# Building An Effective Administrative Record


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# Fundamentals of Litigation Under 502(a)(1)(B)

A. Claims for Wrongful Denial of Benefits: The Civil Enforcement Scheme:

i. ERISA section 502(a)(1)(B), allows a participant or beneficiary (1) to recover benefits due under the terms of the plan; (2) enforce rights under the terms of the plan; or (3) to clarify rights to future benefits under the terms of the plan.

# Fundamentals of Litigation Under 502(a)(1)(B)

ii. Conspicuously absent from the statutory definition is who is the proper party to sue under 502(a)(1)(B). This questions has caused a significant amount of litigation.

In general, courts agree that the employee benefit plan is a proper defendant to recover wrongfully denied benefits.

1. Beyond the plan, the courts are split as to what other persons or entities may or should be included.
2. Majority position seems to recognize that the plan and any person who controls plan administration of benefits are proper defendants.
3. Some courts, however, believe that because recovery is allowed only against the plan, the plan should be the only defendant.

# Fundamentals of Litigation Under 502(a)(1)(B)

iii. Remedies: Limited to Equitable Remedies.

1. Participant entitled only to the benefit provided under the plan if the participant was wrongfully denied benefits.
2. State law causes of action preempted, i.e., bad faith claims, punitive damages, or the extra-contractual damages.

# Fundamentals of Litigation Under 502(a)(1)(B)

iv. Dual claims under 502(a)(1)(B) and 502(a)(3). (See also Appendix A)

1. Varity Corp. v. Howe, 516 U.S. 489 (1996)
2. Impact of CIGNA Corp. v. Amara, 131 S. Ct. 1866 (2011).
3. Trend after Amara

# Building the Administrative Record: Best Practices – Defense Perspective

What is the Administrative Record?

All documents relevant to a claim for benefits. 29 C.F.R. § 2560.503-1(j)

- Anything considered, submitted, or generated in the course of making the determination. § 2560.503-1(m)(8)(ii)
- Materials demonstrating compliance with procedures designed to ensure compliance with plan document. § 2560.503-1(m)(8)(iii)
- Be sure to include plan documents (penalties)
- SSA decision/claim record included?

# Building the Administrative Record: Best Practices

Most ERISA cases are decided based solely on the claim record made prior to suit being filed regardless of which standard of review applies. *Quesinberry v. Life Insurance Company of North America*, 987 F.2d 1017 (4th Cir. 1993); *see also Ferrari v. TIAA*, 278 F.3d 801 (8th Cir. 2002). According to *Quesinberry*, only exceptional circumstances in claims that receive a *de novo* review by the district court will justify receipt of additional evidence.

# What comprises the "administrative record"?

**ii. Plaintiff's perspective**

The term "administrative record" is a misnomer - The ERISA internal appeal process is not an administrative proceeding with due process protections.

- Also misleading because the "administrative record" provided is usually the claim file compiled by the insurer/plan administrator.
- *See* DeBofsky, M., *The Paradox of the Misuse of Administrative Law in ERISA Benefit Claims, 37 J. Marshall L. Rev. 727 (2003-2004)-*"[T]he civil procedure accorded to such suits has been deformed by the courts' mistaken application of an administrative law paradigm to ERISA benefits litigation instead of utilizing the Federal Rules of Civil Procedure as those rules are to be applied . . . . "

# What comprises the "administrative record"? Plaintiff's perspective

From plaintiff's perspective, the "administrative record" produced by the insurer/plan administrator is often missing relevant information or documents provided or generated during the claims and appeal process or fails to include information readily available.

- Correspondence between paper/peer medical reviewers and claims personnel (emails, phone notes, etc.)
- Internal claims notes.
- Research articles related to the medical treatment/disability referenced in claimant's appeal submissions.
- Correspondence between claims personnel and in-house attorneys during the appeals process - The "fiduciary exception"

# What comprises the “administrative record”? Plaintiff’s perspective

Gaps in the administrative record are discovered by the plaintiff during the Rule 26 Initial Disclosures.

