CHAPTER 14

LIABILITY ISSUES UNIQUE TO WELFARE PLANS

2018 MIDWINTER MEETING REPORT

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I. Introduction
No new developments to report.

II. Issues Unique to Health Care Benefit Plans

A. ERISA Health Care Benefit Plans in Changing Times
No new developments to report.

B. Exclusions and Limitations

1. Burden of Proof
No new developments to report.

2. Lack of Medical Necessity
In *Sandy Jo H. v. Cigna Behavioral Health, 2018 WL 4082275 (D. Utah 2018)*, the court held that the plan’s determination that the residential treatment provided to the participant’s dependents was not medically necessary, was reasonable and supported by substantial evidence. The court noted: (1) for dependent M.W., at the time the plan determined their claims, appeals, and expedited internal review, the dependents had not yet undergone a psychological assessment to determine the necessary level of care; and (2) for dependents M.W. and Colby, the residential treatment was not medically necessary for either as the medical assessments for M.S. did not state that their behavioral problems were severe or conclude that residential treatment was medically necessary and for Colby, the records reviewed by the plan did not point towards any clinically significant depression or anxiety and showed that she could receive the necessary treatment on an outpatient basis.

3. Experimental and Investigative Procedures
In *Whitford v. Horizon Blue Cross Blue Shield of New Jersey, 2018 WL 2422020 (D. New Jersey 2018)*, the district court upheld the plan’s refusal to authorize the participant’s request for a “combined ligament and radiocapitellar reconstruction” of her left elbow on the ground that it was investigational. The court noted that the plan’s reviewer at the claim level, the independent reviewers at both required levels of appeal, and the independent reviewer at the external review level each opined that the requested treatment was investigational because there was no sufficient proof, published in peer-reviewed scientific literature that confirmed the effectiveness of the technology as required by the plan.

4. Preexisting Condition Exclusions
No new developments to report.

5. Custodial Care and Skilled Nursing Care
No new developments to report.
6. Intentional Acts, Intoxication, Suicide and Illegal Acts

a) Intentional Acts

No new developments to report.

b) Intoxication

No new developments to report.

c) Suicide

No new developments to report.

d) Illegal Acts

No new developments to report.

7. Limitations for Specific Conditions or Care

a) Mental Health

In *B.D. and S.D. v. Blue Cross Blue Shield of Georgia, 2018 WL 671213 (D. Utah 2018)*, the district court determined that the plan violated the Mental Health Parity and Addiction Equity Act when it denied coverage for expenses related to the participant’s receipt of mental health treatment at a residential treatment center on the ground that its language limited coverage at a residential treatment center if the plan was required to do so by law. Although the final regulations implementing the Act confirmed that skilled nursing facilities are the medical/surgical “scope of services” analogue for residential mental health treatment centers and the treatment was provided prior to their issuance, the court held that the plan’s interpretation of the Act was at odds with the Act’s purpose to achieve coverage parity whenever a plan offers both mental health and medical/surgical benefits and because it was known prior to the final rules that skilled nursing facilities are analogous to residential treatment facilities.

In *Gallagher v. Empire Healthchoice Assurance, Inc., 2018 WL 4333988 (S.D. New York)*, the district court determined that the plan’s denial of mental health benefits for the participant’s wilderness therapy violated the Mental Health Parity and Addiction Equity Act because the plan provided benefits for skilled nursing facilities and rehabilitation centers for medical/surgical patients, but did not provide benefits to those with mental health conditions who seek coverage for a residential treatment center offering wilderness therapy (the plan did not include an exclusion for wilderness therapy).

In *A.Z. by & through E.Z. v. Regence Blueshield, 2018 WL 3769810 (W.D. Wash 2018)*, the district court found that the plan improperly applied the plan’s exclusion for counseling in the absence of illness because the participant was diagnosed with an illness (depression) and attended a wilderness program to treat that illness. The court noted that it made no difference that the plan included “wilderness programs” as an example of a non-covered service because the example illustrated situations where wilderness program services are rendered in the absence of illness.

In *A.H. v. Microsoft Corp. Welfare Plan, 2018 WL 2684387 (W.D. Washington 2018)*, the district court denied the plan’s motion to dismiss the plaintiff’s argument that the plan improperly applied its exclusion for wilderness programs when it denied coverage for behavioral, substance abuse, and mental health services provided at a wilderness therapy
program that was licensed by the state to provide outdoor youth treatment. While the plan excluded coverage for educational or recreational therapy or programs, including wilderness programs, the court noted that the exclusion also included an exception for medically necessary treatment received in these locations if treatment is provided by an eligible provider. The court stated that a wilderness program could be eligible for coverage if it was licensed and provided medically necessary treatment. The court, however, rejected the plaintiff’s arguments that the plan violated the Mental Health Parity and Addiction Equity Act because there was no evidence in the record that demonstrated that the wilderness program exclusion only applied to mental health treatment (thus, the exclusion was not a treatment limitation that was more restrictive for mental health benefits than other medical benefits) or that the plan violated the Affordable Care Act’s non-discrimination provision (finding that the “ACA anti-discrimination provision does not require a health plan to provide coverage for any treatment just because it is rendered by a state-licensed provider. It merely requires that insurers not discriminate against state-licensed providers when their services are covered by a health care plan”).

In *Vorpahl v. Harvard Pilgrim Health Insurance Company, 2018 WL 3518511 (D. Massachusetts 2018)*, the district court construed the plan’s exclusion for “health resorts, spas, recreational programs, camps, wilderness programs (therapeutic outdoor programs), outdoor skills programs, relaxation or lifestyle programs, including any services provided in conjunction with, or as part of such types of programs” with respect to the plan’s denial of mental health services that the plaintiff’s children received at a wilderness program. The court determined that the exclusion was clear that services that might otherwise be covered such as treatment by a licensed provider are not covered when delivered in the setting of a wilderness program. The court also rejected the plan’s motion to dismiss the plaintiff’s argument that the exclusion violates the Mental Health Parity and Addiction Equity Act, stating that the plaintiff alleged a reasonable inference that the wilderness exclusion differentially treats medical/surgical benefits and mental health benefits in application by arbitrarily grouping outdoor/wilderness behavioral healthcare programs with programs that are recreational rather than therapeutic in nature but not for medical/surgical services provided in other residential settings. Lastly the court rejected the plaintiff’s argument that the wilderness program exclusion violates the Affordable Care Act’s prohibition of discrimination with respect to coverage against health care provider who is acting within the scope of that provider’s license. The court stated that the Affordable Care Act’s anti-discrimination provision could not be reasonably construed to mandate that an insurer provide coverage for any and all services that a provider might be licensed to provide.

b) Dental Care

In *Sendik v. Cigna Health and Life Insurance Company, 2018 WL 324892 (E.D. Wisconsin 2018)*, the district court determined that the plan properly denied coverage for the “surgical removal of erupted (impacted) tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth” and related dental implants to treat the dependent’s congenital abnormality in the development of the teeth. The court cited the plan’s exclusion for dental implants and limitation to cover expenses for treatment or diagnosis of an injury or illness and concluded that the plan properly interpreted the limitation as not covering reconstructive surgery for abnormalities of the jaw, dental treatment, and dental implants.
c) Infertility

In *Roibas v. EBPA, LLC, 2018 WL 4690354 (D. Maine 2018)*, the district court determined that the plan’s denial of surrogacy benefits to a participant who asserted that she was a gestational carrier (used another’s fertilized egg), not a surrogate (the pregnant woman uses her own egg), was not arbitrary and capricious as it reasonably interpreted the plan’s exclusion for surrogacy to apply to the participant’s pregnancy and related childbirth. The court noted that the plan’s interpretation was based on a plain meaning of “surrogacy” and was consistent with the overall language and purpose of the plan (the court stated that it was “hard to believe that the [plan intended] to cover the pregnancy expenses of a gestational carrier, but not those of a surrogate”).

d) Bariatric Surgery

No new developments to report.

e) Transgender Services

In *Tovar v. Essentia Health, 2018 WL 4516949 (D. Minnesota 2018)*, an employee and her child asserted that the plan sponsored by Essentia Health West and administered by Health Partners included a discriminatory categorical exclusion for all health services related to gender transition/reassignment and denied the child’s coverage for medically necessary care.

- **Section 1557 Discrimination Claim:** The district court held that the employee and child raised a valid claim for discrimination on the basis of the child’s gender identity under Section 1557 of the Affordable Care Act which prohibits discrimination and the denial of benefits on the basis of race, color, national origin, sex, age or disability under any health program or activity, any part of which is receiving Federal financial assistance. Noting that Section 1557 expressly incorporates four federal civil rights statutes (race, color and national original under Title VI, sex under Title IX, age under the ADEA and disability under the Rehabilitation Act) and applying the standard and burden of proof for a discrimination claim under Section 1557 as determined by the type of discrimination alleged and the relevant statute, the court looked to Title VII as “courts oftentimes look to Title VII when construing Title IX”. Citing that courts have “recognized a cause of action under Title VII for sex discrimination based on gender identity and gender-transition status”, “recognized a cause of action under Title IX for discrimination against individuals who are perceived as not conforming to general stereotypes”, and citing other courts that have held that “Section 1557’s nondiscrimination requirements encompass gender-identity, the court held discrimination”, the court held that Section 1557 also prohibits discrimination on the basis of gender identity.

- The court rejected the defendants’ Spending Clause argument (that because Section 1557 incorporates Title IX and Title IX was enacted as an exercise of Congress’ power under the Spending Clause, they must have adequate notice of circumstances that may subject them to liability under the statute and, furthermore, they did not have notice that Section 1557 prohibited gender identity discrimination until the U.S. Department of Health and Human Services (“DHHS”) issued its final agency regulations implementing Section 1557) on the ground that the plain language of Section 1557 incorporates Title IX and its
prohibition on sex discrimination and, therefore, they were on notice that Section 1557’s nondiscrimination requirements included gender-identity discrimination.

- The court also rejected the defendants’ argument that they were not provided with notice and an opportunity to remedy the plan’s alleged discrimination against transgender individuals as required by Section 1557 via its incorporation of Title IX. The court noted that the defendants had actual notice that the plan violated Section 1557 because the plan was facially discriminatory (they knew of the discriminatory exclusion because they designed, provided and administered it).

- The court also held that nothing in Section 1557 suggests that third party administrators are exempt from its requirements and can be held liable for discrimination.

- The court determined that because the plan was subsequently amended to eliminate the exclusion and reimbursed the employee for out of pocket costs that she incurred to pay for her child’s gender transition care, and her only injury was emotional harm relating to her efforts to obtain medically necessary treatment for her child, the employee lacked Article III standing under the Constitution for federal court jurisdiction. The court stated that emotional harm is not sufficient to convey standing for a parent to seek damages caused by a violation of child’s civil rights. The court noted that the child had Article III standing against the third party administrator.

- Statutory Standing: Applying the U.S. Supreme Court’s statutory standing question in Lexmark, the court determined that the child’s interest (not to be discriminated against on the basis of his gender identity) fell “within the zone of interests protected by the law invoked” and injury (denial of medical necessary treatment) was proximately caused by violations of the statute and, therefore, had standing under Section 1557.

