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LIABILITY ISSUES UNIQUE TO WELFARE PLANS

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I. BENEFIT CLAIMS

A. Eligibility Limitations

1. In Gipson v. Home Life Ins. Co., No. 97 C 100, 1998 U.S. Dist. LEXIS 14196 (N.D. Ill. Sept. 2, 1998), the Illinois District Court concluded that there was nothing in the plan's definition of participant or in ERISA that prohibits the termination of an individual employee's participation in the plan. The Court rejected the plaintiff's argument that ERISA prohibits the total exclusion of an individual employee from all health benefits.

2. In Fallo v. Piccadilly Cafeterias, Inc., 141 F.3d 580 (5th Cir. 1998), the Fifth Circuit concluded that the plan summary can expand statutory rights. Thus, rather than being a "plan limitation," this case involves expanding benefits. In doing so, the Court joined several other circuits in concluding that, at least in some contexts, the unambiguous terms of an SPD control over inconsistent provisions in the plan document. In this instance, the SPD included the 11-month additional COBRA requirement for individuals disabled under Social Security (SSA) but did not state that a qualified beneficiary must send the notice of an SSA disability finding before the end of the initial 18-month extension, nor did it state that the disability must have existed at the time of the qualifying event. Instead, the SPD required only that the notice of the disability finding be given within 60 days of the disability finding.

   The Court rejected looking to the plan language to fill any gaps left by the SPD because such a requirement would undermine the purpose of a simple, easy-to-understand summary. Thus, the plaintiffs were entitled to an extra 11 months of COBRA coverage because they satisfied the less stringent requirements of the SPD.

3. In contrast to Fallo, the Seventh Circuit expressly overruled a rather broad 1997 decision in Williams v. Midwest Operating Engineers Welfare Fund, 125 F.3d 1138 (7th Cir. 1997), cert. dismissed, 118 S. Ct. 907 (1998), which held that in the event of a discrepancy between the coverage promised in the SPD and the coverage provided in the policy, the insured is entitled to claim what is promised in the SPD. In its more recent decision, Mers v. Marriott International Group Accidental Death & Dismemberment Plan, 144 F.3d 1014 (7th Cir. 1998), cert. denied 119 S. Ct. 372 (1998), the Seventh Circuit concluded that an SPD's failure to include its definition of injury (which was found in the policy terms)

did not estop the plan from relying on the policy definition to deny coverage when no direct conflict existed between the SPD and the policy language. The Court stated that it had been in error in Williams because it only turns to the common law when ERISA is silent on an issue. Moreover, if an SPD does not satisfy ERISA's disclosure requirements, a court may estop a plan from denying coverage for terms not included in the SPD but found in the plan.

The Court modified its conclusion in Williams, noting that the Williams analysis applies only when there is a contradiction between the SPD and the policy. The Court indicated that it sided with the Sixth, Fourth, Eighth, and Fifth Circuits on this issue. The Court added that the rule should not be applied if the SPD is silent on an issue that is described in the plan. The Court noted that if silence in an SPD were enough to trump the underlying plan, the SPD would mushroom in size and complexity until they mirrored the plan.

4. On the same "SPD vs. Plan" issue involving a claim for long-term disability benefits, in Porter v. Metropolitan Life Ins. Co., CA-No. 7:98-166-20, 1998 U.S. Dist. LEXIS 15005 (D. S.C. Sept. 15, 1998), a South Carolina District Court held that because the plaintiff could not have taken, or refrained from taking, any action with respect to her disability based on the definition provided in the SPD, she could never show reliance on the SPD. The plaintiff had asserted that she qualified for disability under the SPD definition, but recognized that she did not so qualify under the plan definition. In the disability context, there was no detrimental reliance.

5. In Grady v. The Paul Revere Life Ins. Co., 10 F. Supp. 2d 100 (D. R.I. 1998), a Rhode Island District Court held that despite the fact that the participant was obese, she met the qualifications for being completely disabled under a disability plan and was therefore entitled to benefits. The Court found that the policy contained neither an obesity exception to coverage nor a clause conferring upon the insurer's staff physician the moral authority to deem a disabling condition the fault of the patient. Essentially, this case stands for the proposition that a plan representatives cannot impose conditions for a benefit that are not found in the plan document.

6. In a case that has now been vacated because of en banc review, a panel of the Ninth Circuit initially ruled that a disability plan's language that required "satisfactory written proof" of a disability was not clear enough to vest the plan administrator with discretion

to define what was satisfactory proof, and therefore the administrator's denial must be reviewed de novo in a wrongful denial of benefits claim under ERISA. Kearney v. Standard Ins. Co., 141 F.3d 597 (9th Cir. 1998), op. withdrawn reh'g en banc granted, 152 F.3d 1098 (9th Cir. 1998). De novo review was appropriate because the employer did not retain discretionary authority in the plan and because its decision may have been influenced by a conflict of interest.

7. Individuals with AIDS may sue an insurer alleging that its health insurance policies violate the ADA by providing a lower benefit cap for the treatment of AIDS or AIDS related conditions than for those receiving other medical care. Doe v. Mutual of Omaha Ins. Co., 999 F. Supp. 1188 (N.D. Ill. 1998). The Court stated that the insurer must show that its coverage distinctions are based on sound actuarial principles and actual experience. In another ADA case, the Sixth Circuit found no ADA violation by providing employees with coverage for certain organ transplants but no heart transplants. Lenox v. Healthwise of Kentucky Ltd., 149 F.3d 453 (6th Cir. 1998).

B. Exclusions

1. Lack of Medical Necessity

a. The Tenth Circuit Court of Appeals disapproved of the insurer's claims review procedure in McGraw v. Prudential Ins. Co., 137 F.3d 1253 (10th Cir. 1998). The beneficiary's physician recommended physical and occupational therapy as treatment for her multiple sclerosis. The insurance company stated such treatment was not covered under the plan because it was not medically necessary. In reviewing the insurance company's decision, the Tenth Circuit used an arbitrary and capricious standard of review with decreased deference wherever a financial conflict of interest was manifest. The Court criticized the insurance company for essentially modifying its definition of "medically necessary" to include that the condition being treated have potential for significant improvement, a criterion which was not expressed in the plan. The Court seemed to reason that treatment which prevents or ameliorates the deterioration of a patient should still be considered medically necessary. Furthermore, the Court found it egregious that the plan administrator failed to review the beneficiary's medical records before deciding to deny the benefits. The Court also concluded that the

company's fiduciaries did not evaluate the beneficiary's claim for physical therapy solely in the interest of the beneficiary as required by law, but evaluated it more to reflect the defray of reasonable expenses. Consequently, the Tenth Circuit held that the company's denial of benefits was arbitrary and capricious.

b. In Otis Alcorn v. Sterling Chemicals Inc. Med. Benefits Plan, 991 F. Supp. 609 (S.D. Tex. 1998), the participant suffered a head injury. The plan refused to pay benefits for her treatment at a rehabilitative center because the plan explicitly excluded payments for treatments deemed not "medically necessary." The Court ruled in favor of the plan stating that its denial of benefits was not an abuse of discretion. Furthermore, the Court noted favorably that the plan made its decision after obtaining the opinion of five physicians and reviewing the participant's most recent medical records.

c. The Court denied an insurer's motion for summary judgment in Friends Hosp. v. Metrahealth Service Corp., 9 F. Supp. 2d 528 (E.D. Pa. 1998). The insurer denied coverage for beneficiary's hospitalization for treatment of depression due to lack of medical necessity. However, according to the Court, the evidence presented a genuine issue of material facts as to whether the denial of benefits was arbitrary and capricious because the beneficiary's file had not been reviewed in accordance with the procedures in the plan. Thus, summary judgment for the insurer was denied.

d. In Hosp. Group of Illinois, Inc. v. Prudential Ins. Co., No. 95 C 1659, 1998 U.S. Dist. LEXIS 4203 (N.D. Ill. March 31, 1998), the District Court denied an insurer's motion for summary judgment due to lack of evidence supporting its decision to deny benefits. Based on a report by a consulting physician, the insurer claimed that the beneficiary's stay at the hospital for psychiatric disorders was not medically necessary. Upon reviewing the insurer's decision, the Court noted unfavorably that (i) the treating physician was not allowed to speak directly to the consulting physician, (ii) the consulting physician never examined the beneficiary, and (iii) the consulting physician's memorandum noting the lack of primary data in the beneficiary's medical records indicated that there was insufficient information to make a determination on

benefits. Consequently, the Court concluded that the insurer had not demonstrated a "rational connection" between the evidence presented and its decision to deny benefits.

e. The District Court ruled in favor of a plan's refusal to pay for hospital bills that a participant incurred at a non-contracting hospital. White v. Operating Eng'rs Health & Welfare Trust Fund, No. C96-03204, 1998 U.S. Dist. LEXIS 5151 (N.D. Cal. April 9, 1998). As justification for its claim denial, the plan contended that, regardless of whether the surgery itself was medically necessary, it was not medically necessary to have the surgery performed at the non-contracting hospital. Since the plan only covered services which were a "medical necessity", the participant's claim was denied. The Court found this reasoning to be consistent with the plan.

f. In Hylaszek v. Aetna Life Ins. Co., No. 94 C 5961, 1998 U.S. Dist LEXIS 10209 (N.D. Ill. June 29, 1998), the Court denied class action status to a beneficiary who, on the grounds of lack of medical necessity, was denied coverage for sclerotherapy treatments for her varicose veins. The Court stressed that ERISA requires the court to determine the reasonableness of the denial of benefits on a case-by-case basis.

