

ERISA Litigation Primer 2017



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ERISA Litigation Primer 2017

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Foreword

This is a new edition of a publication that has been offered by DRI, in previous editions, for a number of years.

It provides an overview of ERISA that will benefit specialists, as well as defense practitioners who have occasion to handle ERISA-related matters from time to time.

The new edition is made available to DRI members through the auspices of the DRI Life, Health and Disability Committee. We are indebted to past committee chair and former DRI board member Mark E. Schmidtke of Ogletree, Deakins, Nash, Smoak & Stewart, P.C., in Valparaiso, Indiana, and Jaime Ruth Ebenstein of J R Ebenstein Consultants Chtd. in Boca Raton, Florida, for their generous contributions of time and expertise in preparing this edition.

Jay Ludlam
DRI Director of Publications
April 2017

DRI Mission, Diversity Statements

DRI is the international membership organization of all lawyers involved in the defense of civil litigation.

DRI is committed to: enhancing the skills, effectiveness, and professionalism of defense lawyers; anticipating and addressing issues germane to defense lawyers and the civil justice system; promoting appreciation of the role of the defense lawyer; and improving the civil justice system and preserving the civil jury.

DRI is the international membership organization of all lawyers involved in the defense of civil litigation. As such, DRI wishes to express its strong commitment to the goal of diversity in its membership. Our member attorneys conduct business throughout the United States and around the world, and DRI values highly the perspectives and varied experiences that are found only in a diverse membership. The promotion and retention of a diverse membership is essential to the success of our organization as a whole as well as our respective professional pursuits. Diversity brings to our organization a broader and richer environment, which produces creative thinking and solutions. As such, DRI embraces and encourages diversity in all aspects of its activities. DRI is committed to creating and maintaining a culture that supports and promotes diversity, which includes sexual orientation, in its organization.

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Overview of ERISA Litigation

The Employee Retirement Income Security Act, 29 U.S.C. §1001, *et seq.* (“ERISA”) was enacted by Congress in 1974. The law has been the subject of a tremendous amount of litigation, including numerous United States Supreme Court decisions. Even so, most lawyers, particularly traditional “insurance defense” lawyers, have very little, if any, familiarity with ERISA. After more than 25 years in existence as the “law of the land,” ERISA is still ignored in cases where its application would be unquestioned if the parties and their attorneys were better informed.

The *ERISA Litigation Primer* was originally published in 1992 and revised in 1994. In 1998, a special supplement was published revising Chapter 4 (Standard of Review). The entire *Primer* was again revised in 2000. Since its original publication, there have been numerous refinements to the case law interpreting and applying ERISA as well as several United States Supreme Court opinions. The 2002 edition was reorganized and updated to reflect these developments. In 2003 and 2004, Chapter 3 (Preemption) was revised to reflect significant new Supreme Court precedents. Also in 2004, Chapter 4 (Standard of Review) was revised to add a discussion regarding the Supreme Court’s rejection of the treating physician rule. In 2005, additional material was added to Chapter 2 (Establishing an ERISA Plan), Chapter 3 (Preemption), Chapter 4 (Standard of Review), and Chapter 11 (Jurisdiction and Removal to Federal Court). Further material was added to Chapter 4 in 2006, 2007, and 2010. Further material was also added to Chapter 8 in 2007. In 2008, Chapters 5 and 8 were supplemented to reflect recent Supreme Court precedent expanding the persons with standing to bring actions for breach of fiduciary duties under section 502(a)(2). In 2009 and 2010, Chapter 10 was revised to reflect ongoing developments involving the accrual of limitations periods under ERISA. In 2009, the conflict of interest section of Chapter 4 was rewritten to reflect the recent Supreme Court decision in *Met Life v. Glenn*. In 2010, Chapter 10 was supplemented to include more recent circuit court authority regarding the accrual of contractual limitations periods. Additional material was also added to Chapter 13 (Exhaustion of Administrative Remedies). In 2011, Chapter 2 (Establishing an ERISA Plan) was revised to reflect recent congressional amendments of ERISA affecting Indian tribal government plans; Chapter 4 (Standard of Review) was supplemented with a discussion of the Supreme Court decision in *Conkright v. Frommert*, as well as other developments; and Chapter 8 (ERISA’s Civil Enforcement Scheme) was supplemented with a discussion of the Supreme Court decision in *Hardt v. Reliance Standard*. In 2012, Chapters 6 and 8 were revised to add discussion about the Supreme Court’s decision in *CIGNA Corporation v. Amara*. In 2013, Chapter 2 was revised to add a discussion about the application of ERISA in foreign courts; Chapter 3 was revised to add a discussion about the application of ERISA to individual insurance policies; Chapter 5 was revised to add a discussion about fiduciary violation claims in the context of stock drop cases; Chapter 8 was revised to add a discussion about post-*Amara* cases in the circuit courts and ERISA remedies; Chapter 9 was revised to add a discussion about recent holdings concerning ERISA’s retaliation provision; and Chapter 13 was revised to update case law on exhaustion of remedies. In 2014, Chapter 2 was revised to add discussion regarding recent developments concerning church plans; Chapter 8 was revised to include a discussion of the Supreme Court decision in *U.S. Airways, Inc. v. McCutchen*; and Chapter 10 was revised to add a discussion regarding contractual limitations periods and the Supreme Court decision in *Heimeshoff v. Hartford Life Ins. Co.* In

2015, Chapter 5 was revised to include updated material regarding monetary relief for fiduciary breaches and developments in the law following the Supreme Court decision in *Fifth Third Bancorp v. Dudenhoeffer* and Chapter 8 was revised to discuss recent developments in the remedy of estoppel and other potential remedies under §502(a)(3). In 2016, chapters 3, 5, 7, and 8 were updated to include discussion of recent Supreme Court decisions in *Gobeille v. Liberty Mutual*, *Montanile v. Board of Trustees*, and *Tibble v. Edison*, as well as recently proposed amendments to the claim procedure regulations applicable to ERISA disability plans.

