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In This Issue

A Symbiotic Relationship

Provider Contracting and Plan Limits on the Assignability of Welfare Benefit Claims

By Bryan D. Bolton

At least as far back as the early 1980s, health insurers began adding anti-assignment provisions to employee welfare benefit plans. *See Parrish v. Rocky Mountain Hosp. & Medical Servs. Co.*, 754 P.2d 1180 (Colo. Ct. App. 1988); *Obstetricians–Gynecologists, P.C. v. Blue Cross & Blue Shield of Nebraska*, 219 Neb. 199 (1985); *Kent General Hosp., Inc. v. Blue Cross & Blue Shield of Delaware, Inc.*, 442 A.2d 1368 (Del. 1982); *Augusta Med. Complex, Inc. v. Blue Cross of Kansas, Inc.*, 230 Kan. 361 (1981). The enforceability of welfare plan limits on assignments first percolated up to the federal courts in the early 1990s. At that point, health care providers initiated a series of challenges to the validity of welfare plans prohibiting assignment. The providers achieved some success in the lower courts, but the federal courts of appeals have consistently found anti-assignment plan provisions enforceable. The reasons and rationales employed by the courts vary, but the outcome is the same. This article examines the evolution of the court decisions, the rationale and reasons behind those decisions, and what's next in this area of the law.

The first two federal district courts to consider this issue reached opposite conclusions. The first federal case was initiated in California. *See Davidowitz v. Delta Dental Plan of California*, 753 F. Supp. 304 (N.D. Cal. 1990). Delta Dental Plan ("DDP") provided dental plan benefits to a number of California employees and its plan contracts explicitly stated that DDP "will not honor a beneficiary's assignment of the right to payment." *Id.* at 305. DDP contracted with participating dentists to remit payment directly and participating providers agreed to bill patients for their co-payments. *Id.* Non-participating providers agreed to waive the co-payment obligation in exchange for an assignment. *Id.* Non-participating providers sought direct payments from DDP based on the patient assignments. *Id.* DDP refused to honor the assignments and remit payment to the non-participating providers because the plan prohibited assignments.

The non-participating providers filed a civil action in the United States District Court for the Northern District of California seeking an injunction to compel direct payments. *See id.* The district court determined the non-participating providers offer "a unique service by agreeing to waive the co-payments which beneficiaries would otherwise be required to pay." *Id.* The district court further found this assignment process made dental care "free" from the participants' perspective. *Id.* The district court offered the further thought that "there is a significant possibility that some beneficiaries are unable to obtain dental treatment from either participating or nonparticipating dentists. Though employed, these beneficiaries do not have enough disposable income to afford the standard co-payment." *Id.* According to the district court, this class of beneficiaries could only obtain treatment by assigning their rights and if DDP refused to honor the assignments these beneficiaries may be denied benefits. *Id.* at 305–06. The district court, therefore, granted the preliminary injunction. *Id.* at 308. DDP filed an appeal.

Before the appeal was heard by the Ninth Circuit, the United States District Court for the District of Columbia confronted the same issue, in what the court recognized was a test case, but notably the test case was filed by a participating provider. *See Washington Hospital Center Corp. v. Group Hospitalization and Med. Services, Inc.*, 758 F. Supp. 750 (D.D.C. 1991). In that case, a claim submitted by Washington Hospital was denied based on a pre-existing condition exclusion. Washington Hospital could have pursued a claim under its contract with the insurer, but instead pursued a claim as assignee of the patient. The insurer defended based on the pre-existing condition exclusion and a plan provision stating: "The benefits of this Contract are personal to a Participant and may be received only by the Participant. The Corporation reserves the right to refuse to make payment directly to the Employee and to refuse to honor the assignment of any claim to any person or party." *Id.* at 752. For purposes of resolving the case, the district court assumed Washington Hospital would prove at trial the claim was covered. Even with this assumption, however, the district court found in favor of the insurer.

The court recognized the central question posed was whether the anti-assignment clause was void as a matter of public policy. *Id.* at 753. The court began considering

this issue by noting the benefits of participating provider contracting, including increased patient flow and "rapid, certain and direct payments from the insurer." *Id.* at 754. Insurers benefit from contracting with hospitals by offering 100 percent coverage, reduced reimbursement schedules, and potentially other constraints on participating hospitals. *Id.* The court recognized this contracting process depends on the willingness of hospitals to contract and participate in the insurers' plans. If hospitals were able to gain the advantage of direct payment, without any related provider contract constraints, then the incentive to contract with insurers diminishes or disappears. *Id.* The court further noted Washington Hospital's only proffered rationale for filing an action as assignee, as opposed to under its provider contract, was the potential for recovery of attorney's fees under ERISA, if it was the prevailing party. *Id.* at 755. The court, however, pointed out that the provider contract was negotiated by sophisticated parties, it is an elaborate agreement, and failed to include any attorney's fees provision. The court reasoned that this "kind of tinkering with the balance struck by the parties is not a result toward which public policy should aim." *Id.*

The court further found recovery of attorney's fees as an assignee insufficient grounds to warrant invalidating the anti-assignment provision in the plan. *Id.* Since the anti-assignment provision in the plan was enforceable, Washington Hospital lacked a valid assignment and, therefore, Washington Hospital had no basis for asserting an ERISA claim against the insurer. The court granted summary judgment in favor of the insured. *Id.* at 755–56.

On appeal in *Davidowitz*, the Ninth Circuit recognized the district court's decision in *Washington Hospital Center*, 758 F. Supp. 750 (D.D.C. 1991), was well-reasoned. *See Davidowitz v. Delta Dental Plan*, 946 F.2d 1476, 1478–79 (9th Cir. 1991). The Ninth Circuit, however, characterized the issue on appeal as one of first impression and defined the issue as whether "ERISA prohibits welfare plan non-assignment clauses, and beneficiaries have an absolute right to assign irrespective of contrary language in the plan." *Id.* at 1478.

On appeal, the non-participating providers argued that ERISA mandated assignability. *Id.* at 1479. The non-participating providers first argued by analogy to garnishment cases, that since collection by garnishment was permitted even in the face of a non-assignment clause, assignment should similarly be permitted under an ERISA plan regardless of a non-assignment clause. *Id.* The Ninth Circuit rejected this analogy because the garnishment cases were limited to holding state law mechanisms for collection of judgments were not preempted by ERISA. The second argument advanced by the non-participating providers was by analogy to spendthrift trusts, which generally prohibit assignment, but permit garnishment for "necessities." *Id.* at 1480. The providers argued dental services were necessities, so assignment should be permitted. Id. The Ninth Circuit rejected the necessities analogy, finding plan beneficiaries were not deprived of dental services and dentists are not prevented from receiving compensation. *Id.* The third and final argument the Ninth Circuit rejected was that ERISA common law includes an absolute right to assign. The court observed that Congress carefully considered the subject of welfare plan assignment and chose to remain silent. *Id.* "Having carefully considered the subject and chose to remain silent, this court must conclude that Congress intended not to mandate assignability, but intended instead to allow the free marketplace to work out such competitive, cost effective, medical expense reducing structures as might evolve." *Id.* at 1480–81.

Still further, the Ninth Circuit rejected the argument that refusal to accept the non-participating provider assignments was a breach of fiduciary duty because it was not in the best interests of the beneficiaries. *Id.* at 1481. The court first found DDP was not acting as a fiduciary when the plan terms were negotiated. The court further held demanding compliance with a valid plan provision is not a breach of fiduciary duty. *Id.*

The following year another non-participating provider, St. Francis Regional Medical Center ("St. Francis"), initiated a challenge to a health insurer including a prohibition on policyholder assignments to health care providers in all group policies. *See St. Francis Reg'l Med. Ctr. v. Blue Cross & Blue Shield of Kan., Inc.*, 810 F. Supp. 1209 (D. Kan. 1992). Since some of the group policies were governed by ERISA and others were not, St. Francis challenged the anti-assignment provisions in the policies on both ERISA and state law grounds. Interestingly, the Kansas legislature had recently "authorized Blue Cross to continue to limit the assignment of its insurance benefits to those providers entering into separate contracts with Blue Cross." *See St. Francis Reg'l Med. Ctr. v. Blue Cross & Blue Shield of Kan., Inc.*, 49 F.3d 1460, 1462 (10th Cir. 1995) (citing Kan. Stat. Ann. §40–19c06(b) ["Bill 66"]). St. Francis initially filed the lawsuit in state court, but the insurer removed the action to federal court and prevailed on a motion to dismiss under Fed. R. Civ. P. 12(b)(6). St. Francis appealed to the Tenth Circuit. *See id.*

On appeal, the Tenth Circuit first found that ERISA preempted any state law, including the relevant Kansas statute, affecting the assignability of insurance benefits.

Id. at 1464. The court further found ERISA's silence on the assignability of welfare plan benefits, in juxtaposition to the restriction on assignment of pension plans, to be evidence of Congressional intent not to enact a policy precluding assignment. *Id*. Still further, the court determined Congressional silence was not an invitation for states to establish their own rules. *Id*. Rather, the court interpreted ERISA to leave "the assignability of benefits to the free negotiations and agreement of the contracting parties." *Id*. The Tenth Circuit further found in favor of the insurer on state law grounds, noting the insurer need not prove non-assignability clauses "always or inevitably contain costs" and it was sufficient they were a legitimate cost containment device. *Id*. at 1467.

