TORT TRIAL & INSURANCE PRACTICE

Committee News

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Fall 2014

Health and Disability & Life Insurance Law Committees

FROM JUNK FAXES TO ROBOCALLS: TCPA LITIGATION AGAINST LIFE INSURERS

By: Lewis S. Wiener and Wilson G. Barmeyer[1]

Case filings under the Telephone Consumer Protection Act (TCPA) are on the rise in 2014, and life insurance companies are increasingly being drawn into these lawsuits. Any insurance company that communicates with potential customers, job applicants, and others by phone or text using an automated telephone dialing system—or that has independent or semi-independent agents engaging in such automated communications—faces potential litigation risk under the TCPA. This article provides an analysis of some of the key issues facing the insurance industry under the TCPA.

Background on the TCPA

The Telephone Consumer Protection Act was enacted in 1991 to protect consumers from unsolicited advertisements via telephone and fax. The TCPA regulates and restricts the manner in which a business may market its products and services to consumers'

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MESSAGE FROM THE CHAIRS

We are pleased to present the Fall 2014 issue of the TIPS Life Insurance Law and Health & Disability Committees newsletter, which we hope you will find timely and informative. As always, we welcome your thoughts and comments, and invite you to please consider authoring an article or case note for our next newsletter. Please do not hesitate to contact us or the newsletter co-chairs if you wish to contribute to a future issue.

We would also like to thank Briana Montminy and Natalie Furniss, the outgoing chairs of the Health and Disability Committee and the Life Insurance Law Committee, respectively, for their outstanding leadership during this past year.

Please don't delay in registering for the 41st Annual Midwinter Symposium on Emerging Issues and Litigation Relating to Life, Health & Disability Insurance, Insurance Regulation and Employee Benefits that will be held at the beautiful **Ventana Canyon Resort in Tucson, Arizona on January 15-17, 2015**. Our new format this year will have a boot camp the first afternoon specifically focused on attorneys (in-house and outside counsel) who are new to the Life, Health, Disability & ERISA practice and for attorneys would need a refresher on the nuts and bolts issues. Don't miss this great opportunity to send your new associates and colleagues.

This program offers one of the best values for training and networking. We look forward to seeing many familiar faces along with first-time attendees who will find a warm and welcoming group of gifted professionals who make this educational meeting fun and memorable. We are looking forward to seeing you in Tucson.

Please visit the committee website for more information. ⚖

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SUPREME COURT ISSUES "NARROW" BIRTH CONTROL MANDATE RULING THAT MAY HAVE BROADER IMPLICATIONS FOR CORPORATE RELIGIOUS RIGHTS

By: Russell S. Buhite[1]

In a highly anticipated opinion issued on June 30, 2014, the U.S. Supreme Court ruled 5-4 in *Burwell, Secretary of Heath and Human Services, et al. v. Hobby Lobby Stores*, 134 S. Ct. 2751 (2014), that "closely held" corporations do have religious rights and, therefore, they should be permitted to avoid compliance with the U.S. Department of Health and Human Services' Birth Control Mandate under the Affordable Care Act.

Writing for the majority, Justice Alito held that a closely held corporation does have rights under the federal Religious Freedom Restoration Act of 1993 ("RFRA"). Specifically, the Court held that under the RFRA, certain HHS regulations that require an employer-sponsored health plan to include all FDA-approved contraceptives among the preventative services covered without cost-sharing could not be applied to a closely held for-profit corporation with religious objections to some contraceptives.

Under the RFRA, enacted in 1993, federal government requirements that substantially burden a person's religious freedom must serve a compelling interest and be the least restrictive means of furthering the interest. The Act does not define "person," however, and Hobby Lobby, Inc. as well as the other complainant, Conestoga Wood Specialties, Inc., argued that the term includes both corporations and individuals. The government argued that businesses do not have religious beliefs that are separate from the individual owners and employees and that they cannot pray, worship or observe sacraments. Both the complainants and the government had agreed that the RFRA had been properly applied to churches organized as non-profits.

Under the Affordable Care Act, employer-sponsored health plans are required to cover preventative services rated "A" or "B" by the U.S. Preventative Services Task Force and any other such services for women that are recommended by Health Resources and Services Administration ("HSRA") guidelines. HRSA has added all of the FDA-approved contraceptives to the list following recommendations from the Institute of Medicine. In turn, this was adopted by HHS in a Final Rule in July, 2010. The owners of Hobby Lobby, the Green family, purportedly believe that both emergency contraception and two types of IUD's cause abortion and,

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HOW ERISA CAN PROVIDE EQUITABLE MONETARY RELIEF IN BREACH OF FIDUCIARY DUTY CLAIMS

By: Michelle L. Roberts[1]

The last few years have borne witness to a sea change in the availability of equitable remedies under ERISA[2] – specifically, ERISA § 502(a)(3)(B) – the civil enforcement provision that empowers a participant, beneficiary, or fiduciary to obtain other "appropriate equitable relief" (i) to redress any act or practice which violates ERISA or the terms of an ERISA plan, or (ii) enforce any provisions of ERISA or the terms of an ERISA plan.[3] By way of background, § 502(a)(3) was generally viewed as a toothless civil enforcement provision, often providing no remedy for a wrong.[4] This stemmed from a 1993 U.S. Supreme Court decision, which held that ERISA does not authorize suits for money damages against non-fiduciaries who knowingly participate in a fiduciary's breach of fiduciary duty.[5] The High Court construed § 502(a)(3)(B) to authorize only "those categories of relief that were *typically* available in equity" (such as injunction, mandamus, and restitution),[6] and thus rejected a claim that it deemed as seeking "nothing other than compensatory *damages*" (or legal relief).[7] Subsequent lower court decisions left considerable doubt as to whether monetary relief for breaches of fiduciary duty and other statutory violations were ever available under ERISA.[8] This long-standing doubt effectively changed the status of fiduciary from one that required "the punctilio of an honor the most sensitive into a shield against liability."[9] But, recent court decisions have enfeebled this shield and permit remedies where there were none before, particularly with respect to breaches involving health and life insurance benefits.

Courts Possess the Power to Provide Monetary Compensation for a Loss Resulting from a Trustee's Breach of Duty

After nearly two decades of the emaciation of § 502(a)(3), the U.S. Supreme Court issued a watershed decision in *CIGNA Corp. v. Amara*,[10] which approved of monetary relief under this Section.[11] *Amara* involved CIGNA Corporation's change of its basic pension plan for employees that resulted in less generous benefits. In so doing, CIGNA made certain disclosures about the new plan that violated ERISA's notice requirements.[12] The district court in *Amara* found that CIGNA's notice failures had caused the employees "likely harm," and reformed the new plan, ordering CIGNA to pay benefits accordingly.[13]

The U.S. Supreme Court found that the district court could not reform the plan under § 502(a)(1)(B), which speaks to enforcing the plan's terms, not changing them.[14] However, the district court's remedy resembled three forms of traditional equitable relief that

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2 ERISA stands for the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), 29 U.S.C. § 1001 *et seq.*, a federal law that exclusively governs most employer-sponsored benefit plans, including but not limited to those that provide pension, health, and life insurance benefits.

3 ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3).