- References to internal correspondence are not included in the administrative record.
- Sometimes the insurer/plan administrators fails or refuses to included in the administrative record documents previously provided to the claimant pre-litigation under the ERISA claims regulations.
  - *Fowler v. Aetna Life Ins. Co.*, 615 F. Supp. 2d 1130, 1136 fn.1 (N.D. Cal. 2009)
    - "It is worth noting that plaintiff's counsel asserts that the administrative record filed in this action by Aetna did not include certain documents. Particularly, Aetna's computer print-out entitled “eTUMS Event Profile Report—Disability” was not included. Notably, the profile report stated that plaintiff's position required light physical demand while other documents in the record say her job was sedentary. The categorization of plaintiff's job is a point of contention between the parties. Counsel also asserts that the full administrative record was not provided to plaintiff prior to the lawsuit. Discovery will be permitted into what Aetna chose to include and to exclude from the administrative record.”

# What comprises the "administrative record"? Plaintiff's perspective-ERISA Claims Regulations

Should the "administrative record" comply with the ERISA claims regulations?

29 C.F.R. §2560.503-1(h)(2)(iii) - As part of a full and fair review "a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

29 C.F.R. §2560.503-1(m)(8)(iii) - A document, record, or other information shall be considered "relevant" to a claimant's claim if such document, record, or other information:

- (i) Was relied upon in making the benefit determination;
- (ii) Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;

# What comprises the "administrative record"? Plaintiff's perspective-ERISA Claims Regulations

- (iii) Demonstrates compliance with the administrative processes and safeguards required pursuant to paragraph (b)(5) of this section in making the benefit determination; or
- (iv) In the case of a group health plan or a plan providing disability benefits, constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

# What comprises the "administrative record"? Plaintiff's perspective-Includes information "available" to the administrator

<u>*11th Circuit*</u>: *Blankenship v. Metro. Life Ins. Co.*, 644 F.3d 1350 (11th Cir. 2011)

- A court's review is generally limited to the material "available" to the administrator at the time it made the decision.
- What constitutes material "available" to the administrator?
- *Johnston v. Aetna Life Ins. Co.*, 2017 WL 4654431 (S.D. Fla. Oct. 16, 2017)
  - The material "made available" to the administrator may not always be limited to the administrative record prepared by the plan administrator (i.e. the material "made available" may be oral and a plaintiff could ask the claims examiner if he or she was provided with any oral information concerning the claim.)

# What comprises the "administrative record"? Plaintiff's perspective-Includes information "available" to the administrator

4th Circuit-*Harrison v. Wells Fargo Bank, N.A.*, 773 F.3d 15, 17 (4th Cir. 2014)

- [B]ecause Wells Fargo failed to consider readily available material evidence of which it was put on notice, the review process failed to conform to the directives of ERISA and the Plan's own terms."
- Reversed and remanded to the district court with directions to return the case to Wells Fargo for a full and fair review of Harrison's claims.

*Wilkinson v. Sun Life and Health Ins. Co.*, 127 F. Supp. 3d 545 (W.D.N.C. 2015), aff'd, 674 Fed. Appx. 294 (4th Cir. 2017)(unpublished)

- District court, could consider FMLA document produced by participant's employer, even though document was from outside of administrative record.
- Evidence in the record, including references to FMLA leave in plan administrator's denial letter, that administrator was aware of plan participant's FMLA leave and had at least constructive notice of FMLA paperwork at time that administrator rendered its benefits determination.
- Admissibility of FMLA form informed court's evaluation of the factors used to determine reasonableness of plan administrator's decision.

Fiduciary duty of insurer/plan administrator to obtain all readily available information in order to conduct a full and fair review of a claimant's internal appeal?

# Building the Administrative Record: Best Practices

iii. Final comments and observations: Differences between medical and disability?

# Claims Procedure Regulations

ERISA § 503 requires benefits plans to have claims procedures that:

- (1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and
- (2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

Additionally, pursuant to ERISA § 503 and § 505, the DOL may prescribe regulations governing claims procedures.

*See* 29 U.S.C. § § 1133, 1135

# DOL Regulations

29 C.F.R. § 2560.503-1 sets forth the ***minimum*** **PROCEDURAL** requirements governing claims for benefits under employee benefit plans.

Every plan is required to establish and maintain ***reasonable procedures*** for filing benefit claims, notification of benefit determinations, and appealing adverse determinations.

*See* 29 C.F.R. § 2560.503-1(b)

# Applicable to which plans?

The DOL regulations apply to every employee benefit plan described in ERISA Section 4(a), plans established or maintained by:

(1) by any employer engaged in commerce or in any industry or activity affecting commerce; or

(2) by any employee organization or organizations representing employees engaged in commerce or in any industry or activity affecting commerce; or

(3) by both.