Two years later in *City of Hope Nat'l Med. Ctr. v. Healthplus, Inc.*, 983 F. Supp. 68 (D.P.R. 1997), after a HMO denied coverage for cancer care by an out-of-network provider, City of Hope National Medical Center ("City of Hope") filed an action against the HMO based on an assignment from the HMO member. *Id*. at 70–71. The City of Hope assignment read as follows: "To the degree permitted under any applicable insurance policy, health care service plan, third party payor agreement, or other applicable benefits…the undersigned…herby irrevocably assigns to the hospital any and all rights and interests in insurance profits, benefits of policy provisions payable to or on behalf of patient." *Id*. at 74. The HMO contract with the member provided as follows: "All entitlements of a member to receive covered rights are personal and may not be assigned." *Id*. at 73. Based on the HMO contract, the district court determined the City of Hope lacked standing to sue under ERISA. *Id*. at 74. The City of Hope appealed to the First Circuit. *See City of Hope Nat'l Med. Ctr. v. Healthplus, Inc.*, 156 F.3d 223 (1st Cir. 1998).

The First Circuit reversed the district court on standing to sue as an assignee, finding ERISA only required a party to bring a "colorable claim to vested benefits." *Id*. at 228 (quoting *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 117 (1989)). The court determined City of Hope had a colorable claim, but, on the merits, found in favor of the HMO. *Id*. at 228–29. The First Circuit first focused on Congressional silence on the assignability of welfare plan benefits. *Id*. at 229. The court found Congressional silence significant. Congress, according to the court, could not have intended to mandate assignability, but instead must have intended to leave the issue to the competitive market to resolve. *Id*. ("ERISA leaves the assignability or non-assignability of health care benefits under ERISA-regulated welfare plans to the negotiations of the contracting parties."). The First Circuit, therefore, affirmed the district court decision on the merits. *Id*. at 230.

Only a few years later, the Fifth Circuit reached the opposite conclusion holding a provider lacked derivative standing to sue under ERISA in the face of an anti-assignment provision in a Summary Plan Description ("SPD") for a self-funded plan. *See LeTourneau Lifelike Orthotics & Prosthetics, Inc. v. Wal-Mart Stores*, 298 F.3d 348 (5th Cir. 2002). The SPD provided: "Medical coverage benefits of this Plan may not be assigned, transferred or in any way made over to another party by a participant." *Id*. at 349. The district court found standing and ruled in favor of the provider, but the Fifth Circuit, without discussing any public policy issues concerning assignability, simply determined the provider lacked standing based on the language in the SPD. *Id*. at 351–53.

The Eleventh Circuit reached a similar conclusion in *Physicians Multispecialty Grp. v. Health Care Plan of Horton Homes, Inc.*, 371 F.3d 1291 (11th Cir. 2004). The court characterized the issue on appeal as "whether a provider-assignee can sue an ERISA plan, where the terms of the plan forbid such an assignment." *Id*. at 1295 (quoting *Cagle v. Bruner*, 112 F.3d 1510, 1516 (11th Cir. 1997)). The court was persuaded by precedent, including *Davidowitz v. Delta Dental Plan*, 946 F.2d 1476 (9th Cir. 1991), and Congressional silence, that anti-assignment clauses in welfare plans were a proper subject of negotiation by the contracting parties. *Id*. at 1295. The court found an unambiguous anti-assignment clause voids an assignment by a beneficiary to a provider. *Id*. at 1296. The court determined the provider-plaintiff could not maintain an ERISA action based on an invalid assignment. *Id*.

After the Eleventh Circuit's decision, all went quiet on the non-assignability of welfare plans front for over ten years. In 2017, however, the Second Circuit, in the course of holding an out-of-network provider could assert a state law claim for promissory estoppel, noted the anti-assignment provision in the plan prevented the provider from bringing any ERISA claims. *See McCulloch Orthopaedic Surgical Services, PLLC v. Aetna, Inc.*, 857 F.3d 141 (2nd Cir. 2017).

In 2018, the Third Circuit found an anti-assignment clause in a welfare plan enforceable, but at the same time appeared to retreat from some of the precedent leading to the validation of anti-assignment clauses. *See American Orthopedic & Sports Medicine v. Independence Blue Cross Blue Shield*, 890 F.3d 445, 448 (3rd Cir. 2018). The Third Circuit decision arose from a claim by an out-of-network provider that was denied in substantial part. The provider filed an action against two insurers asserting ERISA claims

based on a purported patient assignment. *See American Orthopedic & Sports Medicine v. Independence Blue Cross Blue Shield*, No. 216-CV-08988, 2017 WL 1243147, at *2–3 (D.N.J. Feb. 24, 2017). The insurers moved to dismiss for lack of standing pursuant Federal Rule of Civil Procedure 12(b)(1). The provider claimed standing based on the Fifth Circuit's decision in *Herman Hosp. v. MEBA Med. & Ben. Plan*, 959 F.2d 569 (5h Cir. 1992), but the district court determined a subsequent Fifth Circuit decision, *LeTourneau Lifelike Orthotics & Prosthetics, Inc. v. Wal-Mart Stores*, 298 F.3d 348 (5th Cir. 2002), found an anti-assignment provision in an ERISA plan was enforceable. The district court dismissed the action, finding the anti-assignment provision clear and unambiguous and, therefore, valid and enforceable. *American Orthopedic*, 2017 WL 1243147, at *4.

On appeal, the provider argued prior Third Circuit decisions permitting provider assignments and conferring provider standing meant the court should now hold assignments cannot be prohibited by the terms of a welfare plan. *See American Orthopedic*, 890 F.3d at 449–50. The Third Circuit disagreed, noting the court had not previously addressed the effect or enforceability of an anti-assignment clause. *Id.* at 450.

The Third Circuit likewise rejected the insurer's argument that ERISA could not have intended to prohibit anti-assignment provisions because Congress surely knew how to achieve this objective legislatively, as it explicitly stated with respect to pension plans. *Id.* Still further, the insurers argued that Congressional intent was reinforced by recent significant ERISA amendments and continued Congressional silence. Building further on this point, the insurers, relying on *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825 (1988), argued the Supreme Court found such Congressional omissions from ERISA significant. The Third Circuit found these arguments less than compelling. *See American Orthopedic*, 890 F.3d at 450–51.

The Third Circuit explained *Mackey* may be less instructive on closer inspection and offered alternative explanations for Congressional silence. According to the court, Congressional silence "may indicate that Congress intended to preserve the rights of individual plan beneficiaries to assign their benefits." *Id.* at 450. This might be true, the court proffered, because the prohibition on pension plan assignments was intended to protect participants, while prohibiting assignments in welfare plans may disadvantage participants. Secondarily, the Third Circuit found assignments were "fairly ubiquitous" and Congressional silence may have been intended to ensure the status quo of permitting assignments. *Id.* at 451.

The Third Circuit further declined to develop the federal common law of ERISA on the grounds the arguments advanced by the parties were in equipoise. The provider argued anti-assignment plan provisions will eventually drive out-of-network providers out of business, thereby reducing patient choice. The insurers argued the anti-assignment provision helped keep premium costs down and ultimately made health care more accessible to patients. The court found neither argument persuasive absent "empirical data," which neither party offered. *Id.* at 452.

Notwithstanding the Third Circuit's views on the parties' arguments, the court found its "Sister-Circuits" decisions were thoughtful and reasoned, which is an interesting comment given the court's questioning of the reasoning underpinning those decisions. *Id.* at 453. The court, nonetheless, was persuaded not to stray from the "black-letter law that the terms of an unambiguous private contract must be enforced." *See id.* (quoting *Travelers Indem. Co. v. Bailey*, 557 U.S. 137, 150 (2009)). The Third Circuit opted to join its Sister-Circuits and held "anti-assignment clauses in ERISA-governed health insurance plans as a general matter are enforceable." *See id.*

Just when it appeared the Third Circuit, albeit reluctantly, had safely sided with its Sister-Circuits on the question of anti-assignment provisions, the court tacked in a new direction. In supplemental briefing, initiated by the court, the provider asked the court to vacate and remand in order to allow for the opportunity to cure the standing defect by perfecting a deficient power of attorney. *Id.* at 454. In response, the insurers argued the plan language was a bar to any claim under a power of attorney and remand would be futile. *Id.* The court disagreed with the insurers' argument, finding a power of attorney was different in "important respects" from an assignment. *Id.* The court, for example, explained, in contrast to an assignment, a power of attorney does not transfer ownership of a claim. *Id.* at 455. From the court's perspective, while an anti-assignment clause is enforceable against an assignment, such a plan provision would not preclude agents from acting for a participant through a power of attorney. *Id.* Despite this language in the court's opinion, the court refused to remand, finding the provider waived the power of attorney argument "by failing to raise them in its opening or reply brief." *Id.*

In sum, while the case law rather clearly establishes the enforceability of anti-assignment clauses in ERISA-governed employee welfare benefit plans, the game is not over yet. The Third Circuit's recent decision appears designed to sow seeds of doubt by offering alternative interpretations

of key arguments underpinning the precedent. Moreover, the Third Circuit, at least in dictum, offered an alternative solution for providers—a power of attorney. The power of attorney solution may sound simple in practice, but prove more complex in reality. Simply handing patients a blanket power of attorney form may present any number of perils, including the validity and scope of the power of attorney based on applicable state law.

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The Article III Standing Issue in *Springer v. Cleveland Clinic Employee Health Plan Total Care*

By Tom Christina

Considering how often the Supreme Court books ERISA for return engagements, the Act has provoked comparatively few constitutional questions. Before the turn of the century, some asked whether the withdrawal liability provisions of the Multiemployer Pension Plans Amendments Act of 1980 were entirely compatible with the Due Process Clause, but the less said about the fate of those efforts, the better, and in any event they belong to the comparatively distant past. Preemption cases never have been in short supply, of course, but most of them involve only the construction and application of ERISA §514(a). At least until recently, only a handful of "conflict" preemption cases demanded any nuanced application of the Supremacy Clause.