4 For example, in *Bast v. Prudential Insurance Co. of America*, 150 F.3d 1003 (9th Cir. 1998), the plaintiff alleged that Prudential's delay in authorizing a potentially life-saving medical procedure resulted in the death of the plan participant. The Ninth Circuit explained that although Prudential may have been unjustly enriched by not paying for the procedure, it could not order money damages for the plaintiff as an appropriate equitable remedy under ERISA. *Id*. at 1010-11. This was despite that ERISA preempted any state law claims that could have provided a remedy. *Id*. at 1008.

5 *Mertens v. Hewitt Assocs.*, 508 U.S. 248 (1993).

6 *Id*. at 256.

7 *Id*. at 255.

8 *See, e.g.*, *Hein v. F.D.I.C.*, 88 F.3d 210, 224 (3d Cir. 1996) (instructing the district court to dismiss all three of the plaintiff's fiduciary duty claims for monetary damages because such damages are not available pursuant to *Mertens*); *Knieriem v. Grp. Health Plan, Inc.*, 434 F.3d 1058, 1064 (8th Cir. 2006) (rejecting "surcharge" remedy as unavailable under ERISA § 1132(a)(3)(B)); *Krauss v. Oxford Health Plans, Inc.*, 517 F.3d 614, 630 (2d Cir. 2008) (finding that the plaintiffs cannot recover money damages through their claim for breach of fiduciary duty under ERISA § 502(a)(3)).

9 Dana M. Muir, *Fiduciary Status as an Employer's Shield*, 2 U. Pa. J. Lab. & Emp. L. 391, 392 (2000).

10 *CIGNA Corp. v. Amara*, 131 S. Ct. 1866 (2011).

11 *Id*. at 1881.

12 *Id*. at 1871.

13 *Id*. at 1868.

14 *Id*.




LIFE INSURER PREVAILS IN FIRST CIRCUIT APPEAL IN ERISA CLASS ACTION CHALLENGING RETAINED ASSET ACCOUNTS

By: Waldemar J. Pflepsen Jr., Michael A. Valerio, Ben V. Seessel, and John C. Pitblado[1]

In a unanimous panel decision, the U.S. Court of Appeals for the First Circuit reversed a trial court's ruling that the defendant, Unum Life Insurance Company of America (Unum), had breached fiduciary duties under the Employee Retirement Income Security Act of 1974 (ERISA) by using so-called retained asset accounts ("RAAs") to disburse death benefits under employer-sponsored benefit plans funded by group life insurance policies that Unum issued to the plans. *Merrimon v. Unum Life Ins. Co. of Am.*, No. 13-2128 (1st Cir. July 2, 2014). In reversing the trial court's liability ruling, the First Circuit also vacated the lower court's $12 million judgment in favor of the plaintiff class.

By way of background, RAAs operate similarly to interest-bearing checking accounts. Upon approval of a life insurance beneficiary's claim, the insurance company provides the beneficiary with a draft book issued by an intermediary bank from which the beneficiary can choose to write a single draft in the entire amount of the benefit, draw the account down via multiple drafts over time, or do nothing, in which case the account continues to accrue interest at or above a guaranteed rate.

In *Merrimon*, the named plaintiffs were life insurance beneficiaries who received RAAs under the terms of ERISA-governed benefit plans funded by Unum group life insurance policies. The named plaintiffs brought a putative class action lawsuit in the U.S. District Court for the District of Maine. They alleged that Unum earned more on the "retained assets" backing the RAAs than the 1 percent guaranteed rate Unum credited to the plaintiffs and other class members through their RAAs, and that by retaining the alleged difference, Unum violated ERISA in two ways: (1) the practice constituted self-dealing in plan assets in violation of ERISA Section 406(b); and (2) the practice violated Unum's duty of loyalty owed to plan beneficiaries under ERISA Section 404(a).

On the parties' cross-motions for summary judgment, the district court rejected the plaintiffs' first theory. However, the court granted partial summary judgment in favor of the plaintiffs on the second theory, certified the class, and set a trial to determine the appropriate measure and amount of monetary relief. Following the bench trial, the district court awarded the plaintiff class $12 million based on a formula the court adopted to calculate the additional interest that the court determined should have been credited to the beneficiaries' accounts.

The plaintiffs and Unum cross-appealed to the First Circuit, with plaintiffs challenging the summary judgment ruling on the ERISA Section 406(b) "self-dealing" claim, and Unum challenging the $12 million judgment against it based on the district court's liability finding under ERISA Section 404(a).

The First Circuit panel affirmed the trial court's summary judgment ruling in favor of Unum on the Section 406(b) claim, finding that the insurer's underlying general account funds, which backed the RAAs, were not plan assets. In doing so, the panel noted that "[t]here is no basis, either in the case law or in common sense, for the proposition that funds held in an insurer's general account are somehow transmogrified into plan assets when they are credited to a beneficiary's account."

The appellate court reversed the trial court's ruling on plaintiffs' second theory for breach of fiduciary duty under ERISA Section 404(a), finding that the district judge erroneously concluded that Unum was acting as a fiduciary by retaining discretion to determine the interest rate and other features associated with the RAAs and "award[ing] itself the business" of administering the RAAs while retaining the assets backing the accounts.

The First Circuit rejected this reasoning, citing the U.S. Department of Labor's (DOL) stated position that

Continued on page 22

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MASSACHUSETTS COURT FINDS NO BREACH OF FIDUCIARY DUTY FOR FAILURE TO PROVIDE NOTICE OF LIFE INSURANCE CONVERSION RIGHTS

By: Joan O. Vorster and Courtney Cruz[1]

In *Prouty v. The Hartford Life & Accident Insurance Co. & C&S Wholesale Grocers Inc.*, 997 F. Supp. 2d 85 (D. Mass. 2014), the U.S. District Court of Massachusetts allowed the defendants' motions to dismiss, finding that the plaintiff could not recover for a breach of fiduciary duty because the plain language of the Summary Plan Description ("SPD") met the requirements of ERISA, 29 U.S.C. § 1022. The court found that the SPD was written in a user-friendly manner with clear language, that ERISA does not require an SPD to include notice of conversion rights, and that ERISA does not require a plan administrator to provide post-termination notice of conversion rights.

Prouty asserted two ERISA claims against her deceased husband's former employer, C&S Wholesale Grocers, Inc. ("C&S"), and the issuer of the group life insurance policy, Hartford Life and Accident Insurance Co. ("Hartford"), claiming they: (1) failed to provide proper notice with respect to the life insurance termination; and (2) failed to provide a SPD that contained an adequate, reasonable, or understandable explanation of Mr. Prouty's conversion right.

The court rejected Prouty's argument that it could not consider the SPD produced by the defendants. The court held that where Prouty could not produce the SPD referenced in her complaint and which formed the basis of her lawsuit, it would be both unfair and improper to prevent the defendants from referencing the SPD they produced and authenticated in their motions to dismiss.

The court agreed that Hartford had no fiduciary duty to draft or distribute the SPD as those are functions of C&S as the plan administrator. The court found that the SPD given to Mr. Prouty by C&S met the requirements of ERISA. It contained sections on termination as required by 29 U.S.C. § 1022, which was indisputably written in a user-friendly manner with clear language. The court found that the SPD went beyond the requirements of ERISA where it provided notice of conversion rights because ERISA "simply does not require that the SPD even include notification to participants and beneficiaries of any conversion rights." 997 F. Supp. 2d at 91. The court reiterated precedent which established that C & S has no duty under ERISA to provide post-termination notice of conversion rights.

