ERIC BUCHANAN AND ASSOCIATES

ERIC BUCHANAN & ASSOCIATES, PLLC
Attorneys at Law

ERISA & DISABILITY BENEFITS NEWSLETTER

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ABOUT OUR FIRM

Eric Buchanan & Associates, PLLC is a full-service disability benefits, employee benefits, and insurance law firm. The attorneys at our firm have helped thousands of disabled people who have been denied social security disability benefits, ERISA LTD benefits, health insurance, life insurance and other ERISA employee benefits, as well as private disability and health insurance benefits.

For more Information about Eric Buchanan & Associates, PLLC, visit our website at www.buchanandisability.com.

Eric L. Buchanan and R. Scott Wilson are certified as Social Security Disability Specialists by the Tennessee Commission on CLE and Specialization.

U.S. AIRWAYS, INC. V. MCCUTCHEN: THE LATEST NEWS FROM THE SUPREME COURT ON ERISA SUBROGATION AND REPAYMENT - BY: ERIC BUCHANAN

The Supreme Court has issued its latest decision in the ongoing saga of what rights plans have to recover health benefits previously paid to plan participants and beneficiaries. In *US Airways, Inc. v. McCutchen*, ___, U.S. ____, 2013 U.S. LEXIS 3156 (U.S. Apr. 16, 2013), the Court held that plan participants could not use equitable defenses to overcome the plain language of ERISA plans, but courts could use equitable principles in establishing default rules where plans are silent.

McCutchen is the latest case in a series of cases that address the claims and remedies that ERISA plans have after previously paying benefits to the plan participants and beneficiaries. Typically, when a person is covered by health coverage through their work at a private employer (either through insurance or funded by the employer), the health care plan falls under the Employee Retirement Income Security Act of 1974, or ERISA. Under most of these ERISA plans, if a covered person is injured by a third party, and the health plan pays medical bills related to that injury, and later the person recovers from the third party, the plans provide that the covered person must repay the health care plan from his or her recovery the amount that was previously paid in health benefits. Some plans also allow the plan to step into the shoes of the injured person and to sue the party causing the injury directly (in other words, to be subrogated to the rights of the injured person). Other plans simply say that health costs incurred because of injuries caused by third parties are not covered.[1]

Similarly, if a person becomes disabled and is covered under a long-term disability ("LTD") plan through work that falls under ERISA, many of those plans allow the LTD plan to reduce the benefits paid when the person receives other income benefits, such as social security or worker's compensation benefits. If the person is first paid LTD benefits, and then later receives back pay from their social security claim, these plans usually allow the plan to recover the LTD benefits that have been previously overpaid by the amount of social security benefits later received. Whether a plan is a health care plan with subrogation or reimbursement rights, or an LTD plan with recovery rights, the rights of the plan are those set out in ERISA and addressed in *McCutchen* and the Supreme Court cases preceding it.

[1]These three types of plan provisions are commonly referred to as "subrogation" provisions, although technically, subrogation only applies to the situation where the plan can step into the shoes of the injured person. The plan provisions that allow the plan to recover from the injured person after that person recovers from the person who caused the injuries is more properly called a "reimbursement" or "recovery" provision. If the plan does not provide the coverage at all, it is commonly called an "exclusionary" provision.

The starting point for the analysis is whether the plan in question has one of the provisions mentioned above, because plans don't have a general right or assumed right not found in the plan. ERISA itself only provides for certain remedies, and remedies not found in ERISA are preempted. ERISA § 502, 29 U.S.C. § 1132 sets out what parties may bring a cause of action under ERISA and what causes of action may be brought:

> (a) Persons empowered to bring a civil action
> A civil action may be brought--
> . . .
> (3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

This is the only relevant part of ERISA's civil action statute that gives a cause of action to a plan fiduciary. Further, the face of the statute limits the cause of action to enforcing the terms of the plan or the terms of ERISA. Since ERISA does not have a provision allowing for recovery or subrogation in the text of the statute, that remedy is only available if it is a term of the plan. Secondly, on the face of the statute, the only relief that can be obtained is "appropriate equitable relief."

The Supreme Court cases explaining how this part of the ERISA statute should be interpreted start with *Mertens v. Hewitt Associates*, 508 U. S. 248, 256-9 (1993), in which the Supreme Court explained that the limitation of "equitable" to the word relief meant that the relief could not be all relief, but only that relief "typically available in equity." *Id*. The Court went on to explain that, in the days of the divided bench (when some courts were law courts and others sat in equity) the limitation to "equity" could not mean that all remedies were available, but only those that were *typically* available to a court sitting only in equity.