Swimming against this current is a case argued before the Sixth Circuit last month, *Springer v. Cleveland Clinic Employee Health Plan Total Care*, No. 17-4181 (6th Cir., June 13, 2018). In Springer, the plaintiff seeks an order requiring his employer's group health plan to pay an invoice for more than $300,000 to an air ambulance company that transported the plaintiff-employee's child to Cleveland from the employee's former home in Utah. The air ambulance company had brought a prior action for the same relief as a purported assignee of the plaintiff-employee, but that action was dismissed when it was determined as a matter of law that the purported assignment was ineffective. Although the reason is not entirely clear, the air ambulance company evidently gave the plaintiff-employee a release of any claim it might otherwise have had against him for the cost of its services. Thus, the plaintiff in *Springer* has nothing to hope or fear financially from the outcome of the case.

ERISA §502(a)(1)(B) provides in no uncertain terms that a civil action may be brought by a participant "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." But does a plan participant have Article III standing to bring a §502(a)(1)(B) action in federal court for the payment of benefits directly to a provider if the provider has relinquished its right to recover the cost of its services from the participant? To put the question somewhat differently, does Article III of the Constitution permit Congress to confer a right to bring a §502(a)(1)(B) action on a participant whose rights and liabilities will not be affected by the outcome of the action?

The district court dismissed the action because the plaintiff lacked standing to sue under Article III, Section 2 of the Constitution. That provision states that "[t]he judicial Power of the United States shall extend" to only to various defined types of "Cases" or "Controversies." Given the language of Article III, Section 2, it has long been held that a party seeking to invoke the jurisdiction of the federal courts "must satisfy the threshold requirement imposed by Article III of the Constitution by alleging an actual case or

controversy." *City of Los Angeles v. Lyons*, 461 U.S. 95, 101 (1983). In fact, federal courts are required to determine whether Article III jurisdiction exists prior to proceeding to the merits of an action. *Steel Co. v. Citizen's For a Better Environment*, 523 U.S. 83 (1998).

The Case or Controversy requirement is not a mere formality. To the contrary, the Supreme Court has repeatedly held that it has transcendent structural significance for the organization of the national government. According to the Court, the law of standing is an integral part of that more general constitutional doctrine, the separation of powers and that in order to remain faithful to the tripartite structure of the federal government, federal judicial power cannot be permitted to intrude upon the powers given to the other branches. *See DaimlerChrysler Corp. v. Cuno*, 547 U. S. 332, 341 (2006); *Lujan v. Defenders of Wildlife*, 504 U. S. 555, 559–60 (1992). Indeed, Chief Justice Rehnquist wrote for the Court in 1997, "No principle is more fundamental to the judiciary's proper role in our system of government than the constitutional limitation of federal-court jurisdiction to actual cases or controversies." *Raines v. Byrd*, 521 U. S. 811, 818 (1997).

The bedrock rule of Article III standing is that a plaintiff may not proceed in a federal court unless the plaintiff shows three irreducible facts necessary to prove the existence of a Case or Controversy:

> [He or she] has suffered an 'injury in fact' that is (a) concrete and particularized and (b) actual or imminent, not conjectural or hypothetical; (2) the injury is fairly traceable to the challenged action of the defendant; and (3) it is likely, as opposed to merely speculative, that the injury will be redressed by a favorable decision.

Friends of the Earth, Inc. v. Laidlaw Envt'l. Servs. (TOC), Inc., 528 U.S. 167, 180–81 (2000), citing *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560–66 (1992).

The possibility that the Case or Controversy requirement might impinge on benefits litigation under ERISA went largely unrecognized for many years, until the Supreme Court's decision two terms ago in *Spokeo, Inc. v. Robins*, 578 U.S. 323 (2016). In that case, the Court elaborated on Article III's requirement that the injury sufficient to satisfy the Case or Controversy requirement must be not only "particularized" but also "concrete." The Court explained the "concreteness" requirement in these terms:

> A "concrete" injury must be "*de facto*"; that is, it must actually exist. … When we have used the adjective "concrete," we have meant to convey the usual meaning of the term—"real," and not "abstract."

Nothing remarkable there. It was what came next that raised the possibility that Article III standing might pose an issue under ERISA. Before *Spokeo*, it had generally been understood that "Congress cannot erase Article III's standing requirements by statutorily granting the right to sue to a plaintiff who would not otherwise have standing." *Raines v. Byrd*, 521 U. S. 811, 820 n. 3 (1997). However, *Spokeo* put meat on those bones by identifying the types of injuries that satisfied the "concreteness" requirement.

The Court identified tangible injuries as the quintessential example of an injury that was concrete in the sense of being real. It then turned to intangible injuries. On that topic, the Court said first that "history and the judgment of Congress play important roles" in determining which intangible injuries are sufficiently real to satisfy Article III. However, it quickly became clear that historically-recognized claims might have an easier time of passing muster. "Because the doctrine of standing derives from the case-or-controversy requirement, and because that requirement in turn is grounded in historical practice, it is instructive to consider whether an alleged intangible harm has a close relationship to a harm that has traditionally been regarded as providing a basis for a lawsuit in English or American courts." In short, common law causes of action that seek redress for intangible harm seem to pass muster under Article III automatically, without further inquiry into whether the intangible harm is "concrete."

The same is not true with respect to Congressionally created causes of action to recover for Congressionally-defined harms. The *Spokeo* Court stated that Congress's judgment in these matters is especially instructive and important where Congress elevates *de facto* injuries to the status of concrete legally cognizable injuries. This is a bit confusing. If an injury already is a *de facto* injury before Congress elevates it, why is any such "elevation" necessary, since according to the *Spokeo* Court, "concrete" means "*de facto*." Without exploring this question, the *Spokeo* Court then cites to Justice Kennedy's concurrence in *Lujan* for the proposition that "Congress has the power to define injuries and articulate chains of causation that will give rise to a case or controversy where none existed before." However, it is apparent that the *Spokeo* Court did not intend this statement to be taken literally, because it is immediately followed by a substantial carve-out.

> Congress' role in identifying and elevating intangible harms does not mean that a plaintiff automatically satisfies the injury-in-fact requirement whenever a statute grants a person a statutory right and purports to authorize that person to sue to vindicate that right. Article III standing requires a concrete injury even in the context of a statutory violation.

Thus, it appears that Congress's power to create statutory causes of action is limited to creating remedies for injuries that are concrete and whose concreteness does not depend on a Congressional statute.

This is the context in which *Springer* was decided in the district court and likely will be decided in the Court of Appeals. (The district court relied heavily on the Sixth Circuit's opinion in *Soehnlen v. Fleet Owners Ins. Fund*, 844 F.3d 576, 581–82 (6th Cir. 2016), which applies *Spokeo* to actions arising under ERISA.) The answer to the standing question in *Springer* is so important that it prompted the Solicitor of Labor not only to file an amicus brief, but to participate in oral argument, as well. That argument was illuminating because it showed that the Sixth Circuit's answer to the question presented in *Springer* might depend on some very fundamental (and potentially very consequential) issues under ERISA.

In her amicus brief, the Solicitor argued that the injury suffered by Dr. Springer was analogous to a common law claim for breach of contract. The Solicitor's office began on the same tack at oral argument until a question from Judge Thapur, who wanted to know whether nominal damages are available under ERISA. The point of this question seemed to be to test how far the breach of contract analogy went. At common law, nominal damages are available for a breach of contract where no damages are proven. Arguably, that means that there is a concrete injury in any case of a breach of contract, *i.e.*, that the breach is itself the *de facto* invasion of a legally cognizable right. However, the Solicitor's office responded by insisting that it was irrelevant to the plaintiff's claim whether nominal damages can be recovered under ERISA. The Solicitor's office also sidestepped the question of whether ERISA actions are generally treated as contract claims.

Of course, the analogy to an action for a breach of contract will only carry so far. For example, no one believes that actions brought under ERISA §502(a)(1)(B) are triable by jury, as the Seventh Amendment would require if those actions sought redress for the typical claim for benefits. Moreover, it is well-established that damages cannot be obtained in an action under §502(a). It might have been better to argue that the *injury* was the same type of concrete injury or belong to the same category of concrete injury as the kind of injury redressed in a breach of contracts action. This might have put it into the category of injuries that are *de facto* by nature, and which Congress is empowered to recognize as sufficient to establish injury in fact for purposes of Article III.

Needless to say, this way of conceptualizing the issue is not necessarily valid. As in other "balance billing" cases, the relief sought is payment directly to the provider. That relief is not necessarily in line with the contract analogy. Nonpayment to the provider is analogous to the harm that arises from breach of a contract only if the substantive provisions of the plan specifically require payment directly to the provider. Yet an employee benefit plan cannot be established for the benefit of providers. *See* ERISA Section 3(1). Thus, a provider cannot be what the Restatement of Contracts calls an "intended beneficiary." Instead, the provider is at best an "incidental beneficiary." The common law did not recognize the right of a third party beneficiary to recover in its own right under analogous circumstances. *See*, *e.g.*, *Winterbottom v. Wright*, 152 Eng. Rep. 402 (1842); and Langridge v. Levy, 150 Eng. Rep. 863 (1837).

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"De Minimis" Violations Are in "Substantial Compliance"—but Is Substantial Compliance "De Minimis"?

By Edna Kersting

The Department of Labor's (DOL) new claims procedure regulations for ERISA-based plans providing disability benefits are now in effect for claims filed on or after April 1, 2018. The DOL made sweeping changes to the prior version of the ERISA claim regulation, especially regarding the information that must be disclosed to a claimant during an administrative appeal. In addition, the rule changes make it easier for a claimant to file a lawsuit before administrative remedies have been exhausted by specifically setting out that a claimant may bring a lawsuit when the claim procedures set out in the regulation were not established or followed and that in such case, the initial denial or appeal is "deemed denied [...] without the exercise of discretion by an appropriate fiduciary." This stricter standard will likely have the most impact among the new claims procedure, as it provides a strong incentive for a claimant to initiate litigation early and cut off the administrative process after the submission of their evidence.

