Court Decisions Interpreting Objective-Proof-of-Disability Requirements in ERISA-Governed Disability Plans (Soft Tissue Conditions)

By: William D. Hittler (Nilan Johnson Lewis P.A.)

An employer sponsoring a long term disability plan for the benefit of its employees governed by ERISA, 29 U.S.C. §1001 et seq., has the right to define the extent, and restrictions on, benefits and coverage. See Lockheed Corp. v. Spink, 517 U.S. 882, 887 (1996). An employer may thus decide in its discretion to limit eligibility for long term disability benefits to a specific time period unless the disability has objective evidence of certain diagnoses. In Wilcox v. The Standard Ins. Co., 340 F. Supp. 2d 1266 (N.D. Ala. 2004), the disability plan prescribed a 12-month maximum benefit period for musculoskeletal and connective tissue disorders (except for certain medical conditions documented by electromyogram and computerized tomography or MRI). Plaintiff argued that he was entitled to continued benefits on the basis of two herniated disks documented by MRI. The district court acknowledged this proof, but upheld the insurer’s decision on the grounds that the electromyogram and nerve conduction studies, either one of which was required in addition to a positive MRI, was negative. Id. at 1282-83.

Similarly, in Marden v. Metropolitan Life Ins. Co., the plan limited long-term disability benefits for soft tissue disorders to 24 months unless the participant provided objective evidence of certain diagnoses, including radiculopathies (defined as “disease of the peripheral nerve roots supported by objective findings of nerve pathology”). Plaintiff argued that he had been diagnosed with “radiculitis,” which was interchangeable with “radiculopathy,” and that MetLife had misinterpreted the language of the Plan. However, the district court agreed that radiculitis is merely inflammation of the root of the spinal nerve, whereas radiculopathy is the disease of the nerve root. Accordingly, the court held that MetLife’s interpretation of the plan terms was reasonable and upheld its denial of plaintiff’s claim on the basis that the objective medical evidence considered did not demonstrate clinical proof of radiculopathy, based in part upon the findings of an independent physician consultant, and granted summary judgment in MetLife’s favor. No. 1:11-cv-015, 2012 U.S. Dist. LEXIS 777576, at *29-35 (D. N.D. June 5, 2012). See also Meraou v. The Williams Co. Long Term Disability Plan, 221 Fed.Appx. 696, 703, 705 (10th Cir. 2007) (insurer entitled to request objective evidence of disabling severity of conditions, including fibromyalgia, a disorder characterized by pain, tenderness and stiffness of tendons and adjacent soft tissue structures).


1 The author gratefully acknowledges the assistance of Ms. Maria Zolokar in the preparation of this article. Maria is a second year law student at St. Thomas School of Law in Minneapolis, Minnesota.
tunnel syndrome, seizure disorder and pedal edema were not, either taken individually or in total, disabling. On this record, the district court held that it was more reasonable for the insurer to interpret and apply long term disability provision clauses if a disability is primarily caused by neuromusculoskeletal/soft tissue disorders and non-neuromusculoskeletal/soft tissue disorders, individually or in combination, are not independently disabling. *Id.* at *9-21. Specifically, the court held that this was a reasonable interpretation particularly where none of Brien’s other disorders were independently disabling and it was the numerous neuromusculoskeletal/soft tissue disorders (including possible radiculopathy) that rendered Brien disabled and eligible for the benefits under the Plan. To rule otherwise “would render the ‘LBD provision meaningless, as no condition, however minor, is ever going to make an already disabled individual any less disabled.” *Id.* at *30.

Courts have also held that ERISA does not bar a broad limited disability condition clause in a plan covering all neuromusculoskeletal and soft tissue diagnoses without the objective evidence exception to the neuromusculoskeletal limitation. *See, e.g., Bland v. Metro. Life Ins. Co.*, No. 5:11-cv-277, 2013 U.S. Dist. LEXIS 599 (M.D. Ga. Jan. 3, 2013). There, the plan provided that benefits for certain conditions (mental/nervous disease, neuromusculoskeletal or soft tissue disorder) were payable up to a maximum of 24 months, with no exceptions. Plaintiff’s physician diagnosed her with post-laminectomy syndrome. In granting summary judgment in favor of the insurer, the district court held that the removal of the exception, while increasing the breadth of any neck or back injury applicable no matter how certain it is an objective evidence exception to the neuromusculoskeletal diagnosis without the limitation.