- Lastly, the court rejected the defendants’ motion to stay the action until the resolution of *Franciscan Alliance, Inc. v. Burwell*, 227 F. Supp. 3d 660, 695 (N.D. Tex. 2016) where the court issued a nationwide injunction enjoining the enforcement of the DHHS’s rule that Section 1557’s prohibition of discrimination on the basis of sex includes gender identity. The court held that a stay was not warranted because its finding that Section 1557 prohibits discrimination based on gender identity relies solely on the plain, unambiguous language of the statute and not on the constitutionality of the DHHS regulation. Thus, the court concluded that the outcome of Franciscan Alliance and any new potential DHHS regulation, will not affect the resolution of the action.

f) Other

In *Doe v. Blue Cross Blue Shield of Tennessee*, 2018 WL 3625012 (W.D. Tennessee 2018), the district court rejected the retiree’s discrimination claims under Section 1557 under the Affordable Care Act as enforced by Section 504 of the Rehabilitation Act and Title III of the Americans with Disabilities Act, breach of contract claim and unjust enrichment claim, which were premised on the retiree health plan’s amendment of the plan to terminate the retiree’s ability to fill his HIV/AIDS medication at his local community pharmacy and classification of
his medication as a specialty drug and, therefore, subjecting his medication to the plan’s mail order program for all specialty drugs. Regarding the discrimination claims, the court noted that there was no “direct evidence of discrimination” in the retiree’s amended complaint as required by the Rehabilitation Act. The court rejected the retiree’s disparate impact claim on the ground that Title IX which Section 1557 incorporates, does not provide for claims based on a disparate impact analysis and because Section 504 of the Rehabilitation Act, in accordance with the U.S. Supreme Court precedent in *Alexander v. Choate*, 469 U.S. 287 (1985), requires the court to find that the plan completely deprived him of access to his HIV/AIDS medication (here, the retiree could fill his prescription via the plan’s mail order program). Finding that the retiree’s ADA claim was based on the terms of the plan’s coverage for specialty medications and not on the availability of coverage for such medication, the court found that the retiree had no claim under Title III of the ADA.

8. Limitations on Amount Paid

a) Usual, Customary, and Reasonable (“UCR”) Charges

In *Zack v. McLaren Health Advantage, Inc.*, 2018 WL 4501488 (E.D. Michigan 2018), the district court, citing the Department of Labor’s claims regulations, ruled that the plan violated ERISA’s notice and disclosure requirements when it failed disclose its pricing methodology, including any fee schedule, as part of the benefit and appeal denials as required by ERISA (requires disclosure of any “internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination) when the plan participant specifically challenged the reasonable and customary amount for reimbursement (this was despite the fact that the participant did not make a request for such methodology). The court further held that the plan acted arbitrarily and capriciously when it determined the “reasonable and customary” amount payable to an out-of-network provider because the plan did not define “reasonable and customary” and refused to disclose how it determined that amount at all during the claim or appeal process (the court noted that the absence of a definition for “reasonable and customary” would allow the plan “to interpret the term however it wished, providing no recourse for participants whose benefits may be reduced according to a rationale which is not disclosed to them”) and that the plan’s method for determining the “reasonable and customary” amount (it used its own negotiated in-network fee schedule) did not comport with a plain reading of the plan language. On remand, the court directed that the plain reading of the term “reasonable and customary amount” be used that is based on the prevailing market rate generally charged for the service in the relevant geographic area, to determine the amount payable. The court further determined that the provider was denied a full and fair review because the plan did not consider “modifier 22” (an appendix used by providers when billing to denote that the procedure was more difficult or complicated than usual) when it determined the “reasonable and customary amount” (neither the appeal denial nor the materials sent to the provider did not mention “modifier 22”).

b) Annual and Lifetime Dollar Limits on Benefits

No new developments to report.

C. Coordination of Benefits, Subrogation, Reimbursement, and Escape Clauses

1. Introduction

No new developments to report.
2. Coordination of Benefit Provisions

In *Mahan v. Farmers Insurance Exchange*, No. 17-13311, 2018 WL 5620869, (E.D. Mich., Oct. 30, 2018), 2018 Employee Benefits Cas. 400,610, the plaintiff had two potential sources of coverage for the medical expenses stemming from an automobile accident: Farmers Insurance and the Plan administered by Blue Cross Blue Shield (“BCBS”). The Plan’s COB provision expressly addressed coverage and stated that other insurance, including the automobile and no-fault, shall be primary and showed the intent of the Plan to subordinate its coverage. The Plan filed a motion for summary judgment, claiming that it was undisputed that the Plan’s coverage obligation was secondary. In response, the plaintiff did not address the Plan’s argument that, contrary to the complaint, coverage under the BCBS plan was secondary. Instead, the plaintiff argued that it was premature to dismiss the Plan because the insurer might not provide coverage. The Court rejected this argument, finding that whether the plaintiff obtains coverage from the insurer is irrelevant to whether the Plan is entitled to summary judgment because there is no genuine issue of material fact that the Plan’s coverage was secondary. The Court also rejected Plaintiff’s contention that the BCBS should remain in the case to protect its interest because the Plan sponsor could be entitled to recover payments made in error. The Court found this argument unavailing, noting that BCBS administered the BCBS plan and had no role in the Trust’s subrogation or reimbursement activities. Accordingly, the Court granted the Plan’s motion for summary judgment.

3. Subrogation, Reimbursement and Escape Clauses

a) Subrogation and Reimbursement Clauses Generally

In *Cognetta v. Bonavita*, 330 F. Supp. 3d 797 (E.D.N.Y. 2018), the Plan paid approximately $110,000 to cover medical expenses incurred by defendants James and Nicole Bonavita as a result of a car accident. Pursuant to ERISA § 503(a)(3), 29 U.S.C. § 1132(a)(3), plaintiff trustees of the Plan filed a motion for summary judgment on their claim that the Plan had an equitable lien or constructive trust in the amount of benefits paid against any award or settlement that defendants might recover in a negligence action against third parties in a state court action where the defendants contended that the New York General Obligation Law § 5-335 (“Section 5-335”) precluded insurers from exercising subrogation or reimbursement rights on a claimant’s tort recovery and prohibited the Plan from obtaining reimbursement from defendants’ possible recovery in their personal injury lawsuit. The defendants, to whom the state court granted summary judgment on the issue of liability, also argued that plaintiffs’ action was premature because defendants did not possess identifiable funds from which the Plan could recover. The Court granted plaintiffs’ motion for summary judgment on their declaratory judgment action.

First, the Court found that the nature of the Plaintiffs’ claim was equitable i.e. the enforcement of the Plan’s subrogation clause to obtain reimbursement for the Plan’s payment of medical expenses related to injuries sustained in a car accident from funds recovered in the participants’ personal injury action against a third party. The Court noted that the trustees sought to enforce the subrogation clause against specific proceeds of participants’ state action, rather than to recover from participants’ general assets.

The Court further determined that the make-whole doctrine did not apply to the trustees’ claim because the Plan’s subrogation, assignment, and reimbursement provision placed participants on notice that, if they recovered from a third party, the Plan had the right to recover
any amount received, to the extent of any benefits paid, arising from accident, regardless of
participants’ other expenses, i.e., regardless of whether participants had been made whole.

In *Heartland Health & Wellness Fund v. Billeter*, 333 F. Supp. 3d 761 (S.D. Ohio 2018), a self-funded, multiemployer fund sued an enrollee in the fund and her attorneys, seeking to recover reimbursement of funds paid from the self-funded trust as medical benefits for the enrollee from funds received or to be received in the enrollee’s settlement against driver of tractor trailer for injuries arising when she was struck as pedestrian by tractor trailer. In response to the parties’ cross motions for summary judgment, the Court held that (1) the fund was entitled to recover reimbursement of funds paid from self-funded trust, and (2) the fund was not entitled to award of reasonable attorney fees and costs. The Court reasoned that because the plain language of Plan’s terms unambiguously provided for an equitable lien, the fund was entitled to recover reimbursement of funds paid by the trust as medical benefits from the compensation received or to be received in enrollee’s settlement against driver of tractor trailer that caused the injuries arising from when the enrollee was struck by the tractor trailer. Though the fund recovered 100 percent of its payments, the Court rejected the fund’s request for reasonable attorney fees and costs from the enrollee because the imposition of additional fees on the enrollee would be unjust.

b) Preemption of State Laws Relating to Subrogation and Reimbursement

In *Humana, Inc. v. Shrader Sc Asocs., LLP*, 584 B.R. 658 (S.D. Tex. 2018), the Court held that ERISA preempted the insurers’ state law claims against a law firm for unjust enrichment and money had and received, seeking reimbursement of clients’ asbestos-related medical costs out of settlement funds obtained from bankrupted debtor via asbestos bankruptcy trust. The Court noted that the state law claims would duplicate, supplement, or supplant ERISA’s civil enforcement remedy.

c) Applying Subrogation and Reimbursement Clauses

In *Nat’l Carriers’ Conference Comm. v. Georgiana*, 311 F. Supp. 3d 776 (E.D. Va. 2018), 2018 Employee Benefits Cas. 171, the plan participant suffered a slip-and-fall on the premises of a hotel and recovered a one-million-dollar settlement in his Federal Employers Liability Act (FELA) case against his railroad employer. The Plan sued the participant for the reimbursement of the medical costs it paid, contending that the participant, in fact, recovered from the hotel, a third-party tortfeasor. The participant filed a motion for summary judgment, contending that the Plan was not entitled to reimbursement because he recovered from his employer in a separate Federal Employers Liability Act (FELA) action and not a third-party tortfeasor, noting that the plaintiffs failed to present any record evidence that the hotel was a third-party tortfeasor and that the plan did not require reimbursement. In granting the participant’s motion, the Court found that the plan administrator failed to present evidence that the hotel was a third-party tortfeasor, which was required for a participant to be required to reimburse the Plan for medical expenses arising from the accident from which he subsequently recovered a settlement action against his employer.

benefit plan, filed a section 502(a)(3) action to recover $68,210.38 in medical benefits MBI paid to defendant. The defendant settled a tort claim with the individual who allegedly caused the accident for $320,000. To support its reimbursement claim, the Plan relied on the SPD that contained a right to reimbursement. Based on the SPD’s reimbursement provision, MBI moved for summary judgment based on the SPD. The defendant filed a partial motion for summary judgment, contending that the SPD was not a plan document and even if it were a plan document, it conflicted with the Administrative Services Agreement that did not have any reimbursement language. The Court granted the Plan’s motion for motion, concluding that, despite its label, the SPD was a plan document and there was no conflict between it and the ASC. The Plan’s reimbursement provision created an equitable lien on the defendant’s recovery, and thus MBI was entitled to the disputed funds as a fiduciary of the Plan.

d) Escape Clauses
No new developments to report.

e) Cooperation Clauses and Acknowledgment Forms
No new developments to report.