Finally, the court held that Prouty could not seek equitable relief "under the terms of the plan" because she was not a plan beneficiary since her late husband's coverage lapsed. *Id.* Likewise, there was no allegation of a change in plan terms that resulted in unjust enrichment so as to form the basis for equitable relief under ERISA. ⚖

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MASSACHUSETTS COURT AWARDS ATTORNEY'S FEES FOR ERISA CLAIM REVERSED ON REMAND

By: Joseph M. Hamilton and Courtney Cruz[1]

In *Petrone v. Long-Term Disability Income Plan for Choices Eligible Employees of Johnson & Johnson and Affiliated Companies*, 2014 WL 1323751 (D. Mass. 2014), the U.S. District Court of Massachusetts awarded attorney's fees without deduction to Petrone, whose claim was allowed after a remand by the court.

Petrone filed suit after her claim for disability benefits was denied by Johnson & Johnson. On cross-motions for summary judgment, the court remanded the claim to Johnson & Johnson on the grounds that it failed to reasonably consider contrary evidence in the record.

Petrone then filed a motion for attorney's fees. After briefing was completed on that motion, Petrone submitted a letter advising the court that Johnson & Johnson had overturned the denial of her claim and had paid retroactive disability benefits.

The court rejected Johnson & Johnson's argument that the motion for fees should be denied because the order of remand constituted only a procedural victory, given that the claim decision was reversed on remand. It also rejected Johnson & Johnson's argument that a remand cannot constitute some degree of success on the merits to warrant an award of attorney's fees. Because the claim determination had been reversed, the court held the case was substantially the same as that reviewed by the U.S. Supreme Court in *Hardt v. Reliance Standard Life Insurance Co.*, 560 U.S. 242 (2010), which allowed a fee award so long as the claimant showed some degree of success on the merits. Therefore, the court allowed Petrone's motion.

Turning to the amount of the fee, the court noted that Johnson & Johnson did not challenge the billable rate of $500 requested by Petrone. Johnson & Johnson, however, did challenge the amount of time that was spent on what Johnson & Johnson argued were legal or factual theories ultimately rejected by the court, such as the conflict of interest argument, which the court found to be of little concern in reviewing the case on the merits.

The court rejected that argument and awarded Petrone the full amount of fees sought. The court held that Petrone's attorney's submissions were developed with care and preparation, which included an exploration of a conflict of interest. The court noted the investigation of that issue was justified where the conflict issue was not clear at the outset and there was no basis that Petrone's inquiries were excessive or disproportionate.

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CLAIM FOR HEALTH BENEFITS REMANDED FOR FURTHER REVIEW

By: Joan O. Vorster and David L. Fine[1]

In *DeVillers v. Blue Cross & Blue Shield of Rhode Island*, 2014 WL 1338420 (D.R.I. 2014), the U.S. District Court of Rhode Island granted partial summary judgment to Blue Cross, but remanded the case to Blue Cross for further review.

DeVillers and his family were covered under an employer sponsored group health insurance plan, which was funded by a policy issued by Blue Cross. A dispute arose between DeVillers and Blue Cross regarding the cost of DeVillers' son's rehabilitation services.

Initially, the issue was whether the care received by DeVillers' son constituted residential rehabilitation services covered under the plan. Blue Cross determined it did not and denied the claim. DeVillers then sued *pro se*.

Applying a deferential standard of review, the court found that Blue Cross was not arbitrary or capricious in concluding that the information provided by DeVillers and the healthcare provider was insufficient to prove that the program met Blue Cross' eligibility and/or credentialing requirements for an acute substance abuse residential program. Therefore, as to DeVillers' claim challenging that decision, the court upheld the decision.

However, the court went further and agreed with DeVillers' position that the claim could reasonably be interpreted to also include one for outpatient chemical dependency treatment services, which were covered under the plan. The court found that early in the claims handling process, Blue Cross treated DeVillers' claim as including outpatient therapy sessions but then opted to view the claim as an all or nothing request for payment of the entire bill.

The court held that, despite the deferential standard of review, it was not deprived of its discretion to formulate a remedy when the plan had acted inappropriately. The court found that Blue Cross acted inappropriately by not considering and making a determination as to whether any of the therapy or counseling services DeVillers' son received were covered and reimbursable under the plan. Thus, the court remanded that issue to Blue Cross for further consideration and retained jurisdiction of the case.

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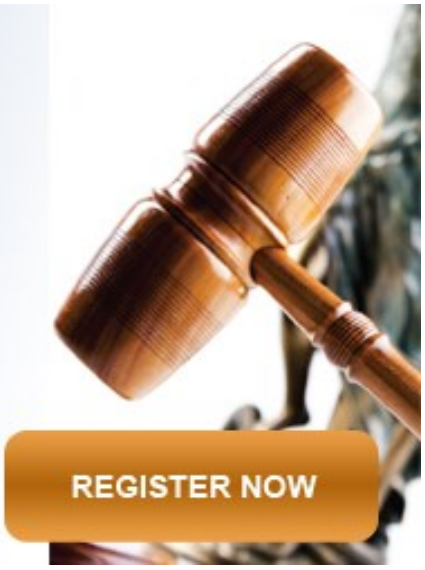

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FROM JUNK FAXES TO…

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cell phones (including via text messages), residential phone lines, and fax machines. Specifically, the TCPA prohibits the use of an "automated telephone dialing system" or an "artificial or prerecorded voice" to make calls to cell phones without the prior express consent of the called party. For marketing calls, the consent must be in writing, and the prohibitions apply to both calls and text messages. In addition, the TCPA prohibits artificial or prerecorded voice calls to residential telephone lines (without prior express consent) and unsolicited fax advertisements. With more and more households abandoning traditional hard-wired landlines in favor of cell phones for their principal means of communication, TCPA risk has increased substantially. Because the TCPA provides for statutory damages of $500 per violation (and up to $1,500 per willful violation) with no maximum cap on recovery, and given the technological capacity of automated dialing systems that can make hundreds if not thousands of calls at the push of a button, potential exposure in a TCPA class action can quickly escalate to millions of dollars.

"…given the technological capacity of automated dialing systems that can make hundreds if not thousands of calls at the push of a button, potential exposure in a TCPA class action can quickly escalate to millions of dollars."

Agent Marketing and Vicarious Liability Issues

Insurance companies often market their products through the use of independent and semi-independent sales forces. Where an agent or agency has allegedly violated the TCPA, the insurer may also be drawn into the litigation on a theory of vicarious liability.

This risk was evidenced in a recent decision in which an Illinois federal court found that a vicarious liability claim could be raised against an insurance company for the actions of its agents and the agents' third-party marketer. The plaintiffs sued three property and casualty insurers, alleging that they received prerecorded, unsolicited calls regarding car insurance policies on behalf of the respective companies. The calls were allegedly made by a third-party telemarketing company through the use of an automated dialing system. If a person answered the call, the telemarketing company would then join the call, take the individual's information, and pass it along to the insurance company's local agent. If the call was not answered, then the telemarketing company left a prerecorded voice message. The complaint acknowledged that the agents, and not the insurance companies, were the ones who had contracted directly with the marketing company.