And not excluded under ERISA Section 4(b)

(1) governmental plans;

(2) church plans;

(3) plans maintained solely for the purpose of complying with applicable workmen's compensation laws or unemployment compensation or disability insurance laws;

(4) plans maintained outside of the United States primarily for the benefit of persons substantially all of whom are nonresident aliens; or

(5) excess benefit plans.

*See* 29 C.F.R. § 2560.503-1; 29 U.S.C. § 1003

# What are *reasonable procedures?*

A claims procedure is ***reasonable*** if:

- It complies with the requirements of sub-paragraphs (c), (d), (e), (f), (g), (h), (i), and (j) as appropriate;
- A complete description of such procedures are included in the SPD;
- Does not ***unduly inhibit*** or ***hamper*** the initiation or processing of claims;
- Does not preclude an authorized representative from acting on behalf of a claimant;
- Includes processes and safeguards to ensure that claim determinations are made in accordance with plan documents; and
- If a plan is established pursuant to a CBA, it must incorporate specific provisions outlined in this section.

*See* 29 C.F.R. § 2560.503-1

# New procedures for disability benefit plans

On 12/19/2016 Obama Administration DOL issued a Final Rule adding additional regulations to all claims for disability benefits filed on or after 1/1/2018.

- New regulations are significant and cover (among other things):
  - Impartiality requirements for persons involved in making benefits determination;
  - Requirement to explain basis for disagreeing with (1) treating physicians, (2) any experts that examined claimant or advised plan in connection with claim, and (3) a determination of disability by SSA;
  - Provision of notices and oral language services (e.g. customer assistance telephone line) in non-English languages;
  - Timing for notifying claimant of an adverse benefit determination; and
  - Consequences for a plan's failure to "strictly adhere" to the requirements of this section.

# New procedures for disability benefit plans

On 2/24/2017, President Trump issued Executive Order 13777 titled "Enforcing the Regulatory Reform Agenda" which seeks to "alleviate unnecessary regulatory burdens placed on the American people."

Pursuant to this E.O., the DOL announced a 90-day delay of the applicability of the new procedures for disability benefit plans.

Thus, the new procedures will only become effective on April 1, 2018, if at all.

# Whose responsibility is it to ensure that the claims procedure is followed?

The Plan itself is ultimately responsible for ensuring that a reasonable claims procedure is both established and followed.

**Effects of Failure to Comply?**

There is no independent right of action for a plan's failure to comply with the DOL's claims procedure regulations. *See Lee v. ING Groep, N.V.*, 829 F.3d 1158, 1161 (9th Cir. 2016) (collecting cases).

See 29 C.F.R. § 2560.503-1; 29 U.S.C. § 1003

# Effects of Failure to Comply

However, if a plan fails to establish and follow reasonable procedures, "a claimant shall be deemed to have exhausted the administrative remedies available under the plan and shall be entitled to pursue any available remedies under section 502(a)."

- This may impact the standard of review (de novo/abuse of discretion) if a claim is brought under Section 502(a).

Under the new regulations that ***may*** go into effect in April, the failure to "strictly adhere" to the claims procedure regulations governing disability plans will result in the claim being deemed "denied on review without the exercise of discretion by an appropriate fiduciary."

- The "strictly adhere" language is stronger the "substantial compliance" now required by courts for at least some of the regulations (e.g. notice requirements).

- *See* 29 C.F.R. § 2560.503-1

# Litigation Under 502(a)(1)(B)

a. Exhaustion doctrine: What is it and how does it apply.
b. Jurisdiction: Federal or state court.
c. Venue
d. Standard of Review
e. Scope of Review: Discovery

# Appendix A

# INTERACTION OF 502(a)(3) AND 502(a)(1)(B) CLAIMS AFTER *ROCHOW* & *SILVA*

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# Introduction

*Varity Corp. v. Howe* cautioned against awarding duplicative relief under 502(a)(1)(B) and 502(a)(3).

Subsequently, most courts concluded that plaintiff could not bring simultaneous claims under or obtain relief under both 502(a)(1)(B) and 502(a)(3).

