Filed 5/15/17 Sanjiv Goel, M.D., Inc. v. Screen Actors Guild-Producers Health Plan CA2/7

NOT TO BE PUBLISHED IN THE OFFICIAL REPORTS

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION SEVEN

SANJIV GOEL, M.D., INC., Plaintiff and Appellant, v. SCREEN ACTORS GUILD-PRODUCERS HEALTH PLAN, Defendant and Respondent.	B268400 (Los Angeles County Super. Ct. No. BC558088)

APPEAL from a judgment of the Superior Court of Los Angeles County, Stephen Moloney, Judge. Reversed and remanded with directions.

Pick & Boydston and Brian D. Boydston for Plaintiff and Appellant.

Bush Gottlieb, Erica Deutsch, David E. Ahdoot and Kirk M. Prestegard for Defendant and Respondent.

INTRODUCTION

Dr. Sanjiv Goel treated an enrollee of the Screen Actors Guild-Producers Health Plan (the Plan), received $6,230.67 of the $56,658.63 he billed for that treatment, and, after receiving an assignment from his patient, filed this action against the Plan to recover the balance. Goel's third amended complaint asserted one cause of action under section 502(a)(1)(B) of the federal Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1001 et seq.) (ERISA).[1] After the trial court sustained the Plan's demurrer to the third amended complaint without leave to amend and awarded the Plan attorneys' fees under ERISA section 502(g)(1), Goel appealed. We reverse the order sustaining the Plan's demurrer without leave to amend and the award of attorneys' fees.

FACTUAL AND PROCEDURAL BACKGROUND

A. *Goel Receives Significantly Less Than What He Billed the Plan*

In April 2012 Goel, a cardiologist, provided emergency medical services to an enrollee of the Plan.[2] Goel did not have a contract with the Plan that covered those services, and his "usual

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[1] Courts, including the United States Supreme Court, regularly refer to the provision codified at 29 United States Code section 1132(a) as "ERISA section 502(a)." (*Coast Plaza Doctors Hosp. v. Blue Cross of California* (2009) 173 Cal.App.4th 1179, 1185, fn. 6.)

and customary total billed charges" for the services were $56,658.63. Goel submitted a bill for that amount to the Plan, through Anthem Blue Cross of California (Blue Cross), pursuant to the claims submission instructions on the patient's health insurance card. In May 2012 Goel received $5,800.67 from Blue Cross as payment for his services.

Having acquired the patient's written authorization to appeal, on the patient's behalf, determinations made by the patient's insurance plan, Goel immediately sent Blue Cross "a written appeal of the under payment." In June 2012 Goel sent Blue Cross "a second written appeal . . . with additional information about the claim." In August 2012, after several exchanges with Blue Cross concerning the progress of his appeals, Goel sent Blue Cross "a third written appeal." After several more communications between Goel and Blue Cross regarding the status of the appeals, Blue Cross notified Goel in September 2012 that he would receive an additional $430. In November 2012 Blue Cross notified Goel that his third appeal was denied.[3] At no time did Blue Cross tell Goel that he should present his appeals directly to the Plan.

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[2] The facts are from Goel's third amended complaint. (See *In re Insurance Installment Fee Cases* (2012) 211 Cal.App.4th 1395, 1402 ["[o]n appeal of a judgment of dismissal entered after the sustaining of a demurrer without leave to amend, we accept as true all the material allegations of the complaint, reasonable inferences that can be drawn from those allegations, and facts that may properly be judicially noticed"].)

[3] Without specifically alleging Blue Cross denied the first and second appeals, the third amended complaint treats the denial of Goel's third appeal as conclusive of the appeals process.

B. *Goel Files This Action To Recover the Balance of His Bill, and the Trial Court Sustains the Plan's Demurrer to His Complaint*

In September 2014 Goel filed this action, asserting causes of action for breach of contract and quantum meruit, to recover the balance of the $56,658.63 he billed for his services. The Plan, as the only defendant,[4] demurred to the complaint on the ground, among others, that Goel did not sufficiently allege exhaustion of his administrative remedies. The trial court agreed, finding Goel's allegation on this point was conclusory, and the court sustained the demurrer with leave to amend.

