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ERISA Benefits Litigation Defenses: Exhaustion of Administrative Remedies and Statute of Limitations

Leveraging Pre-Trial Defenses Amid Divergent Court Standards

A Live 90-Minute Teleconference/Webinar with Interactive Q&A

Today's panel features:

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Exhaustion of Administrative Remedies Under ERISA

By: Todd D. Wozniak

September 16, 2010

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What Is Exhaustion Of Remedies?

- ERISA does not contain any kind of requirement that a plaintiff must satisfy a plan's administrative claims procedures before filing an ERISA claim in court
  - Exhaustion is a judicial requirement imposed by the Courts
  - The exhaustion requirement is supported by ERISA regulations, *see* 29 C.F.R. § 2560.503-1, which require that every employee benefit plan establish and maintain reasonable procedures governing the filing of benefit claims, notification of benefit determinations, and appeal of adverse benefit determinations

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Why Is Exhaustion Of Remedies Required?

- The policy considerations for the exhaustion requirement are best understood in the context of the reasons that ERISA was developed
- Generally, exhaustion of administrative remedies is desirable in that it may render subsequent judicial review unnecessary because a plan's own remedial procedures can resolve most claims
- Other policy considerations include: (1) the reduction of frivolous lawsuits; (2) the promotion of consistent treatment of claimants; (3) a reduction of the cost of claims settlement; and (4) development of a factual record that will assist the court in reviewing a fiduciary's actions

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Additional Practical Benefits Of Exhaustion Of Remedies

- There is limited judicial review for plans that include the appropriate *Firestone* language
  - In *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), the Supreme Court endorsed language in ERISA plan documents giving the plan administrator sole and absolute discretion in interpreting and applying the plan's terms, as well as determining eligibility for benefits. If the magic language appears in the plan, then judicial review of a benefits denial is limited to whether the plan administrator acted "arbitrarily and capriciously."
- There is limited or no discovery in judicial proceedings (the amount of discovery permitted depends on whether the claims administrator has an alleged conflict of interest - *Metropolitan Life Ins. Co. v. Glenn*, 128 S.Ct. 2343 (2008))

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Claims For Benefits Under ERISA Section 502(a)(1)(b)

- All circuits agree that claims for benefits under ERISA Section 502(a)(1)(b) are subject to the exhaustion requirement where the plan at issue mandates exhaustion

- Most circuits also agree that claims for benefits under ERISA § 502(a)(1)(b) are subject to the exhaustion requirement even where the plan at issue suggests that exhaustion is permissive (i.e., the plan language notifies the participant that she "may appeal" to the claims administrator if the benefit claim is denied). *See, e.g., Wert v. Liberty Life Ins. Co. of Boston*, 447 F. 3d 1060 (8th Cir. 2006); *Greifenberger v. Hartford Life Ins. Co.*, 131 Fed. App. 756 (2d Cir. May 16, 2005); *but see Gallegos v. Mt. Sinai Med. Ctr.*, 210 F.3d 803 (7th Cir. 2000) (administrator may be estopped from asserting exhaustion as a defense where the plan language and/or determination letter indicates that claimant "may appeal" and claimant relies on this to his or her detriment).

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Breach of Fiduciary Duty Claims Under ERISA Section 502(a)(2) and 502(a)(3)

- Courts are split as to whether exhaustion is required for breach of fiduciary duty claims brought under ERISA Sections 502(a)(2) or (a)(3)
- The Seventh and Eleventh Circuits generally require exhaustion for all breach of fiduciary duty claims as well as all other statutory violations under ERISA, including Section 510 claims. *See, e.g.*, *Ames v. Am. Nat'l Can. Co.*, 170 F.3d 751 (7th Cir. 1999); *Lindemann v. Mobil Oil Corp.*, 79 F.3d 647 (7th Cir. 1996); *Lanfear v. Home Depot, Inc.*, 536 F.3d 1217, 1224 (11th Cir. 2008); *Bickely v. Caremark Rx., Inc.*, 461 F.3d 1325 (11th Cir. 2006); *Counts v. Am. Gen. Life and Acc. Ins. Co.*, 111 F.3d 105 (11th Cir. 1997).

