

Sixth Circuit - Failure To Adequately Plead Fraud Precludes Reliance On Statute Of Limitations Exception

Cataldo v. U.S. Steel Corp., 676 F.3d 542 (6th Cir. April 13, 2012).

As is increasingly common with production facilities, the steel mills involved here changed ownership many times over two decades. This resulted in changes to the way in which pension benefits were determined by the different plans. The employees/plan participants here alleged they were led to believe that benefits would be determined as if a previous plan applied, but were later told that the current plan would instead control. The plan was not amended to reflect what plaintiffs were allegedly led to believe. After accepting an early retirement option, the plaintiffs began to receive significantly less than what they believed they were promised. Subsequently, plaintiffs sued under ERISA for alleged breach of fiduciary duty based upon misrepresentations as to how their pension benefits were calculated.

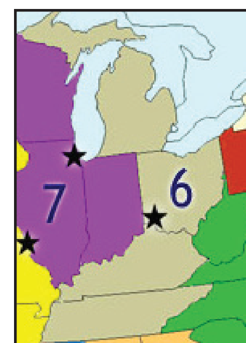
ERISA contains a statute of limitations regarding breach of fiduciary claims which bars actions commenced either: (a) six years after the last alleged breach occurred; or (b) three years after a plaintiff obtained actual knowledge of the alleged breach or violation. 29 U.S.C. § 1113. In addition, the statute contains an exception for fraud or concealment, in which case an action will be barred if it is commenced more than six years after the discovery of such breach or violation. Id. The Plan defendants raised a statute of limitations defense here, claiming that the plaintiffs had actual knowledge they would not receive the benefits allegedly promised well more than three years prior to filing the complaint. The district court dismissed on that basis.

On appeal, the Sixth Circuit considered whether the statute of limitations fraud or concealment exception might apply. There is a split in the circuits regarding whether the exception applies if a claim is based on fraud, yet there are no allegations relating the fraud to an attempt to conceal the alleged fiduciary violations, as was the case here. The Sixth Circuit found that it was unnecessary to rule on that issue because the plaintiffs did not adequately plead their allegations of fraud with particularity so as to survive a 12(b)(6) motion. Thus, it remains unclear which side the Sixth Circuit might choose when squarely presented with that issue.

The Sixth Circuit also held that, although a claim for equitable estoppel can apply to a pension plan under the precedent of *Bloemker v. Laborers' Local 265 Pension Fund*, 605 F.3d 436 (6th Cir., 2010), the special facts giving rise to liability in that earlier case were absent here. Notably, the plaintiffs here failed to adequately plead the elements of fraud or deception (as noted above). Further, the plaintiffs could not satisfy the justifiable reliance requirement because the Plan documents here allowed the plaintiffs to precisely calculate their pension benefits. Thus, the plaintiffs could not establish reasonable or justifiable reliance on allegedly inconsistent representations to the contrary.

Plaintiffs here also argued that the Plan defendants failed to provide requested plan documents in violation of ERISA under 29 U.S.C. § 1024(b)(4). However, the Court found that the Plan defendants provided all documents requested. Further, the Court held that the Plan defendants had no duty to provide those documents which were not expressly requested or obviously referred to, such as actuarial reports, even though those documents were properly considered "Plan documents" subject to the residual clause of 1024(b), and must otherwise be produced in response to a request. The Court was careful not to require plan participants to expressly identify a requested document by name, but instead noted that the plaintiffs here failed to frame a request that would reasonably embody an actuarial report such that production would be mandatory.

Financial Institution That Held Misappropriated Funds Did Not Exercise Sufficient Control To Be Considered A Fiduciary



McLemore v Regions Bank, 2012 U.S. App. LEXIS 11600, 2012 Fed. App. 0172P (6th Cir.)

