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Assessing the Implications and Challenges of a Court's Decision to Remand

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Should There Be a Remand, Ever?

Once the district court determines that the insurer violated ERISA, the remaining question is how to remedy the violation. 29 U.S.C.§ 1132 (a)(1)(B) does not explicitly authorize administrative remand as a remedy. Yet district courts had ordered remand to the administrator under this regulation under a variety of circumstances. Remand has long been an acceptable practice, but twenty years ago, remands were not the norm. "Remand should be used sparingly." *Quesinberry v. Life Ins. Co. of N.Am*. 987 F. 2d 1017, 1025 (4th Cir. 1993)

It can be quite frustrating for the plaintiff's counsel, after years of fighting with the insurer, both during the administrative appeals and litigation, to succeed in its motion for summary judgment, and receive an Order for Remand, sending counsel and client back to the coliseum to battle over the evidence once again. Some courts recognize the repercussion remands have on the claimant. See, for example, *Radford Trust v. First Unum Life Ins.Co. of America*, 321 F.Supp.2d 226 (D. Mass. 2004) In deciding that First Unum's denial was flagrant, resulting in years of delay in the distribution of Doe's benefits, the court reasoned that the company's patently unreasonable interpretation of the policy and decision that was plainly contrary to the facts in the record before it countenanced against a remand.

> "First Unum's conduct resulted in years of delay in distribution of Doe's benefits, and it is by no means clear that First Unum can be trusted fairly to adjudicate Doe's claim on remand. Even if the Court could trust First Unum, and even if the company had acted in good faith, further delay would merely have added to the injustice that Doe has already suffered. Were the Court to remand to First Unum now, when the original events are five years distant, Doe would face possibly insurmountable difficulties of proof. First Unum should not be given the opportunity to profit from its wrongdoing, and Doe should not have to do without needed benefits any longer. Even if First Unum had acted reasonably and in good faith, the long delay and difficulties of proof would favor retroactive reinstatement, rather than remand."

In *Bard v. Boston Shipping Association*, 471, F.3d 229, 244 (1st Cir. 2006) the First Circuit addressed a situation where the "procedural irregularities were serious, had a connection

to the substantive decision reached, and call[ed] into question the integrity of the benefits-denial decision itself." After observing that the administrator's procedural violations had the effect of "sandbagging" the plaintiff, the First Circuit struck the evidence supporting the denial and awarded benefits to the plaintiff based on the remaining evidence. *Id* at 244, 245. The First Circuit recognized that "[i]n other circumstances, it might be an appropriate remedy to remand to a plan administrator for reconsideration," see Id., but declined to do so based on the rather egregious facts of the case. *Id*. at 246.

When is Remand Appropriate?

It is obviously in the claimant's interest to obtain summary judgment that the plan administrator's denial of benefits was an abuse of discretion as a matter of law, leading to an award of benefits. See for example, *Robinson v. Aetna Life Insurance Co.* 443 F.3d 389, 397 (5th Cir. 2006) ("[T]here is no genuine issue of material fact here. We have concluded *both* that Aetna failed to substantially comply with ERISA procedures *and* that Aetna abused its discretion by terminating Robinson's benefits.") (emphasis added).

However, Circuit Courts of Appeals have expressly held that remand of an ERISA case to the plan administrator "is appropriate in a variety of circumstances, particularly where the plan administrator's decision suffers from a procedural defect or the administrative record is factually incomplete." See, for example, *Shelby County Health Care Corp. v. Majestic Star Casino, LLC Group Health Benefit Plan*, 581 F.3d 355, 373 (6th Cir.2009); *Carney v. Int'l Broth of Elec Workers Local Union Pension Fund*, 66 F. App'x 381, 386-7 (3rd Cir. 2003); *Saffle v. Sierra Pacific Power Co. Bargaining Unit Long Term Disability Income Plan*, 93 F.3d 600, 608 (9th Cir.1996).

Many circuits have held that remand to the plan administrator for full and fair review is usually the appropriate remedy when the administrator fails to substantially comply with the procedural requirements of ERISA. See *Krauss v. Oxford Health Plans, Inc.*, 517 F.3d 614, 630 (2d Cir. 2008); *Syed v. Hercules Inc.* 214 F.3d 155, 162 (3d Cir 2000); *Gagliano v. Reliance Standard Life Ins. Co.*, 547 F.3d 230, 240 (4th Cir. 2008); *Chuck v. Hewlett Packard Co.*, 455 F.3d 1026, 1035 (9th Cir 2006); *Caldwell v. Life Ins. Co. of N. Am*, 287 F.3d 1276, 1288-89 (10th Cir. 2002). "A remand for further action is unnecessary only if the evidence clearly shows that the administrator's actions were arbitrary and capricious, or the case is so clear cut that it would

be unreasonable for the plan administrator to deny the application for benefits on any ground." *Caldwell, 287 F.3d at 1289* (internal citations and quotation marks omitted). The court must make this determination on a case by-case basis. See *Robinson, 443 F.3d at 397 & n.5*.

Specific Examples Supporting Remand

1. **Full and Fair Review Lacking**

Where the plan administrator has failed to comply with ERISA appeal-notice requirements in adjudicating a participant's claim, courts have held that the proper remedy is to remand the case to the plan administrator so that a "full and fair review' can be accomplished." *Gagliano v. Reliance Standard Life Ins. Co.*, 547 F.3d 230, 240, (4th Cir 2008). Following an initial denial of the claim based on substantive reasons, Reliance then upheld their denial following an appeal, but based their denial on a new reason theretofore not mentioned; an application of a pre-existing limitation provision. Reliance did not give Gagliano the opportunity to appeal the denial of benefits based on this new ground.