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Breach of Fiduciary Duty Claims Under ERISA Section 502(a)(2) and 502(a)(3)

- The Third, Fourth, Fifth, Sixth, Ninth, and Tenth Circuits have held that exhaustion is not required in a breach of fiduciary duty case. *See, e.g.*, *Harrow v. Prudential Ins. Co.*, 279 F.3d 244 (3d Cir. 2002); *Smith v. Sydnor*, 184 F.3d 356, 365 (4th Cir. 1999) ("We hold that the judicially created exhaustion requirement does not apply to a claim for breach of fiduciary duty as defined in ERISA."); *Milofsky v. Am. Airlines, Inc.*, 442 F.3d 311 (5th Cir. 2006); *Richards v. General Motors Corp.*, 991 F.2d 1227 (6th Cir. 1993); *Horan v. Kaiser Steel Ret. Plan*, 947 F.2d 1412 (9th Cir. 1991); *Held v. Manufacturers Hanover Leasing Corp.*, 912 F.2d 1197 (10th Cir. 1990).

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Breach of Fiduciary Duty Claims Under ERISA Section 502(a)(2) and 502(a)(3)

- Courts in the Second Circuit have also suggested that exhaustion of breach of fiduciary duty claims may not be required. *See, e.g.*, *Richards v. FleetBoston Financial Corp.*, 427 F. Supp. 2d 150 (D. Conn. 2006).

- However, all of these circuits have held that a breach of fiduciary duty claim must be exhausted if the court determines that the claim is, in actuality, a claim for benefits disguised as a claim for breach of fiduciary duty. *See, e.g.*, *Simmons v. Willcox, 911 F.2d 1077 (5th Cir. 1990); Harrow v. Prudential Ins. Co. of Am.*, 279 F.3d 244, 253 (3d Cir. 2002) ("Plaintiffs cannot circumvent the exhaustion requirement by artfully pleading benefit claims as breach of fiduciary duty claims.").

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Implications Of *LaRue* on Exhaustion

- In a concurring opinion in *LaRue v. DeWolff, Boberg & Associates, Inc.*, 128 S.Ct. 1020 (2008), Chief Justice Roberts suggested that when the right at issue arises under the plan terms, then such a claim may fall under Section 502(a)(1)(B). Further, the Chief Justice indicated that if the claim was a claim for benefits, then it was "not clear" that a plaintiff could also bring a claim under Section 502(a)(2).
- Chief Justice Roberts noted that this was an unsettled issue not properly presented in *LaRue*, and that the issue could be taken up on remand and that "other courts in other cases remain free to consider what we have not – what effect the availability of relief under § 502(a)(1)(B) may have on a plan participant's ability to proceed under § 502(a)(2)."

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Other Relevant Considerations

- In order for a claim to be subject to exhaustion, the plan language must support the argument that the claim at issue can be resolved through the administrative remedies
  - If the plan is vague as to the ability to resolve the claim at issue, the court may refuse to require exhaustion
- Additionally, some courts in the Seventh Circuit have found exhaustion to be an affirmative defense which cannot be properly raised in a motion to dismiss where the complaint does not reference exhaustion. *See, e.g.*, *Honeysett v. Allstate Ins. Co.*, 570 F. Supp. 2d 994, 1004 (N.D. Ill. 2008) ("Because failure to exhaust administrative remedies is an affirmative defense, it cannot provide a basis for a motion to dismiss unless the plaintiff's complaint pleads him out of court"); *Lewalski v. Sanlo Mfg. Co., Inc.*, No. 08-cv-311, 2009 U.S. Dist. LEXIS 40915, *10 (N.D. Ind. May 14, 2009) (dismissal on the ground of failure to exhaust would be premature because a plaintiff is not required to plead around affirmative defenses).