The purpose of this *Primer* is to provide insurance defense lawyers, whose practice may span several subject areas from auto accidents to product liability, with a basic background in ERISA. The *Primer* also provides information on some rather unique areas of ERISA to those who concentrate their practice in the area of employee benefits law. While the *Primer* may not equip defense lawyers with all of the information necessary to litigate every ERISA case, it should at least provide a basis for recognition that a particular case is governed by ERISA and the federal common law that has developed under ERISA. Because ERISA law is everchanging, counsel should always be sure to confirm that information obtained from this *Primer* is current.

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Establishing an ERISA Plan

I. ERISA Governs Certain Life, Health, Disability, and Pension Benefits Provided by Employers

The Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. §1001, *et seq.* (“ERISA”), comprehensively regulates life, health, disability and pension benefits provided by employers to employees pursuant to employee benefit plans. A threshold issue in determining whether or not ERISA is applicable in a given case is whether the benefits at issue arise out of an *employee benefit plan*. In struggling with this issue, courts have developed several tests in order to identify what it means to establish or maintain an employee benefit plan under ERISA. These tests include the statutory definition, the “*Donovan*” approach,¹ pertinent Department of Labor regulations, and key United States Supreme Court decisions.

II. Statutory Test

The first step in understanding the elements that make up a benefit plan under ERISA is to review the definitions contained in the statute itself. ERISA defines an employee *welfare* benefit plan as:

Any plan, fund or program which... is established or maintained by an employer or employee organization... to the extent that such plan, fund or program was established or is maintained for the purpose of providing for its participants or their beneficiaries through the purchase of insurance... or otherwise, (A) medical, surgical or hospital care or benefits or benefits in the event of sickness, accident, disability or death or unemployment....

ERISA, §3(1) [emphasis added]. A *pension* benefit plan is defined as:

[A]ny plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that by its express terms or as a result of surrounding circumstances such plan, fund, or program—

- (i) provides retirement income to employees, or
- (ii) results in a deferral of income by employees for periods extending to the termination of covered employment or beyond,

regardless of the method of calculating the contributions made to the plan, the method of calculating the benefits under the plan or the method of distributing benefits from the plan.

ERISA, §3(2)(A).

Accordingly, there are five main statutory prerequisites for a plan to qualify as an employee benefit plan under ERISA:

- 1) a plan, fund or program;
- 2) established or maintained;
- 3) by an employer or an employee organization;

¹ *Donovan v. Dillingham*, 688 F.2d 1367 (11th Cir. 1982).

- 4) for the purpose of providing certain benefits;
- 5) to participants or beneficiaries.

See *Ed Miniat, Inc. v. Globe Life Insurance Group, Inc.*²

Courts have taken varying approaches in determining whether or not a given plan constitutes an “ERISA plan.” Many courts have followed a simplistic approach, holding that where all five statutory prerequisites have been met, the plan is an ERISA plan.

III. The “*Donovan*” Approach

Some courts look beyond the statutory definitions in determining whether an ERISA plan has been established or maintained. Almost all of these courts either rely exclusively on the holding and reasoning of the Eleventh Circuit in *Donovan v. Dillingham*,³ or have incorporated it into a multi-step test.

In *Donovan*, the Court stated that “a plan, fund or program under ERISA is established if, from the surrounding circumstances, a reasonable person could ascertain the intended benefits, class of beneficiaries, source of financing, and the procedures for receiving benefits.”⁴ The determination of whether these criteria are met in a given case is made by the court.⁵ No formal written plan is required.⁶ Moreover, the purchase of insurance does not conclusively establish a plan, but the purchase of one or more group policies covering a class of employees constitutes “substantial evidence” that a plan, fund or program exists.⁷ Interestingly, both plaintiffs and defendants have relied on the language in *Donovan* to support positions for and against the existence of an ERISA plan.

Defense attorneys should be aware that although the United States Supreme Court case *Pilot Life Insurance Co. v. Dedeaux*,⁸ did not specifically decide the issue, the Court assumed that an ERISA plan existed. The level of employer involvement in the group insurance arrangement in *Pilot Life* was fairly minimal. The employer contributed toward disability premiums and forwarded those premiums to the insurer. The employer provided claim forms to its employees and forwarded the completed forms to the insurer. Thus, under what many refer to as the “*Donovan*” approach, very little employer involvement is needed in order to prove the establishment of a benefit plan by the employer. One need only prove that there are intended benefits (an insurance policy providing benefits); a class of beneficiaries (employees who receive those benefits); a source of financing (premium payments); and the procedures for applying for and receiving benefits (the policy and its claim procedures).

IV. The Department of Labor “Safe Harbor” Exemption

Many employers who choose to provide benefits to their employees do so through the purchase of one or more group insurance policies. Plans that are funded in this manner are commonly referred to as insured benefit plans. Insured benefit plans have been particularly problematic for the courts in determining whether

² 805 F.2d 732, 738 (7th Cir. 1986), *cert. denied*, 107 S. Ct. 3188.

³ 688 F.2d 1367 (11th Cir. 1982).

⁴ *Id.* at 1372.

⁵ *Id.* at 1373.

⁶ *Id.* at 1372.

⁷ *Id.* at 1373.