In its decision, the district court first addressed the question of whether the insurance companies could be held directly and/or vicariously liable for the calls placed by the marketing company and the agents. Although the court determined that the insurance companies could not be found directly liable since they did not physically place the calls, the court concluded that one of the companies might be subject to vicarious liability for the actions of the agents. Specifically, the court held that nothing in the TCPA directly prohibits the principles of common law vicarious liability from applying. Noting Congress' intent to protect individuals from receiving certain calls without providing prior consent, the court opined that the actual sellers—i.e., the insurers—were in the best position to monitor and police third-party telemarketers' compliance with the TCPA. Otherwise, in the court's view, there would be a disincentive to monitor telemarketers, and consumers would not have an effective remedy under the TCPA. Applying this rationale to the complaint, the court dismissed the complaints against several insurers, but found that plaintiffs had alleged sufficient facts to support a basis for holding at least one of the insurance companies liable for the marketing company's actions under a subagency theory, where plaintiffs had alleged that the insurance agents who had hired the marketing company were legally agents of the insurance company.

Vicarious liability has also been asserted where a third-party contractor is making the calls. In 2013, a federal district court in California granted class certification to plaintiffs who allegedly received unsolicited text messages on their cell phones on behalf of a life insurance company in violation of the TCPA. In that case, the plaintiffs alleged that the defendant insurance company entered into a marketing agreement with a third-party marketing group to promote its life insurance products. The plaintiffs alleged that they received text messages sent by the marketing group encouraging them to call a toll-free phone number to claim a gift card voucher, which, according to plaintiffs, did not exist. Rather, plaintiffs alleged that the number connected callers to a call center operated by the marketing group that pitched

the insurance company's products and services, as well as the products and services of the marketing group's other clients. Of particular importance to the issue of third-party liability, the insurance company specifically argued that neither it nor the marketing company had actually caused the text messages to be sent, but rather that third-party contractors actually carried out the operation. The court expressed its skepticism of that defense, stating that it was unlikely to be viable, and certified the plaintiff class. The case was later settled on a class basis. Note, however, that more recent case law in the Ninth Circuit may provide additional support for a defense against vicarious liability where a company lacks control over a third party that sends the communications. *See Thomas v. Taco Bell Corp.*, No. 12-56458 (9th Cir. July 2, 2014) (holding that Taco Bell Corp. was not vicariously liable for text messages sent by a company that a third-party advertiser had hired to assist with a product promotion campaign).

Insurer Communications and Consumer Consent

Several cases against insurance companies and their affiliates have raised issues of "prior express consent," which can be a defense to claims under the TCPA. (Since October 2013, "prior express *written* consent" from the called party is required for marketing calls and texts).

In a recent case against an insurer's affiliate, the Eleventh Circuit examined the question of who constituted the "called party" for purposes of consent and held that the "called party" was the person actually called even if the intended recipient was someone else. In the case, the plaintiff took out a car insurance policy and opened a credit card with the insurer and its affiliate and, as part of the application process, provided her housemate's cell phone number as a contact.

In a subsequent attempt to collect past-due payments, the company allegedly called the housemate's cell phone number. The housemate sued under the TCPA and took the position that the calls were made without consent. The court found that under the TCPA, the "called party" is not the intended recipient of the call (in this case the insured) but rather the actual party that is called (the cell phone subscriber/housemate). To constitute valid consent, the company would have had to obtain consent either directly from the cell phone subscriber/housemate or from someone with the authority to provide consent on the cell phone subscriber's behalf. In this instance, the court stated that consent could be established if the plaintiff was in an agency relationship with her housemate, and the case was therefore remanded for further factual determination on that issue.

More broadly, however, the court's holding on the meaning of the term "called party" creates TCPA risk any time the actual recipient of a call is different from the intended recipient. Several courts have held that consent runs with the person and not with the phone number. Even where a caller has consent from the intended recipient of the call (a former subscriber), some courts have held that there can be a violation of the TCPA where the caller does not have consent from the current subscriber to whom the number has been reassigned, even if the caller is unaware of the reassignment. *See* Soppet v. Enhanced Recovery Co., LLC, 679 F.3d 637 (7th Cir. 2012). For companies that make a significant number of automated calls, this fact pattern can arise with some frequency given that there is a regular churn of cell phone numbers being assigned to new subscribers on an ongoing basis.

Several insurance companies have been drawn into TCPA litigation as a result of junk fax advertisements allegedly sent by insurance agents. The issue of consent is central to these cases. In one case against a life insurer, a federal district court granted the plaintiff's motion for class certification in a case alleging that a third-party agent sent unsolicited fax advertisements for low-cost life insurance. The plaintiff further alleged that the faxes lacked the required opt-out that would allow recipients to opt out of future messages. In arguing against class certification, the insurer asserted that determining whether each recipient consented was an individual issue that precluded certification. The court rejected that defense and stated that "no individual inquiry is necessary and [the] established relationship or voluntary consent defenses are unavailable where, as here, the opt-out requirement [of the TCPA] is alleged to have been violated." The case was recently settled on a class basis.

Recruiting Calls

In at least one case, a plaintiff unsuccessfully sued an insurance company under the TCPA for making recruiting calls in an effort to hire new agents. There, the plaintiff had sued an insurance company for allegedly using an automatic dialing system to leave messages on his residential landline phone (not cell phone) requesting that the plaintiff attend a recruiting webinar to learn about the insurer's products and services as part of the insurer's hiring efforts. Because the case involved allegations of calls to a landline rather than to a cell phone, a key threshold issue was

whether the recruiting calls constituted marketing or non-marketing, because non-marketing calls to landlines are not covered by the TCPA.

The federal court agreed with the insurer and dismissed the case, holding that the alleged calls did not constitute advertisements or solicitations. The court reasoned that under the TCPA, the insurer's calls did not constitute a solicitation because they were not made for the purpose of encouraging the purchase of property, goods, or services. Rather, the company's calls were made for the purpose of promoting an employment and/or independent contractor opportunity. To the extent that the calls mentioned the company's products, the court explained that the intent was not to sell the products to the recipients of the call, but rather to encourage the call recipients to contract with the company to sell those products to others. Thus, the court found that the complaint failed to state a claim. The key distinction in this case was that the calls were made to a landline rather than to a cell phone. A risk to any company making recruiting or other non-marketing calls is that the company may not always know whether it is calling a landline or a cellphone, and consumers more and more are relying on cell phones as their only number.

TCPA Insurance Coverage Issues

In addition to cases brought directly against insurance companies for alleged TCPA violations, a growing number of cases have been brought by commercial liability insurers seeking declaratory judgments that they do not have to provide coverage for their insured's alleged TCPA violations. These cases often turn on the specifics of the exclusions in the commercial liability policy at issue. Some commercial liability policies have express exclusions for TCPA claims, while others may contain more general exclusions that may exclude TCPA claims.