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Strategic Considerations

- A strategic determination needs to be made as to whether to pursue exhaustion of administrative remedies
  - Instances where exhaustion may not be desired is when a plan lacks *Firestone* language and when the claims administrator has a clear conflict of interest
- If a determination is made to pursue exhaustion, consider:
  - Whether to move to dismiss or to stay the litigation for failure to exhaust
    - » Relevant considerations include whether the complaint also alleges non-ERISA claims, statute of limitations issues, and judge assignment
  - Whether to file a motion to dismiss and/or transfer for forum non conveniens

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Strategic Considerations

- Once a claim is submitted to the claims administrator, consider the following:
  - What evidence should be included in the administrative record
  - How vague and/or confusing plan provisions should be interpreted and whether the interpretation should be documented
  - How belated attempts by a claimant to supplement the record will be handled

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A Note On ERISA Preemption

- In some cases, plaintiffs may try to avoid ERISA and the exhaustion requirement by bringing tort or contract claims under state law that are really, at their core, ERISA claims
- ERISA expressly supersedes "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan…". 29 U.S.C. § 1144(a).
- Absent a statutory exception, ERISA preempts not only state statutes, but also state common law theories of recovery which relate to ERISA plans. *See* 29 U.S.C. § 1144(c)(1) (defining the term "State law" contained in 29 U.S.C. § 1144(a) to include "all laws, decisions, rules, regulations, or other State action having the effect of law, of any State"); *Aetna Health, Inc. v. Davila*, 542 U.S. 200, 216 (2004) (any state law claim based on the terms of a plan is preempted).

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September 16, 2010

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EXHAUSTION OF ADMINISTRATIVE REMEDIES UNDER ERISA

By: Patrick DiCarlo

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FUTILITY EXCEPTION

- Rigorous showing required
- Initial denial, prior similar denials, etc. are insufficient
- Arguing claim has no merit in litigation can be sufficient

FUTILITY EXAMPLES

- Class of identical claims?
- Remedy Inadequate
- Denied meaningful access to administrative review

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ISSUE EXHAUSTION

- Can't make new claims in litigation that were not exhausted
- What about new arguments?
  - Some authority for remanding to consider new arguments
  - Usually no remand unless administrator deprived of ability to interpret plan in first instance

NEW ARGUMENTS BY PLAN

- What if the administrator relies on new arguments in litigation?
- Claim regulation says claimant must be apprised of reasons for denial
- Some courts say administrator doesn't have to disclose "reasons behind the reasons"

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AVAILABLE REMEDIES

- Remand to Administrator to address new claims and/or arguments is most common remedy
- Could be precluded from asserting new claims or making new arguments
- If Administrator raises new arguments, could be evidence of arbitrary decision making

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VENUE

- Venue is proper "in the district ... where a defendant resides or may be found." 29 U.S.C. § 1132(e)(2).

- A defendant "resides or may be found," in any district in which its "minimum contacts" would support the exercise of personal jurisdiction. *Waeltz v. Delta Pilots Ret. Plan*, 301 F.3d 804, 809-10 (7th Cir.2002)

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VENUE (Cont'd.)

- The minimum contacts standard is satisfied when the "defendant's contacts with the forum are 'substantial' and 'continuous and systematic,' so that the state may exercise personal jurisdiction even if the action does not relate to the defendant's contacts with the state." *Youn v. Track, Inc*., 324 F.3d 409, 417-18 (6th Cir.2003)
- Venue usually improper only if plan had no contacts with district

VENUE (Cont'd.)

- A discretionary transfer makes sense if plaintiff never lived or worked in that district – especially in California
- Forum shopping is becoming more prevalent
- Gives you a free look at the original judge

STATUTE OF LIMITATIONS

- Most analogous state limitations period – usually breach of contract
- Length of time varies by state
- The clock starts running when claim “accrues”

ACCRUAL OF CLAIMS

- Federal rule is that a claim “accrues” when the plaintiff has the right to bring suit
- Some courts have said that ERISA claim does not accrue until administrative process is complete
- However, most courts will not allow plaintiff to benefit from extreme delay in submitting a claim

CONTRACTUAL LIMITATIONS

- Enforceable if reasonable
- Can impose a limit on time to submit claim
- Sometimes clock on contractual limitations period can start running before administrative process is complete
- If so, courts look to reasonableness of time between exhaustion and end of contractual period