⁸ 481 U.S. 41 (1987).

such arrangements constitute ERISA plans. As noted earlier, the *Donovan* court addressed this issue, specifically stating that “the purchase of insurance did not *conclusively* establish a plan, fund or program, but that the purchase was *evidence* of the establishment of such a plan, fund or program.”⁹ The Court further explained that the purchase of a group policy or multiple policies that covered classes of employees would offer *substantial evidence* that an ERISA plan had been established.¹⁰

In what is commonly referred to as the “Safe Harbor” exemption, the Department of Labor has also addressed the issue of group insurance arrangements by promulgating a regulation that specifically excludes certain types of group insurance arrangements from the definition of employee welfare benefit plans.¹¹ In relevant part, the regulation states as follows:

For purposes of Title I of the Act and this Chapter, the terms “employee welfare benefit plan” and “welfare plan” shall not include a group or group-type insurance program offered by an insurer to employees or members of an employee organization, under which

- (1) no contributions are made by an employer or an employee organization;
- (2) participation in the program is completely voluntary for employees or members;
- (3) the sole functions of the employer or employee organization with respect to the program are, without endorsing the program, to permit the insurer to publicize the program to employees or members, to collect premiums through payroll deductions or dues checkoffs and to remit them to the insurer; *and*
- (4) the employer or employee organization receives no consideration in the form of cash or otherwise in connection with the program, other than reasonable compensation excluding any profit, for administrative services actually rendered in connection with payroll deductions or dues checkoffs.

However, the Department of Labor has stressed that in order for this exemption to apply, the employer’s role must be strictly limited:

The functions of the employer or employee organization must be limited to publicizing the program and handling premium payments through payroll deductions or dues checkoffs. The employer... must not hold out the program as a benefit of employment or membership.

Notice of Proposed Rule Making, Dated June 9, 1975. In subsequent comments on these regulations, the Department of Labor stated that there must be an absence of employer involvement:

[The] requirement of employer neutrality is the key to the rationale for not treating such a program as an employee benefit plan, namely, the absence of employer involvement.

40 F.R. 34525 (August 15, 1975).

The Department of Labor has continued to stress the absence of employer involvement for the exemption under §2510.3-1(j) to be applicable. In Opinion Letter No. 77-54 (August 8, 1977), the Department of Labor determined that the regulation was inapplicable simply because the employer collected premiums in a manner other than a payroll deduction, negotiated with the insurer, and assisted members with claims. In Opinion Letter No. 80-22A (April 17, 1980), it found that the regulation was not satisfied when the Trust selected insurance plans, reserved the right to terminate them, and sent out literature under its own auspices.

⁹ *Id.* [emphasis added].

¹⁰ *Id.*

¹¹ See 29 C.F.R. §2510.3-1(j).

Department of Labor Regulations, the Notice of Proposed Rule Making, and subsequent comments in the Federal Register, all clearly indicate that the Department of Labor's view is that all four criteria must be met before a plan will be exempt from ERISA. A majority of courts have agreed and have held that all four criteria must be met before exempting a plan from ERISA.¹²

V. *Ft. Halifax Packing Co., Inc. v. Coyne*

The United States Supreme Court has also commented on what characteristics cause a plan to be an “employee benefit plan” under ERISA. *Ft. Halifax Packing Co., Inc. v. Coyne*.¹³ The issue in *Ft. Halifax* was whether a state statute mandating a one-time severance payment upon closure of a manufacturing plant was preempted by ERISA. The Court held that it was not preempted because the statute did not relate to an ERISA “plan.” The Court stated that the administrative realities of an ERISA “plan” include the fact that an employer makes a commitment systematically to pay certain benefits, undertaking a host of obligations, such as determining the eligibility of claimants, calculating benefit levels, making disbursements, monitoring the availability of funds for benefit payments, and keeping appropriate records in order to comply with applicable reporting requirements. Because the state statute in *Ft. Halifax* did not affect or require the employer to establish any of these “administrative realities,” but only required one-time lump-sum payments to all employees, there was no “plan.”

While the Court's opinion in *Ft. Halifax* speaks to the employer doing this, it is important to note that there was no insurance involved in that case, and therefore it would be only the employer who had these responsibilities. This is an important distinction when plaintiffs point to *Ft. Halifax* to claim that employers have this duty; rather, *Ft. Halifax* states that *someone* should have these duties. Several courts have looked to whether the employer is performing the functions listed in *Ft. Halifax* to determine whether a program “constitutes a plan” under ERISA. See, e.g., *Clark v. Golden Rule Insurance Co.*¹⁴ Other courts have looked to the functions themselves, regardless of who is performing them, in determining whether a program “constitutes a plan” under ERISA. See, e.g., *Gilbert v. Burlington Industries, Inc.*,¹⁵ *Eichner v. Celtic Life Insurance Co.*¹⁶ (*Ft. Halifax* did not rule that the employer himself had to perform the administrative functions under an insurance policy in order for the plan to qualify as an ERISA plan; rather, *Ft. Halifax* ruled that the nature of the employer-provided benefits determines whether the ERISA plan exists, not the identity of the administrator of the plan; essentials of the plan can be adopted explicitly or implicitly from sources outside the plan (e.g., an insurance company's procedure for processing claims)).

¹² See, e.g., *Thompson v. American Home Assurance Co.*, 95 F.3d 429 (6th Cir. 1996); *Shiffler v. Equitable Life Assur. Soc'y*, 838 F.2d 78 (3d Cir. 1988); *U.S. v. Blood*, 806 F.2d 1218 (4th Cir. 1986); *Memorial Hosp. Sys. v. Northbrook Life Ins. Co.*, 904 F.2d 236 (5th Cir. 1990); *Brundage-Peterson v. Compcare Health Servs. Ins. Corp.*, 877 F.2d 509 (7th Cir. 1989); *Silvera v. Mutual Life Ins. Co. of N.Y.*, 884 F.2d 423 (9th Cir. 1989); *Kanne v. Connecticut Gen. Life Ins. Co.*, 867 F.2d 489 (9th Cir. 1988). But see *Kidder v. H & B Marine*, 932 F.2d 347 (5th Cir. 1991) (while language of federal regulation compels reading that the four conditions are jointly sufficient for exclusion from ERISA, it does not compel reading that conditions are also individually necessary for exclusion).

¹³ 482 U.S. 1 (1987).

¹⁴ 737 F. Supp. 376 (W.D. La. 1989).

¹⁵ 765 F.2d 320 (2d Cir. 1985), *aff'd*, 477 U.S. 901 (1986).