2. Experimental and Investigative Procedures

a. High-dose Chemotherapy Treatment ("HDCT")

i. Peruzzi v. Summa Med. Plan, 137 F.3d 431 (6th Cir. 1998) involved a self-insured plan. The patient sought coverage for HDCT for late stage breast cancer. The plan administrator's medical director concluded that such treatment was experimental from his reading of a study by Dr. William P. Peters, a "respected oncologist" and by consulting with fellow physicians. The patient was able to obtain the HDCT treatment without the plan's preauthorization, and then sued for the benefit. The patient subsequently died from leukemia while the suit was pending. The Court adopted the deference standard and granted summary judgment to the plan, reasoning the Peters study was equivocal for patients with advanced breast cancer because the

study recognized the need for further randomized study before making widespread use, it noted the treatment carried a substantial risk of death, and noted only time and further evaluation will allow wider use and recommended trials at major academic centers with experience in similar procedures to test the approach. No evidence of practice within the oncological community was offered during exhaustion, only at trial. The patient was restricted to the administrative record, and the depositions of such experts were not admissible. The Court also held that since the plan could cite some cases finding such procedure as experimental, that established the reasonableness of the plan's conclusion.

ii. In an unpublished opinion by the Tenth Circuit, Healthcare America Plans, Inc. v. Bossemeyer, No. 97-3001, 1998 U.S. App. LEXIS 31323 (10th Cir. Dec. 15, 1998), a health plan excluded transplants and experimental treatments, the latter defined as those which "are considered to be experimental, unproven or obsolete, investigational or educational" and "not generally accepted by the medical community." Id. at *3. The plan conferred discretion on the insurer. The patient had stage II breast cancer involving 14 nodes. The 10th Circuit faulted the patient for providing no criteria for weighing factors to use for the phrase "generally accepted," and said deference must be given even if at the time the insurer was financially strapped and the plaintiff has "marshaled considerable evidence to the contrary." Id. at *14. The Court considered any evidence the insurer looked at was "sound and voluminous" and as from "reputable and pertinent sources" even though none had been medically validated or peer reviewed as was the patient's evidence.

iii. In Elsroth v. Consolidated Edison Co., 10 F. Supp. 2d 427 (S.D.N.Y. 1998), the plaintiff unsuccessfully sought preliminary injunction for preauthorization of HDCT for ovarian cancer. Coverage was under the spouse's health plans, one covered by ERISA, the other governmental. The claim for benefits was

administratively denied as experimental and investigational, after the insurer utilized an "independent review program operating out of Washington, DC, which had access to some 140 oncologists worldwide" and two other oncologists, all of whom opined the treatment was experimental and of doubtful benefit. Id. at 430, 436. The District Court also appointed its own oncologist, who agreed with the others.[1] The Court found nothing wrong with the insurer wording the denial on each appeal slightly differently by quoting different parts of opinions, and concluded since the HDCT would be of little benefit, there could be no irreparable harm from refusal of the injunction, and very little chance of success.

iv. Killian v. Healthsource Provident Administrators, Inc., 152 F.3d 514, (6th Cir. 1998) involved a preauthorization denial and the plan's lack of an appeal procedure from such denial. The Sixth Circuit held that a plan arbitrarily and capriciously refused to consider information submitted by a breast cancer patient in support of her request for preauthorization of HDCT after the initial permission for treatment was denied. The Court concluded that the administrator's decision was shaped by a conflict of interest and because the plan did not provide a procedure for appealing from denial of a preauthorization. Therefore the administrator was not required by the plan's terms to reject such additional material.

The Killian court addressed the difference between an appeal from a claim denial and an appeal from a preauthorization denial, noting that it is not an "empty" distinction. A preauthorization denial implicates wholly different considerations than a denial of a claim for costs already accrued. For an appeal from a claim denial, the universe of relevant information is frozen at the time that the procedure was undertaken; conversely, a pre-authorization denial involves a dynamic situation with constantly

[1] It should be noted this appointment by the Court in effect allowed an opinion outside of and after the administrative record had been completed; this seems to be unnoted by the Court.

evolving considerations. The failure to contain a procedure for appealing from a preauthorization denial influenced the Court's decision.

b. Other "Experimental" Cases

i. In I.V. Services of America, Inc. v. Trustees of the American Consulting Engineers Council Ins. Trust Fund, 136 F.3d 114 (2nd Cir. 1998), the Second Circuit reversed the lower court's grant of summary judgment to the defendants. The drug therapy claims administrator balked at paying outpatient home health service for the administration of Neupogen treatment to counteract neutropenia, which decreases white blood cell count, because the prescribed drugs were not specifically approved by the FDA for the purposes prescribed. The plan terms limit coverage to drugs approved by the FDA "for general use in treating the injury or illness for which they are prescribed." Id. at 116. The Second Circuit said the plan terms, which it found ambiguous, did not necessarily limit coverage to specific FDA-approved indications or even FDA-approved uses. "Off-label" uses could be covered according to the Court. The Second Circuit proposed on remand that the plan bear the burden of providing an official statement of the FDA-approved uses, and that the patient should only then submit a statement for the treating physician indicating the conditions and/or illnesses for which the drugs were prescribed.

3. Pre-existing Conditions

a. In an unpublished opinion, the Tenth Circuit Court of Appeals ruled that the insurer did not act arbitrarily and capriciously in denying a participant's claim for long-term disability benefits. Kaus v. Standard Ins. Co., No. 97-3378, 1998 U.S. App. LEXIS 28154 (10th Cir. Nov. 5, 1998). The participant alleged disability due to depression. The policy excluded benefits for disabilities caused or contributed by a pre-existing condition, which was defined as a condition for which the claimant had consulted a physician, received medical treatment or services, or taken prescription drugs or medication during the ninety-day period before the insurance became effective. The participant was not

specifically diagnosed with major depression until after the ninety-day period had passed. However, during the ninety-day period, the participant's physician prescribed Valium for him and noted that his depression continued to be somewhat of a problem. The Court concluded that this was sufficient evidence to sustain the insurer's denial of benefits.

b. The Court denied the insurer's motion for summary judgment in Medina v. Time Ins. Co., 3 F. Supp. 2d 996 (S.D. Ind. 1998), based on the following unusual scenario. In mid-December of 1995, the participant and his employer were informed by the insurer that the new policy was effective as of December 1, 1995. The participant's spouse received treatment for stomach pains on December 23, 1995, and later had her gall bladder removed on January 17, 1996. In the meantime, at the request of the employer who was dissatisfied because he and his employees did not have the policy and insurance cards for use during the entire month of December, the insurer changed the effective date of the policy to January 1, 1996. Under the new effective date, the insurer denied the spouse's claim for the cost of the operation on the basis that her condition was a pre-existing condition excluded under the terms of the plan. The Court reasoned differently and ruled that a plan sponsor or insurer may not retroactively amend the effective date of an employee health plan if it results in denying benefits to participants and beneficiaries.

c. In Rolf v. Health & Welfare Plan for Employers of Cracker Barrel Old Country Store, Inc., 25 F. Supp. 2d 1200 (D. Kan. 1998), the participant claimed that the plan's pre-existing conditions limitations only applied to late applicants and, since she was not a late applicant, she was entitled to recover benefits stemming from her pre-existing asthmatic condition. The Court found that the summary plan description was not ambiguous, and concluded that a reasonable person would have understood that the plan's pre-existing conditions limitation applied to both timely and late applicants. Consequently, the Court granted the plan's motion for summary judgment.

d. In Leddy v. Mississippi State Med. Association, 7 F. Supp. 2d 819 (S.D. Miss. 1998), the plaintiff's bypass surgery bill for $70,000 was disallowed because of the pre-existing

condition provision of the plan. The test was whether any treatment had occurred the 12 months prior to coverage attaching. Plaintiff became covered in February of 1995. In August and December of 1994, he saw his physician for angina. Because the medical expert noted angina was a precursor to the need for bypass surgery, the claim was denied.

4. Custodial Care

a. In Manginaro v. Welfare Fund of Local 711, 21 F. Supp. 2d 284 (S.D.N.Y. 1998), the Court ruled that the insurance company acted arbitrarily and capriciously when it denied coverage to a beneficiary. The beneficiary suffered from quadriplegia and other severe neurological impairments ever since 1979 when he was severely burned in a store fire and was given an overdose of morphine at the hospital. Upon leaving the hospital, the beneficiary received 24-hour-a-day nursing care which had always been paid for by the fund's medical insurers until 1991. Beginning in 1991, the Union Labor Life Insurance Company ("ULLICO") provided coverage to the beneficiary, which determined that the beneficiary's treatment fell under the exclusion for custodial care. Despite using a deferential standard of review, the Court ruled against ULLICO because it found that the ULLICO's decision was not supported by substantial evidence. The Court weighed heavily the fact that the decision to deny benefits was not based on an examination of the beneficiary or a consultation with the treating physician; rather the decision was based solely on information contained in a medical advisor referral form and notes from a treating nurse covering a two-week period. On remand, ULLICO and the fund were directed to consider the treating physician's opinion, the type of service actually being provided to the beneficiary, and any other relevant evidence that the plaintiffs wished to submit.

b. A participant was granted a preliminary injunction against her health plan and insurance provider in Watts v. Organogenesis, Inc. Civ. A. No. 98-11439, 1998 U.S. Dist. LEXIS 19515 (D. Mass. Dec. 7, 1998). The participant suffered a spinal cord injury resulting in quadriplegia and severe dysreflexia (one to four times a day the participant's blood pressure rose rapidly to dangerous levels in response to a problem or stimulus in her lower body). The defendants denied the participant's claim for home nursing

care based, in part, that such care is custodial and, as such, was excluded from coverage. In ruling in favor of the participant, the Court focused on the fact that although the home nurses did provide some custodial care, managing the participant's dysreflexia attacks was more than mere custodial care.

5. Types of Providers

   a. The Ninth Circuit Court of Appeals upheld the Washington state law requiring health maintenance organizations and health care service contractors to cover such "alternative" medical services as acupuncture, massage therapy, naturopathy, chiropractic services, and others. Washington Physicians' Service Association v. Gregoire, 147 F.3d 1039 (9th Cir. 1998), amended, reh'g *en banc* denied, 1998 U.S. App. LEXIS 20718 (9th Cir. Aug. 24, 1998), and petition for cert. filed, 67 U.S.L.W. 3376 (U.S. Nov. 23, 1998) (No. 98-88). The Court ruled that ERISA does not preempt the statute and remanded the case to District Court with instructions to enter summary judgment in favor of the state.

6. No Participant Obligation

   a. A health plan denied a hearing aid supplier's claims for payment of hearing aids provided to plan participants where the hearing aid provider advertised its services as free to participants, and the plan specifically excluded from coverage any service for which a covered individual is not legally required to pay. Jan Bliwas, Inc. v. Central States Health & Welfare Fund, 21 Employee Benefits Cas. (BNA) 2867 (S.D. Ohio 1998). The Court found this decision rational, and granted the plan's motion for summary judgment.

7. Fertility

   a. In Watermann v. Murphy Oil USA, Inc., Civ. A. No. 97-0635, 1998 U.S. Dist. LEXIS 8156 (E.D. La. May 27, 1998), the issue presented was whether it was arbitrary and capricious for the plan administrator to deny the claim of the insured for medical costs incurred in the removal of an ovarian cyst and treatment of endometriosis. The decision to deny benefits was based on the determination that all of the treatment rendered to the insured was

performed primarily to treat infertility (a condition excluded under the plan), and would not have been performed otherwise. The insured argued that the denial of benefits was arbitrary and capricious because the plan administrator accepted the medical opinion of two consulting physicians over the opinion of the insured's treating physician. The Court held that the plan administrator's reliance on the opinions of the two consulting physicians and its examination of the medical records was sufficient evidence to support its denial of benefits.

