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Life, Health, Disability, and ERISA

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MetLife Signs Consent Order, Agrees to Pay NY $60 Million for Unlicensed Activities

March 28, 2014

Beginning in 2011, the New York State Department of Financial Services (DFS) commenced an investigation into American Life Insurance Company (ALICO) and Delaware American Life Insurance Company (DelAm), formerly subsidiaries of American International Group (AIG), and, as of November 2010, subsidiaries of MetLife, Inc. The DFS investigated whether the subsidiaries were engaging or aiding insurance business in New York without a license. The investigation revealed that ALICO, while operating as a subsidiary of AIG, made misrepresentations and omissions concerning its insurance business activities in New York to the New York State Insurance Department (NYSID), and that the companies have engaged in insurance business in New York without a license, and have solicited and continue to solicit insurance business in New York on behalf of unlicensed insurers.

According to the consent order, the violations arose over the business conducted in New York which the insurers had previously misrepresented as qualifying as "back office" operations, not subject to operations. Under the New York Insurance Law, "back office" functions do not require licensure provided that there is no contact with the public, and so long as such functions are primarily ministerial in nature, and do not involve solicitation or sale of insurance or any other activity proscribed by N.Y. Ins. Law § 1102 (McKinney 2006). The investigation found that ALICO and certain alien insurers have collected approximately $900 million in premiums from multinational corporations involving contact with its New York sales representatives from the period of 2007 to 2012. The DFS found that the acts and practices of MetLife, AIG, ALICO, and DelAm violated N.Y. Ins. Law §§ 1102, 2102(a) and 2117.

The consent order reached between the parties requires MetLife to pay a civil penalty of $50 million to the DFS and $10 million to the district attorney's office representing the profits earned over a two-year period from the allegedly unlicensed activity in New York.

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Life Insurer to Pay $20 Million Fine to NY Insurance Regulators

March 17, 2014

New York Governor Andrew M. Cuomo recently announced that AXA Equitable (AXA) will pay a $20 million fine to the New York State Department of Financial Services (DFS) for violations of insurance law related to variable annuity products, which many consumers rely on for their retirements. The DFS investigation uncovered that AXA made changes to certain variable annuity products that limited the potential returns for existing customers without providing adequate notice to the DFS. According to the DFS, those omissions limited the department's ability to put in place important consumer protections, such as requiring existing customers to affirmatively "opt in" to the altered product rather than remaining in that investment by default.

Benjamin M. Lawsky, the New York Superintendent of Financial Services, stated:

> When it comes to retirement products, insurers must go above and beyond to explain any changes that would alter investor returns. Here, AXA changed the rules on these important products midstream and should have done more to disclose those changes to the Department. AXA has done the right thing in resolving this matter.

From 2009 to 2011, AXA filed requests with New York's insurance regulators seeking to amend the plans of operation for certain variable annuity accounts to implement the AXA Tactical Manager strategy. However, these filings failed to inform and adequately explain the significance of the changes to existing policyholders. The changes altered the nature of the product that the policyholders purchased, yet the filings did not explain that it was making the changes to its variable annuity products. These changes affected tens of thousands of New York consumers.

U.S. Dept. of HHS Says ACA Plans Must Cover Same-Sex Spouses

March 14, 2014

The U.S. Department of Health and Human Services recently stated that health insurers providing spousal coverage under the Affordable Care Act must cover same-sex couples as families. Announced as part of the ACA's discrimination policy which becomes effective in 2015, same-sex couples must be offered benefits in the same manner as opposite-sex couples. Insurers are already required to treat married same-sex couples the same way they treat married opposite-sex couples in purchasing insurance through the marketplaces.

The shift in rules reflects other changes at the federal level following a June decision by the U.S. Supreme Court striking down the Defense of Marriage Act for running afoul of the constitution's guarantee of equal protection. In December 2013, the U.S. Department of Treasury said the Internal Revenue Service will let same-sex married couples change their pretax elections to comply with the Supreme Court's ruling on DOMA. That notice was a follow-up to the August ruling by the Treasury Department and the IRS, which said same-sex couples legally married in states that recognize their marriage will be treated as married for federal tax purposes, regardless of the jurisdiction in which they live. This new announcement means that even if the couple is seeking insurance in a state that does not permit same-sex marriage, officials must still assist them in obtaining financial insurance to get coverage.