C. *The Trial Court Sustains the Plan's Demurrer to the First Amended Complaint*

Goel filed a first amended complaint asserting the same two causes of action and adding allegations describing his appeals with Blue Cross. This time the Plan demurred on two grounds: First, Goel still had not sufficiently alleged exhaustion of administrative remedies because his appeals described by his allegations did not comply with the procedures set forth in the patient's health plan, and second, Goel had not identified the health plan terms the Plan allegedly breached.

The trial court determined the Plan's first argument applied only to Goel's breach of contract cause of action, which he asserted as an assignee of the patient's claimant rights under the

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[4] Although the complaint initially named as a defendant only the Screen Actors Guild-American Federation of Television and Radio Artists (SAG-AFTRA), Goel later added the Plan as a defendant and dismissed SAG-AFTRA.

health plan, not to Goel's cause of action for quantum meruit, which Goel asserted "in [his] own right." The trial court sustained the demurrer to the breach of contract cause of action on the first argument, noting Goel had alleged that the assignment of the patient's claimant rights occurred after Goel pursued his appeals with Blue Cross. The trial court also sustained the demurrer to the breach of contract cause of action for the second reason argued by the Plan: Goel had not identified any contract term obligating the Plan to pay Goel's "usual and customary charges." The trial court granted Goel leave to amend to address these issues.

D. *The Trial Court Sustains the Plan's Demurrer to the Second Amended Complaint*

In his second amended complaint, which asserted the same two causes of action, Goel included an allegation incorporating the terms of the patient's health plan as set forth in a Summary Plan Description (SPD), which Goel attached as an exhibit. He also alleged that, before he pursued his appeals with Blue Cross, the patient signed a "Member Authorization Form for a Designated Representative to Appeal a Determination," which authorized Goel to appeal insurance determinations on the patient's behalf.

In its next demurrer, the Plan argued for the first time that under the SPD the patient's health plan was a "self-funded benefit plan," and therefore ERISA preempted Goel's state law claims. Goel did not dispute this allegation, but asked for leave to convert his claim to an ERISA claim. The trial court sustained the demurrer to the second amended complaint with leave to amend to assert an ERISA claim.

The trial court, however, rejected the Plan's argument that, because Goel did not comply with the appeals procedure set forth in the SPD, Goel's ERISA claim was barred by failure to exhaust administrative remedies. Noting "an ERISA claimant is deemed to have exhausted available administrative remedies . . . when a plan fails to follow claims procedures," the trial court pointed out that Goel alleged Blue Cross acted as the Plan's agent when considering Goel's appeals, making an additional partial payment, and otherwise denying his appeals.

E. *The Trial Court Sustains the Plan's Demurrer to the Third Amended Complaint Without Leave To Amend and Grants the Plan's Request for Attorneys' Fees*

Goel's third amended complaint asserted a single cause of action for refusal to pay benefits under section 502(a) of ERISA. The Plan demurred yet again, repeating its argument that Goel had not sufficiently alleged exhaustion of administrative remedies. The trial court again rejected that argument, in particular rejecting the Plan's contention that Goel should have known, based on the appeal procedure described in the SPD, that Blue Cross did not have authority to act as the Plan's agent.

The Plan also argued Goel failed to state a claim under ERISA section 502(a)(1)(B). The trial court agreed with this argument, ruling: "Plaintiff fails to allege any facts as to how the patient, for whom Plaintiff brings this action, was not paid benefits according to the health plan. Plaintiff fails to allege any facts as to why the patient is due payment of Plaintiff's usual and customary charges under the plan. No facts are alleged as to whether the benefits were incorrectly denied or whether there was an abuse of discretion." The court sustained the demurrer to

the third amended complaint without leave to amend "because it has been made clear that Plaintiff's action can only proceed as an ERISA claim but Plaintiff has persisted in attempting to claim its usual and customary charges instead of focusing . . . on the patient's rights under the health plan."

The trial court also granted in part the Plan's subsequent motion for attorneys' fees under ERISA section 502(g)(1), which, according to the United States Supreme Court's decision in *Hardt v. Reliance Standard Life Ins. Co.* (2010) 560 U.S. 242, gives the court discretion in an ERISA action to award attorneys' fees to a party who can show "'some degree of success on the merits.'" (*Id.* at p. 255; see *ibid.* ["[a] claimant does not satisfy that requirement by achieving 'trivial success on the merits' or a 'purely procedural victor[y]'"].) The trial court determined the Plan was entitled to fees based on the court's order sustaining the Plan's demurrer to the third amended complaint, which "reflected Plaintiff's inability to allege facts to support an ERISA claim." Considering the factors identified by the Ninth Circuit in *Hummell v. S.E. Rykoff & Co.* (9th Cir. 1980) 634 F.2d 446,[5] the