The district court found that Reliance's denial was faulty, reasoning that "it could not support termination of "benefits for an entirely different and theretofore unmentioned reason" in the second denial letter. The court explained that to do so nullified the opportunity for a full and fair review as afforded by ERISA. This success, however, did not entitle Gagliano to an award of benefits on her substantive claim. It was appropriate to remand the case to Reliance because "there is no legal basis to order the payment of benefits as a penalty for violation of the procedural requirements of ERISA." See also *Caldwell v. Life Ins. Co. of N. America*, 287 F.3d 1276, 1288-89 (10th Cir 2002)

A defendant in an ERISA case may not assert new grounds for denial once litigation in federal court has begun. *Harlick v. Blue Shield of California*, 686 F.3d 699, 719 (9th Cir. 2012) *cert. denied*, 133 S.Ct. 1492, 185 L.Ed. 2d 547 (2013). ("The general rule…in this circuit and in others, is that a court will not allow an ERISA plan administrator to assert a reason for denial of benefits that it had not given during the administrative process.") In *Glista v. UNUM Life Ins. Co. of Am.*, 378 F.3d 113, (1st Cir 2004) the 1st Circuit denied Unum's request for a remand, concluded the Unum could not raise the "symptoms clause" for the first time in litigation and thus seek a remand to investigate the application of this clause. The court reasoned that Unum had not brought this up during the appeal, and had sufficient information to raise this defense to

continued payment long ago, (four years had passed since the denial) and "Congress intended ERISA insurers to speak clearly, in plain language to plan recipients." *Id.* at *52.

> "Under these circumstances, we think the "appropriate equitable relief" is to hold Unum to the basis that it articulated in its internal claims review process for denying benefits, *i.e.*, the Treatment Clause. We recognize that ERISA trusts plan administrators to make the first determination as to the availability of benefits and thus that remand may be appropriate in some, or even many, cases. But, given the countervailing concerns raised on the facts of this particular case, we do not find that to be the appropriate solution here. Unum failed to raise the Symptoms Clause in the claims review process even though it had the burden, obligation, and opportunity to do so. We simply do not know, had Unum raised the Symptoms Clause, what additional information would have been provided to Unum by Glista or whether Glista would have settled his claim with Unum earlier. In addition to driving up the cost of proceedings, Unum's failure may well have prevented a more efficient resolution of this case."

2. Restoring the Status Quo

Once a court finds that an administrator has acted unreasonably in denying a claim for benefits, the court can either remand the case to the administrator for a renewed evaluation of the claimant's case, or it can award a retroactive reinstatement of benefits. The proper approach involves the ultimate goal of fully remedying the defective procedures given the status quo prior to the denial or termination.

In cases where the administrator terminated benefits that were already granted, rather than initially denying benefits, many Circuits have held that retroactive reinstatement of benefits is an appropriate remedy for procedural violations in order to return the plaintiff to the status quo in effect before the denial. Many circuits provide examples where the proper remedy is to award retroactive benefits and to order a continuation of benefits until and unless the plan administrator makes a new determination that benefits are no longer due. See, *Cook v. Liberty Life Assurance Co.*, 320 F.3d 11, 24-25 (1st Cir 2003) (affirming retroactive reinstatement and benefits to judgment where the evidence did not support the denial); citing *Welsh v. Burlington N. Inc. Employee Benefits Plan*, 54 F.3d 1331, 1340 (8th Cir. 1995) (recognizing that a district court has power to calculate and award unpaid benefits) The court in *Cook* notes that

> "we have no doubt that in some situations a district court, after finding a mistake in the denial of benefits, could conclude that the question of entitlement to benefits for a past period should be subject to further proceeding before the

> ERISA plan administrator. This might be true. For example, if the denial is less flagrant than in this case and if there were good reason to doubt that a reassessment would justify benefits for some or all of the past period. However, the variety of situations is so great as to justify considerable discretion on the part of the district court and, in this instance, it has not been abused." *Id* at 25.

See also *Lauder v. UNUM Life Insur. Co*, 284 F.3d 375 (2d Cir. 2002); *Grossmuller v. Int'l Union, UAW, Local 813* 715 F.2d 853, 859 (3d Cir. 1983) ("Upon remand the district court should enter an order prohibiting the plan from terminating Grossmuller's benefits until that court has approved the plan's claims procedures consistent with §1133 and until Grossmuller has received a full and fair review"); *Duperry v. Life Ins. Co. of N. Am.*, 632 F. 3d 860, 876 (4th Cir. 2011) ('district court was within discretion in awarding DuPerry benefits up to the date of its decision in lieu of remanding to LINA"); *Vega v. Nat'l Life Ins. Serv. Inc.*, 188, F.3d 287, 302 (5th Cir. 1999); *Elliott v. Metro. Life Ins. Co.*, 473 F.3d 613, 622 (6th Cir. 2006) ("retroactive award is usually proper when [the]claimant had benefits and lost them."); *Schneider v. Sentry Group Long Term Disability Plan*, 422 F.3d 621, 629 (7th Cir. 2005)("restoring the status quo prior to the defective procedures); *Hackett v. Xerox Corp. Long-Term Disab. Income Plan*, 315 F.3D 771 (7th Cir. 2003), *Caldwell v. Life Ins. Co. of N. America*, 287 F.3d 1276, 1288-89 (10th Cir 2002); *Billings v. Unum Life Ins. Co*., 459 F.3d 1088 (11th Cir. 2006). (affirming the district court's final judgment awarding disability benefits to the date of judgment)

a. Standards Change

The status quo must distinguish between periods of disability for which different standards apply under the plan, like the period of STD with one definition of Total Disability and another for Long Term Disability. *Creer v. AT & T Umbrella Ben. Plan No. 1*, 2012 U.S. Dist. LEXIS 14887, (E.D. Cal. Feb. 7, 2012) Plaintiff sought remand for a full and fair review of her continuing short term disability under the plan. The administrator denied Creer the last five days of short term disability benefits, which disqualified her from applying for Long Term disability benefits, under the plan. A remand in this type of case, is a desirable remedy. The court reasoned "Given the shortcomings of Sedgwicks' investigation set forth above, we cannot say on the record before us whether Plaintiff would have continued to receive benefits or not, and we are remanding the matter back to Defendant Plan for further consideration in that regard." *Creer* at *6. "The summary judgment requests are premature because the investigation required to make

an accurate disability assessment by Defendant Plan with respect to the payment of benefits has not yet occurred."

It is common for a court to limit an award of benefits to comport with the total disability standard in effect when the claim was denied. For example, when a claim was denied under the "own-occupation" standard, remand is appropriate. See for example, *Taylor v. Reliance Standard Life Ins. Co*. 2012 U.S.Dist. LEXIS (W.D. Wash Jan 13, 2012)The court awarded Taylor reinstatement of benefits to the end of the own-occupation term of the claim and remanded the case to Reliance to determine whether Taylor is entitled to benefits under the any-occupation standard.