The DOL, however, incorporated an exception for de minimis violations to the regulations, which would preserve the grant of discretionary authority to a violating plan so long as the violations "do not cause, and are not likely to cause, prejudice or harm to the claimant" and there is good cause, such as "an ongoing, good faith exchange of information." The following will review recent case law largely decided under the substantial compliance doctrine and evaluate what, if any, changes we may expect in the future as a result of the codified departure from substantial compliance.

The "De Minimis" Exception

Prior to the April 1, 2018 alterations to the regulations, challenges to ERISA procedural violations were evaluated under the "substantial compliance" standard. *See e.g. Rasenack ex rel. Tribolet v. AIG Life Ins. Co.*, 585 F.3d 1311, 1317 (10th Cir. 2009) (quoting *Gilbertson v. Allied Signal, Inc.*, 328 F.3d 625, 634 (10th Cir. 2003)); *see also Robinson v. Aetna Life Ins. Co.*, 443 F.3d 389, 392–93 (5th Cir. 2006) (citing *Lacy v. Fulbright & Jaworski*, 405 F.3d 254, 257 (5th Cir. 2005)); *Marks v. Newcourt Credit Group, Inc.*, 342 F.3d 444, 460 (6th Cir. 2003); *Halpin v. W.W. Grainger, Inc.*, 962 F.2d 685, 690 (7th Cir.1992).

As long as the purpose of 29 U.S.C.S. §1133 had been fulfilled, then "technical noncompliance with ERISA procedures [would] be excused." The purpose of §1133 is to ensure that claimants are able to have access to the necessary information to "further their administrative review or appeal to federal courts." Substantial compliance also required a "meaningful dialogue" between the beneficiary and the administrator. According to the DOL, the new "de minimis" standard is stricter than a "substantial compliance" requirement.

Now, when a plan's procedural mistake amounts to anything greater than a "de minimis" violation, beneficiaries' administrative remedies are deemed exhausted. In evaluating whether a violation is "de minimis," courts are tasked with considering whether the violation was non-prejudicial, was for a good cause or beyond the control of the plan, and whether the violation occurred within an on-going good faith exchange of information. The regulations further provide that the "de minimis" exception is not available when the violation is part of a pattern or practice of violations by the plan.

Overview of Current Case Law

The new wording of the regulation appears to have been foreshadowed in the recent decision of the Second Circuit in *Halo v. Yale Health Benefit Plan*, 819 F.3d 42 (2d Cir. 2016), where the court was faced with the claimant's argument that the health plan failed to timely comply with the DOL regulations regarding the notice requirements for benefit denial letters. *Id.* at 46. Rejecting the substantial compliance doctrine based on DOL guidance, the Second Circuit applied the DOL's advice that "it will tolerate inadvertent and harmless deviations in the processing of a particular claim, so long as the plan otherwise establishes procedures in full conformity with the regulation, we see no reason why courts should not also tolerate such minor deviations" to its decisionmaking. *Id.* at 57. A such, it held that failure to strictly comply with DOL regulations concerning the timing of issuing denial and appeal determination letters will result in *de novo* review of the administrator's determination unless the plan can show (1) it has established procedures "in full conformity" with the regulations; and (2) its failure to comply with these

procedures with respect to the particular claim at issue was both inadvertent and harmless. *Halo*, at 61.

Subsequent to the *Halo* decision, several district court faced similar situations and *Halo* based arguments from the claimants. The Northern District of Indiana in *Fessenden v. Reliance Std. Life Ins. Co.*, No. 3:15-cv-360, 2016 U.S. Dist. LEXIS 131226 (N.D. Ind. Sept. 26, 2016) looked at the untimeliness of a plan's determination during the appeal review of a claim and while maintaining that substantial compliance was the appropriate standard to apply, even if *Halo*'s rationale governed, the delay in decision-making in that case was not found to be harmful—and in terms of the new regulation, likely "de minimis." In *L.M v. Metro. Life Ins. Co.*, No. 16-8287, 2016 U.S. Dist. LEXIS 168463 (D. N.J. Dec. 2, 2016), the District of New Jersey also applied the substantial compliance doctrine based on Third Circuit guidance, however, considering *Halo*, it found that the plan had "established procedures in full conformity with the [applicable] regulation(s)" and has demonstrated "that its failure to comply with the claims-procedure regulation in the processing of a particular claim was inadvertent and harmless." *Id.* at 12–13. Therefore, it applied an arbitrary and capricious standard of review to its review of the determination.

The Northern District of California in *Norris v. Mazzola*, 231 F. Supp. 3d 412 (N.D. Cal. Feb. 7, 2017) applied Ninth Circuit law, which requires a "flagrant violation of the procedural requirements of ERISA" to cause a loss of deference expressly granted to the plan administrator, and held that the violations were not so "flagrant as to amount to an 'utter disregard of the underlying purpose of the Plan." *Norris*, at 426.

Likewise, in *Brian C. v. ValueOptions*, No. 1:16-cv-93DAK, 2017 U.S. Dist. LEXIS 168409 (D. Utah, October 11, 2017) the District of Utah did not depart from the substantial compliance standard accepted by the Tenth Circuit, however, it considered *Halo* and held that in that case, any violation was inadvertent and harmless. *Id.* at 10.

The court in *Johnston v. Aetna Life Ins. Co.*,17-20996, 2018 U.S. Dist. LEXIS 34622 (S.D. Fla. March 1, 2018) grappled with the interpretation of the "old" regulation but found it to support a loss of discretion in the case of a violation of the procedural standards set out in the regulation. As it further found that the violation at issue caused harm to the claimant, no exception applied—which while called a substantial compliance based exception—focused on the harmfulness of the conduct and the procedural steps undertaken in the review as a "de minimis" review under the new regulations would have to as well.

Most recently, the Middle District of Louisiana in *Green v. Prudential Ins. Co. of Am.*, No. 17-01024-JWD-EWD, 2018 U.S. Dist. LEXIS 70825 (M.D. La. Apr. 24, 2018) was faced with a case involving a lawsuit during the administrative review process, alleging that the regulations had not been complied with and that therefore, a *de novo* standard of review should be applied. Upon the plan's motion for a remand to complete the administrative review, the court examined the circumstances and found that the plan's failure to timely respond to an appeal was indeed a "de minimis" procedural violation in this case given that the plan's interpretation that further information would be forthcoming was not unreasonable. *Id.* at 5–6. Further, as the plan also engaged in a reasonable exchange of information, the court made the determination that the delay would most likely not cause harm or prejudice to the claimant. *Id.* at *6. While the new regulations do not apply to claims submitted prior to April 1, 2018, the case nonetheless provides valuable insight in how courts may treat the "de minimis" exception set out in the regulations.

Analysis

As set out above, and reviewing *Halo* and its progeny, it appears that the departure from the substantial compliance doctrine was indeed foreshadowed by the Second Circuit but that its replacement with the "de minimis" standard as set out in the regulation – albeit per the guidance of the DOL a stricter standard of care than the substantial compliance doctrine – will not result in a drastic departure from previous case law. Courts who would have found that a plan substantially complied with the DOL regulations' mandates pertaining to the handling of a particular claim will likely now find that such a substantially compliant procedure poses a "de minimis" violation of the regulation, assessing harmfulness of the conduct, prejudice to the claimant and the general exchange of information evidenced by the claim file.

If a violation is determined to be prejudicial or harmful or the plan failed to maintain ongoing communication with the claimant, a violation will likely exceed the "de minimis" level – and most likely would also not have been substantially compliant with the goals and purposes of ERISA. It appears further that the burden to demonstrate harmfulness (or prejudice) is on the claimant, see Green, *supra*, while the burden to show good cause or inadvertence is on the plan. Compare *Moore v. Lafayette Life Ins. Co.*, 458 F.3d 416 (6th Cir. 2006) (Plaintiff failed to demonstrate any prejudice due to lack of summary plan descriptions);

Johnson v. Balt. Cty., Civil Action No. 11-cv-3616, 2012 U.S. Dist. LEXIS 92154 (D. Md. July 3, 2012).

A remaining question to be resolved by the courts is likely the pattern and practice exception to the "de minimis" exception, which does not appear to have been discussed (or raised) in any of the recent cases.

Conclusion and Take Away

The DOL has created new procedures in order to maintain ongoing, open communication between the insurer and insured, while helping relieve the insured's financial hardship. The express departure from a substantial compliance standard to the now codified "de minimis" violation standard is expected to bring about increased litigation. Review of recent case law since the Second Circuit's decision in Halo does, however, not necessarily suggest that the outcome of cases challenging the timeliness of benefit determinations will be vastly different from during the substantial compliance era. Indeed, while several district courts continue to apply the substantial compliance doctrine in deciding cases under the "old" regulations, they have been addressing the Halo factors alongside with the substantial compliance assessment with the same result.

While there are certainly many questions that remain, *e.g.* regarding the effects of the pattern and practice exception to the "de minimis" standard, it stands to hope that the departure from the substantial compliance standard may not bring about as sweeping changes in the case law as initially presumed. Based on the review of current case law post Halo and certainly the wording of the new regulations, it appears advisable from a claims handling perspective to remember to always maintain a meaningful dialogue with the claimant during the initial as well as during the appeal phase, providing updates relative to the status of the review, information obtained and still needed as well as steps completed and intended.