8. Intentional Acts, Intoxication, Suicide and Illegal Acts

a. With respect to health plans governed by ERISA, the Eleventh Circuit adopted the common law presumption against suicide and in favor of accidental death where it is unclear how the insured died. In Horton v. Reliance Standard Life Ins. Co., 141 F.3d 1038 (11th Cir. 1998), the insured died in an in-flight fire and airplane crash. The underwriters of the insured's two accidental death policies disputed whether the death was accidental, and denied the surviving spouse's claim for benefits. The Eleventh Circuit affirmed the District Court's decision to incorporate into ERISA the presumption against suicide. The Eleventh Circuit reasoned that such a presumption furthers ERISA's two central goals of (i) protecting the interest of employees and their beneficiaries in employee benefit plans, and (ii) providing uniformity in the administration of employee benefit plans. In applying this presumption to the case at hand, the Eleventh Circuit affirmed the District Court's holding that the insured's death was accidental because the insurance companies' evidence was insufficient to rebut the presumption against suicide which remains in a case until the fact-finder is convinced that it is more likely than not that the deceased committed suicide.

b. In a case involving a possible suicide attempt, Dallas County Hosp. Dist. v. Group Med. Ins. Protection, Civ. A. No. 3:97-CV-0060-D, 1998 U.S. Dist. LEXIS 2641 (N.D. Tex. Feb. 25, 1998), the insurance company refused to pay the medical expenses for the insured following his jump or fall from a highway overpass. The Court found that even though there was evidence that the fall was accidental, there was no abuse of discretion in the insurance company's denial of benefits because there was also

evidence that the insured's injuries were self-inflicted and part of a suicide attempt. Thus, the Court granted summary judgment to the insurance company.

c. In Schadler v. Anthem Life Ins. Co., 147 F.3d 388 (5th Cir. 1998), reh'g denied, No. 97-10491, 1998 U.S. App. LEXIS 21676 (5th Cir. Tex. Aug. 13, 1998), plaintiff's husband died from a mixed drug reaction. He had had a history of drug abuse. The autopsy revealed needle marks "not associated with resuscitative efforts, and a toxicologic examination of his body fluids revealed cocaine, . . . morphine" and other drugs. Id. at 391. The insurance company initially denied benefits because it had never received the appropriate enrollment card. The widow filed a lawsuit in response. The defendants moved for summary judgment, and they asserted for the first time that even if the VAD&D policy had been in effect as to the decedent, coverage was precluded, in part, under an exclusion for intentionally self-inflicted injury. On their appeal from the District Court ruling, the defendants' dropped their assertion that the decedent was not covered, but they still contended that the spouse's claim was precluded under the exclusion for intentionally self-inflicted injuries. The Fifth Circuit concluded that to determine whether benefits were precluded under the self-inflicted injury exclusion, the plan administrator must consider facts bearing upon (i) the decedent's state of mind and intent and (ii) his subjective expectations in taking the particular drugs at issue, and (iii) whether a reasonable person with a similar background to the decedent would have viewed the injury as highly likely to occur as a result of the insured's intentional conduct. Since the plan administrator never made such a determination, the Fifth Circuit remanded the case to the plan administrator for the development of a full and factual record for the making of the decision on whether to grant or deny benefits on the basis of the intentionally self-inflicted injury exclusion.

d. Metropolitan Life Insurance Company ("Met-Life") was successful in several cases in which it denied a claim under its accidental death and dismemberment ("AD&D") policy where the insured died in a car accident while driving under the influence of alcohol. In Cates v. Metropolitan Life Ins. Co., No. 96-6600, 1998 U.S. App. LEXIS 14975 (6th Cir. June 30, 1998), Met-Life denied plaintiff's claim for

recovery of accidental death benefits under her husband's employee benefits plan because the husband had a blood alcohol content of .18% at the time he fatally drove his pickup truck over a bluff. Met-Life reasoned that driving while so impaired rendered the death reasonably foreseeable and, thus, not accidental. Using an arbitrary and capricious standard to review the denial of benefits, the Sixth Circuit affirmed the District Court's ruling in favor of Met-Life, finding that foreseeable harm resulting from a plan participant's intentional actions is not accidental for purposes of ERISA-regulated claims for AD&D benefits.

e. In Cozzie v. Metropolitan Life Ins. Co., 140 F.3d 1104 (7th Cir. 1998), the decedent had a blood alcohol content of .252% at the time he drove his car off the road. Though the AD&D policy did not define the term "accident", Met-Life denied the wife's claim for accidental death benefits because under the circumstances the decedent's death was reasonably foreseeable and not an "accident". Noting that it must use an "extremely deferential" standard of review (i.e., arbitrary and capricious), the Seventh Circuit held that it could not say that Met-Life's decision was unreasonable, and thus affirmed the District Court's decision in favor of Met-Life. However, the Court also cautioned plan drafters from attempting to require such general plan terms to bear too much weight.

f. In Metropolitan Life Ins. Co. v. Potter, 992 F. Supp. 717 (D.N.J. 1998), Met-Life sought restitution of an alleged overpayment of benefits to the spouse of the insured, where the insured had a blood alcohol content of .314% at time of fatally driving her car into a utility pole. The policy did not define "accident" and it did not have an exclusion for alcohol-related deaths, nevertheless, Met-Life denied the spouse's claim for benefits under the theory that "one's own drunk driving is not an 'accident'" for purposes of AD&D claims. The Court concluded that where an AD&D policy fails to define the terms "accident", the test for determining whether a death is accidental should be that the decedent had an "actual expectation of survival," and that the expectation was "objectively reasonable." Since neither party presented evidence of the insured's subjective expectations and the reasonableness of those expectations, the Court ultimately denied the motions for summary judgment from both the insurer and the spouse.

g. Met-Life won a motion for summary judgment in Schultz v. Metropolitan Life Ins. Co., 994 F. Supp. 1419 (M.D. Fla. 1998), where the insured not only had a blood alcohol content of .29% at the time of his fatal car accident, but had ingested cocaine and barbiturates as well. The Court used the following test to determine whether the incident was "accidental": (i) did the insured expect an injury similar in kind to that suffered, and (ii) if he did not, was the expectation reasonable. The Court found that the insured should have known that he was risking his life by driving while intoxicated, and any other expectation would have been unreasonable. Consequently, the Court held that Met-Life did not act arbitrarily and capriciously in denying the claim for benefits.

h. Other insurance companies have denied claims connected to drunk driving under policy exclusions for illegal or felonious acts. In Thomas v. Life Ins. of North America, Civ. A. No. 97-2248, 1998 U.S. Dist. LEXIS 10106 (E.D. La. July 2, 1998), it was undisputed that the insured was driving under the influence of alcohol when his car crossed over the center line of the road and crashed head-on into another car resulting in four deaths including his own. The insurance policy contained an exclusion for losses caused by the commission of a felony. The insurance company argued that the insured committed vehicular manslaughter, a felony, therefore no accidental death benefits should be paid; whereas the insured's beneficiary argued that the insured was never prosecuted of vehicular manslaughter and that driving while intoxicated is merely a misdemeanor. The Court reasoned that the ultimate question was whether the elements of vehicular manslaughter were present and whether vehicular manslaughter is a felony offense. Answering affirmatively to both these questions, the Court granted the insurance company's motion for summary judgment.

i. In Folks v. Kirk Paper Corp. Med. & Dental Benefit Plan, No. C97-3325, 1999 U.S. Dist. LEXIS 359 (N.D. Cal. Jan 13, 1999), the Court ruled in favor of the plan's decision to deny benefits where the insured was injured in an automobile accident for which he was later convicted of drunk driving, and the plan contained an exclusion for expenses sustained as a result of an illegal act.

9. Cosmetic Surgery

   a. The Women's Health and Cancer Rights Act of 1998 applies to employer group health plans on plan years beginning on or after its date of enactment, October 21, 1998. The law adds a new ERISA Section 713 requiring, in part, that group health plans which provide coverage for mastectomies must also cover (i) reconstruction of the breast on which the mastectomy was performed; (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (iii) prosthesis and physical complications of all stages of mastectomy including lymphedemas all in a manner determined in consultation between the attending physician and patient. In addition, such coverage may be subject to annual deductibles and coinsurance provisions as is consistent with those established for other benefits under the plan or coverage. Similar state laws were recently passed in New Jersey (SB 1783z), North Carolina (SB 714), Montana (SB 365), Pennsylvania (SB 176), and California (AB 7).

   b. In Coffey v. Perrigo Co., No. 1:97-CV-401, 1998 U.S. Dist. LEXIS 16783 (W.D. Mich. September 3, 1998), the Court was presented with whether an exclusion for "charges incurred in connection with cosmetic surgery" precluded coverage for the removal of the insured's ruptured silicone breast implants which had originally been implanted in 1977. Id. at *2. The Court stated that such a preclusion is a reasonable interpretation of the plan. Furthermore, the Court found the evidence asserting that the defendants permitted the removal of breast implants in another case to be insufficient, even if true, to demonstrate that the denial of benefits in this instance was arbitrary and capricious. Accordingly, the Court granted the defendants' motion for summary judgment.

10. Work Related Injuries

   a. In an unpublished opinion, the Fourth Circuit Court of Appeals held that a member of a business partnership not required to obtain workers' compensation coverage was entitled to coverage for a workplace injury under his wife's health plan despite that plan's exclusion for work-related injuries. Rader v. American Ass'n of Christian Schools, No. 97-1134, 1998 U.S. App. LEXIS 17806 (4th Cir. Aug. 4, 1998). The plan precluded coverage for any injury in

"which the individual is entitled to benefits under any workers' compensation law." Accordingly, the parties agreed that the dispositive issue was whether the beneficiary was entitled to workers' compensation benefits under West Virginia law. With guidance from the Supreme Court of Appeals of West Virginia that under the circumstances of this case an individual is not eligible for workers' compensation, the Fourth Circuit ruled in favor of the beneficiary.

b. In another case in front of the Fourth Circuit Court of Appeals, an employee who was denied workers' compensation by an administrative law judge ("ALJ") was later denied coverage under the disability plan because of its work-related claims exclusion. Sedlack v. Braswell Services Group, Inc., 134 F.3d 219 (4th Cir. 1998). The Court found that the previous decision by the ALJ did not estop the use of the work-related claims exclusion because the ALJ made no specific finding as to whether the injury was work related; rather the ALJ simply ruled that the "alleged accident did not occur as stated by [the employee]."

11. Other Exclusions

a. In two different disputes, the Ninth Circuit addressed the legality of a plan limitation requiring that claims be submitted within a specified period. But, as noted below, the Supreme Court has agreed to address this issue.

b. In Cisneros v. UNUM Life Ins. Co., 134 F.3d 939 (9th Cir. 1998), petition for cert. filed, 66 U.S.L.W. 3773 (U.S. May 20, 1998) (No. 97-18), the insurer denied a claim for disability benefits because it was made untimely under the terms of the plan. The Ninth Circuit withdrew its earlier decision (115 F.3d 669 (9th Cir. 1997)) and held that a disability plan insurer is required under California law, not federal common law (the basis for its prior decision), to show it was prejudiced by a plan participant's untimely submission of proof in order to deny payment of the participant's claim. The Court ruled that the difference between each state's notice prejudice law is too disparate to result in the fair application of a federal notice-prejudice common law (and acknowledged that its prior decision had the effect of rewriting insurance policies and plans). Ultimately, the Court remanded the case with instructions

to the plan administrator to determine whether the insurer suffered actual prejudice from the untimely claim for benefits.