Barry Stokes, an investment advisor, misappropriated millions of dollars from employee-benefits plans that he managed through his company, 1Point Solutions, LLC. Stokes and 1Point held the fiduciary accounts of the defrauded plans with the Defendant-Appellant bank, Regions. Stokes' bankruptcy Trustee John McLemore and several former clients of 1Point filed suit against the bank, alleging that Regions negligently or knowingly allowed Stokes to steal from the fiduciary accounts held at Regions. In 2008, the district court dismissed the Trustee's ERISA claims, and then in 2010, the district court found that ERISA preempted both plaintiffs' state-law claims and granted judgment on the pleadings in favor of Regions.

On appeal, the Trustee challenged the district court's 2008 dismissal of its ERISA claims under Rule 12(b)(6); and both parties challenged the district court's 2010 grant of Regions' motion for judgment on the pleadings dismissing their state-law claims under Rule 12(c).

The Trustee challenged the district court's 2008 dismissal of his ERISA claims, arguing that the court erred in holding that Regions failed to qualify as an ERISA fiduciary. Regions agreed that it was not a fiduciary and offered as an alternate ground for affirming the judgment that the

Trustee lacked standing to pursue claims on behalf of the defrauded plans. The court rejected Regions' arguments that the Trustee lacked standing and then considered the Trustee's challenge of the district court's conclusion that Regions did not serve as a fiduciary to the victim plans.

The Trustee posited that Regions qualified as a fiduciary by exerting "authority or control respecting management of [plan] assets." and made a number of allegations describing Regions' authority or control over the ERISA-plan accounts. Namely, he alleged that Regions (1) knew that 1Point's accounts held plan assets; (2) should have recognized that 1Point managed these accounts differently than typical third-party administrators of employee-benefits plans; (3) failed to comply with banking regulations that would have uncovered Stokes's scheme; (4) advised 1Point to structure its accounts in a way that circumvented "know your customer" rules; and (5) withdrew over $500,000 in "fees and analysis charges" from the plan funds.

In its analysis, the court found that the first three allegations did not establish liability as Regions merely held the funds on deposit and custody of plan assets alone does not establish control sufficient to confer fiduciary status. The Court also reasoned that Regions' advising on account structuring offered no basis for labeling it a fiduciary because control of the accounts remained with 1Point and Stokes. Finally, Regions' withdrawal of fees did not support a finding that it held fiduciary status because the Trustee simply alleged that Regions regularly withdrew its fees and analysis charges from the trust funds it held. The court concluded that Regions' withdrawal of routine contractual fees constituted no more an exercise of control than any other account holder's request effectuated by a depositary bank and rejected the Trustee's argument that Regions' collection of fees rendered it subject to liability as an ERISA fiduciary.

As to the dismissal of the state law claims, the plaintiffs appealed the district court's dismissal of their respective claims against Regions, which alleged (1) negligence and recklessness, (2) unjust enrichment, and (3) violation of Tennessee's Consumer Protection Act, and all of which rested on common allegations of breach of duty to monitor and to exercise reasonable care in failing to comply with various regulations that would have uncovered Stokes' activities.

The court reasoned that under ERISA, a plan "participant, beneficiary, or fiduciary" may seek an injunction against a non-fiduciary who knowingly participates in a fiduciary's violation of ERISA. (29 U.S.C. § 1132(a)(3).) The Trustee originally sought disgorgement of the bank fees, a remedy in equity, from Regions under ERISA's civil enforcement provision, but the district court had dismissed that claim, finding that there were no "specifically identifiable" funds in Regions' possession and such equitable relief was therefore unavailable. The Plaintiffs then reasserted the claims in amended complaints as state-law claims for unjust enrichment. The appellate court agreed with the district court's finding that Plaintiffs' unjust-enrichment claims were merely a recasting of their ERISA claims and that ERISA preempted the plaintiffs' state law claims. The court reasoned that as to non-fiduciaries, ERISA confines plaintiffs to equitable relief and that by re-styling their ERISA claim as a state-law claim, the plaintiffs sought to hold a non-fiduciary bank personally liable, and such attempts to supplement the remedies available under ERISA had been rejected by the U.S. Supreme Court in *Aetna Health, Inc. v. Davila*, 542 U.S. 200, 209 (2004).