¹⁶ 596 N.E.2d 1124 (Ohio App. 1991).

The Supreme Court has made it clear that a plan is established under the *Ft. Halifax* analysis with “minimal ongoing administrative scheme or practice.” *District of Columbia v. Greater Washington Bd. of Trade*.¹⁷ The *Ft. Halifax* exception is narrow. A minimal ongoing administrative scheme is all that is needed to establish a plan. *Garrett v. Veterans Memorial Medical Center*.¹⁸

VI. Multiple Employer Trusts (METs)

In many instances, an employer makes a decision to fund an employee welfare benefit plan through the purchase of insurance from a multiple employer trust (“MET”). This happens most often with small employers who belong to certain associations that offer to their members the ability to participate in a group insurance trust. The fact that a plan is connected in some manner with a multiple employer trust does not exempt it from ERISA.

While a multiple employer trust itself may not be an employee benefit plan, the purchase of insurance from the trust is evidence of an employer’s intent to form an ERISA-governed plan. An employee benefit plan is distinct from the trust, even though the plan is funded through the multiple employer trust. *Ed Miniat, Inc. v. Globe Life Insurance Group, Inc.*¹⁹ When an employer or group of employers maintains a plan providing benefits for employees, there is an employee benefit plan governed by ERISA,²⁰ regardless of the way in which the plan is funded. See generally, *Memorial Hospital System v. Northbrook Life Insurance Co.*;²⁰ *Ed Miniat, Inc. v. Globe Life Insurance Group, Inc.*;²¹ *Credit Managers Ass’n of Southern California v. Kennesaw Life & Accident Insurance Co.*;²² and *Donovan v. Dillingham*.²³

At the trust level, an MET clearly does not constitute an ERISA plan unless it is established or maintained by an employer or an employee organization. In 1980, the Fifth Circuit issued its seminal decision in *Taggart Corp. v. Life & Health Benefits Admin.*,²⁴ wherein it held that a multiple employer trust, which provides group insurance to employers too small to qualify for group rates on their own, is not an ERISA plan. It noted that ERISA does not regulate the bare purchase of health insurance where the purchasing employer neither directly nor indirectly owns, controls, administers or assumes responsibility for the policy or its benefits. In *Taggart*, the defendants were arguing that the multiple employer trust *itself* was the ERISA plan.

This argument was faulty, in that there were really two levels of concern. One was the policy at the multiple employer trust level; the other was the program established by the employer, which was simply funded by this multiple employer trust policy. It was the employer who established the ERISA plan by funding benefits to his employees, not the multiple employer trust. Nonetheless, the argument made by defendants was that the multiple employer trust itself was the ERISA plan, and the Fifth Circuit correctly noted that this was not true.

Unfortunately, *Taggart* became known as the seminal case for the proposition that the funding of a plan through an MET disqualified the plan from ERISA coverage. The Fifth Circuit recently clarified its position in

¹⁷ 506 U.S. 125 (1992).

¹⁸ 1993 U.S. Dist. Lexis 7187 (D. Conn. 1993).

¹⁹ 805 F.2d 732, 738–39 (7th Cir. 1986), *cert. denied*, 482 U.S. 915 (1987).

²⁰ 904 F.2d 236 (5th Cir. 1990).

²¹ 805 F.2d 732 (7th Cir. 1986).

²² 809 F.2d 617 (9th Cir. 1987).

²³ 688 F.2d 1367 (11th Cir. 1982).

²⁴ 617 F.2d 1208 (5th Cir. 1980).

Memorial Hospital System v. Northbrook Life Insurance Co.,²⁵ wherein it stated affirmatively that an employee welfare benefit plan was not exempt from ERISA merely because an MET was connected in some way with the plan. The Court made specific reference to the Department of Labor regulations, specifying that the four criteria must be met before excluding a group insurance arrangement from ERISA, 29 C.F.R. §2510.3-1(j), and stated that the “and” connector in the regulation indicated that the existence of any one of the four criteria would prevent an employee welfare benefit plan from being excluded under coverage of ERISA. More recently, the Fifth Circuit reiterated its position that an employer who subscribes to an MET for the benefit of its employees establishes an employee benefit plan under ERISA. *McDonald v. Provident Indem. Life Insurance Co.*²⁶

In summary, the mere fact that a trust is involved in issuing a policy of insurance to an employer that covers the employer and his employees is not important in determining whether an ERISA plan has been established. At the employer level, as opposed to the trust level, a plan has been established if there are ascertainable benefits, a source of financing, and procedures for receiving benefits. The MET itself may not be an ERISA plan (assuming it was not established or maintained by an employer or an employee organization). The plan is at the employer level, and establishment occurs by the employer subscribing to the MET for the purpose of providing ERISA benefits to its employees.

VII. Multiple Employer Welfare Arrangements (MEWAs)

ERISA defines a “multiple employer welfare arrangement” as an arrangement involving employees of two or more employers providing for certain benefits under certain circumstances. Specifically, ERISA defines multiple employee welfare arrangement as:

[A]n *employee welfare benefit plan*, or any *other arrangement* (other than an employee welfare benefit plan), which is established or maintained for the purpose of offering or providing any benefits described in paragraph (1) *to the employees of two or more employers* (including one or more self-employed individuals), or to their beneficiaries...

(B) For purposes of this paragraph—

- (i) two or more trades or businesses, whether or not incorporated, shall be deemed a single employer if such trades or businesses are within the same control group,
- (ii) the term “control group” means a group of trades or businesses under common control,
- (iii) the determination of whether a trade or business is under “common control” with another trade or business shall be determined under regulations of the Secretary applying principles similar to the principles applied in determining whether employees of two or more trades or businesses are treated as employed by a single employer under section 4001(b), except that, for purposes of this paragraph, common control shall not be based on an interest of less than 25 percent....

ERISA, §3(40)(a).