The Court followed Cisneros in Ward v. Management Analysis Co. Employee Disability Benefit Plan, 135 F.3d 1276 (9th Cir. 1998), cert. granted, 119 S. Ct. 334 (1998), concluding that an insurer must prove actual prejudice resulting from a claimant's untimely submission of proof of a claim before the insurer may deny the benefits under a plan governed by ERISA. The Court was unpersuaded that passage of time alone established prejudice as a matter of law. The insurer was required to suffer "actual prejudice" as a result of the untimely notice.

c. In Reed v. Prudential Ins. Co., 4 F. Supp. 2d 1148 (M.D. Fla. 1998), the insurer denied the beneficiary's benefits claim for speech therapy despite the fact that an agent of the insurer advised the beneficiary's father that this policy would cover such costs. The insurer contended that that the therapy failed to meet the plan's speech therapy conditions. The Court found that because the language of the plan unambiguously limited such coverage, any oral modifications of the plan by the insurance agent was forbidden. Consequently, the insurer was granted summary judgment.

C. Limitations on Benefits

1. Mental and Nervous Limitations

a. The Mental Health Parity Act

i. The Mental Health Parity Act[2] ("MHPA") became effective for group health plans beginning in plan years commencing on or after January 1, 1998, and it sunsets for services furnished on or after September 30, 2001. In general, the MHPA prohibits employers with more than fifty employees from imposing lower annual or aggregate lifetime dollar limits on mental health benefits than are imposed on medical/surgical benefits. However, the MHPA does not require group health plans to

[2] Pub. L. No. 104-204, Title VII, 110 Stat. 2944 (1996).

offer mental health benefits, nor does it preclude limits on the days of coverage or number of visits.

Interim final rules for the MHPA were promulgated December 22, 1997, effective January 1, 1998.[3] Under the MHPA and the interim rules, a group health plan may comply with the MHPA in any of the following general ways:

- by not including any aggregate lifetime dollar limit or annual dollar limit on mental health benefits;

- by imposing a single aggregate lifetime or annual dollar limit that does not distinguish between medical/surgical benefits and mental health benefits;

- by imposing an aggregate lifetime dollar limit or annual dollar limit on mental health benefits that is not less than the corresponding limits on medical/surgical benefits; or

- in the case of a plan under which aggregate lifetime dollar limits or annual dollar limits differ for categories of medical/surgical benefits, the plan may comply by calculating a weighted average annual dollar limit for mental health benefits. The weighted average must be based on a formula under the interim rules (29 C.F.R. § 2590.712(b)) that take into account the limits on different categories of medical/surgical benefits.

In addition, for the purposes of the MHPA, mental health benefits do not include benefits for the treatment of drug abuse.

Another major thrust of the interim rules was to permit MHPA-exemption for plans after six months, provided they documented a cost increase of one percent or more and gave thirty days notice to participants and the federal government. 29 C.F.R. § 2590.712(f). The rule describes the ratio of two

[3] 62 Fed. Reg. 66,932 (1997).

terms to determine if a plan has incurred a cost increase of one percent or more. The first term is total cost incurred under parity including both mental and medical/surgical costs; the second term is the total cost incurred under parity reduced by the costs incurred only to comply with the law. The costs incurred only to comply with the law include administrative costs but not premium payments.

b. Cases

i. In 1998, the only court reference to the MHPA was the Sixth Circuit in Ford v. Schering-Plough Corp., 145 F.3d 601, 610 (3d Cir. 1998), cert. denied, No. 98-529, 1999 WL 8600 (Jan. 11, 1999) which merely used the statute to buttress the argument that Congress did not intend the Americans with Disabilities Act of 1990 to mandate parity between mental and physical benefits.

ii. In Prudential Ins. Co. v. Doe, 140 F.3d 785 (8th Cir. 1998), reh'g denied, No. 97-1797, 1998 U.S. App. Lexis 9881 (8th Cir. May 8, 1998) the plaintiff sought psychiatric coverage for his daughter above the 30 day limit in the group insurance policy. Because the facts arose prior to the effective date of 29 U.S.C. § 1185a, the restriction was allowed. The court held the definition of "mental illness" should be considered from a lay person's perspective. Accordingly, the restriction was found unambiguous.

iii. In Newman v. Standard Ins. Co., 997 F. Supp. 1276 (C.D. Cal. 1998), the participant's long-term disability benefits were discontinued due to a 24-month limitation for disabilities caused by a mental disorder. The participant sought discovery on the issue of whether the insurer's decision was tainted by its apparent conflict as the administrator and funding source of the plan. The Court reasoned that such discovery would contravene ERISA's goal to provide workers and beneficiaries with an inexpensive and expeditious method for resolving disputes over benefits. Consequently, the Court ruled that no discovery was permitted and, because the standard of review was abuse of discretion, no evidence outside the administrative record was admissible.

iv. In Dorsk v. UNUM Life Ins. Cos., 8 F. Supp. 2d 19 (D. Me. 1998), the parties differed over the meaning of the language limiting benefits for "mental disorders of any type." Id. at 21. The participant, who suffered from Obsessive-Compulsive Disorder ("OCD"), contended that the term did not include disorders with organic causes, while the insurer claimed that the term included all sorts of disorders with mental manifestations, whether they had an organic or non-organic cause. The Court found this language to be ambiguous, and thus, under the rule of *contra proferentem*, adopted the interpretation offered by the participant. However, since the case record was unclear whether OCD has an organic cause, the Court could not decide if OCD was outside the policy's mental-illness limitation. Accordingly, summary judgment for the participant was denied.

v. In a similar case, a participant argued, in part, that disability benefits for his particular kind of depression were not precluded by the plan's limitation for "mental and nervous conditions" because his depression was secondary to and caused by his hepatitis and the treatment of it with Interferon. Tolson v. Avondale Industries, Inc., 141 F.3d 604 (5th Cir. 1998). The Fifth Circuit reasoned that simply because a disability is produced by depression that is itself the product of a pathological disease or of the medication used to treat such a disease, does not alter the fact that the depression is and remains a mental disorder. Accordingly, the Court ruled against the participant and assessed the costs of the appeal to him.

2. Dental

a. Solger v. Wal-Mart Stores, Inc. Associates Health & Welfare Plan, 144 F.3d 567 (8th Cir. 1998), involved a limitation on treatments for temporomandibular joint ("TMJ") conditions. The plaintiff had prior surgery for her TMJ problem. A prosthesis had been put in her jaw. The District Court entered two orders, applying the $5,000 plan limitation to the restructuring of plaintiff's jaw, but lifting the limitation as to the ear and skull repair. The Court noted that the health insurance plan gave the administrator

discretion, thus requiring a deferential review of the decision to deny benefits. The plaintiff appealed the $5,000 cap as to her jaw, Wal-Mart appealed as to the no cap for ears and skull. The Court affirmed the application of the limitation as to the jaw, and applied the limitation to plaintiff's ears and skull "because the condition in Solger's ears and skull was caused by her TMJ implants."

b. A participant cracked his teeth on a hard biscuit in Covington v. United States Fire Ins. Co. Med. Plan, Civ. No. 1:97 CV 00423, 1998 U.S. Dist. LEXIS 8152 (M.D. N.C. March 3, 1998). The administrator denied coverage because the plan expressly excluded dental coverage except in the case of accidental injury to natural teeth, and an injury arising from chewing was not considered accidental. The Court denied both parties' motion for summary judgment because they produced insufficient evidence concerning who had authority to construe the medical plan's coverage terms and the standard of review to apply to that construction.

3. Reasonable and Customary Charges

a. The plaintiff (a nursing service) and defendants (the employer and insurer), disagreed over whether $100 per hour was a "reasonable and customary rate" for professional nursing services. C.N.S., Inc. v. Connecticut General Life Ins. Co., 9 F. Supp. 2d 194 (E.D.N.Y. 1998). The plaintiff expressly refused to submit "concrete proof" that $100 per hour was its own normal rate or that other agencies normally charge a comparable rate of $100 per hour. The plan administrator had a survey establishing that the usual rates were lower than $55 per hour. Accordingly, the Court granted the defendants' motion for summary judgment.

b. In Fallick v. Nationwide Mutual Ins. Co., 162 F.3d 410 (6th Cir. 1998), a participant claimed that the insurer's calculation of reasonable and customary charges deviated from the plan's written description. The Sixth Circuit held that the participant could proceed with his claim under ERISA §§ 408 and 502 without exhausting his administrative remedies because resorting to such procedures would be futile. Furthermore, with respect to participant's motion for class certification, the Sixth Circuit concluded that once a potential ERISA class

representative establishes his individual standing to sue his own ERISA-governed plan, there is no additional constitutional standing requirement related to his suitability to represent the putative class of members of other plans to which he does not belong. (See contrary ruling on class certification in Hylaszek v. Aetna Ins. Co., found on p. 5 of this report.)

4. Lifetime and Annual Maximum Benefit Limitations

a. In Kish v. The Foxboro Co., No. 98-C-4835, 1998 U.S. Dist. LEXIS 19257 (N.D. Ill. Dec. 3, 1998), the plan refused coverage for private duty nursing for the plaintiff, a 20 month old child, because the life time private duty nursing care limit of $50,000 had been reached. The plaintiff claimed (i) she had a right to 24-hour private duty nursing care under the plan, (ii) defendants' denial of her benefits based on the $50,000 lifetime limitation on home nursing was arbitrary and capricious, and (iii) in selecting the plan, plaintiff's father relied on the summary plan description which failed to state a dollar limit for private nursing. The defendants moved to dismiss because the claim failed to allege the name of the plan that her father would have picked otherwise, and because she failed to allege that defendants acted in bad faith. The Court ruled that this claim was adequate to defeat the defendants' motion for dismissal.

b. In Jefferson Parrish Hosp. Service District No. 2 v. Ruby Tuesday's Inc., Civ. A. No. 97-2722, 1998 U.S. Dist. LEXIS 767 (E.D. La. Jan. 23, 1998), an employee of Ruby Tuesday's was admitted to the hospital and received services in excess of $14,000. The hospital sent the bill to the employer's self-funded health care plan, which had previously and erroneously verified the employee's coverage. On further inspection, the health care plan found the employee's annual limits were $5,000 and they had already been exhausted. As a result, the hospital claimed that it detrimentally relied upon the third-party administrator's ("TPA") misrepresentation of the employee's insurance coverage, and it counter-claimed for contractual indemnification based on the administrative services agreement between itself and the TPA. The District Court ruled that neither of these claims involved questions of federal law nor were they pre-empted by

ERISA, thus the case was remanded back to the State Court.

II. Welfare Plan Termination, Cancellation, Transfer & Withdrawal

A. Cancellation and Termination of Welfare Benefits Generally

1. The Tenth Circuit recently held that a plan amendment could not retroactively take away plan benefits. In Members Services Life Ins. Co. v. American National Bank & Trust Co. of Sapulpa, 130 F.3d 950 (10th Cir. 1997) cert. denied, 118 S. Ct. 1843 (1998), the Tenth Circuit held that a retroactive amendment to a medical plan could not deprive a participant of benefits. In Members Services, at the time the plan paid benefits for a beneficiary's injuries, the plan did not contain a subrogation provision. Later, the plan was amended to add a provision allowing the plan a right of recoupment if a beneficiary received money from a negligent third party as a result of injuries for which the plan had paid benefits, and the amendment was retroactive to a period beginning 7 months earlier.