Importantly, the majority was dismissive of Plaintiffs' complaint that the affirming the ruling of the district court would leave them without a remedy against Regions. The court reasoned that "the availability of a remedy under ERISA is not relevant to the preemption analysis."

Judge Merrit disagreed with that reasoning, and dissented with the appellate court's opinion, stating, "The primary purpose of ERISA is to protect the individual who has a pension or health plan from certain kinds of losses, *i.e.*, "to increase the likelihood that participants . . . will receive their full benefits." *29 U.S.C. § 1001b(c)*. It is not to protect a depository bank from general state laws concerning malfeasance in connection with the bank's handling of the bank accounts of participants. In this case, we have no idea whether the bank is liable for misfeasance under state law. The case against the bank has not been tried or the facts proved or the state law analyzed and applied. I dissent because our court is using a doctrine of ERISA preemption not to protect the ERISA participants but to shield the bank from any investigation of the claims against it. The court has given the bank an immunity from general state law liability no matter what its conduct, as though the bank has the status of a sovereign."

Eighth Circuit - Insured's Subjective Expectations Must Be Considered To Determine Whether Death Was "Accidental"

McClelland v LINA, 679 F.3d 755 (8th Cir. 2012)

In this matter, Life Insurance Company of North America (LINA) appealed the district court's ruling that it abused its discretion in denying death benefits to Dawn McClelland based upon her husband Anthony's life insurance policy and also appealed the court's award of attorney fees. The appellate court affirmed the decision on the award of benefits, but reduced the attorney fee award as excessive.

The decedent, Anthony McClelland was a machinist for Graco. His employer provided an ERISA-qualified plan which included insurance coverage in the amount of $250,000 for accidental death. The plan defined a covered accident as:

> A sudden, unforeseeable, external event that results, directly and independently of all other causes, in a Covered Injury or Covered Loss and meets all of the following conditions:
>
> 1. occurs while the Covered Person is insured under this Policy;
> 2. is not contributed to by disease, Sickness, mental or bodily infirmity;
> 3. is not otherwise excluded under the terms of this Policy.

On October 26, 2007, the decedent and his wife had dinner at home, and he consumed a few alcoholic beverages but did not seem intoxicated. The next morning, Saturday, October 27, Anthony told Dawn about his plans for the day and left for a motorcycle ride. He made visits to several friends. No one who encountered him that day thought he seemed to be under the influence of substances. However, shortly after leaving his brother-in-law's house that Saturday, Anthony was in a fatal traffic accident. Toxicology reports indicated that his blood alcohol content was over .20.

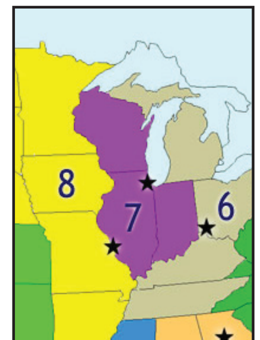
Dawn submitted a claim for accidental death benefits, which LINA denied based upon its position that Anthony's death was foreseeable due to his intoxicated state at the time of the crash and therefore his death was not the result of a covered accident. After the insured's appeal, the insurer's affirmation of denial, and cross-motions for summary judgment at the district court level, the district court ordered LINA to determine on remand whether Anthony's death resulted from an "accident" as defined by *Wickman v. Northwestern Nat'l Ins. Co.*, 908 F.2d 1077, 1088 (1st Cir. 1990).

Upon remand, both parties submitted expert reports, and Dawn submitted affidavits regarding Anthony's behavior on the morning in question. Following consideration of these materials, and heavily relying upon the report of its expert, LINA again decided Anthony's death was not a covered accident. Dawn again appealed this determination to the district court and after a second round of cross-motions for summary judgment, the district court ruled in favor of Dawn, finding that LINA abused its discretion by applying an unreasonable interpretation of the term "accident" as defined by *Wickman*. The court found that LINA did not reasonably analyze Anthony's subjective expectations on the morning of the accident. The district court also awarded attorney fees, in the amount of $134,088.50, and $26,384.11 in prejudgment interest. LINA appealed.