Next, the Supreme Court examined the statute further in *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, (2002), where the Court held that a claim by an ERISA plan to recover a subrogation claim was not one for which a remedy was provided under ERISA at all. In that case, the Court reasoned that the enforcement provision in ERISA plans was founded in contract, and enforcing a contract would be a cause of action at law. Since causes of action at law only provide legal remedies, the Court reasoned, an equitable remedy would not typically be available. Thus, plans did not have a way to enforce their plan terms, which were essentially contract terms.

However, the Supreme Court issued another decision not much later, effectively (but not explicitly) overruling *Knudson*, and allowing ERISA Plans and Plan Administrators to recover in most cases. In *Sereboff v. Mid Atlantic Medical Services, Inc.*, 547 U.S. 356 (2006). The Court held that, since ERISA's civil enforcement provisions allowed plans to sue to enforce the terms of the plan, there must be a remedy available, so long as the plan has a provision allowing it to cover and the plan seeks some sort of equitable remedy. The Court found that typical reimbursement or recovery provisions in ERISA plans created a "lien by agreement" which allows the plan to recover the benefits previously paid, as such a lien agreement provided a remedy typically available in equity. However, the Court left open the question that, because the plans must seek an equitable remedy, would the plan participant or beneficiary, against who recovery is sought, be allowed to raise equitable defenses.

Now, in the recent case of *US Airways, Inc. v. McCutchen*, ___ U.S. ___, 2013 U.S. LEXIS 3156 (U.S. Apr. 16, 2013), the Supreme Court clearly addressed that question, and has held: No, equitable defenses cannot be used to overcome the clear language of a plan. The Court reasoned that since the ERISA plan documents were, in effect, a contract documenting the "expressed commitments" of the parties, that " when parties demand what they bargained for in a valid agreement," one of the parties cannot then ignore the plain language of the agreement by applying equitable defenses. In effect, the Supreme Court has held that ERISA plans are, for these purposes, contracts, and, while the plan's remedy is to seek an equitable lien by agreement, that lien is created by the agreement, and is bound by the terms of the agreement. "[i]f the agreement governs, the agreement governs," reasoned the Court.

However, in the second part of the *McCutchen* decision, the Court found there is still a place for equitable rules in interpreting the provisions of ERISA plans. In this case, in addition to arguing that equitable defenses should bar the recovery by the plan of McCutchen, the beneficiary, McCutchen's attorneys also argued that their fair share of the attorneys' fees earned in obtaining the funds should be protected under the common fund doctrine. Under that doctrine, any reimbursement to the plan should be reduced by the costs incurred in recovering the funds; therefore, the plan should not recover from the costs of the recovery, but rather should share in the cost of the fees paid to the attorneys.

The Court agreed that the common fund doctrine could apply, but *not* because that is an equitable principle that trumps the terms of the plan. Rather, the Court found that the plan did not address whether it could recover out of

attorneys' fees. Since the plan was silent on the allocation of attorneys' fees, the Court reasoned that equitable principles could still be used in construing the contract. While the Plan may have been able to depart from the common-fund doctrine by drafting its terms to say so, where it did not, the Court could use "the well-established common-fund rule" to construe the rules where a plan was silent.

Lessons learned from *McCutchen* and the preceding cases:

The rights of an ERISA plan to recover previously paid health care benefits or overpaid LTD benefits, or any other rights are not common law rights or rights found in the ERISA statute; therefore, if the plan does not contain those provisions, the plan does not have that right. However, where the plan has language allowing it to bring those claims, ERISA § 502(a)(3) gives plans the ability to enforce the terms of a plan.

Because ERISA § 502(a)(3) limits the remedies available when enforcing plan terms to "appropriate equitable remedies" plans must have language that allows them to seek funds in a way that creates a lien by agreement or through other equitable remedies. And, if the plan seeks to enforce those provisions, it should seek an equitable remedy. But if the plan allows that, ERISA participants and beneficiaries cannot use general equitable principles to defeat the terms of the plan.