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**Tips to Avoid Future Lawsuits When Closing an Old Pension Plan to New Hires**

By: Michael R. Pennington & James S. Christie, Jr. (Bradley Arant Boult Cummings LLP)

Many employers are closing traditional pension plans for new hires. As with any other employment changes, such changes create litigation risks. How can an employer avoid future lawsuits when closing an old pension plan to new hires?

For employees choosing where to work, and for employers wishing to attract and keep the right personnel, employee benefits plans can be as important as salary. They can also offer significant tax advantages. “Defined benefit plans,” offering a fixed sum in weekly or monthly retirement payments for life after retirement at specific ages and years of service, were once the norm. According to the Pension Benefit Guaranty Corporation, employers sponsor about 38,000 insured defined benefit plans today compared to a high of about 114,000 in 1985. (http://www.irs.gov/Retirement-Plans/Choosing-a-Retirement-Plan::Defined-Benefit-Plan ). Now, 401(k) plans and other “defined contribution plans,” which do not guarantee a specific monthly or weekly sum at retirement, are much more common.

When an employer decides to phase out an existing pension plan by closing it to new hires, making new employees eligible only for a new plan (and typically less rich for and puts investment risk on the new hires), a number of competing considerations come into play. First, the company may be concerned about minimizing jealousy and conflict among old and new employees over the differing benefit packages for which they are relatively eligible. Second, the employer may be concerned about minimizing notice and other costs associated with the transition. These and similar considerations may lead an employer to minimize educating existing employees about the new plan and not educating the new hires about the older, richer plan.

Such an approach, however, is not without risk. Workers inevitably talk about retirement benefits. New employees often ask old employees to explain the company’s retirement plan. Often, the “old plan” employees already in managerial positions will be the ones hiring “new plan” employees for many years to come. Absent persistent education to the contrary, “old plan” employees asked to explain how the retirement plan works are naturally going to describe the benefits of their own “old plan,” with the result that new employees may be led to believe that they are going to be eligible for the same benefits when they retire. Even though no one will have intentionally misled the new employee in this scenario, the potential for misinformation is high. Having a valued employee plan for retirement based upon misinformation, only to find out too late that his retirement benefits do not include a major component he was counting on, is in no one’s best interest. Moreover, this situation creates employer risk for at least three types of possible claims.

One, the employee might bring a fraud claim against the employer based on reliance on what the employer’s mangers told him or her. Depending on the facts, a court could find such a fraud claim not to be preempted by ERISA. *See, e.g., Pierce v. Wells Fargo Bank, N.A.*, 380 Fed. App’x 635 (9th Cir. 2010) (former employee’s action against former employer’s successor, alleging that successor breached oral contract, under which successor agreed to pay employee if he continued to work for successor, alleged independent obligation to employee that was thus not completely preempted by ERISA); *Marin General Hospital v. Modesto & Empire Traction Company*, 581 F.3d 941, 949-50 (9th Cir.2009) (holding health care provider’s claims based upon an alleged oral contract with the defendants not completely preempted by ERISA); cf. *Whitt v. Sherman International Corp.*, 147 F.3d 1325, 1330-31 (11th Cir. 1998) (holding that an ERISA...
of the law with potential for costly litigation based on unintended alleged misrepresentations about ERISA plans is an unsettled area. Clearly, the actionability and legal consequences of an employer’s opinions interpreting ERISA’s coverage section, ERISA § 4(a), 29 U.S.C. § 1003(a), or its definitions section, ERISA § 3(1), 29 U.S.C. § 1002(1).” Donovan v. Dillingham, 688 F.2d 1367, 1372 (11th Cir. 1982) (en banc); see Williams v. Wright, 927 F.2d 1540 (11th Cir. 1991) (holding that an informal arrangement described in a letter was a plan governed by ERISA); accord Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 18 n.10 (1987) (“The fact that the employer had not complied with the requirements of ERISA . . . does not . . . mean that no such program was in existence.”) (dicta).