On the issue of denial of benefits, the appellate court found that the application of *Wickman* was appropriate. The court found that on remand LINA relied solely upon its expert's conclusions that the decedent's conduct was substantially likely to result in death and disregarded evidence which tended to show that the decedent did not anticipate his own death. The court concluded this was an inappropriate application of *Wickman*. The court found that to properly apply the *Wickman* test, LINA should have taken into account Anthony's characteristics on the day of the accident, rather than relying solely upon its expert's rather categorical conclusion that those who drink and drive should reasonably expect to be killed, and stated, "there was not even a scintilla of evidence that Anthony thought his death was highly likely to occur." Opinion, at 13. At the core of its analysis, the court noted that because the policy did not contain an intoxication exclusion, the inescapable conclusion was that Anthony's fatal motorcycle accident was just that, an accident, and LINA committed an abuse of discretion in denying benefits because its interpretation was contrary to the language of the plan and because substantial evidence did not support LINA's denial.

As to the attorney fees awarded, the appellate court found that while the district court did not abuse its discretion in awarding fees, the amount of fees awarded were excessive. The appellate court reduced the award of fees from $134,088.00 to $85,000.00.

Administrator Did Not Abuse Discretion By Evaluating Physical Requirements According to Dictionary of Occupational Titles, Rather Than Participant's Actual Occupation



Hankins v. Standard Ins. Co., 677 F.3d 830 (8th Cir. 2012)

Bobby Gene Hankins was "Director of Commercial Security Operations" for Stephens Investments, LLC for seven years. He was terminated after he failed a physical evaluation to confirm he could continue to perform the physical duties of his position, and his treating physician found that he would not likely be able to ever perform said duties in the future. Hankins then made a claim for ERISA disability benefits, administered by Standard, which denied the disability claim based on the plan administrator's interpretation of the Department of Labor's Dictionary of Occupational Titles. The administrator found that his occupation was "Security Manager" under the Titles, and that the position was sedentary. Hankins appealed the decision and in support, he submitted a vocational expert's report concluding that his actual duties resembled the much more physical position under the Titles of "Public Safety Officer". Standard upheld its decision and Hankins filed suit. His claims were dismissed by the district court on Standard's motion for summary judgment, finding Standard did not abuse its discretion, and Hankins appealed. The Eighth Circuit affirmed the grant of summary judgment.

The appellate court addressed whether the language of the plan conferred discretion on the administrator, and whether the plan could rely on the Titles in determining the claimant's "regular occupation." The Eighth Circuit found that the plan language conferred discretion on the administrator and reasoned that although "explicit discretion-granting language" must appear in the policy, the actual word "discretion" was not required. The policy language granting the administrator sole responsibility for the administration and interpretation of the plan granted discretionary authority that triggered deferential review. As to use of the Titles to define "Regular Occupation," the court found that

in the absence of a more precise definition, "Regular Occupation" could be interpreted as referring to duties that are commonly performed by those who hold the same occupation as defined by the Titles, or the duties Hankins actually performed. The court reasoned that because the policy language explained that it is not limited to the individual claimant's actual or specific job duties, the use of the Titles to determine Hankins's "Own Occupation" was not at odds with the plain language of the policy. The court further concluded that there was substantial evidence supporting Standard's denial of benefits and affirmed the district court's grant of summary judgment in Standard's favor.

ERISA LITIGATION & EMPLOYEE BENEFITS COUNSELING

Practice Area Overviews

ERISA Litigation

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

Employee Benefits Counseling

We regularly represent national and multinational clients in employee benefits, executive compensation, and ERISA matters. Our broad capabilities and solid experience allow us to create workable plans, provide implementation strategies, counsel employers on sophisticated employee benefit plan matters, and defend employers in disputes arising out of employee benefits, executive compensation, or other ERISA issues.

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