A district court has discretion to remand an ERISA dispute to a plan administrator to interpret and apply plan terms in a way directed by the court. *Champion v. Black & Decker (U.S.) Inc.*, 550 F.3d 353, 362-63 (4th Cir. 2008). (remand to consider the claim under the correct CPT medical classification to determine if additional benefits were appropriate beyond the mental illness limitation)

In *Kosiba v. Merck* 2011 U.S. Dist. LEXIS (D.N.J. March 7 2011), defendants had approved of benefits under the own-occupation and also the any-occupation definition for a short period of time. Defendants then disregarded the historical medical record, including the portions that led to their own first finding of total disability. The court found that defendants ignored any information supporting the plaintiff's claim without any supporting information to the contrary. "Viewing the various factors as a whole the court finds that Defendant's decision to terminate plaintiff's ltd benefits was not the product of reasoned decision-making and substantial evidence." The court concluded that the benefits should be reinstated. The court noted that if Defendant had denied the 'any- occupation" benefits from the outset, the Court would likely remand.

In *Haisley v. Sedgwick Claims Mgmt Services*, 776 F. Supp. 2d 33, 59 (W.D.Pa. 2011), Sedgwick denied the claim months after the any-occupation standard began and the mental illness two year limit had been exhausted. Thus the court remanded for Sedgwick to determine if her physical impairments disabled her after the time period under review. See also *Peterson v. Continental Casualty Co.* 282 F.3d 112, 118 (2nd Cir. 2002) (after finding that the claims administrator's denial of initial LTD benefits was arbitrary and capricious, the district court erred

by also awarding plaintiff continued benefits after twenty-four months because benefits after that date were subject to a different standard that the claims administrator had not yet addressed) See also *Camerer v. Cont'l Cas. Co.*, 76 Fed. Appx. 837, 840 (9th Cir. 2003) where the court awarded benefits through the "own-occupation" period because "the dispute was purely factual and it is patently clear on the factual record before CNA that Camerer was eligible for "regular occupation benefits." In *Saffle v. Sierra Pacific Power Co. Bargaining Unit Long Term Disability Income Plan*, 93 F.3d 600, 608 (9th Cir.1996), the plan failed to apply plan provisions properly, so the proper remedy was remand. In *Saffle* the administrator added terms to the plan, requiring proof of disability by compelling objective evidence. Remand in a case like this affords the plaintiff an opportunity to have their file reviewed fairly.

B. Samples of Status Quo Consideration

Courts have held that ERISA deference does not deprive the court of its discretion to formulate a necessary remedy when it determines that the plan has acted inappropriately "[A] plan administrator will not get a second bite at the apple when its first decision was simply contrary to the facts." "[R]etroactive reinstatement of benefits is appropriate in ERISA cases where, as here, "but for the [insurer's] arbitrary and capricious conduct [the insured] would have continued to receive the benefits' or where there [was] no evidence in the record to support a termination or denial of benefit. " *Grosz-Salomon v. Paul Revere Life Insur. Co*., 237 F.3d at 1163, (9th Cir. 2000); (quoting *Quinn v. Blue Cross & Blue Shield Ass'n*. 161 F.3d 472, 477 (7th Cir 1998). *Petrone v. Johnson & Johnson* 935 F. Supp 2d. 278, *51 (D. MA 2013)"a district court has the power to remand a case to the plan administrator following de novo review where "the integrity of [the plans'] decision making process" is in question and the claimant is entitled to "have the benefit of an untainted process," citing *Buffonge v. Prudential Ins. Co of Am*. 426 F.3d 20, at 31 (1st Cir 2005) 29 U.S.C. § 1132(a)(3).

In *Cook v. Liberty Life Assurance Co. of Boston* 320 F.3d 11 (1st Cir. 2002) the 1st Circuit explains why it is fundamentally unfair to remand a claim simply because the carrier does not have evidence of the claimant's continuing disability from the final denial to the date of judgment. "Liberty argues that there is no evidence of Cook's disability status after October 1998 when it terminated her disability benefits and hence no basis for awarding her benefits past

that date. However, the court reasoned that the absence of information about Cook's disability status resulted directly from Liberty's arbitrary and capricious termination of her benefits. As a recipient of disability benefits, Cook was under a continuing obligation to adduce proof of her disability pursuant to the LTD plan. Once Liberty terminated her benefits, she was no longer obliged to update Liberty on her health status. It would be patently unfair to hold that an ERISA plaintiff has a continuing responsibility to update her former insurance company and the court on her disability during the pendency of her internal appeals and litigation on the off chance that she might prevail in her lawsuit. Moreover, as the district court notes in hits decision, reconstruction of the evidence of disability during the years of litigation could be difficult for a recipient of long-term disability benefits wrongly terminated form a plan." On that basis, the district court awarded Cook 42 months of back benefits, reinstatement to the plan as of May 2002, attorney's fees, and prejudgment interest.

The 9th Circuit affirmed the district court's conclusion in *Pannebacker v. Liberty Life Assur. Co. of Boston*, 542 F.3d 1213 (9th Cir. 2008) that Liberty "failed to properly apply the Plan provisions" and "failed to make a reasonable inquiry into the type of skills Plaintiff possesses and whether those skills may be used at another job" but denied the retroactive reinstatement of benefits. The 9th Circuit reasoned, "if an administrator terminated continuing benefits as a result of arbitrary and capricious conduct, the claimant should continue receiving benefits until the administrator properly applies the plan's provisions, reasoning "[W]hile liberty was given a second opportunity to determine whether Pannebecker was disabled under the plan, that second chance should not have left Pannebecker empty handed during the time that it took Liberty to comply with the Plan's requirements." *Id.*, at 1222.

In *Hackett v. Xerox Corp. Long-Term Disab. Income Plan*, 315 F.3D 771 (7th Cir. 2003), the court ordered the retroactive reinstatement of benefits instead of remand. Twelve years after paying benefits, the claim administrator denied the claim based on a single IME who disagreed with the long-standing established medical support. The court reasoned that Hackett was entitled to a return to the "status quo" of the case, which was to provide benefits, in order to fully remedy the defective procedures given the status quo prior to the termination. But, when the plan administrator terminated benefits under defective procedures, the status quo prior to the defective

procedure was the continuation of benefits. But see *Quinn v. Blue Cross and Blue Shield Ass'n* 161 F.3d 472 (7th Cir. 1998) (The fact that the plan administrator failed to provide the adequate procedures does not mean that the claimant is automatically entitled to benefits-such a holding might provide the claimant "with an economic windfall should she be determined not disabled upon proper reconsideration.")