The Court concluded that because plan administrators have an obligation to operate the plan according to current plan documents, a post hoc amendment clearly cannot alter a plan provision in effect at the time performance under the plan becomes due. The Court referred to ERISA Section 1024(b)(1), which requires plan administrators to make available for inspection all currently operative, governing plan documents, which includes any new bona fide amendments. The Court rejected the employer's argument that retroactivity was acceptable given that ERISA's disclosure rules only require that summaries of significant plan amendments be distributed no later than 210 days after the end of the plan year in which the amendment was adopted.

2. In Medina v. Time Ins. Co., 3 F. Supp. 2d 996 (S.D. Ind. 1998), an Indiana District Court held that retroactive changes of the effective date of coverage, which resulted in the denial of coverage, regardless of the employer's subjective purposes, falls well outside any discretionary authority that might be granted to a plan administrator under ERISA. In this case, Ko's Auto, Inc. adopted a health benefit plan insured by Time Insurance Company, with an effective date of December 1, 1995; however, because the coverage was not available for the full month of December, the employer requested a change in the effective date to January 1, 1996; that date change had the effect of making the

plaintiff's illness a pre-existing condition (starting in December), which precluded coverage for that condition with the new policy. This ruling is consistent with prior decisions holding that where coverage has actually vested, an amendment cannot apply retroactively to deny coverage.

3. In Corn v. Protective Life Ins. Co., No. 3-95-CV-556, 1998 WL 51783 (D.Conn. Feb. 4, 1998), a Connecticut District Court held that the rescission of an individual's group health insurance policy after the health insurance company learned that the plaintiff had misrepresented his medical history on his insurance application was not arbitrary and capricious.

   Because ERISA is silent as to the effect of an insured's alleged material misrepresentations on an application for health insurance, the Court turned to state law principles for guidance and found that under state law, an insurance policy may be voided by the insurer if the applicant made material representations relied upon by the company which were untrue and known by the assured to be untrue when made. (Thus, a misrepresentation made because of mistake, ignorance or negligence is not sufficient grounds for rescissions.) In this case, the Court found the plaintiff's claim of innocent misrepresentation unavailing because the plaintiff was treated by a doctor on over 15 occasions. Thus, the court granted the insurance company's summary judgment motion.

4. In Security Life Ins. Co. v. Meyling, 146 F. 3d 1184 (9th Cir. 1998), the Ninth Circuit, in a per curiam opinion, held that a health plan insurer that automatically recalculates the plan's premiums if it discovers any policy application misrepresentations may not rescind the policy of a participant who lied about his medical history. The court found that the misrepresentations were not "material" because the plan provided for the automatic remedy of premium payment recovery. The insurance company had refused to pay $670,000 in medical claims because of the misrepresentation and instead brought suit to rescind the insurance policy.

5. In Chiles v. Ceridian Corp., 95 F.3d 1505 (10th Cir. 1996) (first reported in 1998), the Tenth Circuit held that a health insurance plan's promise to maintain benefits for a disabled employee if the plan terminates does not create a contractually vested right to premium payments on behalf of long-term disability plan participants where the plan reserves to the employer the right to amend or terminate the plan any time. The Court noted that the

plan provision was not ambiguous with respect to employer's right to modify benefits.

The Chiles court did state, however, that because the plan explicitly listed a qualification to the employer's ability to change the LTD plan (i.e., if the plan terminated the employee would continue to be eligible for benefits), it was proper to infer that the right to make other changes to disabled participants benefits was reserved. In rejecting plaintiff's arguments, the Court stated that it was unwilling to hold that the vesting of benefits upon the occurrence of a specific expressed condition (termination) can be read broadly to include vesting generally upon an unexpressed condition (attaining disability). Simply, the employer could modify or terminate the plan when it deems necessary, but if the plan terminates, certain benefits may not be withdrawn.

B. Transfers and Other Uses of Assets Other than for Benefits

1. The Sixth Circuit held, in Sengpiel v. B.F. Goodrich Co., 156 F.3d 660 (6th Cir. 1998) petition for cert. filed, 67 U.S. L.W. 3473 (U.S. Dec. 10, 1998) No. 98-95), that an employer did not violate its ERISA fiduciary duties by transferring retiree welfare plan liabilities to a new company created as a result of a division spin-off without the retirees' consent, where the firm later reduced retiree welfare benefits, inasmuch as the employer's transfer of benefits was more analogous to amending, modifying or terminating then-existing welfare plans than to administering or managing them, and thus the employer did not act in fiduciary capacity with respect to transfer. The employer's ministerial application of a percentage classification to implement its business decision to spin-off its division was not an exercise of discretion sufficient to trigger ERISA's fiduciary duties.

C. Withdrawal Liability

1. In Eastern Enterprises v. Apfel, 118 S.Ct. 2131 (1998), the United States Supreme Court held that the Coal Industry Retiree Health Benefit Act's scheme for funding health care benefits for coal industry retirees and their dependents, which assesses premiums against coal operators that signed any collectively bargained national coal wage agreement executed between 1947 and 1978 by allocating retirees to those signatories in various ways, is unconstitutional as applied to impose severe retroactive liability on a company that ceased coal mining operations in 1965 and did not participate in negotiations or agree to make contributions to benefit plans under subsequent coal wage agreements.

D. Modification, Reduction and Termination of Retiree Benefits

1. Breach of Contract Claims

a. In Pabst Brewing Co. v. Corrao, 161 F.3d 434 (7th Cir. 1998), the Eighth Circuit held that an employer did not violate ERISA section 502's civil enforcement provision of the LMRA Section 301 by terminating welfare benefits for retirees on the expiration of a labor agreement that promised such benefits for the "life of agreement," since the contractual term promising such benefits merely for "life of agreement" was unambiguous and there was no need to consider evidence outside agreement to establish employer's intent.

b. In Sengpiel v. B. F. Goodrich Co., 156 F.3d 660 (6th Cir. 1998) found that plan documents did not state in clear and express language that retire medical benefits vested. The Court concluded that the following language in a prior SPD neither expressly guaranteed lifetime benefits nor created an ambiguity as to whether such benefits were vested:

> [I]f you retire and are eligible for a pension you shall continue to have the same health coverage,

Id. at 668.

Similarly, the Court stated:

> Somewhat more persuasive but also insufficient to convey a clear intent to vest is language in the plans providing that a retiree's spouse will continue to receive benefits after the retiree dies 'until death or remarriage.' While this language may imply generally that benefits are to continue at the same rate provided to the retiree at his or her death, it falls far short of expressing a clear intent to render such benefits 'forever unalterable.'

Id.

Clearly, the Sixth Circuit has strict requirements to show an intent to vest retiree medical benefits.

c. Rejecting all of the retirees' theories of recovery, the Sixth Circuit, in Sprague v. General Motors Corporations, 133 F.3d 388 (6th Cir.) (en banc), cert. denied, 118 S. Ct. 2312 (1998), rejected the retirees' claim that GM's intent to provide continued health benefits could be inferred from the company's promise to provide "lifetime" health benefits at no cost. Without a clear, express indication that GM intended the retirees' health benefits to vest, the Court stated that it was loathe to infer an intent on GM's part to provide free lifetime benefits, especially given the fact that the company "unambiguously" reserved the right in various documents over the years to amend or terminate the health plans.

At the heart of the decision was the Court's comment that:

> We see no ambiguity in a Summary Plan Description that tells participants both that the terms of the current plan entitle them to health insurance at no cost through retirement and that the terms of the current plan are subject to change.

This rather famous and long-standing dispute arose after GM cut back health care benefits that had previously been provided to GM's salaried retirees. The plan changes included adding annual deductibles, new co-payments, increased cost-sharing in some plans, and the elimination of vision and hearing aid coverage. A majority of the over 84,000 GM retirees who made up the class had accepted early retirement under several GM downsizing programs between 1974 and 1988.

The Court stated that health and welfare plans are exempted from ERISA's vesting requirements and that employers are generally free to adopt, modify, or terminate them at any time for any reason. The Court stated that an employer may choose to vest these benefits but the intent to vest must be in the plan document in clear and express language. There was no such intent expressed in GM's plan and the promise to provide no-cost lifetime health care benefits was qualified by the plan language which reserved GM's right to alter or terminate the plan. Moreover, a plan provision which expressly and unambiguously reserves to the employer the right to modify or terminate these benefits

is contrary to the intent to vest those benefits and thus the terms of the plan are controlling. The court also held that ERISA does not require an employer to disclose that medical benefits are not vested.

The Court rejected the district court's conclusion that the early retirement acceptance documents which the retirees signed were either modifications to the health care plans, or ERISA plans themselves. Oral modifications to plan documents are invalid and unenforceable and GM's representations of life-time no-cost benefits did not purport to modify the plan documents, but rather incorporated the terms of the plan, including the right to alter or terminate the plan. The statements did not constitute ERISA plans because those statements contained none of the information ERISA required to be included in plan documents, such as a funding mechanism or administrative responsibilities.

d. In Frahm v. Equitable Life Assurance Society, 137 F.3d 955 (7th Cir.), cert. denied, 119 S. Ct. 55 (1998). Six retirees challenged Equitable's change in the terms of its health care plan to require higher premiums, deductibles, co-payments, and maximum out-of-pocket limitations, and new cost-sharing obligations on retirees. The retirees claimed that their medical benefits vested at retirement at the level in place on their retirement date, that Equitable had made individual contracts with them which established rights over and above those created by the plan, and that oral statements and letters violated Equitable's fiduciary duty under ERISA or estopped it from enforcing the more restrictive plan provisions.

The District Court concluded that the plan had unambiguously reserved the right to change its terms, which the retirees did not appeal. The Seventh Circuit affirmed the district court on all issues. The Court rejected the retirees' claim that Equitable made a bilateral contract with each of them on terms which differed from the firm-wide plan. Thus, it was impossible for them to prevail on a contract theory.

2. Estoppel Claims

a. In Sprague v. General Motors Corp., 133 F.3d 388 (6th Cir. 1998), cert. denied, 118 S. Ct. 2312 (1998), addressed in

detail above, the Sixth Circuit rejected the GM retirees' claims that GM should be estopped from enforcing the modified plan against them because GM had misrepresented the plan's terms and they had relied on those misrepresentations when they accepted early retirement. The Court held that the retirees were not reasonable or justified in relying on any representations GM made because the plan documents were clearly to the contrary, unambiguously reserving GM's right to alter or terminate the plan. The Court held that reasonable reliance is an essential element of an estoppel claim.

b. In Frahm v. Equitable Life Assurance Society, 137 F.3d 955 (7th Cir.), cert. denied, 119 S. Ct. 55 (1998), the Court rejected the retirees' estoppel argument because it had already held in another case that estoppel is inapplicable to oral assertions in ERISA matters and because the retirees could not provide the elements of estoppel with respect to written statements in letters. The Court noted, among other matters, that there was no detrimental reliance. Moreover, in this instance, the retirees' benefits would have changed two years earlier if they had not retired.