D. Limitations on Recoupment Rights Under Make-Whole and Common Fund
No new developments to report.

E. Recoupment Rights and Equitable Remedies Under ERISA Section 502(a)(3)—Knudson and Sereboff

1. Right to Enforce Reimbursement Provisions
In *Cognetta v. Bonavita*, 330 F. Supp. 3d 797 (E.D.N.Y. 2018), the court found that it was proper for a self-funded ERISA plan to preemptively file a declaratory action to establish a constructive trust in the amount of medical benefits paid against any award or settlement that plan participants recovered in a negligence action against third parties related to their automobile accident injuries, even prior to the existence of the award or settlement. The court found that the nature of the plan’s claim for declaratory judgment was equitable, as was required to bring an ERISA claim to enforce the plan’s subrogation clause. The plan participant argued that the Second Circuit had held that a benefit plan could not preempt application of a New York state law that barred an insurer from seeking the amount paid out as medical benefits to an insured from a personal injury settlement and thus, the plan could not seek reimbursement. The *Cognetta* court, however, found that the plan was an self-funded ERISA plan and thus, ERISA pre-empted the application of this New York statute that would limited an insurer’s reimbursement and subrogation claims. Thus, the court held that the plan’s preemptive declaratory judgment action was a proper means of foreclosing the participant’s ability to dissipate the funds.

2. Available Equitable Relief: Knudson and Sereboff
In *Manuel v. Turner Industries*, 905 F.3d 859 (5th Cir. 2018), the Fifth Circuit held that a plan participant’s claims that he was not timely provided a summary plan description (SPD) and that the SPD did not comply with ERISA requirements were cognizable only under Section 502(a)(3). The plaintiff, a plan participant, participated in his employer’s short-term and long-term disability plans that were insured and administered by a third party administrator (“TPA”). The plan participant alleged that he was unable to work and claimed short term disability
benefits. The TPA, which had the sole discretion to interpret the plan according to its terms, approved and paid the claim for short-term disability benefits. After exhausting his short-term disability benefits, the participant applied for long-term disability benefits. The TPA rejected his claim and denied long-term disability benefits because the plan did not cover disabilities due to a pre-existing condition. Related to this denial, the TPA determined that it paid out the short-term disability benefits in error and demanded repayment from the participant. The plan allowed the TPA to recover any overpayments due to any errors made in processing the claim.

The participant filed suit, alleging *inter alia* that the plan had breached its fiduciary duty under Section 503(a) because it did not timely provide him with the SPD. Further, the SPD did not contain required disclosures, in violation of ERISA’s provision to “reasonably apprise ... participants and beneficiaries of their rights and obligations under the plan.” Specifically, the SPD did not include the plan’s preexisting condition exclusion, overpayment reimbursement provision, delegation of interpretive discretion to the TPA, or the TPA’s name. The Fifth Circuit found that the participant had properly alleged that the SPD contained misrepresentations or material omissions, and that the district court had erred in granting the plan’s motion for summary judgment because the participant could have obtained relief under a Section 502(a)(1)(B) claim for benefits. In fact, the Fifth Circuit stated that where an SPD conflicts with the plan’s terms or omits required disclosures, the participant’s alleged injuries could only be remedied through equitable relief under Section 502(a)(3).

### 3. Aftermath of Knudson and Sereboff

No new developments to report.

### 4. Defenses in Reimbursement Cases: McCutchen and Montanile

In *Carpenter Technology Corp. v. Weida*, 300 F. Supp. 3d 663 (E.D. Pa. 2018), an ERISA plan was precluded from pursuing recovery from a third party settlement due to its delay in requesting equitable relief, by which time the settlement proceeds had turned into general assets owned by the plan participant and his wife.

The plan participant was injured in a car accident and the plan paid medical benefits for the injuries sustained by him. The participant received settlement proceeds from a personal injury case he filed in state court related to this car accident. Subsequently, the plan waited approximately nine months after receiving notice from the plan participant’s personal injury attorney regarding the pending distribution of the settlement proceeds to file its complaint for equitable relief. Ruling on the plan participant’s motion to dismiss, the court stated that plan sought an equitable remedy when it brought an ERISA action to enforce its subrogation provision and establish a constructive trust or equitable lien regarding the settlement proceeds. Although the employer sought identifiable funds that were within the possession and control of the plan participant, by the time it brought suit, the funds were dissipated such that recovery was now sought from the employee’s general assets. When the plan participant deposited the proceeds into a joint checking account held with his wife, they were immediately converted from a specifically identifiable fund to the joint property of the married couple owned in tenancy by the entireties. Thus, the settlement funds became general assets of the couple, “outside the reach” of the plan’s constructive trust or equitable lien. The court also noted that even if the settlement funds had not been converted to property owned as tenants by the entireties, the plan’s claim would still fail. By the time the plan filed a complaint, the settlement funds had been dissipated.
and could not be traced. Money from the joint account was spent on items that were the joint property of the husband and wife and “there was no way to trace and identify whose money was used to pay what.”

5. **Enforcing Recoupment Provisions Through Self-Help**

No new developments to report.

F. **Provider Claims Against Plans: Assignment and Misrepresentation**

1. **Assignment of Benefit Claims**


Plaintiff, an out-of-network provider, performed surgery on the insured, and submitted a claim for almost $60,000 to Defendant insurer. The insurer processed the claim as out-of-network, providing the insured a small payment and informing the insured that he still owed the provider approximately $58,000. The Plaintiff provider appealed through the insurer’s administrative processes, and submitted a form signed by the insured purporting to be an “Assignment of Benefits & Ltd. Power of Attorney.” However, the insurance plan at issue included an anti-assignment provision, which stated that the “right of a Member to receive benefit payments under this Program is personal to the Member and is not assignable in whole or in part to any person, Hospital, or other entity” (emphasis added by the Court). Plaintiff brought suit under ERISA, and the district court dismissed for lack of standing based on the anti-assignment provision. On appeal, the Plaintiff argued that anti-assignment provisions are unenforceable as a matter of law.

The Third Circuit engaged in an in-depth analysis to determine whether anti-assignment provisions are permitted under ERISA, first examining the text of ERISA and finding it “inconclusive on the question” of anti-assignment provisions. The Court then proceeded to examine the question in the context of congressional intent and public policy. Plaintiff argued that anti-assignment provisions would drive out-of-network providers out of business, thereby reducing patient choice and being inconsistent with ERISA’s intent to be construed broadly in favor of extending benefits; Defendant argued that anti-assignment provisions help control cost and thereby make healthcare more accessible, also consistent with public policy goals. The Court found neither argument dispositive.

Ultimately, the Third Circuit elected to join the First, Second, Fifth, Tenth, and Eleventh Circuits, each of which have “conclude[d] that nothing in ERISA forecloses plan administrators from freely negotiating anti-assignment clauses, among other terms.” The Third Circuit found “no compelling reason to stray from the ‘black-letter law that the terms of an unambiguous private contract must be enforced.’”

The Court then rejected Plaintiff’s argument that Defendant had waived its ability to enforce the anti-assignment provision by “accept[ing] and process[ing] the claim form.” The Court noted that “routine processing,” which included payment at an out-of-network rate and denying the informal appeal, was not evidence of the Defendant waiving its anti-assignment rights.
Plaintiff had one last argument: that the case should be remanded because the insured had also signed a power of attorney in favor of the Plaintiff. The Defendant argued that such a delegation was also invalidated by the anti-assignment clause. Notably, the Court rejected Defendant’s argument, finding that a power of attorney delegation was not the same as a transfer of ownership prohibited by the anti-assignment clause, but rather, an agency relationship, and could not be invalidated. However, the Third Circuit still declined to remand, on the basis that Plaintiff had failed to raise the issue in its opening or reply brief. Thus, anti-assignment provisions are now enforceable in the Third Circuit.

In *Eden Surgical Center v. Cognizant Technology Solutions Corp.*, 720 F. App’x 862 (9th Cir. 2018), the Ninth Circuit continued to enforce anti-assignment provisions. In *Eden Surgical*, the Plaintiff provider argued that equitable estoppel and waiver foreclosed enforcement of the anti-assignment provision at issue. In support of the estoppel claim, Plaintiff argued that Defendant administrator had made material misrepresentations regarding the claim: first, about a week before the surgery, by advising the provider regarding the applicable reimbursement rate, and second, about four months after the surgery, mistakenly telling the provider there was no anti-assignment provision. The Court rejected these arguments, finding that the first alleged misrepresentation, regarding reimbursement rates, was irrelevant to the issue of an anti-assignment provision. The Court then found that an alleged misrepresentation regarding assignability, made four months after the surgery, could not give rise to reasonable reliance for Plaintiff’s decision to file suit.

Importantly, the Court rejected Plaintiff’s contention that Defendant had waived its right to enforce the anti-assignment provision by not raising it in the administrative process. Because the claim was denied on another basis (regarding the participant’s deductible), the Defendant did not invoke the anti-assignment provision as a basis to deny the claim, but rather, as a litigation defense against Plaintiff’s standing to sue. Plaintiff did not seek the plan documents until after it filed suit; had it done so prior to filing suit, it would have discovered the anti-assignment provision.

2. **Misrepresentation Claims Brought by Health Care Providers**

   a) **Preemption Issues**

   An unusual set of facts led to a finding of no preemption and remand of state law claims in *Progressive Healthcare Solutions LLC v. United Healthcare Services Inc.*, No. 17-cv-01452, 2018 WL 809020 (W.D. La. Jan. 4, 2018) report and recommendation adopted by 2018 WL 770910 (W.D. La. Feb. 7, 2018). The insured in this case needed complicated back surgery, and the surgeon contacted the Defendant to determine coverage both for the procedure and for medical hardware, which was provided by the Plaintiff vendor. The Defendant provided written approval of coverage for both the procedure and hardware, and the surgery took place. Defendant then denied payment to the Plaintiff (the case does not indicate whether the surgeon was paid), and after further review, finally agreed to pay the claim. However, Defendant refused to pay Plaintiff directly, and instead sent a $49,425 check to the insured. The insured agreed to assign the payment to Plaintiff, but after receiving the check, absconded with the proceeds.

   Plaintiff brought state law claims in state court against Defendant for negligent misrepresentation, detrimental reliance, and breach of oral agreement. Plaintiff also sued the insured for, *inter alia*, conversion. Defendant removed and asserted complete preemption under ERISA. Plaintiff moved to remand, arguing that under *United Health Inc. v. Davila*, 542 U.S.
200 (2004), its claims against Defendant implicated an independent legal duty and therefore were not preempted. The district court agreed, finding that Plaintiff’s claims did “not rely[] on ERISA or the particular terms of an ERISA plan. Rather, it is relying on independent state law duties, i.e., negligent misrepresentation, detrimental reliance, breach of oral contract.”

b)  Estoppel Claims


The Plaintiff, a neurosurgeon, had contacted the Defendant third party administrator to verify that an emergency surgery would be covered. The Defendant stated it would be. After the surgery was performed, the insured suffered extensive complications, which required substantial additional treatment. Plaintiff re-contacted Defendant to verify coverage, and Defendant again stated the treatment would be covered. There was at least one other communication between Plaintiff and Defendant verifying coverage. Defendants (including the plan sponsor) ultimately paid less than one-tenth of Plaintiff’s bills, and Plaintiff sued, under both ERISA (as a purported assignee), and for state law equitable estoppel. Defendants moved to dismiss. The Court denied the motion as to the ERISA cause of action, finding that Plaintiff had adequately pleaded an assignment to survive dismissal.