Not all MEWAs are employee benefit plans governed by ERISA. In determining whether a MEWA is an employee welfare benefit plan, there are two issues to deal with: (1) whether the program itself is a benefit plan; and (2) whether the individual subscribing employers have established employee benefit plans funded by their subscription to the MEWA program.

²⁵ 904 F.2d 236 (5th Cir. 1990).

²⁶ 60 F.3d 234 (5th Cir. 1995).

An employee benefit plan may be established by an employee organization or by an employer, or by both. The Department of Labor has stated that where membership in an association is not conditioned upon one's employment status but is open to both employers and employees, a plan has not been established by an employee organization.²⁷

A benefit plan may also be established by a single employer or by a cognizable, bona fide group or association of employers acting in the interests of its employer members to provide benefits for their employees. The DOL has stated that “where several unrelated employers merely execute similar documents or otherwise participate in an arrangement as a means to fund benefits, in the absence of any genuine organizational relationship among the employers, no employer association, and consequently no employee welfare benefit plan, can be recognized.”²⁸ The DOL has identified several factors to be considered in determining whether an association has established a benefit plan: (1) how members are solicited; (2) who is entitled to participate and who actually participates in the association; (3) the process by which the association was formed, the purposes for which it was formed, and what, if any, were the preexisting relationships of its members; (4) the powers, rights, and privileges of employer members that exist by reason of their status as employers; and (5) who actually controls and directs the activities and operations of the benefit program.

Where some participants in the MEWA are not employers, the DOL has found this fact to be decisive: “[W]here membership in a group or association is open to anyone engaged in a particular trade or progression regardless of employer status, and where control of such association is not vested solely in employer members, such an association is not a bona fide association of employers [under ERISA].”²⁹ This is especially true where the employers themselves do *not* control or manage the plan. In the DOL's view, “employers that participate in a benefit program must, either directly or indirectly, exercise control over that program.”³⁰

In determining whether a MEWA is an employee benefit plan, courts have applied criteria similar to those of the DOL. Like the DOL, courts have looked at the relationship between the various members of the association to determine whether the association is “acting for an employer.”³¹ Specifically, courts have looked to whether members are tied by a common economic or representation interest unrelated to the provision of benefits. *MD Physicians & Associates v. State Bd. of Insurance*;³² *Wisconsin Educ. Ass'n Insurance Trust v. Iowa State Bd.*³³ Courts have also been concerned with whether employers have actual control over the plan, although the Ninth Circuit appears to hold that an individual employer's involvement in an association plan may be minimal. *Kanne v. Connecticut General Life Insurance Co.*³⁴

²⁷ DOL Opinion 91-42A (November 12, 1991).

²⁸ *Id.*

²⁹ DOL Opinion 90-01A (February 9, 1990).

³⁰ *Id.*

³¹ ERISA, §3(5) (defining the term “employer”).

³² 957 F.2d 178 (5th Cir. 1992).

³³ 804 F.2d 1059 (8th Cir. 1986).

³⁴ 867 F.2d 489 (9th Cir. 1988). The *Kanne* decision can be somewhat misleading. Although the opinion appears to say that the association established the plan, there is also language referring to the involvement of the individual employer, thus blurring the distinction between whether the plan existed at the association (MEWA) level or at the individual employer level.

The fact that an association program may not be an employee benefit plan does not end the inquiry of ERISA preemption. One still must consider whether the employer, at the individual level, established an ERISA plan.³⁵

VIII. Statutory Exemptions

There are several important statutory provisions exempting certain types of plans from the definition of an employee welfare benefit plan. These statutory exclusions include (1) a benefit plan established by an employer or an employee organization not engaged in commerce or any industry or activity affecting commerce;³⁶ (2) governmental plans;³⁷ (3) church plans;³⁸ (4) plans maintained solely for the purpose of complying with applicable worker's compensation laws or unemployment compensation or disability insurance laws;³⁹ (5) plans maintained outside of the United States primarily for the benefit of persons substantially all of whom are non-resident aliens;⁴⁰ and (6) plans that are excess benefit plans under ERISA.⁴¹

The exemption for plans established by employers or employee organizations that are not engaged in commerce or in an industry or activity affecting commerce has been narrowly construed. Congress included within ERISA's coverage not only plans established by employers who are directly engaged in commerce, but also plans established by employers engaged in an "*industry or activity affecting commerce*." ERISA's broad coverage was recognized by the district court in *Miller v. The Travelers Insurance Co.*,⁴² where the Court held that a law firm health benefits plan was covered by ERISA because "the practice of law, both generally and as done by plaintiff's employer, affects commerce."⁴³ Given the broad application of the phrase "industry or activity affecting commerce," it may be somewhat difficult to show that a particular employer is not within ERISA's commerce requirement and that the employer's plan is exempt from ERISA regulation. It should be noted, however, that employers do not need to conduct their business in the United States in order for that business to affect interstate commerce. *Lefkowitz v. Arcadia Trading Co.*⁴⁴ Thus, plans maintained outside of the United States may be deemed ERISA plans unless they are primarily for the benefit of persons substantially all of whom are non-resident aliens.⁴⁵

³⁵ See ERISA, §514(b)(6)(C) (providing that ERISA preemption applies to a plan that is not a MEWA, but that is funded by a subscription to a MEWA); *Patelco Credit Union v. Sahni*, 262 F.3d 897 (9th Cir. 2001) (the question of whether a MEWA is an employee benefit plan is a separate question from whether an employer subscribing to a MEWA has established an ERISA plan); *Memorial Hosp. Sys. v. Northbrook Life Ins. Co.*, 904 F.2d 236 (5th Cir. 1990) (distinguishing between whether an MET is a benefit plan and whether an individual employer has established an employee benefit plan funded by a subscription to a MET).

³⁶ ERISA, §4(a).

³⁷ ERISA, §4(b).

³⁸ *Id.*

³⁹ ERISA, §4(b)(3).

⁴⁰ ERISA, §4(b)(4).

⁴¹ ERISA, §4(b)(5).