NY Health Insurer Establishes $1.5 Million Fund and Agrees to Review of Mental Health Claims

March 20, 2014

New York's mental health parity law, known as Timothy's Law, was enacted in New York in 2006, and requires that insurers provide mental health coverage at least equal to coverage provided for other health conditions. Recently, however, an investigation by the New York State Attorney General's Health Care Bureau found that since at least 2011, MVP Health Care issued 40 percent more denials of coverage in behavioral health cases than in medical cases.

Under the settlement, MVP Health Care has agreed to cover residential treatment for behavioral health conditions, including eating and substance abuse disorders, and has designated a fund of $1.5 million for reimbursement of members' past residential treatment claims that had previously not been covered. In a statement, MVP stated that

> Members whose behavioral health claims, filed from Jan. 1, 2011, through March 10, 2014, were denied citing medical necessity as the reason, will have an opportunity to resubmit those claims for review by an independent third party.

MVP anticipates that such claim denials could total more than $6 million in reimbursement to members.

First Circuit: Statute of Limitations Does Not Apply Separately for Each LTD Benefit Payment

Riley v. Metropolitan Life Insurance Company
U.S. Ct. Apps., 1st Cir.; March 4, 2014

In a recent ERISA disability benefits case, the First Circuit answered the following questions involving a claim for the underpayment of monthly benefits: When

does the underpayment claim accrue? And does each new monthly underpayment give rise to a new claim?

In this case, the LTD claim was approved, but the insurer denied the claimant's assertion that the benefits amount was inaccurate. Ordinarily, a cause of action for ERISA benefits accrues when a fiduciary denies a participant benefits. In this case, benefits were paid but the insurer denied the claimant's assertion that the amount of benefits paid was inaccurate. This was not a complete repudiation or a formal denial of all LTD benefits. The court found that it was a clear repudiation of the insured's assertion that he was entitled to higher benefits. In addition, the court concluded that this repudiation, of which the insured was aware, caused the insured's cause of action to accrue, thereby triggering the statute of limitations to start running. It therefore found the claims untimely.

The court then reviewed the issue with respect to the payments that should have been made within the six-year limitations period (like under an installment contract) and concluded that when the act complained of is a one-time miscalculation, the statute of limitations does not start separately for each payment. As such, it ruled that the statute of limitations had run and that the suit was not timely filed.

Eleventh Circuit: "Manipulations Under Anesthesia" Not Medically Necessary

Sanctuary Surgical Centre Inc. v. Aetna Inc.
U.S. Ct. Apps., 11th Cir., November 5, 2013; cert. denied U.S. Sup. Ct., March 24, 2014

On March 24, 2014, the U.S. Supreme Court denied review of the Eleventh Circuit's decision that dismissed claims by medical providers for reimbursement of "manipulations under anesthesia" under ERISA Plans.

In this action, health care providers filed lawsuits against the plan administrators for their failure to pay benefits according to the terms of ERISA plans. The providers alleged claims under ERISA for benefits, breach of fiduciary duty, failure to provide plan documents, and equitable estoppel. The providers claimed that they had performed over a thousand "manipulations under anesthesia." Such largely controversial procedures are performed by chiropractors and orthopedic surgeons on a sedated patient to treat neck and back problems.

The providers asserted that these claims were originally reimbursed by the plan administrators, but that the plan administrators began denying these types of claims in 2006. The defendant administrators asserted that payment for the procedures was denied on the grounds that they were excluded from coverage under the terms of the ERISA plans because the procedures are experimental and thus, not medically necessary.