In *Schneider v. Sentry Group Long Term Disability Plan*, 422 F.3d 621 (7th Cir. 2005), the court held that an insurer's failure to comply with the claim regulations in terminating benefits justified reinstatement in order to restore the claimant to the status quo. "When a plan administrator fails to provide adequate reasoning for its determination, [the] typical remedy is to remand to the plan administrator for further findings or explanations." *Majeski v. Metro. Life Ins. Co*., 590 F.3d 478, 484 (7th Cir 2009). "A direct award of benefits is appropriate only in "the rare case where the record…contains such powerfully persuasive evidence that the only determination the plan administrator could reasonably make is that the claimant is disabled," *Id*. See also *Leger v. Tribune Co. Long Term Disability Benefit Plan*, 557 F.3d 823, 835 (7th Cir 2009) (remanding since "on the record before us, we cannot say definitively that it was unreasonable for the plan to terminate [plaintiff's] benefits.)

Following a judicial remand to the administrator, the failure to make a timely decision entitled the claimant to reversal, not another remand in *Rappa v. Conn. Gen. Life Ins. Co*. 2007 U.S. Dist. LEXIS 91094 (E.D.NY De. 11, 2007) The court determined that since the decision to deny was unreasonable, not based on substantial evidence, the remedy is "reversal" not remand. See also *Zervos v. Verizon N.Y. Inc.*, 277 F.3d 635, (2nd Cir 2002) and *Zuckerboard v. Phoenix Mutual Life Ins. Co.*, 78 F.3d 46, (2nd Cir 1996)

Miller v. American Airlines, 632 F.3d 837 (3rd Cir. 2011) provides some rationale to consider when determining to restore the status quo prior to the unlawful denial of termination:

> "In deciding whether to remand to the plan administrator or reinstate benefits, we note that it is important to consider the status quo prior to the unlawful denial or termination. As such, an important distinction emerges between an initial denial of benefits and a termination of benefits after they were already awarded. In a situation where benefits are improperly denied at the outset, it is appropriate to remand to the administrator for full consideration of whether the claimant is

> disabled. To restore the status quo, the claimant would be entitled to have the plan administrator reevaluate the case using reasonable discretion. In the termination context, however, a finding that a decision was arbitrary and capricious means that the administrator terminated the claimants benefits unlawfully. Accordingly, benefits should be reinstated to restore the status quo. " *48. The court held that retroactive reinstatement of benefits was the proper remedy to restore the status quo to a plaintiff who was denied benefits because of improper review of the administrative record, and making receipt of benefits contingent on procurement of FAA certificate (which was not a part of plan, but was required by Miller's employer). *Miller 632 F.3d* at 856.

In *Hann v. Reliance Standard Life Insurance Co.,* 2011 U.S.Dist. LEXIS 38444 (E.D. Pa April 8, 2011), Reliance's refusal to take into consideration the facts that plaintiff presented to establish that his ex-wife's child was not his and thus not a "dependent" for the calculation of SSA offset was arbitrary and capricious. The Court remanded the claim to Reliance reasoning that their reduction of benefits by the dependency benefit of the child was unlawful and Reliance must determine whether the child is a dependent as defined by the Social Security Act. The court then performed an analysis as to whether plaintiff should be awarded counsel fees. The Court determined that under the Ursic factors (*Ursic v. Bethlehem Mines,* 719 F.2d 670 (3d Cir. 1983), the plaintiff was ultimately the prevailing party in this litigation, his claim was meritorious and an award of counsel fees was appropriate.

3. Is Remand Appropriate When New Facts Arise After Final Denial?

Once suit has been filed, the parties are not permitted except under limited circumstances to supplement or expand the record. *Vega v. Nat'l Life Ins. Servs., Inc., 188 F.3d 287, 298-300 (5th Cir. 1999)* (en banc), *abrogated on other grounds by Metro. Life Ins. v. Glenn, 554 U.S. 105, 128 S. Ct. 2343, 171 L. Ed. 2d 299 (2008)*. Each party must generally make its record before the case comes to federal court. *Robinson v. Aetna Life Ins. Co., 443 F.3d 389, 397 n.5 (5th Cir. 2006).*

Courts have found "special circumstances" justifying remand when new evidence arises that was unavailable before suit, but have refused to remand when the evidence existed before suit. *See Hamburg v. Life Ins. Co. of N. Am., 470 F. App'x 382, 385-86 (5th Cir. 2012)* (per curiam) (finding remand improper when the plaintiff had an opportunity to provide claims administrator with an SSA decision before filing suit); *Offutt v. Prudential Ins. Co. of Am., 735*

F.2d 948, 950 (5th Cir. 1984) ("If new evidence is presented to the reviewing court on the merits of the claim for benefits, the court should, as a general rule, remand the matter to the plan administrator for further assessment."). Some courts, however, have concluded that remand is more broadly justified. *See Moller v. El Campo Aluminum Co., 97 F.3d 85, 89 (5th Cir. 1996)* (remanding when an SSA decision issued before the plaintiff filed suit challenging the benefits denial was not provided to the doctors on the plan's medical board who resolved administrative appeals from benefits-denial decisions).