Defendants also moved to dismiss the estoppel claim on the grounds that it was preempted by ERISA. The Court likewise rejected this argument, citing The Meadows v. Employers Health Ins., 47 F.3d 1006 (9th Cir. 1995) and Catholic Healthcare West-Bay Area v. Seafarers Health & Benefits Plan, 321 F. App’x 563 (9th Cir. 2008), for the proposition that a third-party provider’s claims for estoppel are not necessarily preempted where the provider alleges misrepresentations about payment for medical treatment. Because Plaintiff’s allegations regarding the misrepresentations did not even “discuss[] the ERISA plan,” preemption was not required. Notably, the Court expressly contemplated that it might be inappropriate to permit a provider to proceed with both ERISA and estoppel claims. Yet the Court allowed both causes of action to move forward, because it did not find “precedent prohibiting otherwise.”

3.  Other Claims Brought by Health Care Providers Against Plans

No new developments to report.

G.  Managed Care Issues

1.  Managed Care Basics

No new developments to report.

2.  Managed Care and ERISA Plans: Pegram v. Herdrich

No new developments to report.

3.  Managed Care: Utilization Review

In IHC Health Services, Inc. v. Calfrac Well Services, Corp., 2018 WL 4621761 (D. Ut. Sept. 26, 2018), the District of Utah held that a plan administrator may not deny benefits on account of a participant’s failure to contact the plan’s utilization review department within twenty-four hours of receiving emergency care when the plan’s summary plan description did
not warn participants that the failure to contact the utilization review department could result in the denial of a claim for benefits. The court reasoned that while the summary plan description went to great lengths to unambiguously alert plan participants to the circumstances under which the penalty of a complete denial of benefits would occur, it did not alert participants that a failure to contact the utilization review department would or could result in such a denial. The court also found that the summary plan description was ambiguous as to the requirement to even contact the utilization review department because the summary plan description stated that a participant “may” contact utilization review after being stabilized, but did not instruct participants that they must contact utilization review or face complete denial of the claims.

4. **Managed Care: Precertification and Utilization Review Requirements**

In *Zack v. McLaren Health Advantage, Inc.*, 340 F.Supp.3d 648 (E.D. Mich. 2018), the district court held that the plan administrator’s application of the plan’s out-of-network benefit calculation was arbitrary and capricious because the plan did not define the term “reasonable and customary” or disclose that the plan determined what it considered to be “reasonable and customary” based on the median of what it paid its contracted network providers. The plaintiff participant had hiatal hernia repair surgery at an out-of-network facility and was billed $27,986.00. The plan reimbursed the participant $726.79 for the procedure.

The plan at issue provided that for care received out of network, the plan would pay benefits equal to 60% of the “reasonable and customary amount.” The plan did not define “reasonable and customary amount” or explain how it was calculated. The plan also declined to explain to the participant during the administrative claims process how the “reasonable and customary” amount was calculated. It was not until litigation that the plan disclosed that it based the “reasonable and customary” amount on a median of what it paid to contracted network providers for the identified services.

The court ultimately concluded that the administrator abused its discretion in calculating the benefit amount because the SPD did not define “reasonable and customary” amount and did not disclose that it was based on a median of the amounts paid to contracted network providers.

5. **Managed Care: Service Area Restrictions and Out-of-Network Restrictions**

No new developments to report.

6. **Managed Care: “Any Willing Provider” Laws**

No new developments to report.

7. **Managed Care: Nondisclosure of Contractual Arrangements**

No new developments to report.

H. **ERISA Health Care Benefit Plans and Medical Malpractice**

No new developments to report.

III. **Issues Unique to Disability Benefit Plans**

A. **Eligibility**

In *Griffin v. Hartford Life & Accident Insurance Company*, 898 F.3d 371, (4th Cir. 2018), 2018 Employee Benefits Cas. 271,530, the plaintiff beneficiary sued the administrator of
his long-term disability plan, alleging wrongful termination of long-term disability benefits. The
district court granted the administrator’s summary judgment motion. Plaintiff appealed,
contending that Hartford Life’s decision to terminate his long-term disability benefits was an
unreasonable exercise of discretion because: (1) Hartford Life’s decision rested on a flawed
employability analysis that ignored Griffin’s medical records; (2) Hartford Life, once having
found him eligible for long-term disability benefits, should have been required to carry the
burden of showing that Griffin’s condition had improved; (3) Hartford Life was required to have
Griffin physically examined by a medical professional before finding him ineligible for disability
benefits; and (4) Hartford Life, given its dual role of determining eligibility for benefits and
paying those benefits, had an inherent conflict of interest that infect[ed] the claims process,
rendering it unreasonable.

Hartford Life responded by asserting that (1) its eligibility determination was the result of
a thorough, reasonable, and fair process; (2) the evidence in plaintiff’s case file supported a
finding that he no longer satisfied the definition of “disabled” under the policy and that it did not
have an obligation under the policy to have the participant examined or to show a change in his
condition to justify terminating previously-granted benefits; and (3) there was no evidence
showing that a conflict of interest tainted its claims-resolution process.

With regard to Griffin’s conflict-of-interest argument, the Court recognized that an
inherent conflict can exist when a plan administrator has both the discretion to make eligibility
determinations and the responsibility for paying benefits to those found eligible. However, there
was no evidence that any such conflict impacted Hartford Life’s adjustment and review of the
claim, noting that the structural conflict, alone, was not sufficient to render Hartford Life’s entire
decision-making process unreasonable.

Accordingly, the Fourth Circuit affirmed, holding that (1) the administrator did not abuse
its discretion in discontinuing long-term disability benefits to beneficiary; (2) the requirement for
initial orientation did not disqualify particular sedentary occupations within beneficiary’s
capabilities as suitable alternative occupations for which he was qualified; (3) the administrator
did not have the burden to show a change in beneficiary’s condition to justify terminating his
long-term disability benefits; (4) the administrator did not act unreasonably in not seeking
opinion of another examiner before discontinuing beneficiary’s long-term disability benefits; and
(5) structural conflict, alone, was not sufficient to render the administrator’s entire decision
making process unreasonable.

B. Proving Disability

1. Burden of Proof

No new developments to report.

2. Medical Evidence

a) Treating/Examining Physicians and Nonexamining Physicians

No new developments to report.

b) Types of Medical Evidence Required- Objective and Clinical
Findings and Symptoms Reports

(1) As to Medical Condition
No new developments to report.

(2) As to Work Capacity

No new developments to report.

3. Vocational Evidence

a) “Own Occupation”

In Aitken v. Aetna Life Insurance Company, 2018 WL 4608217, (S.D.N.Y., Sep. 25, 2018), 2018 Employee Benefits Cas. 346, 345, plaintiff sued Aetna claiming that Aetna had erroneously denied his long-term disability benefits and that he was “incapable of performing the material duties of a Group CFO” because he couldn’t handle the “stressful and pressure filled environments” or “extensive travel.” The court denied the parties cross motions for summary judgment because to determine whether plaintiff was disabled based on his alleged need to avoid stress required weighing the physicians’ competing opinions. With respect to the material duties of plaintiff’s occupation, Aetna argued that plaintiff’s alleged disabilities could not be the basis for a disability because the type of travel plaintiff allegedly needed to avoid was not “a material duty of his own occupation.” Further, Aetna argued that stress was not a “material duty” of plaintiff’s own occupation, rather, stress was “one possible reaction to the need to perform a material duty.” The Court agreed and found that extensive travel was not a material duty of plaintiff’s own occupation and therefore plaintiff was not eligible for disability benefits based on his alleged travel restriction. Addressing plaintiff’s disability as a function of stress, the Court explained that the issue was whether plaintiff’s disability was as a result of his alleged inability to handle occupational stress, not whether stress itself was a material duty of his occupation. The Court concluded that a reasonable fact finder could conclude that plaintiff was disabled within the meaning of the plan as a result of restriction on stress.

b) “Any Occupation”

In Reichard v. United of Omaha Life Ins. Co., 331 F. Supp. 3d 435 (E.D. Pa. 2018), 2018 Employee Benefits Cas. 288, 244, plaintiff filed an action against the claims administrator of the Plan to challenge the termination of her LTD benefits, arguing that substantial evidence did not support the medical file review used to support the termination of LTD benefits and that her disability prevented her from retaining any gainful occupation. The Court determined that the defendant could reasonably determine that plaintiff’s disability did not functionally impair her because defendant’s “vocational expert found jobs at which she could take frequent bathroom breaks. Because there were other jobs where plaintiff’s needs could be adequately accommodated, the Court concluded that plaintiff could not meet the “any occupation” requirement and ruled in favor of defendant.

(1) Vocational Assessments, Physical Capacity, and Job Availability

No new developments to report.

(2) Nonmedical Vocational Factors- Age, Education, Prior Work Experience, Fluency in English

No new developments to report.

(3) Impact of Non-exertional Impairments- Pain, Fatigue,
Cognitive Issues

In *Vetter v. Am. Airlines, Inc.*, 299 F. Supp. 3d 714 (D. Md. 2018), plaintiff, who suffered from fatigue, insomnia, headaches and depression, sued the plan administrator challenging the denial of her LTD claim for certain time periods. Defendant filed a motion for summary judgment. Plaintiff argued that defendant improperly ignored substantial evidence supporting plaintiff’s claim and improperly cherry-picked evidence to support its decision. Defendant countered by arguing that while a plan administrator may not arbitrarily refuse to credit a claimant’s reliable evidence, an administrator able to credit reliable evidence was not arbitrarily refusing to credit the claimant’s evidence. The Court found that Defendant’s reliance on evidence that Plaintiff was “sleeping normally” when she submitted the claim for LTD benefits was not enough to support a particular conclusion as there was later evidence showing that plaintiff’s fatigue and insomnia persisted past the time period where defendant claimed plaintiff was no longer disabled. Accordingly, the Court denied defendant’s motion for summary judgment.

(4) Prior Earnings

No new developments to report.

(5) Transferable Skills, Analyses, and Labor Market Surveys

No new developments to report.

c) Functional Capacity Evaluations

4. Effect of Social Security Determination

a) As to Disability

First Circuit

Nothing to report.

Second Circuit

*Thomas v. Fox Long Term Disability Plan*, No. 17-cv-4389, 2018 WL 6514757 (S.D. N.Y. December 11, 2018). The Court found, among other things, that under the de novo standard of review the plaintiff was entitled to LTD benefits because the Social Security Administration had found her to be permanently disabled. The SSDI award was not conclusive evidence of disability but was relevant evidence of her disability.

Third Circuit

*Reichard v. United of Omaha Life Ins. Co.*, 331 F. Supp. 3d 435 (E.D. Pa. 2018). Although the plaintiff argued that the insurer failed to consider the combined effect of medication side effects in determining that he was not disabled, the court disagreed. The plaintiff failed to identify any medical records or opinions showing that the plaintiff was disabled due to the side effects of her medications. In addition, the court rejected the plaintiff’s contention that the insurer failed to consider his award of SSDI benefits because it was not part of the claim file on appeal, and the plaintiff could not imply knowledge of the award on the insurer even though its vendor had handled the plaintiff’s SSDI claim. Moreover, the judge
found the SSDI award to be of limited value because it was based on different records than the LTD claim.