Three, the employee could bring claims for breach of ERISA fiduciary duties and other ERISA statutory claims. Whether equitable relief such as reformation of the old plan or surcharge against the employer might be available for such claims would likely depend on the facts and the jurisdiction. See CIGNA Corp. v. Amara, 131 S. Ct. 1866 (2011) (dicta suggesting that reformation and surcharge might be “appropriate equitable relief” for ERISA statutory violations); Amara v. CIGNA Corp., 2012 WL 6649587 *6 (D. Conn. 2012) (on remand, awarding benefits and holding that the employer’s “deficient notice led to its employees’ misunderstanding of the content of the contract” and that employer’s conduct “affirmatively misled and prevented employees from obtaining information that would have aided them in evaluating the distinctions between the old and new plans”); cf. Kenseth v. Dean Health Plan, Inc., 2013 WL 2881466 (7th Cir June 13, 2013) (based on oral representations, holding that claimant could seek make-whole money damages as an equitable remedy under ERISA) (discussing at length other courts’ opinions interpreting Amara).

Clearly, the actionability and legal consequences of an employer’s alleged misrepresentations about ERISA plans is an unsettled area of the law with potential for costly litigation based on unintended misinformation. The point of this article is not to debate who should or would win such a lawsuit, but to offer suggestions for avoiding the lawsuit altogether, along with the potential for confusion that underlies the risks. And the smart employer who thinks ahead can do a great deal to avoid both.

First, in planning a transition from an old plan to a new plan, the employer must remember that the initial communications and notices concerning the transition involves matters that will be at least as important 20 and 30 years down the road as they are at the time of the transition, for that is when “new plan” hires will start retiring. Care should be taken to permanently maintain records of the transition and all communications about it. Otherwise, 20 or 30 years later, the employer may have no ability to prove anyone was told anything inconsistent with the disappointed retiree’s claim.

Second, care should be taken to educate “old plan” employees that the “old plan” is being closed to new hires and that new hires will be eligible only for a new and different plan. This education should be documented and preserved and should include key eligibility “hire dates” for each plan and instructions that questions about retirement benefits should always be referred to those persons specifically in charge of retirement plan issues within the company. These steps will help avoid the natural tendency of “old plan” employees to describe their own retirement benefits when asked by a newer hire to explain the employer’s retirement benefits.

Direct and carefully documented communication of the key facts to new hires is also important. If, thirty years from now, a disappointed retiree says “I knew I was eligible for the Defined Contribution Plan, but I thought that was in addition to the pension my branch manager told me about, and no one ever told me I would not be eligible for the pension plan,” the employer needs to be able to show him (and the court) otherwise, in a written document the employer can prove the employee received. For example, the enrollment documents that a new plan employee must execute to enroll in the “new plan” could explicitly state that “employee acknowledges he or she is and shall not be eligible for any past or present retirement plan offered by the company except [the new plan], and that no past or present employee of the Company is authorized to bind the Company to provide any other retirement benefits other than those set forth in the official Plan Documents for the [new plan].” This form, permanently maintained, would then be

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2 The other circuits have followed Donovan when considering what is necessary to establish an ERISA plan. E.g., Wickman v. Northwestern National Ins. Co., 908 F.2d 1077, 1082 (1st Cir. 1990); Grimo v. BlueCross/Blue Shield of Vermont, 34 F.3d 148, 151 (2d Cir. 1994); Diebler v. Food & Commercial Workers’ Local 23, 973 F.2d 206, 209 (3d Cir. 1992); Elmore v. Cone Mills Corp., 23 F.3d 855 (4th Cir. 1994); Memorial Hospital System v. Northbrook Life Insurance Co., 904 F.2d 236, 240-41 (5th Cir. 1990); Brown v. Ampco-Pittsburgh Corp., 876 F.2d 546, 551 (6th Cir. 1989); Ed Miniat, Inc. v. Globe Life Insurance Group, Inc., 805 F.2d 732, 739 (7th Cir. 1986); Harris v. Arkansas Book Co., 794 F.2d 358, 360 (8th Cir. 1983); Scott v. Gulf Oil Corp., 754 F.2d 1499, 1503-04 (9th Cir. 1985); Peckham v. Gem State Mutual of Utah, 964 F.2d 1043, 1047 (10th Cir. 1992); Kenney v. Roland Parsons Contracting Corp., 28 F.3d 1254 (D.C. Cir. 1994).

3 But see Curtiss-Wright Corp. v. Schoonejongen, 514 U.S. 73, 82-83 (1995) (emphasizing ERISA’s requirement of a written plan). Under Donovan, whether ERISA’s regulatory requirements were followed and even whether the parties intended for ERISA to apply are irrelevant to whether ERISA applies. Donovan, 688 F.2d at 1372; see Whitt v. Sherman International Corp., 147 F.3d 1325, 1330-31 (11th Cir. 1998) (implying in dicta that Donovan still is correct that an oral ERISA plan is possible despite comments in Curtiss-Wright).
a permanent defensive weapon against future “oral plan” lawsuits, while at the same time helping ensure against misunderstanding. Similar language can easily be included on annual statements to “new plan” employees.