In *Jones v. Metro. Life Ins. Co.*, 2013 U.S. Dist. LEXIS 75397 (S.D. Tex. May 29, 2013) MetLife took the position that once Jones filed suit, it was under no obligation to consider evidence related to his benefits claim. The court remanded the case for 90 days to permit it to consider the evidence Jones submitted after the administrative appeal ended, based on the unusual facts of this case, and stayed the action. The court reasoned that Courts may remand when, after filing suit, the plaintiff obtains new evidence that he could not have submitted before filing suit. "What constitutes the administrative record for ERISA review purposes is a context-dependent question for this court." *See, e.g., Abatie v. Alta Health & Life Ins. Co., 458 F.3d 955, 970 (9th Cir. 2006)* ("[W]hen deciding what record a court should use to decide whether the administrator's decision was reasonable, '[i]t is not clear that any single answer covers all of the variations in ERISA cases; the 'record' may depend on what has been decided, by whom, based on what kind of information, and also on the standard of review and the relief sought[.]'" (quoting *Doe v. Travelers Ins. Co., 167 F.3d 53, 57 (1st Cir. 1999))).*

The court in *Hartwell v. U.S. Foodservice, Inc., 2010 U.S. Dist. LEXIS 95258, at *9 (S.D. Miss. Sept. 13, 2010)* remanded to the plan administrator to consider evidence that the claimant had submitted of her ongoing dire medical condition post-appeal but pre-suit, reasoning,

> "Historically, the Fifth Circuit has sanctioned remand for review of evidence or issues that the plan administrator failed to consider. *Moller v. El Campo Aluminum Co., 97 F.3d 85, 89 n.4 (5th Cir. 1996)*; *Offut v. Prudential Ins. Co. of Am., 735 F.2d 948, 950 (5th Cir. 1984)* (citing *Wardle v. Cent. States, Se. & Sw. Areas Pension Fund, 627 F.2d 820, 824 (7th Cir. 1980)).* If, as *Vega* suggests, this Court's review is not limited to the information presented to the Plan Administrator prior to the decision, then remand would be consistent with *Vega's* policy of encouraging resolution at the administrative level. Accordingly, the matter is remanded with instructions that the Plan Administrator consider the post-appeal, pre-suit evidence Plaintiff presented. Summary Judgment is denied."

Obviously, courts do not want their calendars to be bogged down with cases that are "unfinished." A primary goal of remand is to avoid judicial resolution of purely administrative benefits determinations. *See Moller, 97 F.3d at 89* ("[O]nce it was known that relevant evidence had not been given to the doctors, the evidence should have been supplied to them for redetermination and the lawsuit dropped. The judiciary's scarce resources should not be wasted on problems the parties could have, and should have, taken care of themselves.").

There is also support within the 6th Circuit for remanding so that the Plan Administrator has a fair opportunity to review evidence previously submitted that the administrator refused to consider. *See, e.g., French v. Dade Behring Life Ins. Plan, 2011 U.S. Dist. LEXIS 132653, (M.D. La. Nov. 17, 2011)*; *Ciaramitaro v. Unum Life Ins. Co. of Am., 2013 U.S. App. LEXIS 6968, at *3 n.1 (6th Cir. Apr. 4, 2013)* ("[W]here additional evidence is submitted to the plan, especially evidence as compelling as a confirmation of a diagnosis, ERISA ought to encourage plans to reevaluate their previous decisions, not bind themselves to them.").

Sometimes, even the Defendant does not want a remand. *See Kelley v. LINA, 2007 U.S. Dist. LEXIS 54460, at *6 (S.D. MI July 26, 2007)* Kelly had additional medical evaluations after the final denial and specific results prove further deterioration. Kelly sought a remand, but Defendant LINA objected since it did not believe this evidence should be considered in the case at all. The court disagreed, noting "Defendant argues that it would be prejudiced by a remand because it would delay the adjudication of this dispute and increase expenses. The court does not find this to be compelling. Remand for sixty days to allow [the Plan Administrator] to consider [additional evidence] and make a new disability determination (while staying this action) would be a minor inconvenience. After the new disability determination is made, LINA can (if necessary) re-urge and supplement its existing motion for summary judgment, without having to duplicate its work, thus cutting down on additional expenses."

4. Does The Court Retain Jurisdiction Over a Remand Action

In the 4th Circuit when a court directs a remand to a plan fiduciary, the court retains jurisdiction to consider a later challenge by either party to the determination on remand. See *Dickens v. Aetna Life Ins. Co*. 677 F.3d 288, 234 (4th Cir. 2012). "Thus, a remand "allow[s] either party to challenge the ensuing eligibility determination by motion before the same court." *Id*. and "preserves for appeal the claims administrator's challenges to the remand order and to

"any final judgment entered by the district court following the…decision on remand." *Dickens*, 677 F.3d at 234 (quoting *Young v. Prudential Ins. Co. of Am.*, 671 F.3d 1213, 1216 (11th Cir 2012). (see *Giles v. Bert Bell/Pete Rozelle NFL Player Retirement Plan*, 2012 U.S. Dist. LEXIS 166167 (D. Maryland Nov 20, 2012) See also *Mc Kay v. Reliance Std. Life Ins. Co*. 2008 U.S.Dist. LEXIS 82190 (E.D.TN Oct 16, 2008). Court previously remanded the claim to RSL, which denied benefits again. The Court granted plaintiff's motion to reinstate his prior case because a remand order is not a final judgment in this case.

As a general rule, even after a district court has entered judgment, it retains ancillary jurisdiction to enforce its own orders and judgments. *Peacock v. Thomas, 516 U.S. 349, 356, 133 L. Ed. 2d 817, 116 S. Ct. 862 (1996)* (recognizing "use of ancillary jurisdiction in subsequent proceedings for the exercise of the court's inherent power to enforce its judgments"); *Kokkonen v. Guardian Life Ins. Co. of Am., 511 U.S. 375, 380, 128 L. Ed. 2d 391, 114 S. Ct. 1673 (1994)* (stating that court has ancillary jurisdiction to "manage its proceedings, vindicate its authority, and effectuate its decrees."); *see also 28 U.S.C. § 1367(a)* ("In any civil action of which the district courts have original jurisdiction, the district courts shall have supplemental jurisdiction over all other claims that are so related to claims in the action . . . that they form part of the same case or controversy. . . ."). "'The jurisdiction of a Court is not exhausted by the rendition of its judgment, but continues until that judgment shall be satisfied.'" *U.S.I. Properties Corp. v. M.D. Constr. Co., 230 F.3d 489, 496 (1st Cir. 2000)* (quoting *Wayman v. Southard, 23 U.S. (10 Wheat.) 1, 23, 6 L. Ed. 253 (1825))*; *see also* 13 Charles Alan Wright, Arthur R. Miller & Edward H. Cooper, Federal Practice and Procedure § 3523, at 89 (2d ed. 1984) (stating that ancillary jurisdiction "includes those acts that the federal court must take in order properly to carry out its judgment on a matter as to which it has jurisdiction").