The Florida district court dismissed the lawsuits, finding that the providers failed to state claims under ERISA. The plaintiffs appealed and the Eleventh Circuit affirmed the dismissals. The Eleventh Circuit rejected the providers' claims for benefits because the providers had not sufficiently alleged medical necessity of the procedures. The primary factual support put forth for the allegation that the procedures were medically necessary was their inclusion in the AMA Codebook of Reimbursable Procedures. The court held that while the codebook provides evidence that the procedures are generally accepted, "general acceptance is not the same thing as medical necessity for a particular patient."

Additionally, the court found that the providers lacked derivative standing to assert the breach of fiduciary duty claims based on alleged assignments from the plan participants. Finally, the court rejected the providers' claim for equitable estoppel because it found that the plans unambiguously defined the terms "medical necessity" and "covered service."

Second Circuit: Entitlement to Attorney Fees Even Where No Evidence of Bad Faith

Donachie v. Liberty Life Assur. Co.
U.S. Ct. Apps., 2d Cir.; March 11, 2014

Here, the plaintiff was granted summary judgment awarding him disability benefits for a peculiar heart condition, but the court denied his request for attorney fees, stating that he had "failed to show any bad faith by [the Plan] administrator in making its LTD determination." The Second Circuit found that the district court had committed reversible error by failing to consider all five factors, and denying fees on the sole basis that the plan "had not acted in bad faith [because the court has] explained that 'a party need not prove that the offending party acted in bad faith' in order to be entitled to attorney fees."

While the Second Circuit acknowledged the district judge's broad discretion in awarding fees, the court also noted the policy behind ERISA's fee-shifting provision, which is intended to "encourage beneficiaries to enforce their statutory rights."

As the Second Circuit discussed, the U.S. Supreme Court ruled in *Hardt v. Reliance Standard Life Insurance Co.*, 560 U.S. 242 (2010) that a fee award is justified so long as the claimant has shown "some degree of success on the merits," finding it to be the "sole factor" a court must consider when deciding whether to award fees. The court went on to discuss the possibility of taking into consideration the five factors courts had previously used:

1. degree of culpability or bad faith;
2. the ability to satisfy an award of attorney fees;
3. whether an award of attorney fees would deter other persons acting

under similar circumstances;

4. whether the decision would benefit all participants and beneficiaries of an ERISA plan or resolve a significant legal question regarding ERISA;
5. and the relative merits of the parties' positions.

Analyzing the facts of the instant case, the court found the district court erred by failing to address culpability as well as failing to address the relative merits of the parties' positions. The court cited to *Locher v. Unum Life Ins. Co. of Am.*, 389 F.3d 288, 298-99 (2d Cir. 2004), noting that culpability was found from an insurer's summary rejection of evidence and its reliance on "general assumptions," which was similar to what the insurer had done in the instant matter. The court reversed and remanded the attorney's fee decision with instructions that the district court award plaintiff reasonable attorneys' fees to be calculated on remand.

Seventh Circuit: Jail Time Possible for Attorney and Plan Beneficiary Who Ignored ERISA Subrogation Lien

Central States v. Lewis
U.S. Ct. Apps., 7th Cir.; March 12, 2014

The facts of this case arise under a rather common setting: an ERISA plan pays $180,000 in medical bills and secures an equitable lien. Then, the plan participant settles a tort claim and receives $500,000, but refuses to reimburse the ERISA plan for its subrogation lien.

In response to the suit to enforce the equitable lien, the plan participant and her attorney both claimed that the funds were "dissipated." The court held that the plan was not required to trace settlement proceeds. The equitable lien automatically gave rise to a constructive trust of the defendants' assets.

The district court issued an injunction preventing the disposal of the settlement proceeds until the plan received $180,000. The defendants ignored the court's order. Subsequently, the plan participant claimed she couldn't pay $180,000 because she spent the entire share of the settlement proceeds on a new house and a car. Her attorney received half of the settlement, and he too claimed that he had spent the money.

The Seventh Circuit found the defendants' appeal brief to be a "gaunt, pathetic document" and stated that the evidence put forward did not accurately set forth the assets of the parties.

> Even if [the plan participant] spent every last cent of the settlement proceeds that she received, it does not follow that she is assetless — presumably she has the vehicle and the house.