⁴² 723 F. Supp. 1345 (E.D. Mo. 1989).

⁴³ *Id.* at 1346.

⁴⁴ 996 F.2d 600 (2d Cir. 1993).

⁴⁵ *Id.*

The exemption for governmental plans may be somewhat broader. ERISA defines a “governmental plan” as one that is established by the federal government, by any state government, or “by any agency or instrumentality of any of the foregoing.”⁴⁶ In *Rose v. Long Island Railroad Pension Plan*,⁴⁷ the Court held that a benefit plan established by a railroad was exempt from ERISA coverage where the railroad was an agency or instrumentality of a political subdivision of the state of New York. The Court relied on federal law to interpret the phrases “political subdivision” and “agency or instrumentality.”⁴⁸ Ironically, just before she was elevated to the United States Supreme Court, Justice Ginsburg cited the following factors for determining whether a plan is exempt as a governmental plan:

- (1) did the employer use tax money for operating expenses or did it use fees charged to private institutions?
- (2) was the employer created by federal [or state] charter?
- (3) was the employer created pursuant to any special legislative act?
- (4) was the employer subject to income taxation and did it file returns? and
- (5) does the employer have an independent board of directors?

*Alley v. Resolution Trust Corp.*⁴⁹

An amendment to ERISA under the Pension Protection Act clarified that benefit plans sponsored by an Indian tribal government, or a subdivision or agency thereof, are considered governmental plans and are exempt from ERISA to the extent “all of the participants of [the plan] are employees of such entity substantially all of whose services as such an employee are in the performance of essential governmental functions but not in the performance of commercial activities (whether or not an essential government function).”⁵⁰ At least one court has held that the amendment applies retrospectively.⁵¹

The church plan exemption has recently been the subject of court challenges in some contexts. The exemption is easily applied when, for example, the plan sponsor is a bona fide church or church administrative organization (e.g., Catholic diocese or Lutheran synod). Application of the exemption is more difficult when the plan sponsor has a relationship with a recognized church organization but is not itself a church (e.g., a hospital or medical organization with some form of church affiliation). In *Rollins v. Dignity Health*,⁵² a participant in a pension plan sponsored by a health care organization affiliated with the Roman Catholic church challenged the plan’s status as “church plan.” In the pension context, whether or not a plan is exempt from ERISA as a church plan is significant because ERISA dictates certain funding requirements for pension plans and plans that are exempt from ERISA are not required to comply with those funding requirements. The court in *Rollins* denied a motion to dismiss filed by the plan sponsor, ruling that the plan was not a church plan because a church plan must be established by a church. According to the court, establishment by

⁴⁶ 29 U.S.C. §1002(32).

⁴⁷ 828 F.2d 910 (2d Cir. 1987).

⁴⁸ *Id.* at 915–18.

⁴⁹ 984 F.2d 1201 (D.C. Cir. 1993).

⁵⁰ 29 U.S.C. §1002(32).

⁵¹ *Dobbs v. Anthem Blue Cross and Blue Shield*, 600 F.3d 1275 (10th Cir. 2010).

⁵² 2013 WL 651 2682 (N.D. Cal. 2013).

a church-related organization is not sufficient to satisfy the church plan exemption under ERISA. The court acknowledged that its ruling was in conflict with other court decisions on the subject.⁵³

The Supreme Court has made clear that the exemptions applicable to state-mandated worker's compensation and disability benefits only work to exempt a plan from ERISA where the plan provides only those benefits required by state laws. *District of Columbia v. Greater Washington Bd. of Trade*.⁵⁴

IX. ERISA Regulation of Individual Policies Covering Business Owners: *Sipma v. Massachusetts Casualty Insurance Co.*

The question of the application of ERISA in a dispute over the payment of benefits hinges on two elements: the existence of an ERISA-governed plan and the existence of coverage for participants and/or beneficiaries under the plan. These two issues merge when benefit coverage is limited to the owners of a business because of a Department of Labor ("DOL") regulation promulgated shortly after the enactment of ERISA. The DOL regulation provides that an ERISA plan cannot exist unless the plan covers at least one common law employee of the employer.⁵⁵ Thus, one of the threshold issues in determining whether a plan is governed by ERISA is whether the plan covers at least one employee.

In *Sipma v. Mass. Cas. Ins. Co.*,⁵⁶ the Tenth Circuit wrestled with this very issue. Specifically, the question was whether individual disability policies that covered two owners of a corporation and that were paid for by the corporation were governed by ERISA even though the corporate employer provided no disability coverage to any of the other employees of the corporation. The Tenth Circuit concluded that the policy was governed by ERISA and that Sipma's state law claims, including a claim for bad faith under Colorado law, were preempted by ERISA. The decision is important because it marks the first published decision by a federal appellate court to hold that a shareholder/employee of a small incorporated business who receives benefits through the corporation's purchase of an individual policy of insurance must bring his claim for benefits under ERISA even though the corporation does not provide similar coverage to other employees.

A. An ERISA Plan Must Cover Participants and Beneficiaries

An ERISA plan only exists if it covers participants and/or beneficiaries. ERISA contains specific definitions of "participants" and "beneficiaries" for purposes of an employee benefit plan. ERISA defines a "participant" as

any employee or former employee of an employer... who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer....⁵⁷

ERISA defines "employee" as "any individual employed by an employer."⁵⁸ The statute defines a "beneficiary" as "a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder."⁵⁹

⁵³ See, e.g., *Thorkelson v. Publishing House of Evangelical Lutheran Church in Am.*, 704 F. Supp. 2d 1119 (D. Minn. 2011); *Lown v. Continental Cas. Co.*, 238 F.3d 543 (4th Cir. 2001).

⁵⁴ 113 S. Ct. 580 (1992). See also *Allessi v. Raybestos*, 451 U.S. 504 (1981).

⁵⁵ 29 C.F.R. §2510.3-3(b).