**Fourth Circuit**

Nothing to report.

**Fifth Circuit**

Nothing to report.

**Sixth Circuit**

Nothing to report.

**Seventh Circuit**

In *Dragus v. Reliance Standard Life Insurance Company, 882 F.3d 667 (7th Cir. 2018)*, the Plaintiff received short-term disability benefits for severe neck pain and side effects of prescribed medication, then returned to work. After the pain returned, the Plaintiff left work and submitted a long-term disability claim and a Social Security Disability Income benefits claim. Reliance denied the long-term disability claim after a consulting physician found plaintiff to be able to perform light duty work with no functionally limiting pain or mental disorders. The Plaintiff appealed and Reliance again sought the help of a consulting physician, who additionally found no functionally limiting conditions. Reliance also performed a Transferrable Skills Analysis and found five similar positions for plaintiff to perform given his conditions and work history. Reliance continued to deny long-term disability benefits, so plaintiff filed a complaint that was reviewed under the arbitrary and capricious standard of review. After filing a Motion for Summary Judgment, plaintiff found out his SSDI claim had been approved, and moved to supplement the record with the decision. The District Court denied the motion and proceeded to rule in favor of Reliance. Plaintiff appealed the ruling and argued the District Court’s decision to deny the supplement of the SSDI award was improper. Because the matter was not subject to a de novo review, the Seventh Circuit upheld the refusal to admit the SSDI award.

*Ferrin v. Aetna Life Insurance Company, 336 F. Supp. 3d 910 (N. D. Ill. 2018).* Plaintiff submitted a claim for long-term disability benefits to Aetna following back surgery. After finding her to be totally disabled, Aetna informed plaintiff she may be eligible to apply for Social Security Disability Income benefits and offered to submit an application on her behalf through its vendor, Allsup. After plaintiff’s claim for Social Security Disability Income benefits was approved, her long-term disability benefits were reduced. Two years later, Aetna terminated her long-term disability benefits as it found that she no longer met the Plan’s definition of disability. Aetna cited to a functional capacity evaluation that indicated the plaintiff had the capacity to perform light occupation work with some restrictions. The termination letter noted that plaintiff’s Social Security award was not significant proof that plaintiff was disabled from her regular occupation. Plaintiff appealed the termination of her benefits. After a consulting clinician reviewed the claim file, Aetna upheld its decision to deny long-term disability benefits, referring to the functional capacity evaluation that supported plaintiff’s ability to perform sedentary work and to a vocational review identifying alternative occupations that plaintiff could reasonably perform given her functional capacity and work history. The court applied a *de novo* review and found that the favorable Social Security determination was compelling evidence of plaintiff’s disability. Moreover, since Aetna facilitated the award of Social Security Disability Income benefits and reduced its liability by applying an offset to the long-term disability benefits.
payable to plaintiff, its dismissal of the award in the termination letter was met with the court’s skepticism. The court found plaintiff’s records, Social Security Disability Income award, and Aetna’s previous determination that plaintiff was disabled was sufficient to determine that plaintiff continued to be disabled and entitled to long-term disability benefits.

In *Floerke v. SSM Health Care Plan, et al.*, No. 17-cv-567, 2018 WL 5045770 (W. D. Wis. October 17, 2018), plaintiff applied for disability benefits due to her chronic migraines and comorbidities of anxiety and depression. The insurer of the long-term disability plan, Unum, terminated plaintiff’s benefits under a Plan provision that provided a 12-month limitation for disabling conditions based on self-reported symptoms and regarding mental health. While plaintiff appealed the termination of her benefits, she received a favorable Social Security determination that she was disabled due to her major depressive disorder and migraine conditions. The court found, however, that Unum acted correctly in finding that plaintiff’s disabling conditions were subject to the Plan’s 12-month limitation and upheld its termination of her long-term disability benefits.

**Eighth Circuit**

Nothing to report.

**Ninth Circuit**

*Young v. Sun Life & Health Ins. Co.*, 285 F. Supp. 3d 1109 (E.D. Cal. 2018). The Court found that defendant adequately considered plaintiff’s favorable Social Security determination relative to plaintiff’s disability claim, but nevertheless concluded that defendant abused its discretion by terminating plaintiff’s long-term disability benefits on other grounds. The court was satisfied with the defendant’s argument that the Social Security determination was not dispositive because the long-term disability policy contained conditions that are not necessarily consistent with the Social Security requirements. Moreover, the Social Security determination was from years prior and may not have taken updated medical information into consideration. Under such circumstances, the court determined that the Social Security determination alone did not warrant a heightened skepticism of Sun Life’s decision to terminate plaintiff’s disability benefits.

*Gorbacheva v. Abbott Labs. Extended Disability Plan*, 309 F. Supp. 3d 756 (N.D. Cal. 2018). In this action plaintiff sought long-term disability payments from defendant. The court remanded the action to the Plan Administrator to make an initial determination of Plaintiff’s claim in light of all of the evidence it should have considered in the first instance. On remand, the Plan Administrator upheld the termination of Plaintiff’s benefits on the ground that Plaintiff did not meet the Plan’s definition of “disabled.” The case was reopened, and the court granted summary judgment in favor of defendant. In doing so, the court was satisfied that the Plan Administrator thoroughly compared the definitions employed by the Social Security Administration and the Plan, as well as the medical evidence relied upon in the Social Security determination. Among the issues addressed by the Plan Administrator was the fact that the Social Security award failed to identify the information upon which it relied to determine plaintiff’s job duties; failed to support with medical evidence its conclusion regarding plaintiff’s cognitive abilities; and relied upon Social Security regulations regarding “advanced age,” which are not applicable to a disability determination under the Plan.

**Tenth Circuit**
West v. Aetna Life Ins. Co., 1:15-cv-00379, 2018 WL 858747 (D. Colo. February 14, 2018). The court found unpersuasive Aetna’s attempt to reconcile its determination to terminate benefits with the Social Security Administration’s determination that plaintiff was permanently disabled. Aetna required plaintiff to apply for Social Security and helped her secure expert assistance to help with the application process. On August 22, 2013, the Social Security Administration found plaintiff totally disabled as of March 1, 2009. The court further determined that the standard for establishing disability under the Social Security regime was actually more demanding than under Aetna’s plan, considering Social Security requires a claimant to establish she cannot perform all other occupations in the national economy and Aetna’s plan merely requires a claimant prove she cannot work at any reasonable occupation where the claimant earns at least 60% of her pre-disability earnings. Moreover, the court rejected Aetna’s argument that its decision was based on more recent medical records because Aetna did not point to any new medical records that demonstrated functional capacity. The court scoured the voluminous record for information that supported a change in the evidentiary picture since the Social Security Administration’s decision and found none. Under such circumstances, the court gave more weight to the conflict between Social Security’s decision and Aetna’s than it would have if the plan administrator had provided a legitimate explanation for the contradictory decisions.

Clark v. Lincoln National Life Ins. Co., Civ. 15-15-D, 2018 WL 4502334 (W. D. Okla. September 20, 2018). The court reversed defendant’s termination of benefits and remanded the matter to the defendant for explanation of its denial to include further consideration of the plaintiff’s Social Security award. The court acknowledged that an award of Social Security benefits is not necessarily determinative of a benefit claim under a disability plan but held that it is incumbent upon the Plan to explain why the Social Security award is insufficient to demonstrate eligibility for benefits under the Plan. Here, defendant provided little more than “lip service” to the social security award in its letters denying plaintiff’s appeal, simply noting the procedural difference between the two schemes. The court determined that defendant’s failure to offer any explanation of why it believed the disability finding from the Social Security Administration was inapplicable supported a reversal.

Eleventh Circuit

O’Leary v. Aetna Life Ins. Co. No. 17-15162, ___ Fed. App’x ___, 2018 U.S. App. LEXIS 27771 (11th Cir. 2018). The plaintiff was injured in a motorcycle accident. He received 24 months of LTD benefits under his plan’s regular occupation standard and then began receiving any occupation benefits thereafter. After receiving LTD benefits for nine years and qualifying for SSDI, Aetna decided to terminate the plaintiff’s benefits based on surveillance footage that showed him driving, dragging a trash can to his garage, and dancing at a nightclub, as well as based on the opinion of the consulting physician Aetna retained to review his records. The district court found in favor of Aetna, and the plaintiff appealed. The Eleventh Circuit affirmed, holding that under the arbitrary and capricious standard of review, Aetna was entitled to rely on the surveillance footage and its consulting expert opinions. The Court further held that the award of SSDI benefits was not entitled to controlling weight in support of the plaintiff’s claim because Aetna claimed it was considered in adjudicating his claim.

McCook v. Aetna Life Ins. Co., No. 3:17-cv-823-J-32MCR, 2018 U.S. Dist. LEXIS 21861 (M.D. Fla. November 14, 2018). In upholding the denial of a plaintiff’s LTD benefits, the court held, among other things, that Aetna was not required to request a copy of the
plaintiff’s SSDI file from the Social Security Administration, even though Aetna required the plaintiff to apply for SSDI benefits. Moreover, the insurer was not required to afford deference to the award of SSDI benefits in considering the plaintiff’s claim and it explained the rationale for why it did not do so.

D.C. Circuit

Nothing to report.

b) As to Onset

Nothing to report.

5. Proving Onset

a) Working While Disabled

No new developments to report.

b) Retrospective Diagnosis: Relational Back of Medical Findings

No new developments to report.

c) Process of Nature

No new developments to report.

6. Exclusions and Limitations

a) Burden of Proof

In Krash v. Reliance Standard Life Insurance Group, 723 F. App’x 106 (3d Cir. 2018), plaintiff, who had been receiving long-term disability benefits for more than four years, brought suit following the denial of continued benefits. The defendant denied further benefits based on a plan limit for 24-months of benefits where a mental or nervous condition has contributed to the disability. The court held that it was the plaintiff’s burden to show that her disability was not caused by her mental condition and that she failed to do so where she offered only conclusory statements to meet that burden.

b) Preexisting Conditions

In Green v. Life Insurance Company of North America, No. 17-1383, 2018 WL 4628113, (10th Cir. Sept. 26, 2018) plaintiff alleged that the defendant insurer incorrectly denied his claim for long-term disability benefits due to a preexisting condition. In deciding to uphold the district court’s denial of plaintiff’s appeal the court found that plaintiff’s condition, posterior vitreous detachment (PVD), was a preexisting condition excluded from coverage because it ultimately led to the plaintiff’s later disabling vision loss, and was not merely one of a series of factors that contributed to the vision loss. In addition, the court found that the PVD occurred during the “look-back period,” a requirement that meant, the claimant must have received medical treatment for the condition, including “diagnostic measures,” within three months before the claimant’s “most effective date under the Plan.” Because the claimant had been diagnosed with PVD within two months of the Plan’s effective date, the condition met this look-back period requirement.
c) Mental and Nervous Benefit Limitations: Self-Reported Illness Benefit Limitation

In *Krash v. Reliance Standard Life Insurance Group*, 723 F. App'x 106 (3d Cir. 2018), plaintiff, who had been receiving long-term disability benefits for more than four years, brought suit following the denial of continued benefits. The defendant denied further benefits based on a plan limit for 24-months of benefits where a mental or nervous condition has contributed to the disability. The plaintiff argued that her disability was caused by a physical condition and her mental conditions—depression, anxiety, posttraumatic stress, and psychogenic tremors—were “caused by and subsequent to her physical disability.” The court, however, found that there was ample evidence in the administrative record to support the defendant’s conclusion that her mental conditions have contributed to her disability. The court affirmed the Third Circuits previous rulings that the term, “caused by or contributed to by,” in a mental disorders limitation clause means that benefits may be terminated when physical disability alone is insufficient to render a claimant totally disabled.”

d) Illegal Acts

No new developments to report.

e) Legal Versus Factual Disability

No new developments to report.