# Introduction

The panel will address:

- Whether after *Amara* such decisions need to be re-evaluated.
- How the *en banc* 6th Circuit decision in *Rochow* compares to the 8th Circuit decision in *Silva* and 2d Circuit decision in *New York Psychiatric Ass'n.*
- Whether relief under both sections is ever appropriate.

# Background

Interaction between Sections 502(A)(3) and 502(a)(1)(B) – Why does it matter?

ERISA § 502(a)(1)(B)

- Allows suits by participants against a plan,
- For alleged wrongful denials of benefit,
- To enforce rights under the terms of the plan, or
- To clarify rights to future benefits under the terms of the plan.

# Background

Remedies under ERISA § 502(a)(1)(B) are:

- Limited to the benefits provided under the plan if the participant was wrongfully denied benefits;
- State law causes of action preempted, i.e. bad faith claims, punitive damages, or the extra-contractual damages.

# Background

ERISA § 502(a)(3)

- Suits by participants, beneficiaries or fiduciaries;
- To enjoin any act or practice that violates ERISA or plan terms;
- To obtain other appropriate equitable relief to redress such violations or to enforce ERISA or plan terms.

# Background

ERISA § 502(a)(3) historically understood to be the

- "Catch all" civil enforcement provision for claims that did not fit neatly under § 502(a)(1)(B) or § 502(a)(2), for breach of fiduciary duty seeking recovery on behalf of a plan.
  - Analogue in § 502(a)(5) allows suits by Secretary of Labor to prosecute violations of ERISA's fiduciary and prohibited transaction provisions.
- Remedies under § 502(a)(3) hot topic and frequently before the Supreme Court.

# Background

Supreme Court muddies waters (or clarifies) remedies available under ERISA § 502(a)(3).

- *Mertens v. Hewitt Associates*, 508 U.S. 248 (1993), narrowly interpreted available remedies only to those ***typically*** available in courts of equity during the days of the divided bench, such as injunctions, mandamus, and restitution.
- Excluded monetary reward against non-fiduciaries.
- Result: Suits seeking to compel payment of money, outside of suits for equitable restitution, generally were not recognized.

# Background

*Varity Corp. v. Howe*, 516 U.S. 489 (1996)

- Supreme Court held that participants could seek individual relief against a fiduciary for an alleged breach of ERISA's standards of prudence and loyalty under § 502(a)(3).
- Watershed decision at the time.
- The Court warned, however, that when relief is available under ERISA Section 502(a)(1)(B), relief under ERISA Section 502(a)(3) is not appropriate.
- Confirmed that relief under 502(a)(3) limited to equitable remedies as understood in *Mertens*.

# Background

After*Varity*, courts split on whether to allow a remedy under both 502(a)(1)(B) and 502(a)(3).

- Courts that allowed a suit to proceed under both sections, identified a claim separate and apart from the claim that the participant had been wrongfully denied a benefit and entitled to relief under 502(a)(1)(B).
- Problem: if monetary relief not available under *Mertens*, than what meaningful relief could be awarded for a breach of fiduciary duty to an individual under § 502(a)(3)?

# Background

Along came *CIGNA Corp. v. Amara*, 131 S. Ct. 1866, 1871 (2011), another watershed case refining meaning of equitable relief.

- In *CIGNA*, the Supreme Court held that monetary relief, in the form of equitable restitution, was permissible equitable relief against a breaching ***fiduciary***—as opposed to a non-fiduciary—under ERISA Section 502(a)(3).

# Background

Facts:

- Class action against CIGNA, alleging (1) improper retroactive reduction of vested benefits; and (2) inaccurate communications about benefits in conversion from defined benefit plan to a cash balance plan.
- District court found that CIGNA breached its fiduciary duties in the conversion.

# Background

Facts:

- Class action against CIGNA, alleging (1) improper retroactive reduction of vested benefits; and (2) inaccurate communications about benefits in conversion from defined benefit plan to a cash balance plan.
- District court found that CIGNA breached its fiduciary duties in the conversion.

# Background

Supreme Court decision:

- Held Section 502(a)(1)(B) does not authorize reformation of plan terms.
- Held that ERISA Section 502(a)(3) does.

District court "strongly implied" that it would have provided relief under Section 502(a)(3) but for the fact that

- (1) It had provided relief under Section 502(a)(1)(B); and
- (2) Earlier Supreme Court cases had narrowed the application of equitable relief under Section 502(a)(3) to exclude any monetary recovery.