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[5] In *Hummell* the Ninth Circuit held that, when exercising their discretion under 502(g), district courts "should consider these factors among others: (1) the degree of the opposing parties' culpability or bad faith; (2) the ability of the opposing parties to satisfy an award of fees; (3) whether an award of fees against the opposing parties would deter others from acting under similar circumstances; (4) whether the parties requesting fees sought to benefit all participants and beneficiaries of an ERISA plan or to resolve a significant legal question regarding ERISA; and (5) the relative merits of the parties' positions." (*Hummell*, *supra*, 634 F.2d at p. 453.)

trial court exercised its discretion to award the Plan attorneys' fees in the amount of $33,644.50. Goel timely appealed.

DISCUSSION

Goel argues his allegations stated a cause of action under ERISA section 502(a)(1)(B). The Plan disputes that contention and argues the court should have sustained its demurrer to the third amended complaint on the additional ground that Goel did not adequately plead exhaustion of administrative remedies. The Plan also asks for an award of attorneys' fees incurred in this appeal, pursuant to ERISA section 502(g)(1).

A. *Standard of Review*

"We apply the following well-established law in reviewing a trial court's order sustaining a demurrer without leave to amend: 'We independently review the ruling on a demurrer and determine de novo whether the complaint alleges facts sufficient to state a cause of action. [Citation.] We assume the truth of the properly pleaded factual allegations, facts that reasonably can be inferred from those expressly pleaded, and matters of which judicial notice has been taken. [Citation.] We construe the pleading in a reasonable manner and read the allegations in context.'" (*Tenet Healthsystem Desert, Inc. v. Blue Cross of California* (2016) 245 Cal.App.4th 821, 833; see *Brakke v. Economic Concepts, Inc.* (2013) 213 Cal.App.4th 761, 767 ["'facts appearing in exhibits attached to the complaint will also be accepted as true and, if contrary to the allegations in the pleading, will be given precedence'"].)

"When the trial court sustains a demurrer without leave to amend, 'we decide whether there is a reasonable possibility that the defect can be cured by amendment: if it can be, the trial court has abused its discretion and we reverse; if not, there has been no abuse of discretion and we affirm. [Citations.] The burden of proving such reasonable possibility is squarely on the plaintiff.'" (*Tenet Healthsystem*, *supra*, 245 Cal.App.4th at p. 833; accord, *Brakke*, *supra*, 213 Cal.App.4th at p. 766.)

B. *Goel Stated a Cause of Action Under Section 502(a)(1)(B)*

"ERISA § 502(a)(1)(B) provides: [¶] 'A civil action may be brought—(1) by a participant or beneficiary—. . . (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.' [Citation.] [¶] This provision is relatively straightforward. If a participant or beneficiary believes that benefits promised to him under the terms of the plan are not provided, he can bring suit seeking provision of those benefits. A participant or beneficiary can also bring suit generically to 'enforce his rights' under the plan, or to clarify any of his rights to future benefits." (*Aetna Health Inc. v. Davila* (2004) 542 U.S. 200, 210.) A medical services provider may pursue a claim under section 502(a) in the place of a plan beneficiary where the provider has received a valid assignment of the beneficiary's claimant rights under the plan. (*DB Healthcare, LLC v. Blue Cross Blue Shield of Arizona, Inc.* (9th Cir. 2017) 852 F.3d 868, 876; *Misic v. Building Service Employees Health and Welfare Trust* (9th Cir. 1986) 789 F.2d 1374, 1379.)

Goel argues he stated a cause of action under section 502(a) because he alleged his patient was a plan beneficiary, Goel provided him with covered medical services, the Plan underpaid Goel for those services, and Goel received a valid assignment of the patient's right to pursue a claim. Goel is correct: These allegations stated a cause of action under section 502(a)(1)(B). (See, e.g., *Tolle v. Carroll Touch, Inc.* (7th Cir. 1992) 977 F.2d 1129, 1135 ["[c]onsidering that [the plaintiff] relies on ERISA employee benefits programs as her exclusive basis for [her] breach of contract claim and considering that Section 502(a)(1)(B) allows participants to bring claims for breach when persons or entities fail to comply with the terms of an employee benefit plan," the "allegations . . . raise a claim for relief under Section 502(a)(1)(B)"]; *Haag v. MVP Health Care* (N.D.N.Y. 2012) 866 F.Supp.2d 137, 145 [doctor assignee who claimed he was "entitled to full benefits for [the] medical care" but was paid "less than seven percent of the benefits claim" stated a claim under section 502(a)(1)(B)].)