Finally, employee handbooks, employee benefit websites, or other sources of retirement information accessible to all employees should contain date of hire and other eligibility criteria for each plan. Sunshine is the best disinfectant, as they say, and clearly, openly and continuously publishing the basic eligibility criteria for each plan to all employees can be a powerful safeguard against confusion. Any intra-workforce jealousy this produced will be short-lived and minor in comparison to the lasting benefits of this approach.

Federal Circuits’ Views of Make-Whole Rule

By: Brett Bacon (Frantz Ward)

The Rule

The make-whole rule provides that an insurer cannot enforce subrogation rights unless the insured has been made whole by any recovery. See Copeland Oaks v. Haupt, 209 F.3d 811, 814 (6th Cir. 2000). This is a default rule and will not apply only if it is conclusively disavowed. See Id. at 813. In order to disavow the make-whole rule, the language in the agreement “must be specific and clear in establishing both a priority to the funds recovered and a right to any full or partial recovery.” Id.; see also Farie v. Jeld-Wen, Inc., 2008 U.S. Dist. LEXIS 88893, at * 8-11 (N.D. Ohio 2008) (holding that make-whole rules was specifically and clearly disavowed).

Make-Whole Rule Explanation

In Copeland Oaks, the Sixth Circuit remanded to determine whether the injured employee had been made whole and whether the insurance company had a right to subrogation. Id. at 814. The injured employee had been in a car accident and received a settlement from the driver for $100,000 for bodily injuries and $5,000 for medical expenses. Id. at 812. Meanwhile, the injured employee also sought $300,000 for medical expenses from her employment benefit plan. Id.

In 2012, the Southern District Court of Ohio similarly found that a subrogation clause did not disavow the make-whole rule. Milam v. Am. Elec. Power Long Term Disability Plan, 2012 U.S. Dist. LEXIS 135953, at *22 (S.D. Ohio 2012). The provision used the following language:

If you bring a liability claim against a third party, benefits payable under the plan must be included in that claim as well as in any recovery you obtain, either by judgment, settlement, or otherwise, and you must reimburse the plan for the full amount of benefits paid under the plan, regardless of whether you have been “made whole” as a result of payments by that third party. Id. at *20. The court then remanded for a determination of whether the injured party had been made whole by a settlement. Id. at *23. The injured party had received disability benefits from an employment plan and later received a $250,000 settlement from the driver of the vehicle in the car accident. Id. at *3-4. The payment was a lump sum and did not specify whether the money was for medical expenses or lost wages. Id. The court ordered briefs to determine what the settlement was for and whether the injured party had been made whole. Id. at *23.

Whether A Default Rule

Federal Circuits with the Make-Whole Rule as a Default Rule

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Federal Circuits without Make-Whole Rule as Default

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For more information, please contact ALFA International
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### Circuit Court | Case
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   “When [the Plan’s] language is read in context and viewed in light of all the circumstances, it can only mean that the Plan is entitled to be paid back by the beneficiary all amounts that the Plan has paid to the beneficiary, or on his behalf, to the full extent . . . that the beneficiary recovers from another source . . . .”

Eighth | Waller v. Hormel Foods Corp., 120 F.3d 138, 140 (8th Cir. 1997)

Federal Circuits undecided about Make-Whole Rule

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### U.S. Airways v. McCutchen – Plan Provisions (and a lack thereof) Reign Supreme

By: Angela Logan Edwards (Dinsmore & Shohl LLP)

What the Supreme Court giveth, the Supreme Court taketh away! The parties in the *U.S. Airways v. McCutchen* case know all too well that you can both win and lose within same case at the United States Supreme Court. U.S. Airways, the sponsor of a self-funded health plan, got a split decision from the Court which held, on the one hand, that equitable principles, namely unjust enrichment, do not trump the provisions of a benefit plan. Specifically, a participant cannot defeat a plan’s lien requirements with equitable defenses. The Court also held, on the other hand, that where a plan document is silent on an issue (the allocation of attorney’s fees), equitable principles (the common fund doctrine) can be used to fill the gaps.