# Background

*Amara* was a dramatic departure from the conventional wisdom following *Mertens* and district court cases after *Amara* have shown a willingness to grant monetary relief under 502(a)(3).

- Has *Amara* impacted the *Varity* framework?

In *Montanile v. Bd. of Trustee, Nat'l Elevator Indus. Health Benefit Plan*, 2016 WL 228364 (Jan. 20, 2016), the Supreme Court said, in a cryptic footnote, that the discussion of 502(a)(3) was "not essential to resolving that case," and thus dicta.

- Will this affect the willingness of courts to surcharge fiduciaries for individual participant losses?

# Background

The Court distinguished its earlier holdings that monetary relief was not equitable relief under Section 502(a)(3), by noting that the participant or beneficiary in the earlier cases were seeking monetary relief against a *non-fiduciary* .

Potential post-*Amara* equitable monetary relief

- Surcharge
- Disgorgement
- Prejudgment Interest

*Rochow v. Life Ins. Co. of N. Am.*, 780 F.3d 364 (6th Cir.) cert. denied, 136 S. Ct. 480 (2015)

# Early History: *Rochow v. LINA*

Daniel Rochow was an executive who began experiencing debilitating symptoms in 2001; was forced to resign in January 2002; and was diagnosed with  a serious brain infection in February 2002.

Rochow filed for LTD benefits in December 2002, and LINA denied his claim, finding that Rochow had stopped working before his disability began.

After several unsuccessful administrative appeals he filed action in 2004 and the District Court found in 2005 that LINA had acted arbitrarily and capriciously in denying his LTD benefits.

# Rochow I 482 F.3d 860 (6th Cir. 2007)

6th Cir. affirmed, finding:

- LINA's denial of LTD benefits on basis that Rochow was not disabled when he stopped working was arbitrary and capricious and not based on a reasoned process.
- LINA breached fiduciary duties.

Remand to determine relief, 851 F. Supp. 2d 1090 (E.D. Mich. 2012):

- Ct. held evidentiary hearing; and
- Ordered disgorgement of LINA's profits stemming from amounts that should have been paid (found to be $3.8m).

# Rochow II 737 F.3d 415 (6th Cir. 2013)

Majority Opinion:

- Disgorgement was proper remedy under §502(a)(3) for breach of fiduciary duty;
- §502(a)(1)(B) could not provide all relief sought; and
- §502(a)(3) fiduciary breach claim was not impermissible repackaging of §502(a)(1)(B) wrongful denial of benefits claim.

Dissent:

- Allowing remedies under both sections is a double recovery in violation of *Varity*;
- Fundamental change to ERISA benefits litigation; anc
- Improper windfall.

# Rochow III 780 F.3d 364 (6th Cir. 2015)

The Sixth Circuit subsequently vacated the panel decision and heard the *Rochow* appeal *en banc.*

Reversed finding that disgorgement was proper remedy under §502(a)(3).

Remanded to District Court to determine whether prejudgment interest should be awarded under §502(a)(1)(B).

# Rochow III 780 F.3d 364 (6th Cir. 2015)

Majority identified one issue – whether Rochow was "entitled to recover under both ERISA §502(a)(1)(B) and §502(a)(3) for LINA's arbitrary and capricious denial of long-term disability benefits."

Answer: No because would be "impermissible duplicative recovery."

# Rochow III 780 F.3d 364 (6th Cir. 2015)

Majority noted that under *Rochow I* all wrongfully denied benefits were recovered.

Payment of benefits, attorneys' fees and the possibility of prejudgment interest is sufficient to make plaintiff whole.

Characterized the wrongful benefit denial as a single injury, and thus obtaining relief under both §502(a)(1)(B) and §502(a)(3) for the same injury would be improper double recovery.

# Rochow III 780 F.3d 364 (6th Cir. 2015)

Distinguished from case where plaintiff claimed wrongful denial of benefits and also brought class action for plan-wide relief, noting that there was a "separate and distinct" injury for which §502(a)(3) relief was appropriate.

LINA's withholding of Rochow's benefits for extended period of time and generating profit from the withholding is not a separate injury.

# Rochow III 780 F.3d 364 (6th Cir. 2015)

“A claimant can pursue a breach of fiduciary duty claim under §502(a)(3) … only where the breach of fiduciary duty claim is based on an *injury* separate and distinct from the denial of benefits or where the remedy afforded by Congress under §502(a)(1)(B) is otherwise shown to be inadequate.”