C. Common Proof Issues

1. Risk of Disability

First Circuit

Nothing to report.

Second Circuit

Nothing to report.

Third Circuit

Nothing to report.

Fourth Circuit

Nothing to report.

Fifth Circuit

Nothing to report.

Sixth Circuit

Nothing to report.

Seventh Circuit

Nothing to report.

Eighth Circuit

Nothing to report.
Ninth Circuit

Nothing to report.

Tenth Circuit

_Dardick v. Unum Life Ins. Co. of Am., 739 Fed. App’x 481 (10th Cir. 2018)._ The defendant’s denial of benefits was neither arbitrary nor capricious, particularly in light of the fact that substantial record evidence supported the administrator’s determination that the claimant did not suffer from disabling stress. Plaintiff had submitted a doctor’s report opining that stress contributed to and could precipitate claimant’s diagnosed coronary artery disease. The Plan’s medical expert acknowledged that plaintiff’s job could be stressful, but offered that claimant’s job, physical activities, normal medical exams and the absence of any treatment militated against a finding that plaintiff’s work stress was disabling or could otherwise exacerbate his medical condition.

Eleventh Circuit

Nothing to report.

D.C. Circuit

Nothing to report.

2. **Surveillance**

First Circuit

Nothing to report.

Second Circuit

Nothing to report.

Third Circuit

Nothing to report.

Fourth Circuit

Nothing to report.

Fifth Circuit

Nothing to report.

Sixth Circuit

_Wagner v. American United Life Ins. Co., 731 Fed. App’x 495 (6th Cir. 2018)._ Plaintiff received disability benefits from American as it had determined he was disabled from his regular occupation. Two months short of the change in definition of “disability” to “any gainful occupation,” American terminated plaintiff’s benefits as it had determined he was no longer disabled. Plaintiff unsuccessfully appealed the determination. When plaintiff filed a complaint, the court ruled in favor of American. Plaintiff appealed, and the Sixth Circuit then ruled in his favor. To support its termination of plaintiff’s long-term disability benefits, American cited to video surveillance of plaintiff. The video surveillance only showed plaintiff for a few minutes at a time, however, during the two-hour surveillance period. The Sixth Circuit found fault with the insurer’s decision to forego an in-person examination of plaintiff and rely on
the paper record and video surveillance in its determination, especially given that the surveillance failed to reveal compelling evidence that plaintiff was malingering.

*Eaton v. Reliance Std. Life Ins. Co., No. 2:16-cv-02164, 2018 WL 3639837 (W. D. Tenn. July 31, 2018).* The court upheld the denial of plaintiff’s long-term disability benefits. Plaintiff argued that Reliance departed from a reasonable process in its decision to terminate his long-term disability benefits because it relied upon video surveillance as evidence that plaintiff was not disabled. The court found that conducting video surveillance of a claimant during the determination process was routinely performed by plan administrators, such as Reliance, and therefore was not evidence of impropriety. As the surveillance revealed inconsistencies between plaintiff’s medical records and his physical abilities, the court further found that Reliance’s reference to the video surveillance in its determination was reasonable and appropriate.

**Seventh Circuit**

Nothing to report.

**Eighth Circuit**

Nothing to report.

**Ninth Circuit**

Nothing to report.

*Fleming v. Unum Life Ins. Co. of Am., Civ. 17-01576, 2018 WL 6133859 (C. D. Cal. November 20, 2018).* The court found that Unum erred in terminating plaintiff’s claim for LTD benefits. In so doing, the court assigned little weight to the defendant’s surveillance of plaintiff where it was unclear whether the reviewers actually watched the surveillance footage or only read the accompanying report prepared by the surveillance company. Moreover, the footage actually confirmed certain claims made by plaintiff in support of her claim. The court opined that even if the surveillance footage was somehow inconsistent with Fleming’s medical records and self-reported pain, the Ninth Circuit is understandably skeptical of insurers’ reliance on brief surveillance footage as proof of a claimant’s capacity to work full-time. Thus, the Court saw no reason to credit Unum’s 15 minutes of surveillance footage from one day, especially when it was contradicted by over ten years of medical records.

*Holmgren v. Sun Life & Health Inc. Co., 17-cv-03028, 2018 WL 6336043 (N. D. Cal. December 5, 2018).* Following plaintiff’s claim, Sun Life received a background investigation report and surveillance report regarding plaintiff’s activity. The report reflected that plaintiff is very active on social media and often discusses his pain and treatment. The surveillance report also included video of plaintiff over a five-day period. The surveillance video showed plaintiff driving, entering and exiting vehicles, walking, standing, sitting, and carrying a very small bag. Sun Life pointed to the surveillance video as evidence that plaintiff could sit, stand, and walk, meeting functional capacity he needed to perform his job duties. The court concluded that even accepting Sun Life’s characterization, the surveillance footage does not establish that plaintiff has the functional capacity he needs to perform his job duties because it does not establish that he can perform the functions of his job as a tax director. Moreover, the court rejected as unfounded defendant’s contention that plaintiff’s individual personal musings on social media is evidence of cognitive ability.

**Tenth Circuit**
Nothing to report.

Eleventh Circuit

O’Leary v. Aetna Life Ins. Co. No. 17-15162, ___ Fed. App’x ___, 2018 U.S. App. LEXIS 27771 (11th Cir. 2018). The plaintiff was injured in a motorcycle accident. He received 24 months of LTD benefits under his plan’s regular occupation standard and then began receiving any occupation benefits thereafter. After receiving LTD benefits for nine years and qualifying for SSDI, Aetna decided to terminate the plaintiff’s benefits based on surveillance footage that showed him driving, dragging a trash can to his garage, and dancing at a nightclub, as well as based on the opinion consulting physician Aetna retained to review his records. The district court found in favor of Aetna, and the plaintiff appealed. The Eleventh Circuit affirmed, holding that under the arbitrary and capricious standard of review, Aetna was entitled to rely on the surveillance footage and its consulting expert opinions. The Court further held that the award of SSDI benefits was not entitled to controlling weight in support of the plaintiff’s claim because Aetna claimed it was considered in adjudicating his claim.

Campbell v. Hartford Life & Accident Ins. Co., No. 2018 WL 4963118 (S.D. Fla. October 15, 2018). The Court held that it was not “irrational” for the insurer to rely on surveillance evidence in adjudicating the plaintiff’s claim for continued LTD benefits, or to have a consulting physician review such video footage. The footage showed the plaintiff exercising vigorously at the gym, which the court held was inconsistent with her claimed disability. Moreover, the plaintiff’s treating neurologist also reviewed the surveillance footage and opined that she was capable of full-time sedentary work. The insurer’s determination was upheld.

D.C. Circuit

Nothing to report.

3. Injury Versus Sickness

First Circuit

Nothing to report.

Second Circuit

Nothing to report.

Third Circuit

Nothing to report.

Fourth Circuit

Nothing to report.

Fifth Circuit

Nothing to report.

Sixth Circuit

Nothing to report.

Seventh Circuit

Nothing to report.
Eighth Circuit
Nothing to report.

Ninth Circuit
Nothing to report.

Tenth Circuit
Nothing to report.

Eleventh Circuit
Nothing to report.

D.C. Circuit

Loucka v. Lincoln Nat’l Life Ins. Co., 334 F. Supp. 3d 1 (D.D.C. 2018). Participant brought an action seeking long term disability benefits based upon a diagnosis of Lyme Disease which would have extended his benefits beyond the 24 months he received for a diagnosis for chronic fatigue syndrome. The participant’s tests were negative for Lyme Disease and he relied solely on a single physician’s diagnosis that conflicted with the Center for Disease Control’s criteria for diagnosing Lyme Disease. The plan denied his claim based upon the opinion of multiple independent physicians. The court upheld the decision, finding that plaintiff did not meet the high bar required to overturn the plan’s determination.

4. Combination of Impairments

First Circuit

Kamerer v. Unum Life Ins. Co., 334 F. Supp. 3d 411 (D. Mass. 2018). The plaintiff worked as a consultant. She became disabled in 2004 due to fibromyalgia and a number of related conditions that caused her constant pain. She also struggled with depression. She sought disability benefits under two different Unum LTD plans. Both plans contained a two-year limitation for disability benefits caused or contributed to by so-called “mental nervous” disorders. Both LTD policies also required the plaintiff to be disabled from her “regular occupation” in order to receive benefits. Unum approved the plaintiff’s claim and paid benefits without interruption under both policies from 2004 to 2013. Unum did not assert the mental nervous limitation while her benefits were payable due to her fibromyalgia and related conditions. In 2013, Unum decided she could return to her regular occupation, but her treating physicians disagreed. The plaintiff underwent an IME that the Plaintiff contended in a sworn affidavit lasted approximately five minutes. Her benefits were terminated in September 2014. The Court reviewed Unum’s decision de novo and found for the plaintiff. It noted that although Supreme Court precedent has held that the opinions of treating medical providers are not generally entitled special deference as a matter of law, when the participant’s credibility regarding subjective complaints of pain are at issue in the case, it makes sense to give more weight to the opinions of treating physicians who have personally assessed the participant over an insurer’s record reviewing consultants. Moreover, the fact that the plaintiff had undergone extensive treatment for her condition and took numerous strong medications to treat her pain was strong evidence of her continued disability. The Court disagreed with Unum’s assessment that there was no “objective evidence” of her continued disability because her physicians had repeatedly tested her for fibromyalgia via a trigger point test. Lastly, the Court rejected Unum’s
attempt to assert the LTD plans’ respective mental nervous limitations after having failed to do so for years. The Court noted that her physical limitations were the cause of her disability and that Unum had failed to factually prove otherwise.

Second Circuit

Nothing to report.

Third Circuit

Reichard v. United of Omaha Life Ins. Co., 331 F. Supp. 3d 435 (E.D. Pa. 2018). Although the plaintiff argued that the insurer failed to consider the combined effect of medication side effects in determining that he was not disabled, the court disagreed. The plaintiff failed to identify any medical records or opinions showing that the plaintiff was disabled due to the side effects of her medications. In addition, the court rejected the plaintiff’s contention that the insurer failed to consider his award of SSDI benefits because it was not part of the claim file on appeal, and the plaintiff could not imply knowledge of the award on the insurer even though its vendor had handled the plaintiff’s SSDI claim. Moreover, the judge found the SSDI award to be of limited value because it was based on different records than the LTD claim.