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When Payment of Plan Benefits Make Beneficiaries Whole They Get What They Get and They Can't Get Upset

Life Insurance Benefit Plan Settlement Option Litigation and ERISA's Remedial Scheme

By Ian S. Linker

Several insurers offer beneficiaries of group life insurance plans governed by the Employee Retirement Income Security Act of 1974 ("ERISA") the option of receiving payment of their benefits into a specialized account, akin to a checking account. Under this settlement option, beneficiaries receive a book of drafts, not dissimilar from a check book. They can immediately withdraw the full amount of the benefits by writing a single draft for the entire balance or use the drafts as they see fit over time. The beneficiaries receive interest on the benefits while the funds are in the account ("settlement-option account"), as if it was a bank account. And the insurance companies typically retain the funds in their general accounts to generate investment income as long as there are funds in the account, just like a bank. Everybody wins. Right? Not so fast.

Settlement-Option-Account Litigation

Many of these beneficiaries have filed lawsuits, including multiple putative class actions, against the insurers, which act as ERISA-plan claim fiduciaries, alleging the fiduciaries did not pay benefits in accordance with plan terms and therefore, breached their fiduciary duties under ERISA by:

- paying plan benefits into these accounts, instead of issuing a single check, and
- retaining and generating investment income on the funds.

Because the fiduciaries earned a profit on the funds, the plaintiffs sought disgorgement of these profits in amounts far exceeding the amount of the plan benefits. The results have been a mixed bag, with multiple courts agreeing with the plaintiffs that the fiduciaries breached their fiduciary duties, because they did not comply with the respective plan, some of which require payment into settlement-option accounts and others do not, but make the accounts available to beneficiaries. But the courts could be looking at these cases from a different perspective.

ERISA's Remedial Scheme

ERISA is a "comprehensive and reticulated statute," with a "carefully crafted and detailed enforcement scheme," providing "strong evidence that Congress did not intend to authorize other remedies that it simply forgot to incorporate expressly." G*reat-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002). Courts should therefore be "especially reluctant to tamper with the enforcement scheme embodied in the statute by extending remedies not specifically authorized by its text." Id.

ERISA's remedial scheme is found in 29 U.S.C. §1132. Congress set forth therein who may file suit and for what type of relief. Under 29 U.S.C. §1132(a):

> A civil action may be brought—
>
> (1) by a participant or beneficiary—
>
> (A) for the relief provided for in subsection (c) of this section, or
>
> (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;
>
> (2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;
>
> (3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan.

Plan participants and beneficiaries assert claims for benefits under 29 U.S.C. §1132(a)(1)(B). They may assert claims for breach of fiduciary duty under 29 U.S.C. §1132(a)(2) on behalf of a plan that suffers a loss. And participants and beneficiaries may assert individual claims for breach of fiduciary duties under 29 U.S.C. §1132(a)(3) "to obtain other appropriate equitable relief."

Varity and Its Progeny

Only "appropriate equitable relief" is available under 29 U.S.C. §1132(a)(3). The Supreme Court in *Varity Corp. v. Howe*, 516 U.S. 489 (1996), held "where Congress elsewhere provided adequate relief for a beneficiary's injury," relief, even if equitable, is not appropriate under §1132(a)(3); thus, is unavailable under that section.

In *Rochow v. Life Ins. Co. of N. Am.*, 780 F.3d 364 (6th Cir. 2015)(en banc), the Sixth Circuit decided an issue, similar to the issue considered in *Varity*: whether a plan participant is entitled to recover both benefits under 29 U.S.C. §1132(a)(1)(B) and damages for breach of fiduciary duty under 29 U.S.C. §1132(a)(3), when what the participant really complains about under both causes of action is ultimately an improper denial or payment of plan benefits.

The defendant in *Rochow*, an ERISA-plan fiduciary, denied plaintiff's claim for long-term disability benefits under an ERISA plan. Plaintiff sued. And the court awarded plaintiff benefits under 29 U.S.C. §1132(a)(1)(B). Plaintiff also asserted a cause of action under 29 U.S.C. §1132(a)(3) for disgorgement of the investment income the defendant earned on the unpaid plan benefits. The district court and a Sixth Circuit panel ordered disgorgement of a massive sum, all because the fiduciary had commingled the unpaid benefits with its general assets. Sitting en banc and relying heavily on *Varity*, the court of appeals disagreed and reversed.

Rochow recognized that Congress designed ERISA's remedial scheme the way it did because it was "concerned with the adequacy of relief to redress the claimant's injury, not the nature of the defendant's wrongdoing." The Court held that the district court and the panel erred because, "[i]nstead of focusing on the relief available to make [plaintiff] whole, the award reflects concern that [the fiduciary] had wrongfully gained something, a consideration beyond the ken of ERISA make-whole remedies." The Court emphasized that a "claimant cannot pursue a breach-of-fiduciary-duty claim under §[1132](a)(3) based solely on an arbitrary and capricious denial of benefits where the §[1132](a)(1)(B) remedy is adequate to make the claimant whole." Because the plaintiff had not demonstrated that the benefits he recovered, "plus the attorney's fees awarded, plus the prejudgment interest that *may* be awarded on remand, [were] inadequate to make

[plaintiff] whole, … there is no trigger for 'further equitable relief' under *Varity*." (Emphasis in original).

The Court expressed its concern that if an improper benefit determination "implicated a breach of fiduciary duty entitling the claimant to disgorgement of the defendant's profits in addition to recovery of benefits, then equitable relief would be potentially available whenever a benefits denial is held to be arbitrary or capricious." This outcome, the court recognized, would be "inconsistent with ERISA's purpose to make claimants whole."

The plaintiff in *Rochow* claimed two injuries: "the arbitrary and capricious denial of benefits, and the breach of fiduciary duty consisting of the continued withholding of the wrongfully denied benefits." The Court determined that these injuries were "indistinguishable" from each other, because plaintiff's "loss remained exactly the same irrespective of the use made by [the fiduciary] of the withheld benefits." Plaintiff's "injury was remedied when he was awarded the wrongfully denied benefits and attorney's fees," and "potentially" prejudgment interest.

The Court further noted:

> Despite Rochow's attempts to obtain equitable relief by repackaging the wrongful denial of benefits claim as a breach-of-fiduciary-duty claim, there is but one remediable injury and it is properly and adequately remedied under §[1132](a)(1)(B). Rochow and our dissenting colleagues wholly fail to explain *how* his §[1132](a)(1)(B) remedies are inadequate to remedy his *injury*.

(Emphasis in original). If *Rochow* stands for nothing else, it holds that equitable relief under 29 U.S.C. §1132(a)(3) is not appropriate, as expressly required, if a plaintiff has a viable remedy elsewhere in ERISA's remedial scheme and the other remedy would make him or her whole.

Ogden v. Blue Bell Creameries U.S.A., Inc., 348 F.3d 1284 (11th Cir. 2003), stands for a similar principle. In that case, the Eleventh Circuit addressed whether a plaintiff could seek equitable relief under 29 U.S.C. §1132(a)(3) for plan benefits when *res judicata* bars the claim for benefits under 29 U.S.C. §1132(a)(1)(B). After an Alabama state court *sua sponte* dismissed the plaintiffs' suit for benefits on procedural grounds, plaintiffs filed a second suit in Alabama state court. The defendant removed the action because ERISA preempted plaintiffs' claims. The district court held *res judicata* barred plaintiffs' claim, but that plaintiffs were entitled to equitable relief under 29 U.S.C. §1132(a)(3), even though plaintiffs never sought it.

The district court reasoned that because the fiduciary had failed to review plaintiffs' claim in good faith, it breached its fiduciary duties. The fiduciary appealed. The Eleventh Circuit held that equitable relief under 29 U.S.C. §1132(a)(3) is inappropriate; thus, unavailable, where 29 U.S.C. §1132(a)(1)(B) affords an adequate remedy. This is true, the Court noted, even if a plaintiff does not prevail in his or her claim for benefits under §1132(a)(1)(B). The Court stated:

> our analysis is in no way altered by the fact that the Ogdens' Section [1132](a)(1)(B) claim is now barred by res judicata. At the time the Ogdens' cause of action arose, Section [1132](a)(1)(B) provided them with an adequate remedy. We refuse to grant plaintiffs in the Ogdens' position two bites at the apple by according them a second ERISA cause of action *solely because their first ERISA cause of action was unsuccessful*. The central focus of the *Varity* inquiry involves whether Congress has provided an adequate remedy for the injury alleged elsewhere in the ERISA statutory framework. … Thus, it is irrelevant for *Varity* purposes that the Ogdens no longer have a viable Section [1132](a)(1)(B) claim.

(Emphasis in original; citations and internal quotations omitted).

The outcome in *Korotynska v. Metropolitan Life Ins. Co.*, 474 F.3d 101 (4th Cir. 2006), was no different. There, the plaintiff asserted a claim on behalf of herself and a putative class for breach of fiduciary duties under 29 U.S.C. §1132(a)(3), but did not assert a claim for benefits under 29 U.S.C. §1132(a)(1)(B), reserving her right to assert it at a later time. Indeed, the plaintiff expressly maintained she was "not seeking individualized review of her" benefit claim. She argued that the defendant claim administrator engaged in improper claims procedures to deprive her of a full and fair review of its adverse long term disability benefits determination in violation of its fiduciary duties under ERISA.