The defendants "may think that a mere assertion of inability to pay … precludes a finding of contempt. [The is] not so." In conclusion, the court found the defendants' conduct to be outrageous and direct[ed] the district court to "determine whether the defendants should be jailed (a standard remedy for civil contempt) … until they comply with the order to deposit the settlement proceeds in a trust account." The court urged the district court to forward the opinion and record to the Department of Justice and to the General Counsel of the Georgia Bar.

Tenth Circuit: ERISA Benefit Denial Under Employment-Related Mental or Emotional Disability Exclusion Upheld

Fite v. Bayer Corp.
U.S. Ct. Apps., 10th Cir.; February 4, 2014

In this case, the plan participant had worked as a pharmaceutical representative for several years when, based on a psychologist's diagnosis of major depressive disorder and generalized anxiety disorder, she took leave and applied for STD benefits under the plan. Benefits were originally awarded to the plan participant, but later were denied when a review of medical records did not support the continuation of benefits.

First, while a conflict of interest was conceded, the court gave the conflict of interest factor only limited weight on whether the employer abused its discretion finding that it "took active steps to reduce any potential bias and to promote accuracy" by seeking an independent review of medical records by four different psychiatrists.

Next, among other things, the plan participant claimed that the employer abused its discretion because it "changed the rationale for its denial" and because the final appeal denial letter failed to tell her what additional information she could submit to address the adverse decision. The court noted that the employer had changed the rationale for its denial of benefits between the initial and final decisions, but that that was acceptable:

> The change is readily explained by the new evidence that came to light only during Ms. Fite's appeal." That distinguishes this particular situation from the cases where a plan administrator "asserts an entirely new rationale … during the litigation that it did not rely on in the administrative process.

Lastly, the court held that appeal denial letters are not required to set forth what additional information is needed because different regulations govern what needs to be in an appeal denial letter as distinguished from an initial denial letter:

> Ms. Fite's complaint that the Committee's letter … did not tell her what additional information she could submit to address the Committee's adverse decision relies on a regulation that does not apply to a final decision following an administrative appeal.

The decision of the district court upholding the denial of benefits was affirmed.

Proposed Class Action Against Insurer: Damages Too Individualized to be Addressed on Class-Wide Basis

Franco v. Connecticut General Life Insurance Co.
D.N.J.; April 14, 2014

A U.S. District Court Judge for the District of New Jersey denied class certification to plaintiffs claiming underpayment for out of network claims. The plaintiffs alleged ERISA and RICO violations, claiming that CIGNA used a faulty database (Ingenix) to determine usual customary and reasonable rates under various plans. Previously, the court had denied a motion for certification, finding that the plaintiffs did not carry their burden of showing questions of law and fact. Specifically, the plans sued upon used different language regarding UCR-based ONET benefits. Therefore, the same analysis did not apply to the entire proposed class, each claimant required separate evidence to be determined, and there was no standard method to determine damages. Also, the court noted that the class definition failed to incorporate identifying aspects of membership which limited class membership to underpayment due to Ingenix.

In a renewed motion for class certification, the plaintiffs refined the proposed class definition to limit the class to persons with plans for which CIGNA used Ingenix data to determine the ONET benefits, but did not limit or specify the specific plans or language. The plaintiffs did demonstrate that the plans generally used one of two definitions of UCR. The court noted that self-insured plans could use different definitions, and, even in plans with the basic definition, methodology regarding how the plan may or must select an appropriate UCR. Also, its application was not mechanical. Some plans allowed for the nature and severity of the sickness into consideration, and therefore, required individual investigation of each claim. In addition, the court noted that payment of benefits varied between proposed class members and that the potential application of the abuse of discretion standard allowed for potentially different results in different cases.

The plaintiffs alleged that injury could be established on a class-wide basis because the Ingenix database resulted in a pool of data that was artificially depressed. By design, then, UCR rates were skewed downward. However, the court noted the plaintiffs abandoned the argument that Ingenix suffered from a "downward bias." The court held that the plaintiffs could not prove that all proposed class members suffered an underpayment of benefits. The court also held that plaintiffs could not demonstrate measurable damages across the proposed class, or that the methodology proposed was grounded in plan language.