Fourth Circuit

Vetter v. Am. Airlines, Inc., 299 F. Supp. 3d 714 (D. Md. 2018). The court rejected the plaintiff’s argument that the administrator did not properly consider the combination of her various conditions in assessing her eligibility for LTD benefits because the denial letter indicated that the administrator claimed to have considered all of the documentation submitted on appeal. Nonetheless, the court agreed with the plaintiff that the administrator abused its discretion in denying her claim in that it reached a conclusion that was directly contradicted by all of the medical evidence in the claim file.

Fifth Circuit

Nothing to report.

Sixth Circuit

Nothing to report.

Seventh Circuit

In Floerke v. SSM Health Care Plan, et al., No. 17-cv-567, 2018 WL 5045770 (W. D. Wis. October 17, 2018), plaintiff applied for disability benefits due to her chronic migraines and comorbidities of anxiety and depression. The insurer of the long-term disability plan, Unum, terminated plaintiff’s benefits under a Plan provision that provided a 12-month limitation for disabling conditions based on self-reported symptoms and regarding mental health. While plaintiff appealed the termination of her benefits, she received a favorable Social Security determination that she was disabled due to her major depressive disorder and migraine conditions. The court found, however, that Unum acted correctly in finding that plaintiff’s disabling conditions were subject to the Plan’s 12-month limitation and upheld its termination of her long-term disability benefits.
Eighth Circuit
Nothing to report.

Ninth Circuit
Nothing to report.

Tenth Circuit
Nothing to report.

Eleventh Circuit
Nothing to report.

D.C. Circuit
Nothing to report.

5. Sufficiency and Appropriateness of Treatment

First Circuit
Nothing to report.

Second Circuit
Nothing to report.

Third Circuit
Nothing to report.

Fourth Circuit

*Griffin v. Hartford Life & Accident Ins. Co.*, 898 F.3d 371 (4th Cir. 2018). The plaintiff’s claim for disability benefits was denied because the plaintiff had the continuing burden to show that he qualified for benefits. He had stopped receiving treatment for his condition and was no longer taking pain medication for it either. This, plus other evidence acquired during the claims process, provided the insurer with a factual basis for determining that the plaintiff was no longer disabled.

Fifth Circuit
Nothing to report.

Sixth Circuit

*Davis v. Northwestern Mut. Life Ins. Co.*, No. 1:15-cv-1269, 2018 WL 1068451 (W. D. Mich. February 26, 2018). The court upheld Northwestern Mutual’s decision to deny long-term disability benefits to plaintiff. The applicable Plan stated that a claimant for disability benefits must demonstrate that he or she received ongoing appropriate care or treatment during the time for which disability is claimed. Plaintiff was only examined twice in the period he alleged he became disabled. The court found that two examinations did not fulfill the Plan’s requirement of ongoing appropriate care for a claimed disabling condition.

Seventh Circuit
Nothing to report.
Eighth Circuit
   Nothing to report.

Ninth Circuit
   Nothing to report.

Tenth Circuit
   Nothing to report.

Eleventh Circuit
   Nothing to report.

D.C. Circuit
   Nothing to report.

D. Offset Provisions in Disability Plans

First Circuit
   Nothing to report.

Second Circuit
   Nothing to report.

Third Circuit
   Nothing to report.

Fourth Circuit
   Nothing to report.

Fifth Circuit
   Nothing to report.

Sixth Circuit
   In *Barber v. Lincoln Nat’l Life Ins. Co.*, 722 Fed. App’x 470 (6th Cir. 2018), the Sixth Circuit upheld the district court’s decision to dismiss plaintiff’s claim against Lincoln for offsetting his long-term disability benefits due to the outside earnings he received as a political consultant. The Plan governing plaintiff’s long-term disability benefits states that Lincoln is entitled to apply an offset to the payable long-term disability benefits from other sources of income that a claimant receives. As plaintiff’s income from working as a political consultant qualifies as another source of income per the terms of the Plan, the court found against plaintiff.

Seventh Circuit
   Nothing to report.

Eighth Circuit
   Nothing to report.
Ninth Circuit

Abrams v. Life Inc. Co. of N. Am., 725 Fed. App’x 553 (9th Cir. 2018). The Court affirmed the judgment of the district court holding that the plan did not breach its terms by offsetting the claimant’s monthly benefits by 50% of his monthly wages because the “work incentive” provisions contained in the plan were adequately disclosed. The court concluded that the summary plan description clearly explained how the claimant’s monthly benefit would be impacted by money he earned while receiving disability benefits. Moreover, the work incentive benefit, as described in the underlying policy, did not violate the reasonable expectations doctrine, which supplemented ERISA’s express disclosure requirement, because the words of the benefit were clear, the benefit plainly described how monthly benefits were offset by 24 months of disability, and the benefit and its limitations were sufficiently conspicuous in the policy.

Rustad-Link v. Providence Health & Servs., 306 F. Supp. 3d 1224 (D. Mont. 2018). The court granted plaintiff’s motion for summary judgment, finding that she was entitled to recover because the plan administrator wrongfully offset amounts recovered from a medical malpractice suit against her disability benefits. In particular, the claimant, who had multiple sclerosis (MS), suffered a below-the-knee amputation from negligent medical care, and after she recovered from a medical malpractice lawsuit, the administrator offset her plan benefits and sought repayment of benefits. The plan, however, only permitted such an offset when the settlement was payable as a result of the same disability, and contained no provision for apportionment based on different medical conditions. The record also revealed that the administrator changed the claimant’s injury-causing disability designation from MS to amputation in order to take advantage of the claimant’s third-party settlement. In light of the circumstances, the court also ordered that plaintiff receive attorney’s fees and pre-judgment interest.

Tenth Circuit
Nothing to report.

Eleventh Circuit
Nothing to report.

D.C. Circuit
Nothing to report.

IV. Issues Unique to Life Insurance Benefit Plans

A. Eligibility
No new developments to report.

B. Exclusions

1. Suicide
No new developments to report.

2. Intoxication

In White v. Life Insurance Company of North America, 892 F.3d 762 (5th Cir. 2018), the Fifth Circuit concluded that the plan administrator abused its discretion in denying a claim for
life insurance benefits under the Intoxication exclusion where the insurer could not determine the
exact level of impairment of the insured by drugs at the time of the accident. After being
involved in a head-on collision, the insured was rescued by an ambulance and both blood and
urine screenings were conducted. Both tested positive for a variety of drugs, but no alcohol.
Additionally, the testing did not reveal the amount of drugs in the insured’s system at the time of
the accident. The Court of Appeals determined that because the insurance company could not
determine whether and to what extent the insured was impaired at the time of the accident, it was
an abuse of discretion to deny the claim.

3. Other Intentional Acts

No new developments to report.

V. Issues Unique to Severance Benefit Plans

A. Limitations and Exclusions

First Circuit

Nothing to report.

Second Circuit

Nothing to report.

Third Circuit

Nothing to report.

Fourth Circuit

Nothing to report.

Fifth Circuit

Nothing to report.

Sixth Circuit

Nothing to report.

Seventh Circuit

Nothing to report.

Eighth Circuit

*Boyd v. ConAgra Foods, Inc., 879 F.3d 314 (8th Cir. 2018).* Plaintiff submitted a claim
to ConAgra for severance benefits under the applicable policy’s Good Reason clause for self-
termination following the acquisition of another company, Ralcorp, on the basis that his
employment duties had changed significantly. ConAgra denied the claim for severance benefits,
as plaintiff had not ended his employment within the 90-day period after the Good Reason began
(i.e., 90 days after the merger) pursuant to the terms of the Plan, and found that his Good Reason
was not valid, as there was no material reduction in his position, duties, or responsibilities.
Plaintiff appealed the decision and ConAgra upheld its previous denial. Plaintiff then sued
ConAgra. The District Court found ConAgra had not breached its fiduciary duty or abused
discretion under the Plan by denying plaintiff’s claim, as there was substantial evidence for the
denial and no evidence of breach of fiduciary duty. Plaintiff then appealed the judgment. The
Eighth Circuit found plaintiff had failed to show how ConAgra’s determination was unreasonable or unsupported by the record. After due consideration, the court further determined that plaintiff failed to establish that a less deferential standard applied, as he failed to prove that ConAgra had breached its fiduciary duty to him.

Ninth Circuit

Nothing to report.

Tenth Circuit

**Manna v. Phillips 66 Co., 304 F. Supp. 3d 1064 (N. D. Okla. 2018).** Plaintiff sought severance benefits under the Phillips 66 Severance Pay Plan, contending that his job was eliminated, and therefore his termination was a “Layoff” as defined in the Plan entitling him to severance pay under the Plan. The defendant argued plaintiff was not laid off but instead was terminated; however, it cited no documentation to support the termination, either with regard to work performance, timely completion of projects, or hours. The defendant also contended Plaintiff did not qualify for severance pay because Plaintiff did not receive a written Notice of Layoff, as required by the Plan. The Court determined that the record lacked adequate evidence supporting the employer’s justification for terminating Plaintiff, and further, was unwilling to find plaintiff ineligible for benefits under the Plan based solely upon the absence of a formal Notice of Layoff since such circumstances were entirely under defendant’s control. The court, thus, determined that the decision to deny Plaintiff’s claim for severance pay was arbitrary and capricious.

**Himsl v. CVS Pharm., Inc., 2:16-cv-1142, 2018 WL 3730865 (D. Utah August 6, 2018).** The Severance Plan in this matter provided that a director-level employee that is laid off would receive a severance payment equivalent to 39 weeks of salary. During plaintiff’s employment, defendant began issuing Restricted Stock Units (“RSUs”) (owned when vested) to employees. The RSU agreement provided that vesting of the RSUs shall continue through the end of any “severance period” that is set forth or specified in the agreement providing for severance pay. On September 2, 2015, plaintiff was notified that he would be laid off in 60 days. At the time of the notice, plaintiff, as a Director, was eligible for a severance payout of 39 weeks of pay pursuant to the Severance Plan. Plaintiff also had various RSUs that were scheduled to vest in April 2016. Plaintiff executed a Confidential Separation Agreement (“Separation Agreement”) with the company on November 4, 2015. On December 11, 2015, CVS paid Plaintiff 39 weeks of severance pay in a lump sum. On December 15, 2015, Plaintiff received an email from his brokerage account indicating that his interest in the CVS stock options which would have vested in April 2016 had been cancelled. On November 7, 2016, Plaintiff filed suit seeking a ruling that his RSUs should have continued to vest for the 39 weeks following the termination of his employment. In denying defendant’s motion for summary judgment, the court concluded that the Administrator provided no rationale for his determination that the Separation Agreement, and not the Severance Plan, was the agreement providing for Severance Pay. Further, the Administrator also failed to provide any analysis or consideration of the definition of “Severance Period” in the Severance Plan. Under these circumstances, the court determined that a material question of fact existed as to whether the Administrator’s decision was arbitrary and capricious.