Recently, the court in *LeClair v. Liberty Life Assur. Co. of Boston* 2013 U.S. Dist. LEXIS 93049 (W.D.N.Y. July 2, 2013) declined to order the matter stayed and declined to retain jurisdiction during the remand. Instead, the Court remanded the case to defendant with instructions to undertake a full and fair review of the plaintiff's claim on administrative appeal. The court noted that following defendants' administrative determination, plaintiff may, if necessary file a motion for leave to re-open this case and thereby prevent incurring the additional costs of filing a new case.

See also Spanos v. TJX Cos., 220 F. Supp. 2d 67, 75 (D. Mass 2002), citing *Maida v. Life Ins. Co. of North America*, 949 F. Supp. 1087, 1094 (S.D.N.Y. 1997) (concluding that when a court is remanding a case to the plan administrator the court should "retain jurisdiction over [the] case pending the outcome of the remand while at the same time ensuring that the remand is dealth with expeditiously " rather than view the remand as "a final disposition of the matter… and enter judgment.")

The 10th Circuit in *Metzger v. Unum Life Ins. Co. Of Am., 2005 U.S. App. LEXIS 21796 (10th Cir. Oct. 6, 2005)* concluded that the district court had ancillary jurisdiction to enforce its remand order. Following a district court order remanding her ERISA complaint to Unum for further proceedings, Metzger filed a sanction motion with the district court claiming Unum had not followed the procedures required by the remand order. The district court ruled it lacked subject-matter jurisdiction to hear her motion.

5. Are Remand Orders Appealable? Is it a Final Decision?

The majority of Circuit courts have held that a district court order remanding to an ERISA claims administrator does not constitute a final, appealable decision. See *Popotto v. Hartford Life & Accident Insurance Co.*, 2013 U.S. App. LEXIS 19660 (3d. Cir. Sept. 26, 2013); *Dickens v. Aetna Life Ins. Co.*, 677 F.3d 228; (4th Cir. April 20, 2012); *Young v. Prudential Ins. Co. of Am.*, 671 F.3d 1213, 1215-16 (11th Cir. 2012); (concluding that remand of ERISA dispute to claims administrator for further proceedings is not appealable); *Shannon v. Jack Eckerd Corp*., 55 F.3d 561, 563 (11th Cir. 1995) (stating that the district court "retained jurisdiction, . . . indicating that further action is required"); *Graham v. Hartford Life & Accident Ins. Co*., 501 F.3d 1153, 1161 (10th Cir 2007); *Borntrager v. Cent. States, Se. & Sw. Areas Pension Fund*, 425 F.3d 1087, 1091 (8th Cir. 2005); *Bowers v. Sheet Metal Workers' Nat'l Pension Fund, 365 F.3d 535, 537 (6th Cir. 2004). Petralia v. AT&T Global Info. Solutions Co., 114 F.3d 352, 354* (1st Cir. 1997)("Ordinarily implicit in a federal district court's order of remand to a plan fiduciary is an understanding that after a new decision by the plan fiduciary, a party seeking judicial review in the district court may do so by a timely motion filed in the same civil action, and is not required to commence a new civil action.); The Sixth Circuit has held that there can be no final decision under *28 U.S.C. § 1291* when a remand to an ERISA plan administrator occurs for

additional fact finding, regardless of whether the district court characterizes the case as open or closed on its docket.

Two circuits have taken the minority view that, in certain circumstances, a district court's remand to an ERISA claims' administrator may constitute a final decision. Those decisions conclude that, because orders remanding administrative benefit determinations to administrative agencies are appealable, orders remanding pension benefit determinations to ERISA plan administrators should be appealable too. *Perlman v. Swiss Bank Corp. Comprehensive Disability Prot. Plan*, 195 F.3d 975, 978-80 (7th Cir. 2000). In *Perlman*, the Seventh Circuit relied specifically upon the similarity between remands to plan administrators in ERISA cases and remands to the Commissioner of Social Security in social security cases. *Perlman*, 195 F.3d at 979. Social Security remand orders are final judgments under sentence 4 of 42 U.S.C.S. § 405(g), but as the Fourth Circuit recently mentioned, **ERISA** has no comparable provision. No statutory language permits similar appeals under ERISA. See *Dickens v. Aetna Life Ins. Co.* 677 F.3d 228, (4th Cir. April 20, 2012).

The 9th Circuit in *Hensley* agreed with the Seventh Circuit in concluding that an ERISA remand may, in the proper circumstances constitute an appealable order. Hensley drew no analogy to the Social Security provision, but relied on the Ninth Circuit precedent, that a remand is appealable if it satisfies a three-part test (1) the district court order conclusively resolves a separable legal issue, (2) the remand order forces the agency to apply a potentially erroneous legal rule which might result in a wasted proceeding, and (3) review would, as a practical matter, be foreclosed if an immediate appeal were unavailable." *See Hensley v. Northwest Permanente P.C. Retirement Plan & Trust*, 258 F.3d 986, 993 (9th Cir. 2001), *overruled on other grounds by Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955 99th Cir. 2006)

VI. Counsel Fees

Prevailing Party Standard (pre-Hardt)

Pre –*Hardt v. Reliance Standard Life Ins. Co.*, 560 U.S. 242 (2010), the standard for counsel fees was a determination that the party was a "prevailing party." It stands to reason that "Interim fees are available under ERISA to the same extent as they are available under civil rights statutes if a party has prevailed on the merits of at least some of its claims." *Kaye v. Pacific Lumbar Co.*, 51 F.3d 1449, 1468-69, n.15 (9th Cir. 1995) There are many cases providing examples of whether a "remand order" justifies

the fee-shifting award, where courts held that an ERISA plaintiff who secures a remand to the plan administrator can be a prevailing party and may be entitled to an award of fees and costs. These courts conclude that where a court holds that a defendant violated ERISA and remands a case to the plan administrator for a redetermination of benefits eligibility, and the plaintiff sought a redetermination as potential relief, the plaintiff is a prevailing party.