Conclusion

The trend of high-dollar class action settlements has spurred a large increase in TCPA filings over the past few years, including an increase in complaints filed against the life insurance industry. The issues facing insurers in these cases are similar to the issues facing companies in other industry segments: consent and the scope of that consent, vicarious liability issues arising from the acts of agents and third-party marketers, and large potential exposure due to TCPA statutory damages. Companies in all industries are continuing to adjust to new Federal Communications Commission rules that went into effect in late 2013, which set a high standard for the type of written consent required for marketing calls made to cell phones. It is expected that life insurance companies will need to continue to stay on top of TCPA issues relating to marketing, compliance, and potential litigation exposure.

SUPREME COURT ISSUES...

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therefore, that mandated coverage would violate their fundamental Christian beliefs and those of their company. The owners of Conestoga, the Hahns, apparently believe that coverage for two types of emergency contraception violates their Mennonite beliefs and those of their company. Both Hobby Lobby and Conestoga had sought injunctions below against enforcement of the contraceptive coverage mandate.

The government argued that, as corporations, rather than individuals, the "free exercise of religion" rights of individuals would not be implicated by enforcement of the mandate. Further, they argued, as a matter of fundamental corporate law, corporations exist as separate entities from the individual owners. The government also argued that for-profit corporations do not "exercise religion" in the traditional sense in that as a corporate entity they do not pray, perform sacraments, or have religious beliefs. The Oklahoma District Court, concluding that for-profit corporations do not exercise religion, sided with the government and denied the request by Hobby Lobby for an injunction. The Pennsylvania District Court similarly denied Conestoga's request. On appeal, the Tenth Circuit reversed the decision below and granted Hobby Lobby an injunction. By contrast, the Third Circuit in the *Conestoga* case upheld denial of an injunction. The Solicitor General filed a certiorari petition in *Hobby Lobby* seeking the Supreme Court's ruling on whether a for-profit corporation could rely upon the RFRA in denying its employees contraceptives, to which they would be entitled under federal law, under their health plan based on the religious objections of their owners. Conestoga also sought review of the Third Circuit opinion and the two cases were consolidated for consideration by the Supreme Court.

The Court's majority, in which Justice Alito was joined by Justices Roberts, Scalia, Kennedy, and Thomas, determined first that the U.S. Code's Dictionary Act should apply to determine what the RFRA meant by "person" and that this law included within that term corporations, partnerships, individuals and other entities. Importantly, neither the Dictionary Act nor the RFRA make a distinction between for-profit and non-profit companies, and the government's concession that non-profit corporations can be "persons" within the RFRA, made it easy for the majority to conclude that closely-held for-profit corporations could assert RFRA rights. The majority was equally unpersuaded by the government's argument that a for-profit corporation cannot "exercise religion." As Justice Alito wrote, "Furthering [for-profit corporations'] religious freedom also 'furthers individual religious freedom.'" *Burwell*, 134 S. Ct. at 2769. In other words, allowing Hobby Lobby and Conestoga to assert RFRA rights "protects the religious liberty of the Greens and the Hahns." *Id.* In so doing, the Court dismissed the argument that the profit-making motive precluded such claims. For support, it cited a case where a sole-proprietorship seeking to make a profit could assert free-exercise claims, and treatises for the proposition that modern corporations were not solely in business to make money at the expense of altruistic or humanitarian objectives. The majority saw no reason why a for-profit corporation's religious objectives were not worthy of protection.

In addition, the Court refuted government claims that the RFRA did no more than codify Free Exercise Clause precedent prior to the *Employment Division, Department of Human Resources v. Smith*, 494 U.S. 872 (1990), case and that such precedent did not recognize free-exercise rights of for-profit corporations. The Court noted that the RFRA, as originally drafted, merely referenced First Amendment free-exercise rights as opposed to prior case precedent and, moreover, the 2000 amendment stated that the exercise of religion "shall be construed in favor of a broad protection of religious exercise. . . ." *Burwell*, 134 S. Ct. at 2772 (internal quotation marks and citation omitted). The majority was unmoved by the arguments that prior precedent had not recognized standing to sue of for-profit companies nor was it concerned by the argument that it would be difficult to ascertain the sincere "beliefs" of a corporation. It found it unlikely that this issue would come up often with large public companies but, in any event, as concerns closely-held companies, owned and operated by a single family "no one has disputed the sincerity of their religious beliefs." *Id.* at 2774. Thus, the Court held that a federal regulation's restriction on the activities of a for-profit closely held corporation must comply with RFRA.

Next, the Court tackled the issue of whether the HHS contraceptive mandate "substantially burden[s]" the free exercise of religion. *Id.* at 2775. The Court had "little trouble" concluding that it did. *Id.* Pointing to the "sincere beliefs" of the Hahns and the Greens that life begins at conception, requiring their companies to arrange for coverage for certain birth control methods would demand that they engage in conduct that violates their religious beliefs or suffer penalties that would run into the millions of dollars. *Id.* at 2775-76. The Court refused to entertain the argument that the connection between providing health coverage for birth control, and what the corporations find to be wrong, is too attenuated since to go down this road would require the Court to examine whether the beliefs were reasonable. The Court merely accepted that it was the "honest conviction" of these corporations. *Id.* at 2779.

Finally, the majority of the Court examined whether, given the finding of substantial burden on the free-exercise of religion, the HHS has shown that the contraceptive mandate is in furtherance of a compelling governmental interest and that it is the least restrictive means of furthering that compelling interest. While assuming that the interest in guaranteeing cost-free access to the four challenged contraceptive methods is a compelling governmental interest, the Court concluded that the government had failed to show that it was the least restrictive means of furthering that interest. The government could, for example, assume the cost of providing these contraceptives to employees or it could afford the same accommodation that HHS has already established for religious non-profits whereby the insurer administered the contraceptive benefit separately.

The Court was careful to limit its decision to the contraceptive mandate, as opposed to other insurance coverage mandates such as vaccinations or blood transfusions. Nor would the decision, the Court stated, afford protection to employers wishing to engage in discrimination under the guise of religious practice. It also limited its decision to closely-held corporations such as Hobby Lobby and Conestoga.

In a blistering and eloquent dissent, authored by Justice Ginsberg, joined by Justices Sotomayor, Kagan, and Breyer, she accused the majority of stepping into a "minefield . . . by its immoderate reading of the RFRA." *Id.* at 2805. In particular, she expressed her concern in

the 35-page dissent that the "startling breadth" of the majority opinion would allow commercial enterprises to "opt out of any law (saving only tax laws) they judge incompatible with their sincerely held beliefs." *Id.* at 2787. In the dissent's view, the plaintiffs' claims were foreclosed by the *Smith* case, *supra*, where members of a Native American Church were fired from their jobs after ingesting peyote at a religious ceremony. The Court in *Smith* held that no First Amendment violation occurs when prohibiting the exercise of religion is but an incidental effect of a generally applicable and valid regulation. In Justice Ginsberg's view, the Affordable Care Act's contraceptive coverage mandate applies generally, is "otherwise valid" and "trains on women's well-being," rather than on the exercise of religion and, therefore, as in *Smith*, its effect on the exercise of religion is merely incidental. *Id.* at 2790. She also strenuously argued that to allow the accommodation to plaintiffs here would significantly impinge upon the rights of women employees and dependants and "deny legions of women who do not hold their employers' beliefs access to contraceptive coverage that the ACA would otherwise secure." *Id.*

The dissent found no support for the majority's argument that free exercise rights under the RFRA apply to a for-profit corporation. For-profit companies, Justice Ginsberg argued, use labor to make a profit, rather than to perpetuate religious values such as would be the case for religious organizations which exist to serve a community of like-minded believers. Justice Ginsberg wrote: "Until this litigation, no decision of this Court recognized a for-profit corporation's qualification for a religious exemption . . . . The exercise of religion is characteristic of natural persons, not artificial legal entities.". *Id.* at 2794. The dissent expressed great concern that the majority's reasoning could allow large for-profit companies, public and private, to deny contraceptive and other rights. Finally, the dissent argued that there is an insufficient connection between the Green and Hahn families' respective religious beliefs and the contraceptive coverage mandate to be considered "substantial" under the RFRA.