Eleventh Circuit
Nothing to report.

**D.C. Circuit**

Nothing to report.

*Peck v. SELEX Sys. Integration, Inc.*, 895 F.3d 813, 2018 EB Cases 252 (D.C. Cir. 2018). Defendant terminated Plaintiff after Plaintiff refused to relocate to a different city for a different position with different responsibilities and duties. Defendant’s severance plan provided for “separation benefits” to eligible full-time employees “whose employment terminates due to lack of work, elimination of position, or change of control.” Plaintiff argued that his position was being eliminated, hence the requirement that he move to a different job in a different location. The court disagreed, finding that plaintiff “was terminated because he would not return to Kansas to serve in a different capacity, not because [SELEX] was eliminating the marketing position in D.C.” and reasoned that being terminated for refusing to relocate was not one of the criteria for receiving the severance benefit. It therefore denied his claim for the severance benefit.

**B. Releases of Claims**

**First Circuit**

*Hernandez v. Lexis Nexis de P.R., Inc.*, No. Civil 17-1718CCC, 2018 WL 1468561 (D. P.R. March 23, 2018). A release of claims contained in an ERISA severance plan was enforced as valid, thereby barring a wrongful discharge claim by the plaintiff.

**Second Circuit**

Nothing to report.

**Third Circuit**

Nothing to report.

**Fourth Circuit**

Nothing to report.

**Fifth Circuit**

In *Beggins v. CBRE Capital Mkts. Of Tex. L.P.*, No. H-17-1541, 2018 WL 3741976 (S. D. Tex., Aug. 7, 2018), plaintiff refused to sign a prepared release agreement that would have allowed him to receive severance pay benefits. Plaintiff then sued CBRE for wrongful denial of severance benefits. The Plan stated that, as a condition of receiving severance benefits, a claimant for such benefits is required to sign a release agreement. The court found no provision in the Plan providing for a claimant’s right to refuse to sign such an agreement. As such, there was no basis for plaintiff to continue to refuse to sign the release. The court found that plaintiff was not entitled to any severance benefits because he did not sign the appropriate agreement construing such benefits.

**Sixth Circuit**

Nothing to report.

**Seventh Circuit**

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Nothing to report.

**Eighth Circuit**

Nothing to report.

**Ninth Circuit**

*Kennedy v. Columbus Mfg.,* 17-cv-03379, 2018 WL 1911808 (N. D. Cal. April 23, 2018). Following the elimination of his position and extensive negotiations, plaintiff signed a written severance agreement with defendant. By signing the severance agreement plaintiff agreed to release any and all claims arising from or related to his employment with defendant, including claims for age and disability discrimination. After receiving a severance payment of $54,798.04 in exchange for the release, plaintiff initiated a lawsuit claiming disability and age discrimination. The court rejected plaintiff’s contention that he was unduly pressured to accept the terms of the severance agreement by defendant’s statement that it would withhold severance benefits unless the agreement was signed. The Court found that the severance agreement valid and enforceable, and therefore granted defendants motion for summary judgment.

**Tenth Circuit**

Nothing to report.

**Eleventh Circuit**

Nothing to report.

**D.C. Circuit**

Nothing to report.

**C. Business Sales and Other Corporate Events**

**First Circuit**

Nothing to report.

**Second Circuit**

Nothing to report.

**Third Circuit**

Nothing to report.

**Fourth Circuit**

Nothing to report.

**Fifth Circuit**

Nothing to report.

**Sixth Circuit**

In *Harrison v. PNC Fin. Servs. Grp.,* No. 3:17-cv-75, 2018 WL 3870914 (S. D. Ohio, Aug. 20, 2018), plaintiff applied for benefits under his former employer’s Severance Benefits plan that was adopted two months prior to its acquisition by PNC. Less than two years later, plaintiff submitted his voluntary resignation, as he stated his new position with PNC had
changed drastically, and subsequently submitted a claim for severance benefits. Plaintiff was informed that he was not an eligible participant under the plan, as he had not achieved an eligible grade level prior to the elimination date. Plaintiff appealed the denial of his claim twice and then filed suit. The court found the continued denial of plaintiff’s claim on the basis that he had not achieved the necessary grade level to be arbitrary and capricious, and remanded the matter to the reviewing committee responsible for administering Plan benefits to determine if plaintiff was an eligible participant in the Plan. The committee did find that plaintiff was a plan participant, but continued its denial of severance benefits, this time stating that plaintiff’s rationale for resigning, the expansion of geographic territory changes his “principal location of work,” did not fulfil the criteria for voluntary resignation. As the Plan did not provide a definition for the “principal location of work” specifically, the court found that the committee’s denial of severance benefits was not arbitrary or capricious but rather the result of reasonably construing the Plan terms.

Seventh Circuit

Nothing to report.

Eighth Circuit

Nothing to report.

Ninth Circuit

Schumann v. Microchip Tech, Inc., 302 F. Supp. 3d 1101 (N. D. Cal. 2018). In this case, and a related case, Berman v. Microchip Tech., Inc. 17-cv-1864, 2018 WL 732667 (N.D. Cal. Feb. 6, 2018), the court granted in part and denied in part defendant’s motion to dismiss plaintiffs’ suit for a denial of severance benefits. Defendant is alleged to have expressed its agreement to honor a severance plan established by the Atmel Company, with which defendant merged. Approximately three weeks following the merger defendant announced that it would, in fact, not honor the severance plan provisions established by Atmel, and thereafter terminated several employees without cause. The court held that plaintiffs adequately alleged that the acquiring company was a fiduciary in breach of its duties under ERISA. Plaintiffs were also permitted to bring their claim for equitable relief under section 502(a)(3) and were found to have pled sufficient facts to state a claim for injunctive relief and equitable estoppel.

Tenth Circuit

Nothing to report.

Eleventh Circuit

Nothing to report.

D.C. Circuit

Nothing to report.

D. Plan Amendments Just Before Employee Terminations

First Circuit

Nothing to report.

Second Circuit

Nothing to report.
Third Circuit
   Nothing to report.

Fourth Circuit
   Nothing to report.

Fifth Circuit
   Nothing to report.

Sixth Circuit
   Nothing to report.

Seventh Circuit
   Nothing to report.

Eighth Circuit
   Nothing to report.

Ninth Circuit
   Nothing to report.

Tenth Circuit
   Nothing to report.

Eleventh Circuit
   Nothing to report.

D.C. Circuit
   Nothing to report.

VI. Welfare Plan Termination, Cancellation, Transfer, and Withdrawal Issues
   A. Cancellation and Termination of Welfare Benefits Generally

   In two notable cases this past year, large companies defeated lawsuits challenging the termination of health coverage for retirees. In Beale v. Kraft Heinz Foods Company,\(^1\) the court considered whether health plan retirees could establish a reasonable claim that Kraft acted to modify or terminate vested welfare benefits. The court determined that the plan document was not ambiguous as all of the SPDs effective for the different retirees contained almost identical reservation of rights provisions reserving the right to amend or terminate benefits at any time. Further, the CBAs did not contain language supporting the contention that benefits vested. The court refused to entertain extrinsic evidence presented by the retirees because of the lack of ambiguity in the written contracts.

   The Sixth Circuit similarly held that General Electric Co.’s\(^2\) decision to cancel health care benefits for retirees over the age of 65 aligned with the CBA’s reservation of rights

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\(^1\) 2018 WL 2085277 (S.D. Iowa Mar. 27, 2018)

\(^2\) IUE-CWA v. General Electric Co., 745 F. App’x 583 (6th Cir. 2018)
clause. While the clause limited GE’s ability to amend, suspend, or terminate benefits while the CBA was in force, those limitations ceased on expiration of the CBA.

1. **Claims Involving Rescission of Coverage and Retroactive Coverage Changes**

   In *Texas v. United States*, the ACA’s individual mandate was held to be unconstitutional. Accordingly, 42 U.S.C. § 300gg-12, prohibition of rescissions, was held to be unconstitutional as not severable from the remainder of the ACA. After a stay was granted, an appeal was filed on January 7, 2019.

2. **Claims Involving Inadequate Disclosures By Plans**

   No new developments to report.

3. **Preemption Issues**

   In *Greenbrier Hotel Corp. v. UNITE HERE HEALTH*, the Fourth Circuit affirmed in part, but on different grounds, a district court decision ruling that the multiemployer welfare fund must remit excess plan assets to a new plan established by a contributing employer that was required to cease participating in the multiemployer fund. The court determined that the district court incorrectly applied the “relate to” doctrine and preemption principles. While the district court used complete preemption in its analysis, the Fourth Circuit determined that the jurisdiction issue implicating complete preemption was not present in the case. Applying a conflict preemption analysis, the court held that ERISA did not preempt the state law breach of contract claims. The court reasoned that contract law did not overlap with ERISA in this instance.

   The court in *Gates v. Morris* cited Greenbrier in its analysis of several claims, including state law claims. The court applied conflict preemption, as used in Greenbrier, but came to an opposite conclusion. In dismissing the state law claims, the court explained that actions to enforce a contract rely on the existence and interpretation of an ERISA plan. It further noted that the relief requested would be paid under the terms of the plan. Therefore, the claim was entirely dependent upon the terms of the plan and concerned parties directly contemplated by ERISA.

**B. Transfers and Uses of Plan Assets**

1. **Department of Labor Advisory Opinions**

   No new developments to report.

2. **Cases Under ERISA and the Labor Management Relations Act**

   No new developments to report.

3. **IRS Rulings**

   No new developments to report.

**C. Withdrawal Liability**

No new developments to report.

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4 719 F. App’x 168 (4th Cir. 2018)
D. Modification, Reduction, and Termination of Retiree Benefits

1. Contract-Based Claims
   a) Claims Relying on Section 301 of the Labor Management Relations Act

      In *IUE-CWA v. General Electric Co.*, 6 retirees sought to prevent GE from altering medical benefits provided under the CBA. Suing under Section 301 of the LMRA, the retirees argued that the language of the CBA made benefits available to participants “when they attain age 65 and after they have retired.” The retirees also pointed to the language “Lifetime Maximum Benefits” as implying benefits would be vested. The Sixth Circuit relied on several of its previous decisions in determining that the reservation of rights clause defeated any argument for vested benefits.

   b) Claims Relying on Section 502(a)(1)(B) of ERISA

      No new developments to report.

2. Communications-Based Claims
   a) Estoppel Claims

      No new developments to report.

   b) Breach of Fiduciary Duty Claims

      No new developments to report.

3. Adverse Changes During Bankruptcy

   A coal company was not required to pay premiums to two multiemployer plans providing retiree health care benefits after filing for Chapter 11 bankruptcy and selling its assets.7 The Eleventh Circuit rejected the plans’ argument that the company was obligated under 11 U.S.C. § 1114 to continue making payments, determining that obligations may be modified or terminated if necessary for a company’s reorganization.

6 745 F. App'x 583 (6th Cir. 2018)
7 *In re Walter Energy, Inc.*, 911 F.3d 1121 (11th Cir. 2018)