3. Breach of Fiduciary Duty Claims.

a. In Sprague, supra, addressed above, the Sixth Circuit also held that GM did not breach its fiduciary duty by altering the retirees' health and welfare plan. The Court held that GM was not acting as a fiduciary when it amended the plan and although it may have been acting in a fiduciary capacity when it explained its retirement program to the early retirees it did not breach its fiduciary duty by not telling them at every possible opportunity that the terms of the plan were subject to change.

The Court found that GM was not required to disclose in its SPD that the plan was subject to amendment or termination and ERISA's fiduciary standard cannot be used to imply a duty to disclose information that ERISA's comprehensive and detailed disclosure provisions do not require to be disclosed. The Court held that there is a "world of difference" between an employer's deliberate misleading of employees and the failure to begin every communication to plan participants with the caveat that what it says is subject to change. The Court held because GM's representations of its health care program were

accurate when they were made, there was no breach of fiduciary duty.

b. In Frahm v. Equitable Life Assurance Society, 137 F.3d 955 (7th Cir.), cert. denied, 119 S. Ct. 55 (1998) discussed above in section 1, the Seventh Circuit also addressed the retirees' assertion that Equitable officials breached their fiduciary duty by providing inaccurate and/or misleading information. The Seventh Circuit rejected the notion that an administrator's fiduciary duty under ERISA makes plan administrators guarantors of accurate information at all times and that any error in communicating a plan's terms violates the duty and entitles the recipients of the erroneous information to the benefits promised orally instead of those in the plan documents. The Court noted that Equitable did not undertake a campaign to provide its employees with misinformation and that the district made findings that Equitable trained its benefits staff to give correct advice was not clearly erroneous. The Court stated that the administrator's duty of care is not a duty of pre-vision and an administrator does not violate the statute because of a portion of advice, thought reasonably accurate when given, turns out to be misleading.

The Court emphasized that an administrator's duty of care applies to overall plan management rather than to the quality or oral advice to particular beneficiaries. A plan administrator satisfies his or her fiduciary duty by taking appropriate precautions to avoid misinformation through training the benefits staff and providing written explanations, even if the precautions may sometimes turn out to be insufficient. The Court noted that a holding otherwise would undermine one of ERISA's established principles -- that there are no oral variances from written plans.

c. In Babcock v. Hartmarx Corp., No. Civ. A. 96-3862, 1997 U.S. Dist. LEXIS 19598 (E.D. La. Dec. 9, 1997), the Court held that the fiduciary duties owed by a plan sponsor and administrator include the duty to advise plan participants of any termination or material change in insurance policies.

III. Provider Claims Against Plans: Assignment and Misrepresentation

A. Subrogation and Coordination

1. Subrogation

a. Wal-Mart's Administrative Committee did not abuse its discretion in determining that the Plan was entitled to full reimbursement because the Plan was unambiguous and did not include a provision that required reduction of reimbursement recovery by a *pro rata* portion of covered person's attorney's fees. According to the court, the "Plan Priority" norm vested the Plan with a presumption of unconditional full reimbursement. Walker v. Wal-Mart Stores, Inc., 159 F.3d 938 (5th Cir. 1998).

b. Petition filed in state court personal injury action to apportion settlement funds did not trigger removal jurisdiction for ERISA-covered Plan that was served with a copy of the petition. The court found that Section 502 was not implicated because the petition did not seek a payment from the plan. Alternatively, the court found that the removal was defective because the respondent did not seek the consent to remove from the other parties asserting liens and did not assert removal based upon § 1441(c). Speciale v. Seybold, 147 F.3d 612, (7th Cir.) cert. denied, 119 S. Ct. 542 (1998).

c. Reduction of reimbursement amount based upon a *pro-rata* share of covered person's attorney's fees not required where plan requires full reimbursement and does not affirmatively require attorney fee reduction. United McGill Corp. v. Stinnett, 154 F.3d 168 (4th Cir. 1998).

d. Disagreeing with FMC Med. Plan v. Owens, 122 F.3d 1258 (9th Cir. 1997), the court held that a fiduciary seeks "appropriate equitable relief" in a recoupment action by seeking specific performance. Blue Cross & Blue Shield of Alabama v. Sanders, 138 F.3d 1347 (11th Cir. 1998).

e. Full recoupment awarded to plan with no reduction for attorney's fees. Covered person's request for civil penalties for failure to timely provide plan documents denied because no prejudice was shown and because no request was made to that plan administrator. Devine v.

American Benefit Corp., 27 F. Supp. 2d 669 (S.D. W. Va. 1998).

f. Resolving an issue of first impression in the Fourth Circuit, the court declined to adopt a federal common law make-whole rule because doing so would contravene the express terms of the plan. Great-West Life & Annuity Ins. Co. v. Barnhart, 19 F. Supp. 2d 584 (N.D. W. Va. 1998).

g. Resolving an issue of first impression in the First Circuit, the court held that application of the federal common law make-whole rule is precluded by straightforward language even if the language does not specifically address priority of payment. Interestingly, the court reduced the reimbursement amount by a *pro rata* portion of the covered person's attorney's fees because the plan did not specifically negate such a reduction. Harris v. Harvard Pilgrim Health Care, Inc., 20 F. Supp. 2d 143 (D. Mass. 1998).

h. Court reduced reimbursement amount by *pro rata* portion of covered person's attorney's fees and costs where plan did not specifically state that reimbursement amount could not be reduced. Ward v. Wal-Mart Stores, Inc. Assocs. Health & Welfare Plan, 7 F. Supp. 2d 927 (W.D. Mich. 1998).

i. Where reimbursement provision did not specifically negate attorney fee reduction, court allowed reduction to compensate covered person's attorney. However, the court awarded plan counsel an offset for its attorney's fee under 29 U.S.C. § 1132(g) because the plan substantially prevailed in the litigation. Great-West Life & Annuity Ins. Co. v. Clingenpeel, 996 F. Supp. 1348 (W.D. Okla. 1998).

j. Subrogation claim rejected as to medical expenses that were not proven to be causally related to covered person's malpractice action. Hamanne v. Central States, Southeast & Southwest Areas Health & Welfare Fund, 11 F. Supp. 2d 1065 (D. Minn. 1998).

k. Indiana anti-subrogation law held preempted by ERISA. Plan entitled to full reimbursement to the extent of benefits paid and make-whole rule held inapplicable where plan administrator vested with discretion to interpret plan terms. Court declined to apply Indiana common fund doctrine

because plan administrator interpreted subrogation provision to provide for full recovery. For the same reason, the federal common law make-whole rule was held inapplicable. As a result, the covered persons were ordered to execute the subrogation agreements that the plan requested they sign, which obligated the covered persons to recognize the plan's full lien. Cagle v. Flick, 3 F. Supp. 2d 982 (N.D. Ind. 1998).

l. Plan entitled to full reimbursement of settlement amount without reduction for attorney's fees or based upon the make-whole rule despite the fact that the plan paid $41,598.59 and the covered person's total recovery was $12,500.00. Walker v. Wal-Mart Stores, Inc., 27 F. Supp. 2d 699 (S.D. Miss. 1998), aff'd, 159 F.3d 938 (5th Cir. 1998).

m. Covered person sustained severe burns and the plan paid $1.2 million dollars on his behalf. Covered person recovered $600,000 in a state court lawsuit. The plan filed a separate action in federal court seeking reimbursement of the $600,000. The court held that abstention was inappropriate, that the plan was seeking "appropriate equitable relief", that the make-whole did not apply, and summary judgment granted in favor of the plan. Walker v. Rose, 22 F. Supp. 2d 343 (D.N.J. 1998).

2. Coordination of Benefits

a. The Plan's interpretation of its excess insurance provision is held to be arbitrary and capricious. Under de novo review, the court found that the Plan is primary because the default rule in one of the Plan's provisions provided that the Plan will be primary if it has covered the individual for the longer period of time. Because the Plan covered the covered person longer than the no-fault carrier, the Plan was held to be primary. Farm Bureau v. General Ins. Co. v. Morton Bldgs., Inc. Employee Health & Welfare Benefit Plan, No. 5:97-CV-191, 1998 U.S. Dist. LEXIS 14976 (W.D. Mich. Aug. 28, 1998).

b. The court held that a no-fault policy's coordination of benefits provision did not conflict with an ERISA plan's coordination of benefits provision. When those two provisions were read together, the Plan was primary. Therefore, there was no need to apply the rule that the

COB clause of an ERISA plan must be given effect over a conflicting COB clause in a traditional insurance policy. Citizen's Ins. Co. v. Northstar Print Group, Inc., No. 2:97-CV-144, 1998 U.S. Dist. LEXIS 4224 (W.D. Mich. Feb. 24, 1998).

B. Assignability of Welfare Benefits

1. ERISA permits the assignment of benefits under ERISA-governed welfare benefit plans. However, if the Plan provides that benefits are not assignable, that provision is enforceable. City of Hope Nat'l Med. Ctr. v. Healthplus, Inc., 156 F.3d 223 (1st Cir. 1998).

2. Benefits are assignable under ERISA and healthcare providers have standing as assignees to sue under ERISA. I. V. Services of Am., Inc. v. Trustees of the Am. Consulting Eng'rs Council Ins. Trust Fund, 136 F.3d 114 (2d Cir. 1998).

3. Benefits are Assignable to Medical Care Providers Under ERISA. Lutheran Gen. Hosp., Inc. v. Printing Industry of Illinois/Indiana Employee Benefit Trust, 24 F. Supp. 2d 846 (N.D. Ill. 1998).

4. Applying Illinois law, the court found that a medical provider had standing as an assignee to sue under ERISA because "the surrounding circumstances and the parties' actions support[ed] a finding that the parties intended to create an assignment." Loretto Hosp. v. Local 100-A Health & Welfare Fund, No. 97C1353, 1998 U.S. Dist. LEXIS 19260, at *4 (N.D. Ill. Dec. 4, 1998).

C. Misrepresentation Claims Brought by Health Care Providers

1. Summary judgment on misrepresentation claim granted to health plan where medical provider alleged that health plan represented it would cover the medical provider's costs by referencing in a facsimile to the medical provider the procedural requirements of the health plan. The court held that this statement was not a "definite misrepresentation of fact" about a willingness to pay for medical services that was sufficient to establish an estoppel claim. City of Hope Nat'l Med. Ctr. v. Healthplus, Inc.,156 F.3d 223 (1st Cir. 1998).

2. The Plan's insurance carrier pre-authorized coverage for covered person's treatment. In fact, the covered person was no longer employed by the Plan sponsor at the time the covered person sought treatment and the covered person failed to elect continuation coverage. The Plan sponsor had not instructed the

insurance carrier to terminate the covered person's insurance retroactive to a time prior to covered person's request for pre-authorization. Summary judgment granted as to healthcare provider's equitable estoppel claim because "[a] statement such as a pre-authorization cannot modify the Plan's requirement that only full-time employees are participants and that discharged employees must pay for continued coverage" and covered person had terminated employment and failed to elect continuation coverage. Southern Maryland Hosp. Center v. Corley, 6 F. Supp. 2d 461 (D. Md. 1998).