Plan Design Approaches to Maximize Defenses to ERISA Claims

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Comply With ERISA's Claims Procedures and Afford Participants a Full and Fair Review

- Basic Requirements
  - Section 503 of ERISA
  - Plans must provide written notice of a denial of a claim for benefits including the specific reasons for the denial
  - An appeal process affording "full and fair review"

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Consequences of Failure to Comply With Claims Procedures

- Time limits to appeal may not be enforced against claimant
- Deemed exhaustion
- Courts typically remand to administrator to do over
- May result in loss of deference

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Processing a Claim

- Identify benefit claims and funnel through the process
- Determine who is responsible based upon plan documents and procedures
- Acting as an ERISA fiduciary
- Consider the claim in light of governing plan documents
- Process claim within applicable time frames
- Notice of denial must contain certain information

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Content of Denial

- The specific reasons for the denial
- Reference to relevant plan provisions
- Description of the plan's review procedures and time limits
- Health and disability claims:
  - any internal rules, guidelines and protocols relied upon.
  - If based on medical necessity, experimental treatment, etc., an explanation of the scientific or clinical judgment relied upon

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Appeals – Opportunity for Full and Fair Review

- 60 days to appeal; 180 days if group health plan or disability plan
- Opportunity to submit additional documents, comments, information
- Opportunity to review claim file and obtain information "relevant" to claim upon request
- An appeal process under which all claimant-submitted information and other relevant information is reviewed and considered

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Appeal Decision

- Make a record
- Should reflect a full and fair review of claim
- Describe the evidence considered
- Make findings resolving any conflicting evidence and explain rationale
- Recite relevant plan language
- Address each argument presented

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Plan Design Approaches to Statute of Limitations

- No express statute of limitations in ERISA for 502(a)(1)(B) claims
- Matter of state law – Ex. – IL, 10 years

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What is Reasonable?

- 39 months–*Doe v. Blue Cross & Blue Shield Utd. Of Wis.*, 112 F.3d 869 (7th Cir. 1997)
  - Noting that suit under 502(a)(1)(B) is "the equivalent of a suit to set aside an administrative decision, and ordinarily no more than 30 or 60 days is allowed…"
- 3 years–*Koert v. GE Group Life Assurance Co.*, 231 Fed. Appx. 117 (3d Cir. 2007) (enforcing 3-yr plan limitation instead of Penn. 4-yr).
- 90 days–*Northlake Reg'l Med. Ctr. v. Wafle House Sys. Employee Benefit Plan*, 160 F.3d 1301 (11th Cir. 1998)
- 45 days–*Davidson v. Wal-mart Assocs. Health & Welfare Plan*, 305 F. Supp. 2d 1059 (S.D. Iowa 2004)
  - Very short time period. Relied on Seventh Circuit dicta in *Doe*.
  - Filed complaint 62 days after the Plan's appeal decision

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Make Sure Any Contractual Limitations Period is in the SPD

- *Haymond v. Eighth Dist. Elec. Benefit Fund*, 36 Fed. Appx. 369 (10th Cir. 2002) (refusing to enforce limitations period in plan where ambiguities in SPD)
- *Dodson v. Woodmen of World Life Ins. Soc'y*, 109 F.3d 436 (8th Cir. 1997) (refusing to bar claim where SPD did not include the limitations period and participant was prejudiced by omission).

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Plan Design Approaches to Claim Accrual

- Matter of Federal Law
- Discovery Rule – cause of action accrues when plaintiff discovers, or should discover with due diligence, the injury that is the basis of the lawsuit
- Modified in ERISA context
  - clear repudiation rule
  - very few decisions holding that claim accrued prior to final appeal decision

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Plan Design Approaches to Claim Accrual (cont'd)