In summary, the plaintiffs could not demonstrate they could litigate their claims through evidence common to the class, and would not advance resolution of claims. Therefore, for the second time, the court denied class certification.

Plan Did Not Waive Statute of Limitations for LTD Claim by Re-Opening Claim After Statute of Limitations Had Passed

Gordon v. Deloitte & Touch LLP Group Long Term Disability Plan
U.S. Ct. Apps, 9th Cir.; April 11, 2014

The claimant worked until October 2000, when she claimed she could no longer work due to depression. The plan administrator initially began paying benefits in March 2001, but terminated those benefits in January 2003 based on the claimant's failure to furnish continuing proof of disability. The letter gave the claimant 180 days to appeal. The claimant did so, and the denial was upheld, and again the claimant was advised that she had 180 days to appeal. The claimant appealed, and upon review, the plan determined the claimant was entitled to benefits for January to March 2003, but that beyond those dates benefits were unavailable because mental illness benefits were limited to 24 months by the plan.

The claimant was notified of the decision in November 2003, and advised that she had 180 days to appeal. The claimant did not appeal, and took no action for more than four years. When she finally called in 2007, she was informed the deadline to appeal had passed. Another year passed with the claimant taking no further action. In 2009, the California Department of Insurance contacted the plan administrator and asked it to reevaluate the claimant's claim. The plan administrator agreed, and allowed the claimant to submit further information for consideration.

After review, the plan upheld its decision regarding the 24-month limitation, and advised that she could appeal within 180 days, and that if the appeal was denied, she could bring a civil action under 502(a) of ERISA. The claimant appealed, and while the plan was reviewing, the claimant filed suit. The plan moved for summary judgment based on the four-year statute of limitations as well as the three-year plan statute of limitations. The court held that the claimant's right to file an ERISA action accrued at the time her final right to appeal would expire — i.e., 180 days after the November 2003 decision, even if the November 2003 letter was not a final denial.

The claimant argued that by reconsidering the claim in 2009, the statute of limitations was revived under California law. The court held that because ERISA accrued under federal law, the statute of limitations must also be determined by federal law. Following *Martin v. Construction Laborer's Pension Trust*, 947 F.2d 1381 (9th Cir. 1981), the court held the re-opening of the claim did not revive the statute of limitations:

> Reviving a limitation period when an insurance company reconsiders a claim after the limitation period has run would discourage reconsideration by insurers even when reconsideration might be warranted.

The court also found that the plan was not estopped based on its representation — after the statute of limitations had run — that the claimant could bring an ERISA action. Since the statute of limitations had already run by that time, the claimant could not have relied on the statement to her detriment. Further, the plan did not waive the statute of limitations by representing in December 2009 that the claimant could bring suit, noting that under California law an insurer cannot waive a statute of limitations by beginning an investigation after it has run.

The court also noted the distinction between waiver and estopped had been blurred in the insurance context, and required detrimental reliance or some element of misconduct on the insurer's part for a waiver to be found. The court held that more than simply making a statement that the claimant could sue after the statute of limitations had run was required for waiver, and in particular, the insurer received no consideration for a waiver of its defense.

In a dissenting opinion, Circuit Judge Stephen Reinhardt noted that California had not addressed the specific facts of the case, and that in equity, it would likely find a difference between failing to inform an insured about a potential limitation and actively inviting suit.

ERISA Preempts State Reporting Statute

Liberty Mutual Insurance Company v. Donegan

U.S. Ct. Apps., 2d Cir.; February 4, 2014

Vermont enacted a statute that provided for the maintenance of a "unified health care database." Vt. Stat. Ann. Tit. 18, §9410(a)(1). The purpose of the database is to provide information regarding capacity of resources, identify needs, compare cost and effectiveness, inform the public regarding health care, and improve the quality and affordability of health care coverage. As part of that law, health insurers, health care providers, and other entities were required to file reports required by the Vermont Department of Banking, Insurance, Securities, and Health Care Administration, including reports regarding health insurance claims and enrollment information, and information regarding costs, prices, quality, utilization, or resources. The department promulgated a regulation to implement the law, which required regular reporting of data by health insurers, including third-party administrators, and, "to the extent permitted under federal law," any administrator of an insured, self-insured, or publicly funded health care benefit plan."