⁵⁶ 256 F.3d 1006 (10th Cir. 2001).

⁵⁷ 29 U.S.C. §1102(7).

⁵⁸ 29 U.S.C. §§1002(6).

⁵⁹ 29 U.S.C. §1102(8).

The overwhelming number of federal appellate courts that have addressed the issue have held that an owner of an incorporated or an unincorporated employer who is covered under an employee benefit plan is considered a “beneficiary” under ERISA, at least where the plan also provides coverage to other employees.⁶⁰ Several other federal appellate courts have held that where the employer is incorporated, a shareholder/employee who is covered under an employee benefit plan is also considered to be a “participant” under ERISA, at least where the plan also covers employees who are not shareholders of the incorporated employer.⁶¹

The DOL has ruled that a plan must cover at least one common law employee in order to be considered an “employee benefit plan” under ERISA and that ERISA excludes plans that do not cover any employees:

For purposes of Title I of the Act and this chapter, the term ‘employee benefit plan’ shall not include any plan, fund, or program... under which *no employees* are participants covered under the plan... For example, a so-called ‘Keogh’ or ‘H.R. 10’ plan under which *only partners or only a sole proprietor* are participants covered under the plan will not be covered under Title I. However, a Keogh plan under which one or more common law employees in addition to the self-employed individuals are participants covered under the plan, will be covered under Title I.⁶²

The regulation then states that, for purposes of determining whether a corporation-sponsored plan covers at least one employee, one cannot consider the owner of the corporation an “employee” where coverage is limited to the owner and *where the corporation is wholly owned by the covered owner or by the owner and his spouse*:

For purposes of this section:

- (1) An individual and his or her spouse shall not be deemed to be employees with respect to a trade or business, whether incorporated or unincorporated, *which is wholly owned by the individual or by the individual and his or her spouse....*⁶³

The clear terms of the regulation exclude, for purposes of determining whether a plan covers any employees, only sole owners or the equivalent of sole owners (*i.e.*, where a company is owned by an individual and his/her spouse). Nothing in the regulation excludes from the employee determination joint owner/employees of a corporation who are not married.

⁶⁰ See, e.g., *Engelhardt v. Paul Revere Life Ins. Co.*, 139 F.3d 1346 (11th Cir. 1998) (“[employee’s] status as a shareholder does not preclude him from being a beneficiary under the ERISA Plan.”); *Wolk v. Unum Life Ins. Co. of Am.*, 186 F.3d 352 (3d Cir. 1999) (stating that “all of the Courts of Appeal that have analyzed the term “beneficiary” in a similar context have adopted this plain language interpretation.”); *Harper v. American Chambers Life Ins. Co.*, 898 F.2d 1432 (9th Cir. 1990) (partner insured by policy that is part of an ERISA plan has standing to sue under ERISA as a “beneficiary”); *Prudential Ins. Co. of Am. v. Doe*, 76 F.3d 206 (8th Cir. 1996) (controlling shareholder was a beneficiary under ERISA program); *Vega v. Nat’l Life Ins. Servs., Inc.*, 188 F.3d 287 (5th Cir. 1999) (same).

⁶¹ See, e.g., *Madonia v. Blue Cross & Blue Shield of Va.*, 11 F.3d 444 (4th Cir. 1993) (a shareholder/employee of a corporate professional corporation was held to be a plan participant where the corporation benefit plan covered the shareholder as well as other employees of the corporation); *Vega v. Nat’l Life Ins. Servs., Inc.*, *supra* (same); *Robinson v. Linomaz*, 58 F.3d 365 (8th Cir. 1995) (noting that “[w]e are inclined to believe that the Madonia court’s approach was correct” in holding that a shareholder of a corporation is an employee under ERISA); *Prudential Ins. Co. of Am. v. Doe*, *supra* (based on the authority in *Madonia*, “we would likely find” that a controlling shareholder of a corporation is an employee and thus a participant under ERISA).

⁶² 29 C.F.R. §2510.3-3(b) [emphasis added].

⁶³ *Id.* at §2510.3-3(c) [emphasis added].

Shortly after the Department of Labor issued the above regulation, it issued an advisory opinion stating that, where a corporation is owned by multiple shareholders who are not married, a plan sponsored by the corporation is governed by ERISA even though the shareholder/employees are the only persons covered by the plan. The specific question posed to the DOL was whether a plan would be exempt from Title I of ERISA “if the only participants... are shareholders or spouses of shareholders.”⁶⁴ The DOL responded by saying that the plan would be exempt from ERISA *only* where the stock of the corporate employer was wholly owned by one shareholder and his/her spouse and the shareholder and his/her spouse were the sole participants. The DOL stated as follows:

For purposes of Title I of ERISA, the term ‘employee benefit plan’ does not include any plan, fund, or program... under which no employee participants are covered under the plan (section 2510.3-3(b) of the enclosed regulation). According to section 2510.3-3(c)(1), an individual and his or her spouse are not employees with respect to an incorporated business if the business is wholly owned by the individual or by the individual and his or her spouse. *Thus, your interpretation is correct only where the stock of the corporation is wholly owned by one shareholder and his or her spouse and the shareholder or the shareholder and his or her spouse are the only participants in the plan.*⁶⁵

The fact that the regulation exempts only plans limited to *sole* shareholders is confirmed by other DOL commentary stating that the DOL’s concern in enacting the regulation was to exclude plans that were limited to a sole owner and his family.⁶⁶

Although most federal appellate courts have agreed with the DOL that a business owner is a participant and/or beneficiary where he is covered by a benefit plan that also covers other employees, the question left open by the courts up to now has been whether a business owner would still be considered a participant or beneficiary if coverage is not provided to other employees. The broader question is whether a plan that covers only an owner is still governed by ERISA. *Sipma* answers this question in the affirmative where the employer is a corporation and the corporation is owned by at least two persons who are not spouses.