3. Claims processor provided pre-authorization to healthcare provider. The Plan later denied coverage because the covered person was not in fact a plan participant when he received treatment. The Plan moved to dismiss the action. The court dismissed the healthcare provider's claim for "ERISA promissory estoppel" because "this is not a case of a plan administrator's interpretation of an ambigiuous plan provision." The court denied the motion as to the healthcare provider's state law claims for breach of contract and "state law promissory estoppel," finding that those claims were not preempted by ERISA based upon Memorial Hosp. System v. Northbrook Life Ins. Co., 904 F.2d 236, 250 (5th Cir. 1990). National Rehabilitation Hosp. v. Man Power Int'l, Inc., 3 F. Supp. 2d 1457 (D.D.C. 1998).

IV. Managed Care Issues

A. Managed Care Issues Generally

B. Utilization Review

C. Enforcement of Precertification and Utilization Review Requirements

D. Service Area Restrictions

E. Medical Malpractice

1. Vicarious Liability

2. Utilization Review

F. Other Managed Care Issues

1. "Any Willing Provider" Laws

2. Nondisclosure of Contractual Arrangements

3. Mandatory Arbitration

G. Cases Received from S. Sheldon Weinhaus on February 15, 1999

1. 1998 Cases in Which ERISA Preemption Not Found

a. Gardner v. E.I. DuPont De Nemours & Co., ___ F.3d ___ (table), 22 Employee Benefits Case. (BNA) 1903 (full text) (4th Cir. 1998). At the time of plaintiff's husband disability retirement, he continued participation in the employer's non-particpatory plan, but he had too few years of service to be eligible to continue in the far more generous contributory plan except by conversion to an individual policy. He did not elect conversion. However, three years after retirement DuPont started deducting an amount from the disability check for this contributory insurance and did so until his death. When his wife sued for benefits under state law, DuPont sought to remove under ERISA. But the court found that the deceased could not qualify as a plan participant because he had no reasonable expectation of ever returning to employment and he had no vested rights under the plan. Although he did not convert, had he, DuPont and the ERISA-covered plan would not be involved. Since he was not a participant, his wife was not a plan beneficiary, and would have had no ERISA standing. Her suit remains in state court wherein which she can present state claims.

b. Pappas v. Asbel, No. 98 E.D. 1996, 1998 Westlaw 892074 (Pa. Sup. Ct. Dec. 23, 1998). MCO delayed approval of transferring patient from an emergency room to a hospital selected by emergency room doctors who felt that there was a neurological emergency due to an epidural abscess pressing on the spinal column. The MCO would not allow transfer to the hospital recommended, but gave the patient options to go to other hospitals once the emergency doctors started raising hell. More delays ensued to find which other hospital would take patient, by which time the continuing compression on her spine turned her into a permanent quadriplegic. In the suit brought against the treating physician and emergency hospital, the latter third-partied in the MCO. The Pennsylvania Supreme Court ruled negligence claims against an HMO do not "relate to" and ERISA plan; a concurring opinion offers that the conduct of the HMO fell within "quality of care."

c. Shannon v. McNulty, 718 A.2d 828 (Pa. Super. 1998). "[W]hen decisions are made to limit a subscriber's access to treatment, that decision must pass the test of medical reasonableness." Id. at 835. The court found that the MCO dictates and directs subscribers' medical care, in a case in which the ob-gyn and the telephone nurses did not recognize patient was in premature labor, thinking her complaints some five months into the pregnancy only evidenced back pain. The premature baby died within two days of birth. If the MCO intends to have telephone nurses give advice, it will subject itself to malpractice claims. Trial is tentatively set for September 1999.

d. Visconti v. U.S. Healthcare, No. Civ. A. 98-CV-0006, 1998 Westlaw 968473 (E.D. Pa. Sept. 28, 1998). The Viscontis were one of the original plaintiffs in Dukes v. U.S. Healthcare, Inc., 57 F.3d 350 (3rd Cir.) cert. denied, 516 U.S. 1009 (1995) (claims for direct negligence of HMO remanded to state court for determination of whether preemption was mandated). After remand from the Third Circuit, U.S. Healthcare tried once again to remove based on an amended report they received from their defense expert who said the treating physician committed no malpractice, that U.S. Healthcare was alone to blame for the stillbirth of the Visconti's infant. The MCO insisted under the circumstances there is no ordinary medical negligence, but only an (ERISA prempted) denial of benefits. The district court held that since the plaintiffs did not amend, defendants and the district court were bound by the remand order. Trial has been scheduled in the state court to begin April 5, 1999.

e. Moscovitch v. Danbury Hosp., 25 F. Supp. 2d 74 (D. Conn. 1998). Suicide of a 16 year old patient at the care facility to which he had been transferred, found to present a quality of care claim and not a claim to benefits, even though part of the original complaint was in terms of denying health benefits. The plaintiff amended by removing the denial/plan-coverage allegations when the insurer sought to remove to the federal court. The district court remanded based on Dukes.

f. O'Gara v. Locker, No. 97-0784 (D.C. Super. Ct. 11/10/1998). This is another case in which the parent of a

suicide victim sues the MCOs and insurers. The court determined the HMO could be liable if the patient looked to the HMO for care and not solely to the doctors, especially when the HMO limits the choice of doctor selection and requires physicians to agree to follow the HMO's guidelines. However, the court dismissed as to the insurer which had no interaction with the doctors involved and did not participate in the selection of the doctors.

g. Cf. Jones v. Chicago HMO Ltd, 703 N.E. 2d 502 (Ill. App. Ct. 1998). HMO may be vicariously liable for the alleged malpractice of a physician where the HMO aggressively recruited the Medicaid recipients and assigned them to specific physicians, creating a factual issue as to whether the physician was an apparent agent of the HMO.

2. 1998 Cases in Which Court Found Preemption

a. Huss v Green Spring Health Servs., Inc., 18 F. Supp. 2d 400 (D. Del. 1998). On two separate occasions health services provider mistakenly told family seeking referrals to medical personnel for urgently needed care that they were not enrolled in plan even though they were. One of the referrals sought was for a psychiatrist or psychologist for the covered daughter who was deeply depressed, and not getting such aid, who subsequently committed suicide. Court found only error was the mistake as to coverage, a plan administrative error and not a Dukes' quality of service issue, and thus preempted under ERISA, leaving plaintiff with no remedy.

b. Bast v. Prudential Ins. Co., 150 F.3d 1003 (9th Cir. 1998). Delay because of earlier denial of high dose chemotherapy treatment for breast malignancy because plan insurer labeled it experimental, but then relented, but by the later date the cancer had spread to beneficiary's brain and she was no longer an eligible candidate for the HDCT/bone marrow transplant and died. Her family sued under state law for breach of contract, breach of duty of good faith and fair dealing, state consumer protection act and the state insurance code. All claims save those under ERISA were held preempted, even though plaintiffs claimed to be suing

the insurer only under the insurance policy. Prudential was held entitled to keep the moneys it saved, whether unjust or not since the moneys were never "ill-gotten profits" from any plan moneys, and since the plan never paid out any moneys, it had never "lost" moneys that under constructive trust principles could be returned.

c. Person v. Physician's Health Plan, Inc., 20 F. Supp. 2d 918 (E.D. Va. 1998). Insurer denied required surgery in the mistaken understanding that the procedure was for a liver transplant rather than for the heart ailment, and without the surgery patient died within days of the refusal, her family then received a letter that the plan would pay. Plaintiffs pleaded negligence, but district court found "complete preemption," that the claim had more to do with quantity of care rather than quality of care, and refused to remand case to state court. The court was also swayed by the fact that the plaintiffs sued no hospital or doctor claiming negligence, making it more an administrative decision plaintiff was challenging rather than presenting a malpractice claim.

d. Pope v. Africare House (D.D.C. 1998), now on appeal to the DC Circuit, No. 98-7162. Mrs. Pope, then in Ethiopia and having complications with her pregnancy, was (according to her complaint) denied evacuation to the US for further care as her doctor recommended. After some period of delay she was taken to Israel, where the baby was born prematurely and died. Africare provides its employees with health insurance through Aetna. The parties disagreed on whether the evacuation benefit was part of the ERISA insurance plan. The district court first deemed all that was pleaded was a malpractice action, but then changed its mind and found ERISA preemption and dismissed. The appellees argue because the Popes were injured because of the benefits they did not receive, not because of the benefits they did receive, that even if the evacuation benefits were outside the plan nonetheless "their claims are inextricably intertwined with decisions made under an ERISA plan."

e. ERISA preemption may not insure liability-free outcome even it assures freedom from compensatory and punitive damages.

i. Cf. Maltz v. Aetna Health Plans of New York, Inc., 114 F.3d 9 (2d Cir. 1997). (dicta: fiduciary breach may occur if MCO does not provide medical care providers who can give the kind of care necessary to the condition of the patient). See also DOL opinion letter to Diana O. Ceresi, February 19, 1998 (selection of qualified medical providers is a fiduciary requirement of ERISA medical plan).

ii. Compare Herdrich v. Pegram, 154 F.3d 362 (7th Cir. 1998) (year-end bonus to physician based on moneys saved, is financial incentive to induce physician to delay treatment to woman whose appendix ruptured in the meantime), with Ehlmann v. Kaiser Found. Health Plan, 20 F. Supp. 2d 1008 (N.D. Tex. 1998) (HMO has no duty under ERISA to disclose compensation arrangements with physicians). See 24 BPR 2317; 25 BPR 414, 2055, 2183 for a history of the Ehlmann litigation.

V. Treating Physician Rule

A. Applicable

1. Woo v. Deluxe Corp., 144 F.3d 1157, 1162 (8th Cir. 1998) (applying the sliding scale abuse of discretion standard as a result of a conflict, the court held that where plaintiff suffered from an uncommon disease, scleroderma, and the administrator "merely had an in-house medical consultant review [plaintiff's] claim," the opinions of plaintiff's treating physicians, who specialized in this field, were given considerable weight, in part because the administrator failed "to use proper judgment by not having a scleroderma expert review her claim." See also Pappas v. Reliance Standard Life Ins. Co., 20 F. Supp. 2d 923, 931 n. 22 (E.D. Va. 1998) (completely discounting treating physician's opinion was only one of several errors made by insurance company in arbitrarily denying plaintiff long term disability benefits to a plaintiff diagnosed with post traumatic intractable migraines after suffering a head injury).

B. Not Applicable

1. Marsteller v. Life Ins. Co. of N. Am., 24 F. Supp. 2d 593, 597 (W.D. Va. 1998) (where the court did not address a potential conflict of interest but applied the traditional abuse of discretion standard, treating physician rule will not trump plan administrator's decision to deny benefits to plaintiff, who was terminated for misappropriating funds, making unauthorized trades and engaging in other unacceptable business practices, where substantial evidence existed to support administrator's decision, including one treating physician's statement after the fact which contradicted notes made at the time plaintiff was placed on leave and another treating physician's statement setting the date of disability after plaintiff's leave had commenced).