The Court considered whether 29 U.S.C. §1132(a)(3) could adequately redress the plaintiff's alleged injury. The Court stated that "there is no question that what plaintiff is pressing is a claim for individual benefits" and "the only injury" the plaintiff complains about "is the termination of benefits and the resulting financial harm to her." Applying *Varity*, the Court recognized that there is "no question that [the plaintiff's] injury is redressable elsewhere in ERISA's scheme." The Court continued:

> Section 1132(a)(1)(B) allows plan participants to obtain individualized review of an allegedly wrongful denial of benefits. The plaintiff's injury here—denial of benefits by the plan administrator—plainly gives rise to a cause of action under §1132(a)(1)(B) and as such would usually be appealed under that provision. … The fact that the plaintiff has not brought

> an §1132(a)(1)(B) claim does not change the fact that benefits are what she ultimately seeks, and that redress is available to her under §1132(a)(1)(B).

The Court held that even though the plaintiff had not asserted a cause of action under 29 U.S.C. §1132(a)(1)(B), that section "affords the plaintiff adequate relief for her benefits claim, and a cause of action under §1132(a)(3) is thus not appropriate."

History of the Settlement-Option-Account Cases Under ERISA

Such should be the outcome in the settlement option account cases, in which the plaintiffs typically allege that:

- in setting up the accounts, the plan fiduciary—payor of benefits—failed to properly pay benefits in accordance with the terms of the plan; thus, breaching its fiduciary duties; and
- the fiduciary wrongfully retained and profited from the retained funds, a prohibited transaction under ERISA, and a further breach of fiduciary duty.

The defendant fiduciaries typically argue that they were not acting as a fiduciary when they established the accounts and invested the funds for profit, and even if they were, the complained-of conduct was not a breach of fiduciary duty. The litigants have drawn these battle lines from the beginning. There is a common thread among these cases, however, the significance of which the courts and parties have thus far overlooked. And a quick summary of the cases will help draw out the common thread.

In *Mogel v. Unum Life Ins. Co.*, 547 F.3d 23 (1st Cir. 2008), the First Circuit reversed the district court's dismissal of plaintiff beneficiaries' breach of fiduciary duty claims under ERISA for failure to state a claim. The plan in *Mogel* stated: "[u]nless otherwise elected, payment for loss of life will be made in one lump sum." The defendant plan fiduciary deposited the plan benefits into settlement-option accounts and sent the beneficiaries a draft book and a letter explaining that the funds were on deposit, that plaintiffs could write drafts on the benefits, and that they would receive interest on the account. The defendant moved to dismiss and argued that it was acting as a fiduciary when it approved payment, but that it was not acting as a fiduciary when it established the accounts and invested the proceeds.

The court of appeals found that "delivery of the checkbook did not constitute a 'lump sum payment' called for by the" plan and that the fiduciary "cannot be said to have completed its fiduciary functions under the plan when it set up the … [a]ccounts and mailed the checkbooks, retaining for its use the funds due until they were withdrawn." In other words, the fiduciary failed to pay benefits in accordance with the terms of the plan and continued to act as a fiduciary when it retained the funds.

In *Faber v. Metropolitan Life Ins. Co.*, 648 F.3d 98 (2d Cir. 2011), the plan language and the outcome were different, but the arguments were the same. Unlike the First Circuit in *Mogel*, the Second Circuit in *Faber* affirmed the district court's dismissal on the grounds that the fiduciary paid benefits in accordance with the plan terms. One of the two plans at issue in *Faber* stated:

> Payment of a death benefit of $7,500 or more is made [into a bank account]. The death benefit amount is deposited in an interest bearing money market account and your beneficiary is provided with a checkbook to use for writing checks to withdraw funds. Other payment options are available. However, if the total death benefit is less than $7,500, a lump sum payment will be made.

The Court invited the Department of Labor to opine on the issue. The DOL stated that the fiduciary discharged "its ERISA fiduciary duties by furnishing beneficiaries a [settlement-option account] in accordance with plan terms and does not retain plan benefits by holding and managing the assets that back the [account]." According to the DOL, once the fiduciary "creates and credits a beneficiary's [settlement-option account] and provides a checkbook, the beneficiary has effectively received a distribution of all the benefits that the Plan promised," and "ERISA no longer governs the relationship between [the fiduciary] and the … account holder[]."

Relying heavily on the DOL, the Second Circuit affirmed. Because the fiduciary paid benefits in accordance with the terms of the plan, unlike the fiduciary in *Mogel*, where the plan did not require payment into a settlement-option account, the Court found the fiduciary was no longer acting as a fiduciary once it set up the account and credited it with the plan benefits. Distinguishing *Mogel*, the Second Circuit recognized that the First Circuit found for the plaintiff in that case because the fiduciary there had not paid benefits in accordance with the terms of the plan, while the fiduciary in *Faber* had.

The plan at issue in *Edmonson v. Lincoln Nat'l Life Ins. Co.*, 725 F.3d 406 (3d Cir. 2013), was a bit different. The plan stated:

> "[u]pon receipt of satisfactory proof of a Dependent's death while insured under this Policy, the Company will pay the amount of the Dependents [sic] Life Insurance in

> effect on the date of such death," and that "[a]ny benefits payable under this Policy will be paid immediately after the Company receives complete proof of claim."

So unlike the plan in *Mogel*, requiring the fiduciary to pay benefits as a lump-sum, and unlike the plans in *Faber*, requiring payment into a settlement-option account, the plan in *Edmonson* was silent with respect to method of payment. The plan only required immediate payment. On the fiduciary's claim form, however, the fiduciary stated that its "usual method of payment is to open a [settlement-option account] in the beneficiary's name." The plaintiff beneficiary submitted a claim for $10,000 in plan benefits. The fiduciary opened an account in plaintiff's name and sent her a draft book. Three months later, plaintiff withdrew the entire amount and the fiduciary paid her the interest owed.

Plaintiff sued under ERISA arguing the fiduciary breached its fiduciary duties by using a settlement-option account and investing the proceeds for its own profit. Plaintiff sought disgorgement of the fiduciary's profits. The court held that:

> [b]ecause the [plan] here is silent as to the form of payment, [the fiduciary] had discretion as to how to comply with its requirements, under its contractual obligations and, as we concluded above, under ERISA. Accordingly, [the fiduciary] fulfilled its obligation to pay [plaintiff] when it established the [account].

Yet again, *Edmonson* turned on whether the fiduciary paid benefits in accordance with the terms of the plan and recognizing the plan granted the fiduciary discretion to construe the plan, the court refused to reverse the benefit determination, much like it would have if applying the abuse of discretion standard of review to an adverse benefit determination under 29 U.S.C. §1132(a)(1)(B).

Similar to the plan in *Faber*, the plan in *Merrimon v. Unum Life Ins. Co.*, 758 F.3d 46 (1st Cir. 2014), required the plan fiduciary to make settlement-option accounts available to the beneficiaries of life insurance plan benefits. Even though the fiduciary in the case paid benefits into the accounts, the plaintiffs nevertheless sued for breach of fiduciary duties. The First Circuit recognized that "fiduciary duties relate principally to ensuring that monies owed to beneficiaries are disbursed in accordance with the terms of the plan." In *Merrimon*, the court concluded that the fiduciary did precisely that; paid benefits in accordance with the terms of the plan.

In denying defendant's motion for summary judgment on plaintiffs' breach of fiduciary duty claims, the court in *Owens v. Metropolitan Life Ins. Co.*, 210 F. Supp. 3d 1344 (N.D. Ga. 2016), concluded that because the plan there required payment of life insurance benefits in a lump sum, "the creation of the [settlement-option account] in [plaintiff's] name and delivery of a blank draftbook [sic] did not satisfy this requirement of the [plan]." In other words, the court in Owens found that the defendant breached a fiduciary duty by not adjudicating benefit claims in accordance with the plan terms.

In *Huffman v. Prudential Ins. Co. of Am.*, 2017 U.S. Dist. LEXIS 201440 (E.D. Pa. Dec. 6, 2017), the court granted plaintiffs' motion for summary judgment for breach of fiduciary duty. The fiduciary paid life insurance plan benefits into a settlement-option account. The court found for plaintiffs even though the plan's summary plan description ("SPD") required payment into the accounts. The plan, however, required payment in a lump sum. The court reasoned that because the SPD stated the plan governed when there were discrepancies between the plan and the SPD, the plan governed. Thus, because the plan required the fiduciary to pay plan benefits in a lump sum and it did not, the fiduciary breached its fiduciary duties.

How *Varity* and Its Progeny Should Impact Settlement-Option-Account Litigation

Every single one of these cases turned on whether the fiduciary paid benefits in accordance with the plan. But not every one of these plaintiffs prevailed on his or her claim for breach of fiduciary duty under 29 U.S.C. §1132(a)(3). In some of the cases, where the court found the defendant fiduciary failed to pay benefits in accordance with plan terms, *e.g.*, the lump-sum cases, the court found a breach. In the other cases, where the court found the fiduciary paid benefits in accordance with the terms of the plan, *e.g.*, the mandating-payment-into-a-settlement-option-account cases and the immediate-payment cases, the court found no breach.

Typically, plaintiffs complaining of an improper benefit determination, *e.g.*, improper payment or improper denial of benefits, will file suit under 29 U.S.C. §1132(a)(1)(B) to remedy their injury. Arguably, however, as the court in *Rochow* warned, every improper determination constitutes a breach of fiduciary duty, because the fiduciary is obligated to adjudicate claims in accordance with the terms of the plan. But because 29 U.S.C. §1132(a)(3) is a catchall and plaintiffs seeking to remedy an improper benefit determination would have a viable cause of action under 1132(a)(1)(B), relief under 1132(a)(3) is unavailable to plaintiffs seeking to remedy the breach.