Further, attorneys who represent ERISA participants and beneficiaries in other cases, such as underlying tort cases, may not have their attorneys' fees protected if the plan allows the recovery with clear language overcoming the common-fund doctrine. Only if the plan is silent on a disputed term can courts look to general equitable principles to fill in the gap.

What this case means to most lawyers who practice in the areas of personal injury, medical malpractice and the like, is that attorneys now have even more reasons to obtain copies of their client's ERISA healthcare plans early on in the representation. If the plans have language that allows the recovery (and most due), then attorneys and their clients will likely have to recognize the plan's rights, and should be prepared to deal with an ERISA plan's claims.

The best practical advice I can give is that, when an attorney first takes on a case in which their client is covered under an ERISA health care plan, the attorney should ask the Plan Administrator for a copy of the plan. If the plan in question, like most plans, has a right of recovery, the attorney should consider negotiating with the plan early on to ask if the plan will agree to a reasonable sharing of any recovery and attorneys' fees. If the health care costs that the plan can recover are large, and would be equal to most or all of the client's recovery in the underlying tort claim, the plaintiff's attorney has to either work something out with the ERISA plan early, or maybe decline to take the case. If the attorney waits until the end of the case, after the money is recovered or about to be, then the attorney has no leverage to negotiate with the plan. Since most plans have the necessary language, the attorney and his client may discover that they have done all the work in the underlying case for nothing more than the ability to repay the health care plan.

ERISA & DISABILITY BENEFITS NEWSLETTER

CASE NEWS: BENEFITS AWARDED TO THE PLAINTIFF BY THE COURT OF APPEALS FOR THE SIXTH CIRCUIT - BY: ERIC BUCHANAN

Scott Wilson, a partner at Eric Buchanan & Associates, recently obtained a very favorable decision in the Court of Appeals for the Sixth Circuit. In *Neaton v. Hartford Life and Acc.Ins.Co.*, 2013 U.S.App.LEXIS 5814 (6th Cir. March 21, 2013)(unpublished), the Court of Appeals reversed an unfavorable decision by the district court and ordered benefits paid to the Plaintiff.

Mr. Neaton had worked for his employer for 32 years and developed a medical condition that caused him to seek frequent medical treatment and surgeries. Because of his treatment, he sometimes required up to a week at a time to recover, and would be unable to work. Mr. Wilson argued, on behalf of Mr. Neaton, that the frequency of his medical treatment would cause him to miss too much work so that he could not perform any occupation. The Court of Appeals for the Sixth Circuit agreed with the arguments.

The court of appeals agreed that Hartford had not fairly reviewed Mr. Neaton's decision when Hartford chose to rely on the opinion of a doctor who had not examined Mr. Neaton over that of Mr. Neaton's own doctors. The court was especially critical of the reliance on a non-examining doctor in this case, because the amount of time off Mr. Neaton needed to recover from his medical treatment was, in part, a credibility determination. In making its findings on this point, the court cited *Kalish v. Liberty Mut.*, 419 F.3d 501, 508 (6th Cir. 2005) ("While it is not per se improper to rely on the opinion of a non-examining medical consultant, whether a doctor has physically examined the claimant is a factor that may be considered in determining whether a plan administrator acted arbitrarily in giving greater weight to the opinion of its consulting physician"); *Smith v. Cont'l Cas. Co.*, 450 F.3d 253, 260 (6th Cir. 2006) ("holding that it was improper to rely on non-examining medical consultant to determine severity and credibility of pain"); and *Calvert v. Firstar Finance, Inc.,* 409 F.3d 286 (6th Cir. 2005) ("The plan administrator's failure to require a physical examination 'may, in some cases, raise questions about the thoroughness and accuracy of the benefits determination.' ") *Neaton*, 2013 U.S.App.LEXIS 5814, at 20-21. The court was especially critical of the reliance on a non-examining doctor in this case, because the amount of time off Mr. Neaton needed to recover from his medical treatment was, in part, a credibility determination.

Additionally, the court criticized Hartford's evaluation of the frequency of Mr. Neaton's absences, because Hartford found that the average time off was not enough to interfere with work, but Hartford averaged in the number of absences Mr. Neaton had during the time he was still working to support its conclusion. *Id*., at 25-27. The court explained:

> A vocational expert's opinion that a claimant can perform certain jobs is only substantial evidence to the extent that the vocational expert had a complete, accurate understanding of the claimant's restrictions and limitations. Felisky v. Bowen, 35 F.3d 1027, 1036 (6th Cir. 1994). The vocational expert's opinion here, based upon calculating the average frequency of Neaton's surgeries over a timeline beginning prior to the time he claimed to be disabled, results in an artificially low assumption as to the frequency of his surgeries and work absences, and does not constitute substantial evidence to support Hartford's denial of benefits.