2. Fergus v. Standard Ins. Co., No. 97-1644-KI, 1998 WL 777034 (D. Or. Sept. 1, 1998) (even when the abuse of discretion standard is applied with heightened scrutiny, "[a]ccepting the opinion of the insurance company's medical consultant over the opinion of the treating physician is not clearly erroneous" where reviewing doctors specialized in claimant's impairments).

VI. Disability Plan Issues

A. ERISA Disability Claims Compared to Social Security Claims

1. In General

a. Ladd v. ITT Corp., 148 F.3d 753, 754 (7th Cir. 1998) (where plan's lawyer failed to articulate any difference between plan's provision defining total disability and the definition under the Social Security Act, court assumed that plan's definition of total disability should be interpreted consistent with the Social Security Act's meaning).

2. Social Security Determinations as Guidance

a. Martin v. E.I. Dupont De Nemours & Co., 999 F. Supp. 416, 424 (W.D.N.Y. 1998) (favorable determination from Social Security that plaintiff cannot currently engage in any substantial gainful activity and that condition is expected to continue for a period of not less than twelve months may be considered as evidence of disability, but it is not binding on plan administrator where medical evidence does not exist to support a finding of disability under plan terms which define disability as a condition immediately before termination which prevents the participant from "pursuing

any gainful occupation" and all medical records at the time of plaintiff's termination at most indicated that she had restrictions on lifting but could return to light duty).

b. Metropolitan Life Ins. Co. v. Solomon, 996 F. Supp. 1473, 1476 (M.D. Fla. 1998) (Social Security Administrative Law Judge's (ALJ) finding that participant was disabled under Social Security's provisions was not relevant in determining her entitlement to benefits under the plan because the ALJ made the disability determination two years after administrator had terminated participant's benefits; the ALJ's decision was not binding on the district court; and the ALJ made his determination based on a different definition of disability than the plan's).

3. Social Security Determinations as a Plan Requirement

a. Vance v. Holland, 22 F. Supp. 2d 529, 533-34 (W.D. Va. 1998) (where the plan provided disability retirement benefits to participants who, after ten years of service, become eligible for Social Security benefits as a result of a mine accident, which was defined, in part, in the plan's rules and regulations as an injury caused by "force or impact" to the body not simply the miner's own physical weakness, plan administrator did not abuse its discretion when it denied participant disability benefits because although claimant was entitled to Social Security disability benefits because of a back injury which occurred while he was actively employed, substantial evidence existed which showed that his injury was caused by claimants own physical weakness and not by an external factor).

B. "Own Occupation" and "Any Occupation Standard"

1. Own or Regular Occupation

a. Definition

(i) Wilkins v. Baptist Healthcare Sys., Inc., 150 F.3d 609, 614 (6th Cir. 1998) (where plan defined disability as "unable to perform all the material duties of his regular occupation" court stated that "[e]ssentially the Plan required Wilkins to show that he was no longer able to perform the duties of his job;" in applying this standard, court held that plaintiff able to perform his job as a janitor, despite an

alleged rotator tear and severe shoulder pain where x-rays, an arthrogram and MRI did not indicate that the alleged tear ever occurred, no lesion could be identified and no positive diagnosis of any pathology occurred with respect to the allegedly injured shoulder). See also Porter v. Metropolitan Life Ins. Co., 17 F. Supp. 2d 500, 506 (D.S.C. 1998) (fact that plaintiff's doctor stated that she could perform isolated parts of her job but not all of her duties on a full-time basis was not sufficient to show she was disabled from her own occupation according to court which found that under own occupation standard claims administrator need only show that that she is not wholly and continuously unable to do her job (i.e. there is some part of her job that she can do)).

b. Evidence

(i) Gawrysh v. CNA Ins. Co., 8 F. Supp. 2d 791, 794 (N.D. Ill. 1998) (where claims administrator did not deny that participant's disabling symptoms existed but concluded that she was not disabled because the symptoms could not be matched to a specific illness, denial was arbitrary and capricious because administrator should have either hired outside experts to evaluate claim or had plaintiff examined by its own doctors instead of simply having an inside disability specialist, who did not appear to have any medical training, deny claim because she could not match plaintiff's symptoms to Center for Disease Control's definition of chronic fatigue syndrome).

(ii) Grady v. Paul Revere Life Ins. Co., 10 F. Supp. 2d 100, 22 Employee Benefits Cas. (BNA) 1367 (D.R.I. 1998) (plan defined disabled as unable to perform the important duties of his own occupation, under the regular care of a doctor, and not working at all; under de novo review, court considered evidence not before the administrator and found administrator's decision denying long term disability benefits wrong where administrator based denial on fact plaintiff did not see her treating physician from November 1994 to April 1995 which was not consistent with a medical problem compelling her to leave and plaintiff's reason for leaving active employment was at the request of her employer

rather than at a specific medical recommendation from her physician, even though record indicated that nearly four months before plaintiff's leave began her treating physician had suggested she no longer work, but she did not do so because of financial conditions).

c. Accommodations as a Factor

(i) Layes v. Mead Corp., 132 F.3d 1246 (8th Cir. 1998) (no abuse of discretion occurred where evidence supported finding that participant might be able to perform his job if provided with a motorized cart to accommodate his medical needs and company was willing to accommodate participant, but participant ignored offer). See also Ross v. Indiana State Teacher's Ass'n Ins. Trust, 159 F.3d 1001, 1112 (7th Cir. 1998) (holding that it was not an abuse of discretion for the Board of Trustees to consider the actual accommodations offered claimant in determining whether he remained disabled under the own occupation standard).

2. Any Occupation

a. Definition

(i) Doyle v. Paul Revere Life Ins. Co., 144 F.3d 181, 186 (1st Cir. 1998) (under any occupational standard, although the court noted that the provisions should not be so literally applied to require an individual to be utterly helpless, the fact that plaintiff was 54 years old with a college education in both engineering and business management and retained a sedentary work capacity, even though he might be initially limited to performing part-time work, precluded the court from finding that administrator's decision denying long term disability benefits was arbitrary and capricious).

(ii) Ladd v. ITT Corp., 148 F.3d 753, 754 (7th Cir. 1998) (where plan defined disability as "'unable to engage in any and every duty pertaining to any occupation or employment for wage or profit for which you are qualified, or become reasonably qualified by training, education or experience,'" the court assumed that

plan's definition should mean the same as Social Security's because claims administrator did not articulate any difference between the plan language and Social Security's requirement that a person be disabled from any substantial gainful activity until oral arguments on appeal when the claims administrator's attorney argued that the plan terms required a participant to be unable to do even part-time work).

b. Training/Education

(i) Terry v. Bayer Corp., 145 F.3d 28, 41 (1st Cir. 1998) (benefit committee's decision to deny disability benefit to participant with knee injury not arbitrary and capricious where participant was not precluded from performing any job since he was trained to be a computer technician, and, as such, he was able to perform a job readily adaptable to his sedentary needs).

(ii) Heller v. Fortis Benefits Ins. Co., 142 F.3d 487, 491 (D.C. Cir.) cert. denied, 119 S. Ct. 337 (1998) (where claimant had a college education, previous experience in sales and three outside medical examiners found her "fit for certain kinds of employment" and participant's treating physician stated she was "available for 'light work duty' and was 'OK' for 'sedentary work,'" plan administrator's denial of disability benefits was upheld because all evidence indicated that based on her education and experience plaintiff was capable of gainful employment in insides sales and such positions paid at least 50% of her monthly earnings before she went on disability, as required by the plan).

(iii) Mein v. Pool Co. Disabled Int'l Employee Long Term Disability Benefit Plan Co., 989 F.Supp. 1337, 1350 (D.Colo. 1998) (plan administrator's decision to terminate benefits based on conclusion that plaintiff could perform some type of sedentary work but without a current vocational assessment was arbitrary and capricious where participant had been receiving long term disability benefits for over 10 years and medical report stated that plaintiff may be able to return to light duty work but given his

extended absence from work and lack of education and training, he would at least required vocational assessment to determine whether he is employable at that work duty level and reeducation or further training to allow him to return to the work force).

(iv) Buchanan v. Reliance Standard Life Ins. Co., 5 F. Supp. 2d 1172, 1186 (D. Kan. 1998) (under the any occupation standard, "fact that plaintiff would have to learn procedures or information specific to a particular job does not make him ill-suited by education, training, and experience" for such a position; and, therefore, administrator's determination that plaintiff was not disabled was not arbitrary and capricious where in addition to the fact that plaintiff was employed as a master controls operator at a television station after he was forced to leave his job as a machinist due to an eye injury, a transferable skills analysis indicated that based on his education, training and experience there were 25 alternative occupations for which plaintiff was qualified).

c. Job Availability

(i) Quinn v. Blue Cross & Blue Shield Ass'n, 161 F.3d 472, 476 (7th Cir. 1998) (acknowledging that although plan administrator is not required to undergo a full-blown vocational evaluation of plaintiff's job, plan administrator's denial of benefits was arbitrary and capricious where plan administrator admitted that she did not know what plaintiff's job entailed; what her exertional requirements were; any training and experience she possessed; or any transferable skills she may have obtained but merely based her opinion on what a payroll accounts assistant does, i.e. clerical work, and concluded that plaintiff was not disabled because, since plaintiff's job was neither highly skilled or highly paid, there were thousands of clerical jobs in the Chicago area that plaintiff could perform; and, therefore, she could perform a comparable occupation which provides a similar salary range for a person with similar skills and education as required by the plan).

(ii) Heller v. Fortis Benefits Ins. Co., 142 F.3d 487, 494 (D.C. Cir.) cert. denied, 119 S. Ct. 337 (1998), (plaintiff's mere speculation that realistically it would be difficult at her age to get an inside sales job, which was one position listed on vocational assessment, and that none of the jobs listed on the assessment were available one year after the assessment was completed, did not sustain plaintiff's burden of proving that she had an "'impairment which would prevent [her] from performing some identifiable job'").

(iii) Marciniak v. Travelers Ins. Inc., 990 F. Supp. 1035, 1039 (N.D. Ill. 1998) (where plaintiff claimed that she was entitled to long term disability benefits because although "'she may be capable of some form of work,'" the claims administrator had not found her proper employment, court found that under the plan, the claims administrator had no duty to find plaintiff alternative employment; and with respect to whether the denial were proper, the issue was not whether plaintiff can or has found an alternative job she likes, but whether there exists any employment for which she is qualified).

d. Physical Capacity

(i) Davidson v. Liberty Mutual Ins. Co., 998 F. Supp. 1 (D. Me 1998) (administrator's determination that plaintiff was not disabled under the any occupation standard was proper even though plaintiff physically could not perform her previous position because of her limits on lifting and repetitive motions; plaintiff had been offered a part-time position within the company but refused it because it offered no long term disability benefits and was annually funded; plaintiff had applied for unemployment benefits by which she admitted that she was capable of and looking for active employment; and plaintiff actually applied for clerical positions in several offices, including a "fast-paced office," which showed she was not disabled).