Commentators on the Left and Right have, predictably, either decried the breadth and implications of the decision or, alternatively praised it as upholding religious freedom. The ACLU has focused on the effects of the decision on women employees of companies such as Hobby Lobby and wonder whether it will cause other companies to assert religious beliefs to deny employees a benefit otherwise permitted by law. The Becket Fund for Religious Liberty focused on the decision's recognition of religious liberty and the fact that the government has found alternative means for compliance with the contraceptive mandate. Most insurers are awaiting regulatory guidance from HHS in light of the Court's decision before addressing any questions that may be presented by for-profit, "closely held" corporations. Because at least 90 percent of private companies in the U.S. could be considered "closely held," requiring insurance carriers to take on contraceptive coverage themselves could be a very costly proposition. As to self-funded plans, the Self-Insurance Institute of America Inc. (SIIA) trade group has expressed its concern to HHS about the prospect of expanding the prior non-profit accommodation to include religiously inclined for-profit employers. The SIIA's letter argues that the accommodation already places third-party administrators for self-insured health care plans sponsored by nonprofits in the position of either terminating their contracts with religious nonprofit clients or pay out of their own pocket for the coverage with little chance of being reimbursed in full. ⚖

HOW ERISA CAN PROVIDE…

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would be available under § 502(a)(3). In analyzing the available forms of equitable relief, *Amara* explained that equity courts possess the power to provide monetary compensation for a loss resulting from a trustee's breach of duty, or to prevent the trustee's unjust enrichment.[15] This type of remedy, known as a surcharge, used to be exclusively equitable prior to the merger of law and equity, and extended to a breach of trust committed by a fiduciary encompassing any violation of a duty owed by that fiduciary.[16] Looking to the law of equity, the Court found that a fiduciary can be surcharged under § 502(a)(3) only upon a showing of actual harm proved by a preponderance of the evidence.[17] A plan participant or beneficiary must show that the violation injured him or her by showing harm and causation.[18] The Court denounced a strict detrimental reliance standard for all forms of equitable relief.[19]

How Does a Plaintiff Properly Allege a Breach of Fiduciary Duty Claim Warranting an Equitable Surcharge Remedy?

To successfully survive a motion to dismiss,[20] a complaint seeking a surcharge remedy for a fiduciary's breach of duty should contain certain factual matter: (1) the defendant is an ERISA fiduciary; (2) the defendant owed a duty to the plaintiff; (3) the defendant breached its duty; (4) the fiduciary's breach caused the plaintiff harm; and (5) a surcharge against the fiduciary is necessary to remedy the breach.

1. Is the Defendant an ERISA Fiduciary?

ERISA §3(21) provides that a person is a fiduciary with respect to a Plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan.[21] Thus, an ERISA fiduciary is any person or entity who exercises discretionary authority or control with respect to the management or administration of an ERISA-governed Plan. A person or entity may still be deemed a fiduciary even if it does not have discretion to grant or deny benefits.[22]

A complaint should clearly allege that the breaching person or entity is an ERISA fiduciary and the bases for that assertion (i.e., the entity is a named fiduciary in the Plan or has discretionary responsibility in the administration of the Plan). Although the named Plan Administrator is undisputedly an ERISA fiduciary, some defendants attempt to avoid liability under § 502(a)(3) by arguing that no formal fiduciary relationship has been recognized.[23] However, this argument swims against a strong current of federal court decisions, which hold that § 502(a)(3) does not require a formal fiduciary relationship, but focuses instead on the act or practice which violates any provision of Title I of ERISA.[24] Following this logic, a § 502(a)(3) claim can proceed against a person or entity who assumed fiduciary duties and obligations attendant to plan administrators.[25]

2. Did the Defendant Owe a Fiduciary Duty to the Plaintiff?

Under common law trust principles, a fiduciary has an unyielding duty of loyalty to the beneficiary.[26] An ERISA fiduciary must act in accordance with ERISA § 404, which provides, in relevant part, that:

> a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and—

15 *Id.* at 1869.

16 *Id.* at 1880.

17 *Id.* at 1881.

18 *Id.*

19 *Id.* at 1882.

20 "To survive a motion to dismiss, a complaint must contain sufficient factual matter, accepted as true to 'state a claim to relief that is plausible on its face.'" *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (quoting *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007)).

21 ERISA § 3(21)(A); 29 U.S.C. § 1002(21)(A).

22 *Krase v. Life Ins. Co. of N. Am.*, 962 F. Supp. 2d 1033, 1038 (N.D. Ill. 2013).

23 *See Breyan v. U.S. Cotton, LLC Long Term Disability Plan*, 2014 WL 991946, at *3 (W.D.N.C. Mar. 13, 2014).

24 *See Harris Trust & Savs. Bank v. Salomon–Smith Barney, Inc.*, 530 U.S. 238, 246 (2000). It should be noted that liability under § 502(a)(3) is not limited to the Plan itself or its fiduciary. *Everhart v. Allmerica Fin. Life Inc. Co.*, 275 F.3d 751, 753 (9th Cir 2001).

25 *Breyan*, 2014 WL 991946, at *3.

26 *Griggs v. E.I. DuPont de Nemours & Co.*, 237 F.3d 371 (4th Cir.2001) (citing *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 152–53 (1985)) (Brennan J., concurring) ("Congress intended by § 404(a) to incorporate the fiduciary standards of trust law into ERISA, and it is black-letter trust law that fiduciaries owe strict duties running directly to beneficiaries in the administration and payment of trust benefits.").

> (A) for the exclusive purpose of: (i) providing benefits to participants and their beneficiaries; and (ii) defraying reasonable expenses of administering the plan;
>
> (B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims . . . .[27]

Courts have recognized that in communicating with a participant about ERISA plan benefits, a fiduciary must provide accurate information and act in his best interests.[28] This includes situations where a plan representative communicates with a participant about disability benefit offsets,[29] makes representations, in the medical benefit context, that a procedure will be covered under the applicable plan,[30] or in the life insurance context, fails to provide a participant with necessary information regarding enrollment.[31] The Seventh Circuit Court of Appeals has determined that the fiduciary's duty to provide complete and accurate information, even if the beneficiary does not specifically inquire, is triggered when the beneficiary makes the ERISA fiduciary "aware of the beneficiary's status and situation."[32] The Fourth and Eighth Circuit Courts of Appeals suggested that an insurance company's act of wrongfully accepting premiums may give rise to a claim under § 502(a)(3).[33]

3. Did the Defendant Breach Its Fiduciary Duty?

Courts determining whether a breach of fiduciary duty has occurred consider a variety of case-specific factors. A few of the Circuit Cases that have permitted a § 502(a)(3) claim to proceed in the medical benefit and life insurance contexts involved sympathetic losses, which would have been left without an adequate remedy pre-*Amara*.

a. Wrongful collection of insurance premiums.