Id., at 26-27.

Further, the court of appeals found that Hartford acted arbitrarily and capriciously by relying on a vocational expert who cited, without support, "the common practice of employers" to accommodate absences due to recovery periods "of 3 to 4 days bi-monthly." *Id.*, at 27. The court found that "t[]he vocational specialist cited no evidence or data about allowable rates of absenteeism beyond 'the common practice of employers.' " The court explained that a "fiduciary has an obligation to evaluate its hired expert's opinion and to make certain that reliance on the expert's advice is justified under the circumstances. *Gregg v. Transp. Workers of Am. Int'l*, 343 F.3d 833, 841 (6th Cir. 2003)" Id., at 27-28. The court went on to explain, "[m]oreover, conclusory medical and vocational opinions that fail to provide evidence or reasoning to support the conclusions are insufficient to support a denial of benefits. *Elliott v. Metro. Life Ins. Co.*, 473 F.3d 613, 618-19 (6th Cir. 2006)."

Over Hartford's objections that the Department of Labor's statistics were not in the ERISA administrative record, the court took judicial notice of Bureau of Labor Statistics showing what rate of absenteeism would normally be tolerated. The statistics showed that employees of longer than 25 years' experience would only be allowed 10.6 days off for medical absences, and more recent statistics showed employers only allowed eight

days of absences per year, while the court noted that Mr. Neaton would miss 20-28 days per year. The court of appeals found that under Federal Rule of Evidence 201, the court could take judicial notice of facts that "can be accurately and readily determined from sources whose accuracy cannot reasonably be questioned." Citing Fed. R. Evid. 201(b)(2). The court went on to explain that

> Courts commonly consult reference sources in order to better understand matters that are not typically common knowledge. *Doss v. Barnhart*, 247 F. Supp. 2d 1254, 1259 (N.D. Ala. 2003); see, e.g., Brooking, 167 F. App'x at 549 n.5 [*31] (claimant sued plan administrator for denying her LTD benefits, and the court took judicial notice of 20 C.F.R § 220.132, which defines "sedentary" and "light work" pursuant to Fed. R. Evid. 201); *Sevens v. Metro. Life Ins. Co.*, 190 F. App'x 429, 436 n.7 (6th Cir. 2006) (recognizing that courts may take judicial notice of the Dictionary of Occupational Titles).

Neaton, at n. 16. However, the court of appeals went on to explain that even if this evidence were not admissible, "there is a significant lack of evidence to support Hartford's denial of benefits where the record is silent as to [the employer's] acceptable rate of absenteeism."

The court of appeals concluded that, because Hartford had previously found Mr. Neaton disabled and entitled to benefits before he was cut-off, and because "Neaton presented objective evidence of ongoing disability based on the frequency of his surgeries and the restrictions prescribed by his doctor," the appropriate remedy was to award retroactive LTD benefits wrongfully withheld and to reinstate benefits.

Unfortunately, the court chose not to publish this case. This is unfortunate, because the case sets out important limits on an ERISA fiduciary's ability to blindly rely on its file-reviewing experts, provides important analysis about the inability to work due to excessive absenteeism, and further clarifies the ability of courts to take judicial notice of such information as Department of Labor statistics.

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- K. Molina Haynes, Office Manager

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ERIC BUCHANAN & ASSOCIATES, PLLC UPCOMING CLE SPEAKING ENGAGEMENTS

Eric Buchanan will be speaking at the National Business Institute Seminar in Chattanooga, TN scheduled for June 5, 2013 on "Handling a Social Security Disability Case".

Eric Buchanan will be speaking at the American Association for Justice Conference in San Francisco, CA scheduled for July 20 -24, 2013 on "Workers' Compensation Settlements: How they Impact LTD and SSD and Necessary Language".

NEED A SPEAKER?

The attorneys at Eric Buchanan & Associates are available to speak to your organization regarding Social Security Disability, ERISA Long-term Disability, Group Long-term Disability, Private Disability Insurance, ERISA Benefits, Denied Health Insurance Claims and Life Insurance Claims.

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