See *Soltysiak v. Unum Provident Corp.,* 480 F.Supp.2d 970, 974 (W.D.Mich.2007) (holding that where "Plaintiff obtained a reversal of Defendant's denial of benefits and an order requiring Defendant to conduct a full and fair review of Plaintiff's disability claim," where "there were serious flaws in the decision-making process, and ... there was evidence of bad faith and a lack of substantial justification for the Plan's position," that it was within the court's discretion to award fees and costs to the plaintiff); *Frei v. Hartford Life Ins. Co.,* 2006 U.S. Dist. LEXIS 34784 (N.D. Cal. May 23, 2006). (Awarding fees under the Hummell test, noting that the Court's Order "altered the legal relationship of the parties in that Defendant is now under court order to reconsider Plaintiff's disability benefits claim in accordance with the remand order, and specifically to determine "whether Plaintiff can perform the essential duties of her occupation as a sales assistant/Assistant Vice-President at a trading desk in the investment banking sector in view of her limitations, without simply assuming accommodations that may not be available."); *Atwood v. Swire Coca Cola USA et al,* 2007 U.S. Dist. LEXIS 20599 (D. Utah March 22, 2007) ("While it is true that Atwood did not obtain relief in the form of unpaid long-term disability benefits as originally sought in the complaint, he prevailed at the critical stages of the case including the motion to dismiss and the ultimate decision at trial. The court therefore concludes that the fee request need not be reduced for failure to obtain a particular type of relief."); *Palmiotti v. Metro. Life Ins. Co.,* 2006 U.S. Dist. LEXIS 37490, (S.D.N.Y. June 6, 2006) (awarding fees and costs in the amount of $186,585.66 where the court did not award benefits, but remanded the plaintiff's application to the defendant for further consideration); *Peterson v. Continental Casualty Co.,* 282 F.3d 112 (2d Cir. 2002) affirmed fees for litigation costs and fees earned for performing the administrative remand ordered by the district court. *Mizzell v. Provident Life and Accident Insurance Co.*, 32 Fed. Appx. 352, 354 (9th Cir.2002). upheld an award of $177,351.22 where the district court did not award benefits, but remanded the case to the plan administrator for a new determination on the plaintiff's claim; "Relying on a common-sense, plain language reading of the Supreme Court's "prevailing party" precedents, the Mizzell court concluded that the plaintiff "succeed[ed] on [a] significant issue in litigation,' i.e., whether [the plan administrator] abused its discretion in denying [the plaintiff]'s claim, which 'achieve[d] some of the benefit [the plaintiff] sought in bringing suit,' i.e., to obtain a full and fair review of his claim." *Colby v. Assurant Employee Benefits* 635 F.Supp.2d 88, *13 (D. Mass. 2009); affirmed on appeal, 705 F.3d 58, 68 (1st Cir. 2013). (See the cases cited therein).

See the opposite approach, *Quinn v. Blue Cross and Blue Shield Ass'n,* 161 F.3d 472, 478-79 (7th Cir.1998) The plaintiff succeeded in persuading the district court that her LTD plan administrator violated ERISA by arbitrarily and capriciously terminating her LTD benefits. As a

remedy the district court-ordered that the claim be remanded to the plan administrator for reconsideration, and granted the plaintiff's motion for attorney's fees and costs. The Seventh Circuit affirmed the finding of an ERISA violation, but reversed the award of fees and costs, reasoning that "While Quinn may be a 'prevailing party' in that she will have her case remanded, she is not a prevailing party in the truest sense of the term.... Should Quinn ultimately succeed in her claim and be awarded benefits, she will then have the benefit, as the prevailing party, of the modest presumption that she is entitled to reasonable attorney's fees."

Hardt Changes the Legal Standard justifying an award of Attorneys Fees

Hardt v. Reliance Std. Life Ins. Co. of Can., 560 U.S. 242 (2010) changed the landscape for actions for counsel fees in these disputes. According to 29 U.S.C. §1132(g)(1), in a civil action for benefits "the court in its discretion may allow a reasonable attorneys fee and costs of action to either party." The Supreme Court concluded that a "fee claimant need not be a 'prevailing party' to be eligible for an attorney's fee award under 29 U.S.C. §1132(g)(1), "a fees claimant must show 'some degree of success on the merits' before a court may award attorney's fees. In *Hardt*, an ERISA case, the district court denied the parties' cross-motions for summary judgment, and remanded the matter to the plan administrator because, *inter alia*, it had failed to comply with ERISA guidelines in terminating the plaintiff's long-term disability benefits. 130 S. Ct. at 2153–54. On remand, the plaintiff was found eligible for benefits and was awarded more than $50,000 in accrued, past-due benefits. *Id.* at 2154. The plaintiff then moved for attorney's fees under § 1132(g) (1) of ERISA, which the district court awarded. *Id.* at 2154–55. The defendant appealed the fee award, which the Court of Appeals vacated. *Id.* at 2155. The Supreme Court ultimately reversed the decision of the Court of Appeals, finding that the district court properly exercised its discretion in awarding plaintiff attorney's fees because Plaintiff achieved some success on the merits of her case. *Id.* at 2158–59.

As noted, the Supreme Court determined that a fee claimant need not be a prevailing party in order to be eligible for attorney's fees under § 1132(g)(1), but rather, needs to show "some degree of success on the merits" in order to recover fees under this section. *Id.* at 2158. In *Hardt*, the Court found that the plaintiff satisfied this standard for several reasons.

First, it noted the district court's determination that the plan administrator had failed to comply with certain ERISA guidelines, thereby precluding the plaintiff from receiving the review she was entitled to under the applicable law. *Id.* at 2158. Second, the Court noted that the

district court had not only found compelling evidence that the plaintiff was disabled, but had also stated that it "was inclined to rule in [the plaintiff's] favor." *Id.* at 2158. Last, the Supreme Court observed that the district court instructed the plan administrator to adequately consider all of the evidence on remand within thirty (30) days, "[o]therwise, judgment will be entered in [the plaintiff's] favor." *Id.* at 2159. Notably, the Court declined to decide "whether a remand order, without more, constitutes 'some success on the merits' sufficient to make a party eligible for attorney's fees under § 1132(g)(1)." *Id at* 130 S. Ct. at 2158–59.