And that is how the courts should be deciding the settlement-option-account cases. As in *Korotynska*, the plaintiffs' first alleged injury in these cases is that the fiduciaries failed to pay benefits properly, *i.e.*, in accordance with the terms of the plan. And as in *Rochow*, the plaintiffs' second alleged injury, the profits the fiduciary earned on the funds in the accounts, is indistinguishable from the injury allegedly arising from the improper payment of benefits, because plaintiff's "loss remained exactly the same irrespective of the use made by [the fiduciary] of the withheld benefits," even if the defendant fiduciary profits from investing the retained funds. Thus, because these beneficiaries claimed that the plan fiduciary did not pay benefits in accordance with the terms of the plan, they should have brought their actions under 29 U.S.C. §1132(a)(1)(B) to enforce their rights under the plan. So under the reasoning of *Varity*, *Rochow*, *Ogden*, *Korotynska*, and their progeny, because the plaintiffs in these cases had viable claims for benefits under 29 U.S.C. §1132(a)(1)(B) to enforce their rights under the plan, even if they do not ultimately prevail in or even assert a claim under §1132(a)(1)(B), their claims under 29 U.S.C. §1132(a)(3) should have failed as a matter of law. Accordingly, because the plaintiffs should have sued under §1132(a)(1)(B), the courts should not be entertaining the claims under §1132(a)(3).

So what would one of these suits under 29 U.S.C. §1132(a)(1)(B) look like? Hypothetically, a group life insurance beneficiary submits to a plan fiduciary a claim for benefits under an ERISA plan. The plan requires a lump-sum payment of benefits and may, or may not, grant the fiduciary discretionary authority to construe the plan. But instead of issuing a check to the beneficiary, the fiduciary establishes a settlement-option account and sends a draft book to the beneficiary. If the beneficiary objects to this method of payment, he or she would potentially need to exhaust the plan's administrative remedies before filing suit and request a check from the fiduciary. The fiduciary could reverse and simply shut down the account and issue the check, which would certainly be the cleanest and least costly outcome, or not.

If the beneficiary chooses not to object to the fiduciary, but instead decides to run into court and file suit, the fiduciary could move to dismiss on failure-to-exhaust-administrative-remedies grounds. A court would likely grant the motion in one form or another, because the exhaustion requirement is a universal principle in ERISA litigation and a prerequisite to filing suit, though there is a question given the crux of the dispute, *i.e.*, the method of payment, whether ERISA's notice requirements; thus, the exhaustion requirement would be implicated. *See*, *e.g.*, *Pompano v. Michael Schiavone & Sons, Inc.*, 680 F.2d 911 (2d Cir. 1982) (court affirmed pension committee's determination regarding method of payment when pension plan granted committee authority to make such determinations). Perhaps at that point the court would remand and allow the beneficiary to object directly to the fiduciary. And then, again, the fiduciary could reverse, or not.

But what if the fiduciary decides not to reverse? It looks at the facts and the plan language, considers whether the beneficiary already depleted the account, or simply concludes payment via bank account satisfies the plan's lump-sum-payment requirement. The beneficiary could decide at that point whether to pursue in court his or her request for a check. If the plan grants the fiduciary discretionary authority, the court's review, depending on the jurisdiction, of course, would be for an abuse of discretion. (Courts would review these determinations *de novo* if the plan does not grant discretionary authority or if a state ban on discretionary clauses applies.) There likely would be little, if any, discovery. The court's review would be limited to the administrative record compiled by the fiduciary. The court would affirm the determination to pay plan benefits via settlement-option account, unless the beneficiary could show the determination was unreasonable, an uphill battle for sure. If the court determines the fiduciary abused its discretion, or incorrect under *de novo* review, then the fiduciary would decide whether to appeal. If it decided to accept the court's judgment, it would issue a check, presumably less any funds already taken out of the account by the beneficiary, possibly pay prejudgment interest, and likely reimburse the beneficiary for his or her attorneys' fees.

Varity's principle is well-established in ERISA litigation: A court should dismiss a claim for breach of fiduciary duties if the plaintiff has a viable claim for benefits or some other remedy under ERISA and the multiple alleged injuries are in reality indistinguishable from each other. The principle should apply neatly in the settlement-option-account-litigation context where the plaintiffs do not allege a separate injury or a discrete wrong beyond the alleged improper benefit-payment determination. Accordingly, defendants in these cases should assert *Varity* and its progeny as an independent basis to defeat plaintiffs' claims for breach of fiduciary duty.

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ERISA Update

By Joseph M. Hamilton, ERISA Update Editor

Third Circuit

Third Circuit Enforces Anti-Assignment Provision, but Then …

In *Am. Orthopedic & Sports Med. v. Indep. Blue Cross Blue Shield*, 890 F.3d 445 (3d Cir. 2018), the Third Circuit considered the effect of an anti-assignment provision in an ERISA plan. The plan participant underwent shoulder surgery with a provider who was not a participant in the insurer's network. As a result, the provider's charges substantially exceeded the insurer's allowable reimbursement and the participant was charged the additional amounts. The participant then assigned his right to pursue a claim for the additional amounts to the medical provider. At issue was whether the plan's anti-assignment provision prevented the provider from bringing the lawsuit.

Joining several other circuits, the Third Circuit agreed with the insurer that the anti-assignment clause was enforceable. Finding no guidance in ERISA, the court resorted to federal common law and concluded that the unambiguous terms of a contract should be enforced. However, the Court cautioned that such a provision will not be enforced if it is buried in "fine print."

The provider argued that even if the anti-assignment was valid, the insurer waived enforcement of it. The Court disagreed again. According to the Third Circuit, the "routine processing of a claim form, issuing payment at the out-of-network rate and summarily denying the appeal" did not equate to a "surrender" of the insurer's right to object to the provider's standing in federal court.

But the Third Circuit gave providers one victory. It held that while an anti-assignment provision is enforceable, a power of attorney was completely different since it did not transfer ownership interest. Therefore, a participant can confer on an agent his authority to assert a claim on his behalf notwithstanding an anti-assignment clause. But since the provider in this case acknowledged that its power of attorney was deficient under state law, the Third Circuit affirmed the dismissal of the lawsuit.

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Fourth Circuit

Life Insurer Not Responsible for Reduced Coverage Caused by Employer's Administrative Errors

In *Gordon v. CIGNA Corp.*, 890 F.3d 463 (4th Cir. 2018), the Fourth Circuit held a life insurance company did not breach any fiduciary duty under ERISA when an employer's administrative errors resulted in a participant's reduced coverage under a group life insurance plan.

Steven Gordon paid premiums for $300,000 in life insurance coverage under his employer's group life insurance plan. The plan provided a guaranteed issue amount of $150,000, but required evidence of insurability for amounts greater than $150,000. Mr. Gordon provided no evidence of insurability and was never asked to provide such evidence. His employer, however, collected premiums for the full $300,000 in coverage. The employer submitted monthly bulk premium payments to the insurer, without identifying covered employees or amounts paid for any individual employee. When Mr. Gordon died, the insurer paid only $150,000 because he had only been approved for $150,000 in coverage. Mr. Gordon's wife sued for the difference between the two amounts, asserting breach of fiduciary duty claims against the insurer.

The district court found the errors leading to Mr. Gordon's reduced coverage resulted from mistakes made by his employer—the plan administrator—not the insurer. The district court granted summary judgment for the

insurer because the insurer did not breach any fiduciary duty under ERISA or "knowingly participate" in any breach of trust by the employer. (After the district court's decision, the employer settled with Mrs. Gordon.) Mrs. Gordon appealed the summary judgment decision.

On appeal, Mrs. Gordon argued the insurer was an ERISA fiduciary because it exercised discretionary authority over plan "assets," when it received bulk premium payments from the employer. The court rejected this argument, holding premiums paid for a life insurance contract—a guaranteed benefit policy—are not plan assets as defined by ERISA. The court further found the plan documents allocated no authority, responsibility, or managerial capacity to the insurer to solicit supporting materials from participants for coverage beyond the guaranteed issue amount or to notify participants of the need to complete the evidence of insurability requirement. Indeed, this responsibility was entrusted to the employer in its role as the plan administrator. The court, therefore, held the plan imposed no fiduciary duty on the insurer, either formally or functionally, with respect to the screening and submission of applications for coverage over the guaranteed issue amount.

The court further considered Mrs. Gordon's novel claim that even if the insurer were not a fiduciary, it was liable for "knowingly participating in a breach of trust by a fiduciary." The appellate court expressed skepticism that such a cause of action exists under ERISA. Assuming without deciding that the cause of action was cognizable, the court held it would still fail because the insurer knew nothing about the employer's alleged breach of fiduciary duty until after it occurred. Indeed, the bulk premium payments received by the insurer provided no information about any specific employee's coverage. The insurer could not have "knowingly participated" in any breach of trust by the employer absent knowledge Mr. Gordon was paying for unapproved coverage. The Fourth Circuit, therefore, affirmed summary judgment in favor of the insurer.

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Ninth Circuit

Accident Coverage Exclusion for Loss Applies if the Disease "Substantially Contributed" to the Loss

In *Dowdy v. Met Life*, 890 F.3d 802 (9th Cir. 2018), under an ERISA governed accidental death and dismemberment policy, there was coverage for a leg amputation where Dowdy had diabetes, badly injured his leg in a car accident, the injury did not respond to treatment, and the leg was later amputated. The policy provided a dismemberment benefit not described in the opinion and excluded loss caused or contributed to by physical illness or infirmity. The court ruled that the exclusion did not apply unless the diabetes "substantially contributed" to the loss of the leg. The court ruled that it did not.

Dowdy was in a car accident in which he suffered a semi-amputated left ankle. He was hospitalized for 28 days, discharged to rehabilitation, and the injury to his leg failed to improve. Approximately three months later, he was transferred back to the hospital for treatment of the persistent infection of the leg. Five months after the accident, he elected to have his leg amputated.