# Rochow III 780 F.3d 364  (6th Cir. 2015)

Court noted that "other appropriate equitable relief" isn't necessary to make Rochow whole.

Prejudgment interest is available under ERISA §502(a)(1)(B).

Prejudgment interest is compensatory, not punitive.

Prejudgment interest cannot be awarded at a rate high enough to constitute punitive damages.

Remanded to District Court to determine whether to award prejudgment interest and how much.

# Rochow III 780 F.3d 364 (6th Cir. 2015)

Concurring opinion (3 judges), said question is not whether there is a separate and distinct injury but whether additional equitable relief is "appropriate" under the circumstances, such as where there is self-dealing.

Dissent (7 judges) said district court found failure to pay benefits plus self-dealing establishing two distinct violations warranting two remedies.

# *Silva v. Metropolitan Life Ins. Co.*, 762 F.3d 711 (8th Cir. 2014)

# *Silva* Background

Employee was participant in ERISA-covered life insurance plan offered by his employer.

He then elected and paid premiums for supplemental life insurance for six months until his death.

When his father, as his beneficiary, sought payment of the supplemental benefits, MetLife refused to pay because Silva had not filled out a statement of good health.

# *Silva* Background

Certificate of health requirement was not anywhere in the Plan, but "evidence of insurability" was.

Defendants (plan sponsor and MetLife) claimed that 100-page Plan document was also SPD, but couldn't prove decedent had received it.

Also, couldn't prove that online prompt had asked decedent to fill out statement of health.

After this lawsuit was filed, MetLife discovered that approx. 200 other employees of company had not filled out form and let them do so (but not plaintiff Silva, the father of deceased insured).

# *Silva* Background

After MetLife refused to pay, Silva sued in state court asserting a claim for benefits under 502(a)(1)(B), and defendants removed.

Silva later sought to amend to add 502(a)(3) claim but district court refused, saying that (a)(3) did not allow him to make a claim for monetary relief.

The court then granted summary judgment to defendants on claim for benefits.

Silva appealed both (a)(1)(B) and (a)(3) rulings.

# *Silva* – Reverse & Remand of benefits claim

Too many unknowns including what "evidence of insurability" meant.

Court noted its duty to review whether MetLife abused its discretion in denying benefits and many outstanding questions of fact prevented it from doing so.

# *Silva* – Section 502(a)(3) claim

Court also allows motion to amend to include (a)(3) claim for equitable relief.

Found that Silva stated a proper claim that Company breached its fiduciary duty by failing to provide an SPD with the statement of health requirement.

- Disagreed that 100-page plan document served as such.

# *Silva* – Section 502(a)(3) claim

Also held that Amara changed the legal landscape to allow the equitable remedy of surcharge for breach of fiduciary duty, if proven, of make-whole monetary relief ($429,000 in benefits that he should have had).

# *Silva* – Section 502(a)(3) claim

Reformation potentially available against MetLife:

- Arguably fraudulent to collect premiums and then claim never had an approved policy.
- Also collected premiums from 200 other employees that were never approved (until later).

# *Silva* – Section 502(a)(3) claim

Equitable estoppel might also be available

- Evidence that collected premiums from 200 others convinces court that decedent relied on this.
- Unclear what a reasonable person in his position could have done differently.

# Simultaneous claims allowed

Rejected redundancy argument.

Varity and precedent from the Eighth Circuit only bars duplicate recoveries.

Does not limit the ways a party can initially seek relief at the motion to dismiss stage.

Silva was presenting two alternative – as opposed to duplicative – theories of liability.

- Either entitled to benefits or to equitable relief for breaches.

# *Amara* supports

Notes that after discussing 502(a)(1)(B) and holding that plaintiffs could not get relief under that section, the Supreme Court in *Amara* allowed remand to consider claim for equitable relief under (a)(3).

If the district court here finds the defendants liable for benefits, then need not reach his claim for equitable relief under (a)(3).

# *New York State Psychiatric Ass'n, Inc. v. UnitedHealth Grp.*, 798 F.3d 125, 60 EB Cases 1505 (2d Cir. 2015)

# *NYSPA* Background

Psychiatric association (NYSPA), mental health care providers, and employer-sponsored health benefit plan subscribers vs. insurers, which acted as third-party claims administrators for the subscribers' plans.