James McCutchen, a U.S. Airways employee and participant in the self-funded health plan, sustained serious injuries in an auto accident. The plan paid $66,866 for Mr. McCutchen’s medical expenses incurred as a result of the accident. The plan included reimbursement provisions requiring that participants reimburse the plan “out of any monies recovered from a third party.” Importantly, the plan did not expressly address whether the plan or the participant would be responsible for paying any attorney’s fees incurred in obtaining any recovery from the third party.

Mr. McCutchen’s recovery from the third party, after attorney’s fees, was $66,000, just less than the amount the U.S. Airways plan paid in medical bills. U.S. Airways sought reimbursement of the $66,866 it paid in medical expenses, but Mr. McCutchen declined to pay. U.S. Airways filed suit seeking to enforce the plan’s reimbursement provisions. U.S. Airways prevailed at the district court level receiving $41,500 held in trust by Mr. McCutchen’s attorney and $25,366 from Mr. McCutchen’s own resources, but the Third Circuit reversed holding that U.S. Airways had been unjustly enriched.

In an April 2013 decision, the Supreme Court held that the U.S. Airways plan’s reimbursement provisions control and have priority over equitable defenses, including McCutchen’s unjust enrichment arguments. The Supreme Court concluded that the plan terms must be applied and the parties’ written agreement enforced. Relying on these same principles, the Court permitted the application of the common-fund doctrine to plug a “contractual gap” in the U.S. Airways plan document(s). As a result, the U.S. Airways plan’s recovery was reduced by its share of the costs incurred pursuing the third party tortfeasor.

The *McCutchen* decision underscores the importance of plan drafting. A strong reimbursement provision paved the way for U.S. Airways’ recovery, but the absence of plan language about attorney’s fees served to diminish the monies U.S. Airways ultimately received. Does your plan say what you want and need it to in light of *McCutchen*?

By: Robert Paschal (Young Moore and Henderson P.A.)

In June of 2013 the United States Supreme Court addressed a life insurance case, Hillman v. Maretta, 133 S.Ct. 928 (2013). Justice Sotomayor delivered the opinion for the 9-0 majority.

The case arose out of a dispute between the former and current spouse of Warren Hillman. In 1996, Warren Hillman named his wife, Judy Maretta, the beneficiary of his Federal Employees’ Group Life Insurance ("FEGLI") policy. The Federal Employees’ Group Life Insurance Act establishes a life insurance program for federal employees and allows the employee to designate a beneficiary who will receive proceeds of the policy when the employee dies. In 1998, Warren and Judy divorced. Mr. Hillman passed away in 2008, without having changed the beneficiary designation on his FEGLI policy to his new wife, Jacqueline Hillman. When Mrs. Hillman attempted to claim the benefits under the policy, her claim was denied because she was not the designated beneficiary. Instead, Judy Maretta received the full amount of benefits. Thereafter, Mrs. Hillman sued Judy Maretta to recover the full amount of the insurance proceeds.

Virginia state law applied to Mrs. Hillman’s suit and provided that, when a divorce is finalized any beneficiary designations between former spouses are revoked and life insurance proceeds are automatically directed to the current spouse. However, federal law under the Federal Employees’ Group Life Insurance Act dictates that death benefits from FEGLI policies shall go to the designated beneficiary regardless of any state law to the contrary.

The trial court applied Virginia state law and granted summary judgment in favor of Mrs. Hillman. The Supreme Court of Virginia reversed the trial court’s decision and held that federal law preempted the Virginia state law. Thereafter, Mrs. Hillman appealed to the Supreme Court of the United States.

The Supreme Court was faced with the issue of whether the Federal Employees’ Group Life Insurance Act preempts a Virginia state law that revokes a spouse’s beneficiary designation upon divorce. The Supreme Court held that the Federal Employees’ Group Life Insurance Act did preempt the Virginia state law, thereby entitling the designated beneficiary, Ms. Maretta, to the insurance proceeds. Additionally, the Court found that allowing the current spouse to sue the former spouse conflicts with congressional intent to have FEGLI insurance proceeds go to the designated beneficiary.

The takeaway from this decision is the importance of encouraging your clients to keep their beneficiary designations absolutely current and up to date.