In *McCravy v. Metropolitan Life Insurance Co.*,[34] the defendant accepted life insurance premiums from a plan participant on behalf of the participant's 25-year-old daughter for several years, even after the daughter became ineligible for coverage after her 19th birthday.[35] When the participant filed a claim following her daughter's death, MetLife denied the claim and attempted to refund the multiple years' worth of premiums.[36] Similarly, in *Silva v. Metropolitan Life Insurance Co.*, the defendants withheld and accepted premium payments for supplemental life insurance benefits from a participant's paycheck but then the insurer subsequently denied payment of the claim after the participant died because he did not provide evidence of insurability.[37] Notably, with respect to this particular employer, the insurer did not have evidence of insurability for about 200 other employees who enrolled for the insurance coverage.[38]

b. Failure to convert or port coverage.

In *Weaver Brother. Insurance Associates, Inc. v. Braunstein*,[39] the plan participant became disabled from cancer and started collecting disability from the employer.[40] The employer informed her that her benefits would continue as though she was an active employee and she completed paperwork updating her life insurance beneficiaries, which the employer reviewed and approved.[41] However, unbeknownst to

27 ERISA § 404(a); 29 U.S.C. § 1104(a).

28 *Breyan*, 2014 WL 991946 at *3.

29 *Id*.

30 *Kenseth v. Dean Health Plan, Inc.*, 610 F.3d 452, 466 (7th Cir. 2010).

31 *Silva v. Metro. Life Ins. Co.*, 2014 WL 3896156, at *8 (8th Cir. Aug. 7, 2014).

32 *Killian v. Concert Health Plan*, 742 F.3d 651, 669 (7th Cir. 2013) (citing *Kenseth*, 610 F.3d at 466).

33 *McCravy v. Metro. Life Ins. Co.*, 690 F.3d 176, 182-83 (4th Cir. 2012) ("In sum, with *Amara*, the Supreme Court clarified that remedies beyond mere premium refunds—including the surcharge and equitable estoppel remedies at issue here—are indeed available to ERISA plaintiffs suing fiduciaries under Section 1132(a)(3). This makes sense—otherwise, the stifled state of the law interpreting Section 1132(a)(3) would encourage abuse by fiduciaries. Indeed, fiduciaries would have every incentive to wrongfully accept premiums, even if they had no idea as to whether coverage existed—or even if they affirmatively knew that it did not."); *Silva*, 2014 WL 3896156 at *12; *but see Moon v. BWX Techns., Inc.*, 956 F. Supp. 2d 711 (W.D. Va. 2013) (finding employer's act of accepting employee's premium payments and advising participant about eligibility for benefits did not make employer an ERISA fiduciary).

34 690 F.3d 176 (4th Cir. 2012).

35 *Id*. at 178.

36 *Id*.

37 *Silva*, 2014 WL 3896156, at *1.

38 *Id*. at *4.

39 2014 WL 2599929, at *1 (E.D. Pa. June 10, 2014).

40 *Braunstein*, 2014 WL 2599929, at *1.

41 *Id*.

the participant, her life insurance policy had lapsed after one year that she stopped active work, and she did not exercise her right to convert the policy to an individual policy.[42] In *Horan v. Reliance Standard Life Insurance Co.*,[43] the employee had life insurance, supplemental life insurance, and AD&D coverage through his employer.[44] The life insurance, including supplemental insurance, at a max of $524,000 could be "ported" under the terms of the employer's plan; however, the AD&D coverage of $143,000 did not offer right to port.[45] The insurance company which funds the plan offered and confirmed in writing that the employee had $667,000 in term life coverage and the employee paid premiums for that amount.[46]

c. Promises to provide medical benefits or cover procedures.

In *Gearlds v. Entergy Services, Inc.*,[47] the plaintiff was worked for the defendant company for 18 years before stopping active work and collecting long-term disability benefits, which he received for about 8 years.[48] The plaintiff's long-term disability benefits ended in 2002, and although his employment was not terminated, he did not receive any pay from the employer from that point on.[49] In 2005, the plaintiff took early retirement at the age of 55, receiving a reduced pension and full medical, dental, and vision benefits.[50] The plaintiff alleged that he agreed to retire early because the defendants told him orally and in writing that he was covered by the employer's medical benefits plan and would continue to receive medical benefits.[51] However, after he retired, the employer discontinued his medical benefits, his eligibility for which the employer said was based on a computational error.[52] In *Kenseth v. Dean Health Plan, Inc.*,[53] the health plan denied a claim for insurance benefits for surgery to revise the plaintiff's gastric bands where the customer service representative told the plaintiff over the phone that the plan could cover the procedure with only a $300 co-payment.[54] The defendant encouraged plan participants to call for coverage information before undergoing procedures, told the plaintiff that defendant would pay for the procedure, and did not alert the plaintiff that she could not rely on the advice she received – all of which lulled the plaintiff into believing that defendant would cover the costs of the procedure.[55]

Given the recent caselaw, courts are recognizing as cognizable breach of fiduciary duty claims where a fiduciary communicates inaccurate information to a plan participant about her benefits or, by action or omission, causes the plan participant to believe that she has benefit coverage when she does not.

4. Did the Defendant's Breach Cause Plaintiff Harm Warranting a Surcharge Remedy?

To impose an equitable remedy, a court must consider two questions: (1) what remedy is appropriate; and (2) whether the plaintiff established the requisite level of harm as a result of the breach.[56] An ERISA fiduciary can be surcharged under ERISA §502(a)(3) only upon a showing of actual harm, proved by a preponderance of the evidence. That actual harm might consist of detrimental reliance, "but it might also come from the loss of a right protected by ERISA or its trust-law antecedents."[57]

In the situations where a fiduciary's breach caused beneficiaries of a trust estate to lose life insurance proceeds, a surcharge against the fiduciary in the amount of the lost proceeds may be an appropriate equitable remedy.[58] It may also be an appropriate remedy where a beneficiary may not have been entitled to benefits in

42 *Id.*
43 2014 WL 346615 (D.N.J. Jan. 30, 2014) (not for publication).
44 *Id.* at *1.
45 *Id.* at *2.
46 *Id.* at *3.
47 709 F.3d 448 (5th Cir. 2013).
48 *Id.* at 449.
49 *Id.*
50 *Id.*
51 *Id.*
52 *Id.*
53 722 F.3d 869 (7th Cir. 2013).
54 *Id.* at 872.
55 *Id.* at 882.
56 *Frommert v. Conkright*, 738 F.3d 522, 535 (2d Cir. 2013).
57 *Amara*, 131 S.Ct. at 1881.
58 *McCravy v. Metro. Life Ins. Co.*, 690 F.3d 176, 181 (4th Cir. 2012); *Silva v. Metro. Life Ins. Co.*, 2014 WL 3896156, at *9 (8th Cir. Aug. 7, 2014); *Weaver Bros. Ins. Assocs., Inc. v. Braunstein*, 2014 WL 2599929, at *24 (E.D. Pa. June 10, 2014).