Alleged that insurers improperly denied mental health and substance abuse treatment in violation of ERISA, MHPAEA, ACA, and other laws.

# *NYSPA* Background

The Southern District of New York granted United's motion to dismiss Plaintiffs' claims.

Plaintiff Denbo was a participant in health plan administered by United, which denied his claims for outpatient psychotherapy.

Denbo claimed that United improperly administered the Plan by treating medical claims more favorably than mental health claims.

As to Denbo, the district court dismissed his § 502(a)(3) claims on the ground that adequate relief is available under § 502(a)(1)(B).

# Claims Administrators Are Proper Parties to Section 502(a)(1)(B) Claims

United can be sued under Section 502 because "Indeed, when a claims administrator exercises total control over claims for benefits under the terms of the plan, that administrator is a logical defendant in the type of suit contemplated by § 502(a)(1)(B)—a suit "to recover benefits," "to enforce ... rights," "or to clarify ... rights to future benefits under the terms of the plan."

Holding in accord with 5th, 6th, 7th, 8th, 9th, and 11th Circuits.

# Claims Administrator Can Be Held Liable Under Section 502(a)(3)

United argued that it cannot be held liable under § 502(a)(3) for violations of the Parity Act because it is the claims administrator of a self-funded plan. The 2nd Circuit, relying on *Harris Trust*, held that "§ 502(a)(3) may impose a fiduciary duty arising indirectly from the Parity Act even if the Parity Act does not directly impose such a duty."

In other words, liability under Section 502(a)(3) does not depend on whether ERISA's substantive provisions impose a specific duty on the party being sued.

Section 502(a)(3) admits of no limit on the universe of possible defendants. United is a proper defendant.

# Adequate Relief Under Section 502(a)(1)(B)?

2nd Circuit found that district court dismissal was premature.

*Varity Corp. v. Howe* – Section 502(a)(3) is a "catchall" provision offering appropriate equitable relief for injuries caused by violations that Section 502 does not elsewhere remedy.

Important to distinguish between a cause of action and a remedy under Section 502(a)(3). *Varity* did not eliminate a private cause of action for breach of fiduciary duty when another potential remedy is available.

# Adequate Relief Under Section 502(a)(1)(B)?

But, if a plaintiff succeeds on both claims, the district court's *remedy* is limited to such equitable relief as is considered appropriate.

Not clear at motion to dismiss stage whether monetary benefits under Section 502(a)(1)(B) alone will provide sufficient remedy.

Too early to tell if Denbo's claims under Section 502(a)(3) are in effect repackaged claims under Section 502(a)(1)(B).

# Adequate Relief Under Section 502(a)(1)(B)?

If Denbo prevails under both Section 502(a)(1)(B) and Section 502(a)(3), the district court should then determine whether equitable relief under Section 502(a)(3) is appropriate.

Court added that injunction coupled with "surcharge" constitutes equitable relief under Section 502(a)(3). In accord with every sister circuit that considered the issue: 4th, 5th, 7th, 8th, and 9th Circuits.

# Appropriate Equitable Relief Under Section 502(a)(3)?

Denbo's request for monetary compensation for any losses resulting from United's violations of the Parity Act and ERISA, and declaratory and injunctive relief prohibiting United from violating the Parity Act and ERISA in the future "closely resemble" the traditional equitable remedies of injunctive relief and surcharge.

# Appropriate Equitable Relief Under Section 502(a)(3)?

But, monetary compensation resembling legal damages – such as compensation that would neither redress a loss flowing from United's breach of fiduciary duty nor prevent unjust enrichment – would be unavailable as an equitable remedy under Section 502(a)(3).

# Did the Game Change?

Was *Amara* a game changer?

- Did it change the *Varity* principle cautioning against duplicative recovery?
- Did it significantly change the meaning of equitable remedies post-*Mertens?*
- Other thoughts?

# Pleading Issues

Does Rule 8 require specific pleading of remedies?

- Rule 8(a) requires a short and plain statement of the claim showing that the pleader is entitled to relief and a demand for the relief sought, which may include relief in the alternative or different types of relief.

Are claims subject to dismissal based upon legal (or factual) implausibility of remedy sought?

# Questions or Comments?

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