Retired Insured Not Entitled to Disability Benefits

By: Larry Kristnik (Nelson Mullins Riley & Scarborough LLP)

On July 16, 2013, the Fourth Circuit Court of Appeals in Linton v. AXA Equitable Life Insurance Co., 2013 WL 3614633 (4th Cir. July 16, 2013), affirmed summary judgment dismissing a claim for disability benefits by an insured who was retired at the time of the onset of the alleged disability. The plaintiff filed a claim for long term disability benefits under an individual policy issued by the defendant contending that he had become disabled after an exposure to the chemical bronopol used in his home for mold remediation. In documentation submitted during the processing of his claim, the plaintiff disclosed that he had been retired for at least five years prior to the bronopol exposure. The claim for disability benefits was denied by the defendant, and the plaintiff filed a lawsuit in South Carolina. Prior to the taking of any depositions, the defendant moved for summary judgment, arguing that the terms of the policy required the insured to have an “occupation” in which he was “regularly engaged for gain or profit” at the time of the onset of disability.

The U.S. District Court for the District of South Carolina granted the motion for summary judgment, holding that there was no dispute that the plaintiff was retired when he was allegedly exposed to bronopol and that the policy language required him to be working in an occupation at the time he allegedly became disabled. The district court rejected the plaintiff’s contention that his activities of daily living and the management of his own financial affairs could constitute an occupation for gain or profit. The district court also refused to entertain extrinsic evidence as to the defendant’s prior handling of the claims of other retirees, explaining that extrinsic evidence is inadmissible to construe a policy when the terms of the policy are unambiguous. In dismissing the claims, the Court characterized the plaintiff’s suit as an attempt “to fit his square-shaped situation into the round hole provided by [the policy] terms.”

On appeal, the Fourth Circuit Court of Appeals found that the policy language was unambiguous and rejected the plaintiff’s attempts to construe the terms “gain” and “profit” in a non-monetary context. The Fourth Circuit also affirmed the district court’s ruling that no additional discovery was necessary prior to ruling on the summary judgment motion. The district court and Fourth Circuit holdings in Linton reaffirm established South Carolina law that courts cannot rewrite insurance policies in order to create coverage and that the plain and unambiguous terms of a policy must be enforced.
Case Summary: Noe v. Wal-Mart Store, Inc. - Permissible Conduct Concerning the ERISA Appeals Process

By: Cristin J. Mack & Matthew J. Hegarty (Hall & Evans L.L.C.)


In Noe, the plan administrator terminated the claimant’s long term disability benefits, about three-and-a-half years after it had started to pay her benefits and following a two-year evaluation process during which it had collected medical records from her treating medical providers, completed two independent medical record reviews of her file, and conducted an employability analysis. Id. at *2. After long term disability benefits were terminated, the claimant submitted a written appeal and additional documentation. Id. Once the claimant’s submissions were received, the plan administrator engaged a third-party medical vendor, MES Solutions, to arrange three additional independent medical record reviews of the claimant’s file, each performed by a separate physician. Id. at *2-3. As part of the physicians’ reviews, MES Solutions directed each physician to contact at least one of the claimant’s treating medical providers and to take those medical providers’ opinions into account as part of their record reviews. Id. at *3, *15-16. After the last physician issued his report, the plan administrator issued a decision denying the claimant’s appeal and then provided the claimant with her complete claim file, including the reports from the physicians engaged by MES Solutions. Id. at *3-4. The claimant then filed suit for judicial review under ERISA, seeking reinstatement of her long term disability benefits. Id. at *4.

The district court considered the claimant’s motion to conduct discovery and for trial de novo. Id. For its first task, the court determined the plan administrator was entitled to abuse of discretion review rather than de novo review, because the plan gave the administrator “full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of The Policy.” Id. at *5; see Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989). The court then considered, and rejected, the claimant’s argument that, despite this grant of discretion to the administrator, “serious procedural irregularities” in the handling of her appeal mandated de novo review. Noe, 2013 U.S. Dist. LEXIS 6160, at *6.

First, the district court reasoned that the independent medical record review reports performed as part of the administrator’s review of the claimant’s administrative appeal were completely proper, based on ERISA regulations requiring the administrator to consult with health care professionals who were not involved in the adverse benefit determination. See id. at 8; 29 C.F.R. §§ 2560.503-1(h)(3) (iii), 2560.503-1(h)(3)(v). As a corollary to this conclusion, the court determined the administrator was not required to give the claimant any copies of the reports before it terminated her benefits, because allowing a claimant “to receive and rebut medical opinion reports generated in the course of an administrative appeal . . . would set up an unnecessary cycle of submissions, review, re-submission, and re-review” that would assuredly lengthen the appeal process. Noe, 2013 U.S. Dist. LEXIS, at *9-10 (quoting Metzger v. Unum Life Ins. Co. of Am., 476 F.3d 1161, 1167 (10th Cir. 2007)). The court also rejected the claimant’s argument that de novo review should ensue because the administrator had discussed the possibility of the claimant’s depression as another reason to deny her appeal even though the claimant did not suffer from depression. Id. at *12-13. The court rejected this related argument for the reason that, even assuming the administrator committed a procedural violation in adding this new reason without consulting the claimant, such alleged violation was merely another factor for the court to consider under the abuse of discretion standard. Id. at *13.