Liberty Mutual administered a self-funded health plan that provided benefits to 137 individuals in Vermont and 80,000 nationwide. The plan contained certain provisions requiring that all contributions be used for the exclusive benefit of participants, and that all medical information be kept confidential. Liberty Mutual's TPA met the definition of "mandatory reporter" under the Vermont law, and Vermont issued a subpoena demanding the TPA provide information regarding the Liberty Mutual plan. Liberty Mutual filed suit, asserting ERISA preempted the Vermont statute and regulation, and seeking injunction of the subpoena.

Noting ERISA prempts any and all state laws insofar as they relate to any employee benefit plans, the court opined that the broad preemption was intention to eliminate the "multiplicity of conflicting or inconsistent state law, and to achieve broad preemptive effect in areas of record-keeping, reporting, and disclosure." Vermont argued that Congress did not intend that broad of a preemption because the National Health Planning and Resources Development Act of 1974 allowed states to establish health planning agencies to assemble data. It was, however, repealed in 1984, and the court rejected the argument.

The court noted that one of ERISA's core functions related to reporting, and reporting is a distinct function from disclosure. In laws that impose no particular form of record keeping or only slight burdens and sought information readily available from an employer, or that subject plans to inconsistent state obligations or impose burdensome regulations, broad disclosure would be preempted by ERISA:

> The trend toward narrowing ERISA preemption does not allow one of ERISA's core functions — reporting — to be laden with burdens, subjected to incompatible, multiple and variable demands, and freighted with risk of fines, breach of duty, and legal expense.

Sixth Circuit: "Arbitrary and Capricious" Standard Makes a Comeback

McClain v. Eaton Corporation Disability Plan

U.S. Ct. Apps., 6th Cir.; January 24, 2014

The *McClain* court began its decision by noting that the Seventh Circuit's decision in *Cozzie v. Metropolitan Life Ins. Co.* 140 F.3d1104 (7th Cir. 1998) correctly stated that review under the arbitrary and capricious standard was "extremely differential" and the "least demanding form of judicial review." *Cozzie* also, however, noted that courts could not simply rubber stamp a plan determination and that the standard was not without some teeth. Ultimately disagreeing with how subsequent courts have interpreted *Cozzie*, the *McClain* court stated:

> [While the standard is not] without some teeth, it is not all teeth. … [T]hese cautionary metaphors, at times, may have even eclipsed the meaning of the standard and

> rendered arbitrary and capricious review nearly indistinguishable from the competing and more demanding *de novo* review standard.

It went on to note that *Cozzie* itself employed an "extremely deferential review."

Holding that an "'extremely deferential review,' to be true to its purpose," must actually honor an "extreme" level of defense and be upheld if it results from a deliberate principled reasoning process supported by substantial evidence, the court held that according to the arbitrary and capricious standard a decision must be upheld if it results from a deliberate principled reasoning process and supported by substantial evidence: "When it is possible to offer a reasoned explanation, based on evidence, for a particular outcome, that outcome is not arbitrary or capricious." Id. (citations omitted)

In the case before it, the claimant asserted that the plan was limited in what the plan could review, and that it could not not "cherry pick" the records. The Sixth Circuit rejected that argument, and held the plan was entitled to review the entire administrative record because it had consistently denied the plaintiff's claim on the same basis and afforded the claimant the opportunity to submit additional medical records. Noting the ultimate issue was not whether each discrete act was arbitrary and capricious, but rather whether the ultimate decision was, the plan was entitled to review and rely on the whole of the administrative record. Ultimately, the court held that even if the plan was restricted to the review suggested by the claimant, the denial was not "arbitrary and capricious" because the plan reasonably allowed for denial based on that record alone.

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