The Plan argues the allegations were not specific enough. The Plan cites several federal district court decisions dismissing claims under section 502(a)(1)(B) for failure to identify a specific plan provision conferring the benefit in question. (See, e.g., *Almont Ambulatory Surgery Center, LLC v. UnitedHealth Group, Inc.* (C.D. Cal. 2015) 99 F.Supp.3d 1110, 1120, 1159 [ruling the plaintiffs did not meet their pleading burden under section 502(a)(1)(B), but noting it was "a close call" and "quite likely that the deficiencies . . . can easily be corrected" and granting leave to amend]; *Stewart v. National Educ. Assn.* (D.D.C. 2005) 404 F.Supp.2d 122, 130 ["[a] plaintiff who brings a claim for benefits

under ERISA must identify a specific plan term that confers the benefit in question"].)

As the Plan recognizes, however, California's pleading standards determine whether Goel stated a claim. "The California Supreme Court has consistently held that 'a plaintiff is required only to set forth the essential facts of his case with reasonable precision and with particularity sufficient to acquaint a defendant with the nature, source and extent of his cause of action. . . .' [Citation.] 'The particularity required in pleading facts depends on the extent to which the defendant in fairness needs detailed information that can be conveniently provided by the plaintiff; less particularity is required where the defendant may be assumed to have knowledge of the facts equal to that possessed by the plaintiff. [Citation.]' [Citation.] There is no need to require specificity in the pleadings because 'modern discovery procedures necessarily affect the amount of detail that should be required in a pleading.'" (*Ludgate Ins. Co. v. Lockheed Martin Corp.* (2000) 82 Cal.App.4th 592, 608, quoting *Youngman v. Nevada Irrigation Dist.* (1969) 70 Cal.2d 240, 245; see *Schulz v. Neovi Data Corp.* (2007) 152 Cal.App.4th 86, 95; *Doheny Park Terrace Homeowners Assn., Inc. v. Truck Ins. Exchange* (2005) 132 Cal.App.4th 1076, 1099.)

Goel's allegations "sufficiently acquainted" the Plan with the "nature, source and extent" of Goel's claim. As Goel aptly puts it: "[T]here is n0000000000000000000000000000o issue that the services provided were covered by the [patient's health plan], the issue is whether or not [the Plan] is obligated to pay more than it did for those services." And Goel points to specific language in the SPD that he alleges obligated the Plan to pay

more than it did.[6] Goel has pleaded his cause of action with enough specificity. (See *Texas General Hospital, LP v. United Healthcare Services, Inc.* (N.D. Tex., June 28, 2016, No. 3:15-CV-02096-M) 2016 WL 3541828, at p. 4 [in the ERISA context, "[a] complaint must contain enough facts about an ERISA plan's provisions to make a § 502 claim plausible and give the defendant notice as to which provisions it allegedly breached"].) Any possible remaining uncertainty on the part of the Plan will be cured by the Plan's first set of interrogatories or requests for admission.

Moreover, the federal district court decisions the Plan cites are distinguishable because the plaintiffs in those cases failed to identify plan terms entitling them to any benefit at all. (See *Almont Ambulatory Surgery*, *supra*, 99 F.Supp.3d at p. 1158 [plaintiffs, surgery centers and physicians who treated patients for morbid obesity, did "not actually allege that the specific services they provided to the patients at issue were covered under the terms of the relevant plans or describe the plan terms that

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[6] The language Goel cites appears in sections addressing "Co-insurance, Co-payments and Out-of-Pocket Maximums" and "Allowable Charges or Allowed Amount or Allowance" and in a table labeled "Major Medical Co-insurance." Taken together, Goel argues, this language states the Plan "will pay 80% of the 'Plan Allowance' for out of network medical charges, but then fails to define the 'Plan Allowance,'" except by "the hopelessly overbroad and ambiguous statement that 'Allowance' is an 'amount . . . established by the Board of Trustees from time to time, for the area in which the charges are incurred.'" (The Plan does not dispute this interpretation.) Goel also alleged the Plan abused any discretion it had under these terms when it paid him what it did.