A plaintiff has experienced "some degree of success on the merits" when he presents a claim that the defendant violated his rights and the court rules that the defendant did violate those rights even if ultimately, the claimant loses on remand. Courts recognize that "this means that even the ultimate loses could receive an award of attorney's fees and costs, if on the way to defeat the litigant won a skirmish that conferred some legal benefit." *Loomis v. Exelon Corp*., 658 F.3d 667, 674-75 (7th Cir. 2011).

When the court determines that the claimant had "some success on the merits", she is then eligible for an award of attorney's fees under S 1132(g) (1) under Hardt, and it remains for the district court to determine whether fees are appropriate. Hardt itself "d[id] not foreclose" the application of an additional test in order to determine whether fees should be awarded to a party whose litigation success has made her eligible for such an award. 130 S. Ct. at 2158 n.8. Courts have thus applied what is commonly known as the "five-factor" test.

Courts typically apply five factors when deciding a motion for attorneys fees in remand cases. These are (1) the degree of the opposing parties' culpability or bad faith; (2) the ability of the opposing parties to satisfy an award of attorney's fees; (3) whether an award of attorney's fees against the opposing parties would deter other persons acting under similar circumstances; (4) whether the parties requesting attorney's fees sought to benefit all participants and beneficiaries of an ERISA plan or to resolve a significant legal question regarding ERISA itself; and (5) the relative merits of the parties' positions. *Florence Nightingale Nursing Serv., Inc. v. Blue Cross/Blue Shield of Alabama*, 41 F.3d 1476, 1485 (11th Cir. 1995); *Hummell v. S.E. Rykoff & Co*., 634 F.2d 446, 452 (9th Cir. 1980) "the Hummell factors") *Bittner v. Sadoff & Rydoy Indus.* 728 F.2d 820, 830 (7th Cir. 1984); *Cottrill v. Sparrow, Johnson & Ursilla, Inc*., 100 F.3d 220 (1st Cir. 1996).

The following are some examples of cases where counsel fees were awarded following *Hardt.*

Geist v. Hartford Life and Accident Ins. Co., 2010 US Dist. LEXIS 134869 at *3 (W.D. NY 2010): Awarding fees where the plaintiff obtained a remand because he "prevailed on a critical issue and he has expended significant fees just to get back to square one, *i.e.*, the opportunity to have a full and fair appellate review of his appeal..."

Bowers v. Hartford Life and Accident Ins. Co., 2010 US Dist. LEXIS 114663 at *2, 7 (S.D. Ohio 2010): "Based on its finding that Hartford's denial of Bowers' LTD benefits was arbitrary and capricious, this Court remanded the case to the Plan administrator... On remand, Hartford will have to consider this evidence, which may lead to a reinstatement of Bowers' benefits. This Court, therefore, concludes Bowers has achieved 'some success on the merits' at this remand stage and is, therefore, eligible for attorney's fees under § 1132(g)(1)."

Olds v. Ret. Plan of Int'l Paper Co., Inc., CIV.A. 09-0192-WS-N, 2011 WL 2160264, *1 (S.D. Ala. June 1, 2011), attorneys' fees were warranted in a case in which the district court remanded the claim to the administrator for "gross violations" of ERISA.

Holmstrom v. Metro. Life Ins. Co., 2011 US Dist. LEXIS 58766 at *12 (N.D. Ill. 2011): Awarding the plaintiff "fees for work performed during the initial case... [which] undoubtedly caused Defendants to agree to a second administrative appeal — in essence a 'voluntary remand.' This result qualifies as 'some degree of success on the merits' under *Hardt*."

Heath v. Metro. Life Ins. Co., 2011 US Dist. LEXIS 101504 at *6 (M.D. Tenn. 2011): "the outcome of the remand was a gain realized by Plaintiff and thus can fairly be characterized as 'some degree of success on the merits.' Indeed, as explained above, this Court is of the opinion that the remand in this case suggested that Defendant's evaluation of Plaintiff's condition was gravely flawed, not simply inconclusive... In light of this analysis, Plaintiff has established that he is eligible for an award of attorney fees under *Hardt*."

Kirkpatrick v. Liberty Mutual Group, Inc. 2012 US Dist. LEXIS 83925 *6 (S.D. Ind. 2012): "Kirkpatrick has established an ERISA violation and forced Liberty Life to review her

application for benefits with the proper care. For these reasons, Kirkpatrick has achieved 'some success on the merits.'"

Raybourne v. Cigna Life Ins. Co. of New York, 700 F.3d 1076, 1085-86 (7th Cir. 2012): Affirming the district court's fee award for litigation that culminated in a remand requiring Cigna to consider a Social Security Disability Insurance award that it had "simply ignored."

Mullins v. Prudential Ins. Co. of Am., 2012 US Dist. LEXIS 43723 at *8-9 (W.D. Ky. 2012): "In ordering remand for a full and fair review, this court found that Prudential's decision did not reflect that certain evidence had been considered... Thus we find that this remand was more than 'trivial' or 'purely procedural.' Mullins achieved 'some degree of success on the merits' on his claim for wrongful denial of benefits." (citations omitted).

Hayden v. Martin Marietta Materials, 2012 US Dist. LEXIS 156880 at *9-10 (W.D. Ky. 2012): "In the present case, the Court remanded Plaintiff's mental-health claim because it found that Defendant's benefits determination on that portion of her disability claim was arbitrary and capricious. Following *Hardt* and *McKay*, a remand to Defendant in the present case represents 'some degree of success on the merits' for Plaintiff and, thus, makes an award of attorneys' fees and costs available under § 1132(g)(1)."

Thies v. Life Ins. Co. of N. Am., 839 F.Supp.2d 886 at 890-891 (W.D. Ky. 2012): Citing multiple cases and holding that "[i]n the present case, the Court remanded to LINA because it found that LINA's benefits determination was arbitrary and capricious. Following *Hardt* and *McKay*, a remand to LINA represents 'some degree of success on the merits' for the plaintiffs and makes an award of attorney's fees and costs available under § 1132(g)(1)."

Conclusion

Remand should be used sparingly. Retroactive reinstatement of benefits is appropriate in ERISA cases where the court concludes that but for the insurer's improper conduct, the insured would have continued to receive the benefits. The claimant should continue receiving benefits until and unless he no longer proves his entitlement under the Plan. Counsel fees should be

awarded the plaintiff under the Lodestar method of calculation of attorneys fees, since a remand qualifies as “success on the merits” of the claim.