Second, the district court reasoned that the fact that state physician-patient privilege law may have prohibited the physicians connected with MES Solutions from directly contacting the claimant’s treating medical providers via telephone and other means as part of their records reviews, while the claimant’s administrative appeal was pending, was of no consequence to an ERISA claim. Id. at *15-19. The court so reasoned because an ERISA claim, for which federal law supplied the rule of decision, was grounded exclusively in federal law and thus subject only to federal common-law privileges, which does not include a physician-patient privilege. Id. at *17-18. Accordingly, the court concluded it was not improper for MES Solutions’ physicians to have directly contacted the claimant’s treating medical providers. Id. at *18-19. The court then denied the claimant’s request to conduct the deposition of the administrator’s employee who had authored the final decision denying her appeal. Id. at *19.

Obviously, certain particularities of the ways federal district courts and federal circuit courts of appeals treat ERISA claims will vary from circuit to circuit and district to district. Nevertheless, the Noe case should provide a helpful analytical and procedural framework for plan administrators and entities providing legal representation to those administrators that are seeking to protect themselves from...
Replacement of the Dictionary of Occupational Titles (DOT) by Occupational Information Network (O*NET) In Vocational Reviews

By: Scott Trager (Semmes, Bowen & Semmes)

In Patel v. United of Omaha Life Ins. Co., 2013 WL 212863 (D. Md., Jan. 18, 2013), the plaintiff, Ranna Patel, worked as an Account Manager for Empower IT, where she managed an assigned group of clients within a defined territory. The defendant, United of Omaha Life Insurance Company, defined the plaintiff’s position, which was not listed in the United States Department of Labor Dictionary of Occupation Titles (DOT), using the DOT definition of “Sales Representative, Data Processing Services,” a light physical demand occupation that was the most closely related position.

After long-term disability benefits were awarded, United of Omaha reevaluated the plaintiff’s arthritis condition and ultimately terminated long-term disability benefits. After exhausting her administrative remedies, the plaintiff filed suit under ERISA to recover her long-term disability benefits.

The plaintiff argued, inter alia, that United of Omaha relied on the 1991 DOT definition of “sales representative, data processing services,” which required only minimal typing, to deny disability by redefining Ms. Patel’s regular occupation. The plaintiff contended that United of Omaha should not have used the DOT to define her position because the DOT is considered obsolete and the Department of Labor replaced it in 1999 with a new, online service called the Occupational Information Network (O*NET). The plaintiff asserted that the O*NET provides relevant information regarding the work activities of an IT database manager, defining the position “Information Technology Manager” to involve computer use and, specifically, e-mail use, as the most common work activities.

United of Omaha countered that it used the current version of DOT to define Ms. Patel's position. Moreover, it argued that the plain language of the policy provided that plaintiff’s regular occupation will be based upon descriptions in the DOT and, therefore, it was not required to substitute a comparable service. United of Omaha also argued that it did consult sources other than the DOT in defining plaintiff’s occupation, including OASYS, a vocational software program, and the 2010-2011 Occupational Outlook Handbook.

The United States District Court for the District of Maryland noted that the Policy provided that a “regular occupation . . . will . . . be considered to be a similar position or activity based on job descriptions included in the most current edition of the U.S. Department of Labor Dictionary of Occupational Titles (DOT).” United of Omaha relied on the DOT definition, even though the United States Department of Labor website noted that the DOT “has been replaced by the O*NET.” While the court found that United of Omaha’s decision-making was not unreasonable or unprincipled based on case precedent, it did state that United of Omaha should consider the most current definition, i.e., the O*NET definition, on remand, or explain its deviation from the policy language.

Accordingly, the court denied the parties’ cross-motions for summary judgment and remanded the plaintiff’s claim to the plan administrator for further administrative proceedings.
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