- Decisions Discussing Claim Accrual
  - *Carey v. Int'l Bhd. Of Elec. Workers 363 Pension Plan*, 201 F.3d 44 (2d Cir. 1999)
    - Clear repudiation rule
    - Stature of limitations period starts after denial of appeal
  - *Union Pac. R.R. v. Beckham*, 138 F.3d 325, 330-31 (8th Cir. 1998
    - Rare instance where court found claim accrued prior to formal and final denial
  - *Daill v. Sheet Metal Workers' Local 73 Pension Fund*, 100 F.3d 62, 65-67 (7th Cir. 1996)
  - *Martin v. Constr. Laborer's Pension Trust for S. Cal.*, 947 F.2d 1381, 1384-86 (9th Cir. 1991)
  - *Miller v. Fortis Benefits Ins. Co.*, 475 F.3d 516 (3d Cir. 2007)
  - *See Hoover v. Bank of America Corp.*, 286 F. Supp. 2d 1326 (M.D. Fla. 2003)
    - Specialty holding that formal administrative denial is required

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Can a Plan Provide Its Own Accrual Period?

- Very few decisions holding that claims accrued prior to exhaustion of the claim and a formal denial
- Plans started to design this into plan documents
- Recently we have seen some decisions in this area

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Court Approaches to Plan Attempts to Design Accrual

- *Burke v. Price Waterhouse Coopers LLP Long Term Disability Plan*, 572 F.3d 76 (2d Cir. 2009)
  - Upheld plan limitations period that required participant to file suit within "three years after the time written Proof of Loss is required to be furnished."
  - Focused on NY law, which allows parties to change limitations periods by contract and alter accrual date by contract
  - Cites Seventh, Fifth, Sixth, and Eighth as in concert

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Court Approaches to Plan Attempts to Design Accrual (cont'd)

- *Rice v. Jefferson Pilot Financial Ins. Co.*, 578 F.3d 450 (6th Cir. 2009)
  - Recent case upholding contractual accrual language
  - Notes that there may be a case where the accrual provisions could be unreasonable in combination with the limitations period, but under plan claims were deemed denied after 90 days and therefore no potential for this issue

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Court Approaches to Plan Attempts to Design Accrual (cont'd)

- Eighth Circuit has rejected this language and requires "clear repudiation" – *Wilkins v. Hartford Life & Accident Ins. Co.*, 299 F.3d 945 (8th Cir. 2002)
- Recent Fourth Circuit case rejects idea that a Plan can provide its own contractual accrual date as in conflict with ERISA. *White v. Sun Life Assurance Co. of Canada*, 488 F.3d 240 (4th Cir. 2007)

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Contractual Forum Selection Clause

- Not very common - default is Section 502(e)(2) of ERISA
- A majority of courts have upheld forum selection clauses
  - *Gipson v. Wells Fargo & Co.*, 563 F. Supp. 2d 149 (D.D.C. 2008)
  - *Laasko v. Xerox Corp.*, 566 F. Supp. 2d 1018 (C.D. Cal. 2008)
  - *Klotz v. Xerox Corp.*, 519 F. Supp. 2d 430 (S.D.N.Y.2007)
  - *Sneed v. Wellmark Blue Cross & Blue Shield of Iowa*, 2008 WL 1929985 (E.D. Tenn. Apr. 30, 2008)
  - *But see Nicolas v. MCI Health and Welfare Plan No. 501*, 453 F. Supp. 2d 972 (E.D. Tex. 2006) (holding ERISA venue provision precludes forum selection clauses)
- Should select a forum that would be permissible under ERISA

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Arbitration Clauses

- Every Circuit Court that has considered the issue has held that ERISA claims are arbitrable: Second, Third, Eighth, and Tenth.
- Several district courts have followed: *See e.g., Chaitman v. Wolf Haldenstein Adler Freeman & Herz LLP*, 2004 WL 2471372 (S.D.N.Y. 2004) (compelling arbitration of ERISA breach of fiduciary duty claim based on terms of Contract Partner Agreement).
- Arise most often under broad arbitration clauses contained in employment agreements and collective bargaining agreements
  - Very common issue in the health plan context for unionized employees or retirees–issue is commonly whether the CBA's collective bargaining provision extends to unilateral change in health benefits

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Arbitration Clauses (cont'd)

- Can integrate arbitration provisions directly into plan design.
  - Health Plans have done this: *See Franke v. Poly-America Med. and Dental Benefits Plan*, ___F.3d ___ (8th Cir. 2009)

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Plan Design Approaches to Maximize Defenses to ERISA Claims

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