would support such coverage"]; *Innova Hospital San Antonio, L.P. v. Blue Cross and Blue Shield of Georgia, Inc.* (N.D. Tex. 2014) 995 F.Supp.2d 587, 601-602 [medical service providers generally alleged the 33 defendant health plan administrators failed "'to make payments of benefits . . . as required under the terms of the [ERISA-governed] plans,'" but did not allege any facts about the benefits due under the plans]; *Afram v. United Food & Commercial Workers Unions & Participating Employers Health & Welfare Fund* (D.D.C. 2013) 958 F.Supp.2d 275, 279 [surgeon who alleged plan administrator promised to pay his fee did not identify any plan term entitling him to such payment]; *Stewart*, *supra*, 404 F.Supp.2d at p. 132 [plaintiffs failed to identify any terms of an ERISA-covered life insurance contract entitling them to proceeds derived from the life insurance company's privatization].)

By contrast, Goel alleged he provided covered medical services and, according to language in the SPD, was entitled to more payment for those services than he received. Indeed, it is undisputed Goel was entitled to some payment for those services—after all, the Plan initially paid him $5,800.67 and, as a result of his appeals, paid him an additional $430. The issue is simply whether the Plan was obligated to pay him more. Again, the Plan's first set of written discovery will eliminate any possible confusion about which provisions in the plan Goel contends entitled him to additional payment.

C. *Goel Pleaded Exhaustion of Administrative Remedies*

The Plan also contends that the trial court's order sustaining the Plan's demurrer to the third amended complaint without leave to amend was proper because, although the trial

court rejected this argument, Goel failed to allege he exhausted his administrative remedies or allege facts excusing him from that requirement. The Plan argues "Goel failed to follow the express internal administrative review procedures set forth in the SPD." Those procedures provide, in relevant part: "If your denied claim is . . . for hospital or medical benefits, you may appeal one time to the Benefits Committee of the Board of Trustees [(Benefits Committee)]." The Plan argues Goel's decision to appeal to Blue Cross, rather than the Benefits Committee, bars his claim.

ERISA generally requires a plan participant to avail himself of the plan's own internal review procedures before bringing suit. (*In re Marriage of Rich* (1999) 73 Cal.App.4th 419, 424; see *Bilyeu v. Morgan Stanley Long Term Disability Plan* (9th Cir. 2012) 683 F.3d 1083, 1088 ["'[a]s a general rule, an ERISA claimant must exhaust available administrative remedies before bringing a claim in federal court'"]; *Vaught v. Scottsdale Healthcare Corp. Health Plan* (9th Cir. 2008) 546 F.3d 620, 626 (*Vaught*) ["we have consistently held that before bringing suit under § 502, an ERISA plaintiff claiming a denial of benefits 'must avail himself or herself of a plan's own internal review procedures before bringing suit in federal court'"].)[7] For this

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[7] In *Vaught* the Ninth Circuit explained: "ERISA itself does not require a participant or beneficiary to exhaust administrative remedies in order to bring an action under § 502 of ERISA, 29 U.S.C. § 1132. . . . However, based on both the text of ERISA and its legislative history, we long ago concluded that 'federal courts have the authority to enforce the exhaustion requirement in suits under ERISA, and that as a matter of sound policy they should usually do so.'" (*Vaught*, *supra*, 546 F.3d at p. 626; see *id.* at pp.

reason, some federal courts have required a plaintiff bringing an ERISA claim to allege exhaustion of administrative remedies. (Compare *In re Managed Care Litigation* (S.D. Fla. 2009) 595 F.Supp.2d 1349, 1353 ["the Eleventh Circuit requires plaintiff to affirmatively plead exhaustion on the face of the complaint"] with *Encompass Office Solutions, Inc. v. Ingenix, Inc.* (E.D. Tex. 2011) 775 F.Supp.2d 938, 968 [exhaustion of administrative remedies is an affirmative defense to an ERISA claim and need not be pleaded].) Nevertheless, although "'there is disagreement among the federal courts as to whether a plaintiff must affirmatively plead exhaustion or if the failure to exhaust is merely a defense,'" "'at least one court in the Ninth Circuit has noted that the Supreme Court's decision in [*Jones v. Bock* (2007) 549 U.S. 199, 212] indicates that exhaustion is typically an affirmative defense under the Federal Rules, and that therefore dismissal due to a failure to affirmatively allege exhaustion would be improper." (*Almont Ambulatory Surgery*, *supra*, 99 F.Supp.3d at pp. 1178-1179.)[8]

Goel alleged he "exhausted all available administrative remedies" before filing his third amended complaint. The Plan argues Goel did not adequately plead exhaustion because the allegations describing his appeals to Blue Cross establish he did

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626-627 & 626, fn. 2 [this "judge-made exhaustion requirement" is not "a jurisdictional requirement"].) The Plan cites no California decision adopting this exhaustion requirement for ERISA claims. On the other hand, Goel does not dispute the requirement applies. We assume, without deciding, the requirement applies here.