The policy covered loss which occurs within 12 months of the injury and which was a "direct result of the accidental injury, independent of other causes." The policy excluded "any loss caused or contributed by…physical …illness or infirmity, or the diagnosis or treatment of such illness or infirmity."

The court noted that Congress specifically stated that it is the policy of ERISA to protect the interests of the participants in the employee benefit plans and to increase the likelihood that the participants "receive their full benefits."

The court ruled that the record established that "diabetes was a factor in the injury. Nonetheless, the factual record does not support a finding that diabetes substantially contributed to [Dowdy's] loss."

In order to be considered a "substantial contributing factor for the purpose of restricting coverage to 'direct and sole causes' of injury, a pre-existing condition must be more than merely a contributing factor." The court went on to rule that to distinguish between a responsible cause and a philosophic, insignificant cause, there must be some evidence of a significant magnitude of causation, citing the Restatement (Second) of Torts, Section 431, comment a.

The court held that the record fell short of showing that diabetes was a substantial contributing factor. The attending physician wrote that Dowdy's "wound issues" post-surgery were "complicated by his diabetes." But, he did not elaborate on how much of a role the diabetes played in Dowdy's failure to recover.

The car accident resulted in a severe injury which "came close to amputating his lower leg." The attending physician wrote that when attempts were made to correct the lower leg, subsequent wound issues were complicated by diabetes and the fracture was slow to heal. Ultimately, however

[Dowdy] had a deep infection that the attending physician considered "related to the original injury."

It remains to be seen if this decision is limited to ERISA cases or if the 9th Circuit will apply its reasoning on "substantial cause" to exclusions under non-ERISA coverage. Further, the court stated what is insufficient to support a finding of "substantial cause" but has not stated what record will support such a finding. It criticized the record as being "thin" on the role of diabetes in the amputation of the leg, suggesting it might be more receptive to the argument with a more fully developed record on the causative role which the excluded condition played in the loss.

But, the clear conclusion from *Dowdy* is that the 9th Circuit is very skeptical of applying exclusions to coverage in ERISA cases.

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Parity Act Requires Equivalent Coverage for Mental Health Conditions

In *Danny P. v. Catholic Health Initiatives*, 891 F.3d 1155 (9th Cir. 2018), the Ninth Circuit found that under the Parity Act, 29 U.S.C. §1185, coverage for mental health care at a licensed residential facility must be no more restrictive than for treatment at a skilled nursing facility. The case involved a claim under a self-funded ERISA Plan covering Catholic Health Initiatives employees and their dependents. The Plan covered mental health services at a skilled nursing facility defined as, an institution or part of an institution "primarily engaged in providing comprehensive skilled services and rehabilitative Inpatient care." The Plan covered "bed, board and general nursing care" as well as "ancillary services" at the skilled nursing facility. The Plan also provided coverage for treatment at residential treatment facilities which are licensed facilities dealing with illnesses affecting mental health, but did not specifically cover room and board.

The plaintiffs sought benefit payments for the cost of treatment and services, including room and board, in a residential treatment program. The Plan denied room and board coverage, though paid for other services. The plaintiffs brought suit, and the district court upheld. The plaintiffs appealed.

The Ninth Circuit reversed, finding that the district court erred in its determination that "the Parity Act did not require that the Plan's coverage for stays at a licensed inpatient residential treatment facilities had to be no more restrictive than stays at skilled nursing facilities." The court found the language of the Parity Act is clear that benefits for mental health treatment shall be "no more restrictive" than benefits for medical or surgical services, though there was a gap of "uncertainty or ambiguity regarding its application to specific ERISA plan terms and situations." The court can fill the "gap" with its interpretation of the statute. Quoting *Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 576, 587–88 (2000), the court stated, "a court will 'impose its own construction on the statute…in the absence of an administrative interpretation."

The court then looked to agency regulations and comments to interpret and apply the Parity Act to the facts at hand. The Parity Act designates three agencies the power to issue rules and guidance, the Department of Labor, Department of Health and Human Services and the Department of Treasury. The regulations state that mental and medical/surgical benefits "must be congruent" and "limiting the former while not placing a similar limitation on the latter would be improper."

The court found the Parity Act intended that "a plan cannot allow room and board costs at a skilled nursing facility where one is an inpatient, while denying them at a residential treatment facility where one is an inpatient." As a result, the Parity Act "precludes the Plan from deciding that it will provide room and board reimbursement at licensed skilled nursing facilities for medical and surgical patients, but will not provide room and board reimbursement at residential treatment facilities for mental health patients." The court reasoned, "[w]ere it otherwise, the lack of equity that the Parity Act was designed to repress would have become renascent."

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Eleventh Circuit

Interpleader: Court Holds Plan Benefits Must Be Distributed to Beneficiary and Insured's Estate May Not Assert Claims Against Plan Trustee Regarding Distribution of the Death Benefits

In *MetLife and Annuity Co. of Conn. v. Akpele*, 886 F. 3d 998 (11th Cir. 2018), the substantive issues on appeal were (1) whether MetLife deposited the correct amount of life insurance proceeds into the district court's registry and (2) which defendant was entitled to the proceeds. In addition,

the Court was to determine whether a party that is not a named beneficiary of an ERISA plan, here the deceased's estate, could assert a claim against the Plan or the Plan Trustee for plan benefits.

MetLife instituted the interpleader action because it could not determine the proper beneficiary under a life insurance policy for Dr. Ignatious Akpele. By its terms, the sole beneficiary of the policy was Dr. Akpele's employee welfare benefit plan, the AIE Surgical Practice Defined Benefit Plan ("Plan"). The minor children of Dr. Akpele's widow and one of their minor children (the "Akpeles") claimed they were entitled to the policy death benefit and the trustee for the Estate of Dr. Akpele (the "Estate Trustee") claimed the Estate was entitled to the death benefit. The Plan was also an interpleader defendant. Complicating the matter, prior to his death, Dr. Akpele had executed a will that established a trust for his two minor children and he had begun divorce proceedings against his widow, but the divorce was not finalized before his death.

The Estate Trustee filed a motion to enforce a settlement agreement and/or motion for partial motion for summary judgment against the Akpeles stating the Estate and the Akpeles had reached a compromise for the equal division of the policy proceeds although they never executed a final settlement agreement. The Akpeles claimed that they were entitled to the death benefit and, further, that such benefit was $5,418,206, not the $635,562.25 MetLife had deposited in the district court's registry. The district court entered summary judgment for MetLife, and discharged it from all liability and enjoined further litigation against it related to the policy. The court also denied the Akpeles' motion for summary judgment as to the proceeds due under the policy. And, after denying the Estate Trustee's motion to enforce settlement agreement and/or partial summary judgment, during an evidentiary hearing to resolve the settlement issue, the district court ended the hearing and ordered the Plan Trustee to file a motion to disburse the death benefit to the Plan, which the court granted over the objection of the Estate. The funds remained deposited with the court's registry during the appeal that followed.

The Eleventh Circuit held that the trial court correctly determined the amount of death benefit was $635,562.25, not the $5,418,206 full face value of the policy. The decedent purchased a "pension whole life" policy with a death benefit of $5,148,206 with annual premiums of $204.383.78. The policy established both a death benefit and a cash value in the event that annual premiums were paid. In the event the annual premiums were not paid, the policy contained a non-forfeiture provision and a "Paid-Up" provision, which reduced the applicable benefits. The decedent paid the premiums for 2005–2008, but failed to pay the 2009 yearly premium. The insurer timely informed the decedent of the missed payment and that, pursuant to the non-forfeiture provision, the policy was converted to a "Paid-Up" policy and the death benefit was reduced to $516,108. The insured's widow had submitted an affidavit averring the decedent had ceased making premium payments pursuant to advice given to him by the plan sponsor and others that the fund was overfunded and that additional premiums could not be made. Accordingly, the Court determined that there was no material issue of material fact that after 2008 no premiums were received and that MetLife had properly converted the policy to a "Paid-Up" policy and reduced the death benefits. The Court further rejected arguments made by Uzo Akpele that the decedent failed to pay the 2009 premium because he did not receive the premium notice, he was sick at the time the premium was due, and that the decedent had intended to include a "Lapse of Protection Guarantee" rider to the policy.

The Eleventh Circuit also affirmed the district court's determination that the Plan Trustee was entitled to receive the policy benefit, and that, as the Plan documents and ERISA require, the Plan Trustee must then distribute the funds to the surviving spouse, citing 29 U.S.C. §1055. The Court further held in accordance with Supreme Court precedent in *Kennedy v. Plan Administrator for DuPont Sav. & Inv. Plan*, 555 U.S. 285 (2009), that the Estate Trustee could not bring claims directly against the Plan or the Plan Trustee because "a party who is not a named beneficiary of an ERISA plan may not sue the plan for any plan benefits." While the Supreme Court in *Kennedy* left open the question of whether a separate action or other avenue of recovery could be pursued against an ERISA plan beneficiary, other Circuits and district courts have held that after the funds have been distributed to a plan beneficiary, a lawsuit could be brought against the beneficiary to recover ERISA benefits. In accordance with these decisions, the Court held that any claims of the Estate Trustee against the Akpeles to enforce the settlement agreement or for breach of contract were not ripe, in part, because the Plan Trustee had not yet distributed the funds but that *after* the funds are distributed, the Estate Trustee could bring separate claims—not involving the Plan or the Plan Trustee—for breach of contract or to enforce the alleged settlement agreement against the insured's widow. In so holding, the Court stated: "[the Estate Trustee] is free to sue the Akpeles to enforce any settlement in a separate action in which the Plan trustee is not a party but may do

so only after the Plan benefits have been distributed to the ultimate beneficiary under the Plan."

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