the first instance, but where the fiduciary affirmatively and repeatedly represented to the participant that he had such coverage and the participant relied on those representations.[59]

A trickier situation presents itself in the medical benefit context, however, where a participant might have no alternative but to undergo a medical procedure not covered by her health plan. In *Kenseth*, the district court concluded that even if the plaintiff could demonstrate a breach of fiduciary duty by the health plan, she could not prove that its actions harmed her where the breach was the failure to give correct information regarding the lack of coverage for the gastric bypass procedure since the proper make-whole remedy would be to place the plaintiff back in the position she would have been in if the health plan provided correct information.[60] The district court found that the plaintiff had failed to demonstrate that she could have elected to forego the surgery, that she could have waited until she obtained alternative insurance coverage, or that she could have obtained the procedure elsewhere for less.[61] Because the plaintiff did not set forth any viable alternatives to the surgery, the district court concluded that she would have incurred the cost of the surgery whether or not the health plan had provided the correct information regarding coverage, and thus, any breach did not harm the plaintiff.[62]

In vacating the district court's opinion, the Seventh Circuit Court of Appeals noted that the health plan's actions had the singular effect of making it impossible to place the plaintiff back in the literal position she would have been in if the breach had not occurred, and also rendered very difficult the proof of viable alternatives.[63] The health plan presented no evidence that the surgery was the plaintiff's only option.[64] The Court noted that there was a genuine issue of fact regarding whether the plaintiff could have avoided some or all of the costs she incurred.[65] Relevant to the demonstration of harm in this context is whether a participant testifies credibly that she would not have undergone the procedure if provided with correct information, whether viable less expensive alternatives were available, or whether the plaintiff lost the opportunity to negotiate a lower price with the health plan providers or some other provider.[66] Therefore, the amount of a surcharge remedy may not always be measured in the value of the benefit lost or in the value of the benefit a participant believed she had as a result of a breach of fiduciary duty.

Conclusion

In light of the U.S. Supreme Court's decision in *CIGNA Corp. v. Amara* and its progeny, ERISA plan participants and beneficiaries have a wider scope of available equitable remedies they can pursue, including the surcharge remedy which can provide monetary relief for breaches of fiduciary duty that was previously considered unavailable. To successfully pursue a surcharge remedy, a plaintiff must be sure that she can demonstrate each element of her case: that the defendant is an ERISA fiduciary who owed a duty to the plaintiff, which it breached, causing the plaintiff harm, and for which a surcharge against the fiduciary is necessary to remedy the breach.

59 *Horan v. Reliance Standard Life Ins. Co.*, 2014 WL 346615, at *13 (D.N.J. Jan. 30, 2014); *see also Gearlds*, 709 F.3d at 452 (finding that plaintiff's allegation that he should be made whole in the form of compensation for lost benefits states a plausible claim for relief); *but see Gabriel v. Alaska Elec. Pension Fund*, 755 F.3d 647, 665 (9th Cir. 2014) (finding equitable remedy of surcharge unavailable where there is no loss to the trust or unjust enrichment in pension benefit matter).

60 *Kenseth v. Dean Health Plan, Inc.*, 722 F.3d 869, 883 (7th Cir. 2013).

61 *Id.*

62 *Id.* at 883-84.

63 *Id.* at 885.

64 *Id.*

65 *Id.*

66 *Id.*

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a life insurer discharges its fiduciary duties associated with the disposition of benefit claims when it provides a death benefit through the establishment of an RAA, where this method of payment is called for under the plan's terms. The DOL had stated its position in an *amicus* letter brief which it filed at the court's request in an earlier appeal involving similar issues before the U.S. Court of Appeals for the Second Circuit. *See* Faber v. Metropolitan Life Ins. Co., 648 F.3d 98 (2d Cir. 2011).

The DOL's letter brief stated that the defendant insurer in that case, MetLife, and the ERISA benefit plans at issue "effectively discharge their ERISA obligations when they furnish beneficiaries a [retained asset account] in accordance with plan terms" and that, therefore, "MetLife does not retain plan benefits by holding and managing the assets that back the [RAA]."

The Second Circuit followed the DOL's guidance, affirming dismissal of the putative ERISA class action in MetLife's favor, and notably distinguishing the First Circuit's earlier decision based on somewhat different facts than *Faber* and *Merrimon*. In the previous First Circuit case, Mogel v. Unum Life Insurance Co. of America, 547 F.3d 23, 26 (1st Cir. 2008), the First Circuit held that the use of RAAs violated ERISA fiduciary duties where the terms of the benefit plan at issue required "lump sum" payment of death benefits.

However, as the Second Circuit did in *Faber*, the First Circuit in *Merrimon* distinguished *Mogel*, limiting it to its facts, because the plan documents in *Merrimon* specifically called for payment of death benefits through RAAs.

In the only other decision at the federal appellate level to touch on similar issues, Edmonson v. Lincoln National Life Insurance Co., 725 F.3d 406 (3d Cir. 2013), the Third Circuit confronted plan documents which did not specify the manner in which the death benefit should be provided. Nevertheless, the Third Circuit held that the defendant insurer did not breach ERISA fiduciary duties by providing the plan benefit in the form of an RAA.

In sum, the *Merrimon* decision is in harmony with the approaches taken by the Second and Third Circuits and reinforces the view that, unless an insurer utilizes a different form of payment than the form specified under the terms of the plan, the insurer does not breach ERISA fiduciary duties by providing the benefit in the form of an RAA.

2014 - 2015 TIPS CALENDAR

October 2014

6 **Member's Monday** **Free Teleconference**
Contact: Ninah F. Moore – 312/988-5498

15-19 **TIPS Section Fall Leadership Meeting** **Meritage Resort and Spa**
Contact: Felisha A. Stewart – 312/988-5672 **in Napa Valley**
Speaker Contact: Donald Quarles – 312/988-5708 **Napa, CA**

23-24 **2014 Aviation Litigation Program** **Ritz Carlton Hotel**
Contact: Donald Quarles – 312/988-5708 **Washington, DC**

November 2014

5-7 **FSLC & FLA Fall Meeting** **Ritz Carlton Hotel**
Contact: Donald Quarles – 312/988-5708 **Philadelphia, PA**

December 2014

8 **Member's Monday** **Free Teleconference**
Contact: Ninah F. Moore – 312/988-5498

January 2015

15-17 **LHPR Midwinter Symposium** **Loews Ventana Canyon**
Contact: Ninah F. Moore – 312/988-5498 **Tucson, AZ**

21-23 **Fidelity & Surety Committee Midwinter Mtg** **Waldorf Astoria Hotel**
Contact: Felisha A. Stewart – 312/988-5672 **New York, NY**

February 2015

5-8 **ABA Midyear Meeting** **Hilton of the Americas**
Contact: Felisha A. Stewart – 312/988-5672 **Houston, TX**

19 -21 **Insurance Coverage Litigation Midyear Mtg** **Arizona Biltmore**
Contact: Ninah F. Moore – 312/988-5498 **Phoenix, AZ**

March 2015

11- 13 **Transportation Megaconference** **Sheraton Hotel**
Contact: Donald Quarles – 312/988-5708 **New Orleans, LA**