[8] Because we conclude Goel adequately pleaded exhaustion, we need not take sides on this issue.

not appeal to the Plan's Benefits Committee as required by the SPD.

It is true "[a] complaint is . . . vulnerable to demurrer on administrative exhaustion grounds where the complaint's allegations, documents attached thereto, or judicially noticeable facts indicate that exhaustion has not occurred and no valid excuse is alleged in the pleading to avoid the exhaustion requirement." (*Parthemore v. Col* (2013) 221 Cal.App.4th 1372, 1379.) But the allegations here do not establish Goel failed to comply with the appeals procedure set forth in the SPD because Goel alleged that, at all relevant times, Blue Cross acted as the Plan's agent. Therefore, giving the complaint a reasonable interpretation (*Jones v. ConocoPhillips* (2011) 198 Cal.App.4th 1187, 1193), Goel complied with the appeals procedure described in the SPD by appealing to the Plan's agent for such matters, i.e., Blue Cross.

To be sure, the Plan challenges Goel's allegation that Blue Cross acted as its agent. But "[a]n allegation of agency is an allegation of ultimate fact that must be accepted as true for purposes of ruling on a demurrer." (*City of Industry v. City of Fillmore* (2011) 198 Cal.App.4th 191, 212; accord, *Blickman Turkus, LP v. MF Downtown Sunnyvale, LLC* (2008) 162 Cal.App.4th 858, 886; see *Doe v. City of Los Angeles* (2007) 42 Cal.4th 531, 550 ["the complaint ordinarily is sufficient if it alleges ultimate rather than evidentiary facts"]; *Garton v. Title Ins. & Trust Co.* (1980) 106 Cal.App.3d 365, 376 ["[g]enerally, an allegation of agency is an allegation of ultimate fact and is, of itself, sufficient to avoid a demurrer"].) Because "an allegation of agency as such is a statement of ultimate fact," at the pleading stage "further allegations explaining how this fact of agency

originated become unnecessary." (*Skopp v. Weaver* (1976) 16 Cal.3d 432, 439.) Goel adequately pleaded exhaustion of administrative remedies.

D. *Remand is Also Required for The Trial Court To Reconsider The Plan's Entitlement to Attorneys' Fees*

Because we are reversing the trial court's order sustaining the Plan's demurrer without leave to amend, we deny the Plan's request for attorneys' fees incurred on appeal. Moreover, "some degree of success on the merits" is essential to an award of attorneys' fees under section 502(g)(1) (*Hardt*, *supra*, 560 U.S. at p. 255), and our decision deprives the Plan of the success that supported the trial court's award of $33,644.50 in attorneys' fees. Therefore, we remand the matter for the trial court to consider, after giving the parties an opportunity to be heard, whether the award of attorneys' fees to the Plan can stand. (See *Marine Forests Society v. California Coastal Com.* (2008) 160 Cal.App.4th 867, 877 ["procedural success during the course of the litigation is insufficient to justify . . . attorney fees where the ruling is later vacated or reversed on the merits"]; *Allen v. Smith* (2002) 94 Cal.App.4th 1270, 1284 [same]; *Miller v. California Com. On Status of Women* (1985) 176 Cal.App.3d 454, 458 [same].)

DISPOSITION

The judgment is reversed. The trial court is directed to vacate its order sustaining the Plan's demurrer to the third amended complaint without leave to amend and to enter a new order overruling the demurrer. The trial court is also directed to reconsider its order granting in part the Plan's motion for

attorneys' fees under ERISA section 502(g)(1). Goel is to recover his costs on appeal.

SEGAL, J.

We concur:

ZELON, Acting P. J.

SMALL, J.*

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*Judge of the Los Angeles Superior Court, assigned by the Chief Justice pursuant to article VI, section 6 of the California Constitution.