B. Sipma v. Massachusetts Casualty Insurance Co.

Randy Sipma applied for disability insurance from Massachusetts Casualty Insurance Company in 1993. At that time, Sipma was employed by Bob’s Excavating and Snow Removal, Inc. (“the Corporation”). The majority of the shares of the Corporation were owned by Robert Byron. Sipma was the only other shareholder. It was undisputed that the Corporation paid all of the premiums on Sipma’s disability insurance.

The Corporation had several other employees and purchased benefits for some of these employees. The shareholders, Byron and Sipma were the only ones covered for disability. They also received health and life

⁶⁴ Department of Labor Advisory Opinion 76-67, 1976 ERISA Lexis 58 (May 21, 1976).

⁶⁵ *Id.* [emphasis added].

⁶⁶ *See, e.g.*, DOL Advisory Opinion 95-06A, 1995 ERISA Lexis 31 (May 18, 1995) (regulation excluding plans sponsored by corporation that is wholly owned by one individual are to exclude from ERISA governance a program that covers only the owner and/or his immediate family); DOL Advisory Opinion 92-21A, 1992 ERISA Lexis 22 (October 19, 1992) (same); DOL Advisory Opinion (Unnumbered), 1985 ERISA Lexis 57 (January 18, 1995) (“regulation section 2510.3-3(c) excludes *certain* owner-employees from the term ‘employee’ in regulation section 2510.3-3”) [emphasis added]; DOL Advisory Opinion 81-88A, 1981 ERISA Lexis 31 (July 9, 1981) (“The provisions of 29 C.F.R. §2510.3-3(c)(1) apply, in the case of a corporation, only where a trade or business is wholly owned by an individual or by an individual and his spouse”).

insurance, also paid for by the Corporation. For other employees, the Corporation also provided health insurance coverage which the Corporation paid for after an employee had been working for the Corporation for six months.

After MCIC denied Sipma's claim for benefits in connection with an alleged injury that occurred in June 1996, Sipma sued. Sipma alleged that Massachusetts Casualty breached the policy and committed bad faith. Sipma's claims were purportedly based upon violations of Colorado law. Sipma sought substantial compensatory and punitive damages.

Massachusetts Casualty filed a motion for summary judgment, arguing that Sipma's disability coverage was governed by ERISA and that Sipma's state law claims, including his claim of bad faith, were preempted by ERISA. Sipma disputed Massachusetts Casualty's arguments, saying among other things, that the coverage afforded to Sipma and Byron did not constitute an ERISA plan because Sipma and Byron were the owners of the Corporation and should be considered employers rather than employees of the Corporation. As employers, Sipma and Byron could not be considered "participants" or "beneficiaries" under ERISA. Sipma's argument continued that because disability coverage was not provided to any "participants" or "beneficiaries," there was no ERISA plan and Sipma's state law claims were not preempted.

The district court ruled in favor of Massachusetts Casualty and granted summary judgment against Sipma, fully dismissing his suit. The district court noted that it was undisputed that the health insurance coverage provided to Sipma, Byron, and other employees of the Corporation was governed by ERISA because the coverage applied to employees in addition to Sipma and Byron. The district court went on to rule that the disability policies provided to Sipma and Byron were part of an overall multi-benefit employee benefit program that included the health and disability coverage and that the entire program was governed by ERISA. Because Sipma's benefits were governed by ERISA and because Sipma brought only state law claims against Massachusetts Casualty that were preempted by ERISA, the district court dismissed Sipma's complaint and granted summary judgment to Massachusetts Casualty. Sipma did not seek, nor did the district court allow, amendment of Sipma's complaint to bring a claim for benefits under ERISA.

Sipma appealed the district court ruling, again arguing that because no employees were covered by the disability policies issued to Sipma and Byron, they were not part of an ERISA plan and his state law claims were not preempted. The Tenth Circuit affirmed the district court summary judgment, but on different grounds than were relied on by the district court. The Tenth Circuit chose not to address the question of whether the disability policies could be combined with the health insurance to constitute one overall multi-benefit employee benefit program. Instead, the Court held that the disability policies issued to Sipma and Byron, standing alone, were governed by ERISA and that Sipma's state law claims were preempted by ERISA.

Discussing employee status under ERISA generally, the Tenth Circuit followed the lead of the DOL and held that an ERISA plan cannot exist without coverage for at least one employee. The Court noted that ERISA defines the term "employee" circularly and that the United States Supreme Court has looked to common law definitions of "employee" in order to fill in the gaps left by the statute. *See Nationwide Mutual Insurance Co. v. Darden*⁶⁷ (holding that common law definitions of an "employee" may be applied under ERISA to determine if a person is an employee or an independent contractor).

Addressing Sipma's argument that as the only shareholders of the Corporation, he and Byron were employers rather than employees under ERISA, the Tenth Circuit looked to common law principles governing

⁶⁷ 503 U.S. 318 (1992).

corporations generally. The Court held that under Colorado law and corporation law generally, corporations are treated as legal entities separate and apart from their shareholders. Corporations are empowered to enter into contracts and to own property. To equate the corporation with its shareholders would require piercing the corporate veil, something which the Court held is done only in extraordinary circumstances. The Tenth Circuit held that these common law principles applied equally under ERISA and that there is nothing unusual under ERISA about considering a shareholder like Sipma to be separate from the corporation he owned:

Looking to common law agency principles as required by *Darden*, we find that Mr. Sipma is an ‘employee’ of the corporation for ERISA purposes. Mr. Sipma received a regular annual salary from the corporation. It is undisputed that the corporation was in business. The record indicates that the equipment used was owned by the corporation. There is no indication in the record that Mr. Sipma’s association with the corporation was intended to be of limited duration. To the contrary, the record shows that Mr. Sipma received a regular annual salary from the corporation for at least three consecutive years. Mr. Sipma also supervised other employees of the corporation. His duties—excavation and snow removal—were central to the regular business of Bob’s Excavating and Snow Removal, Inc. Viewing together all of the incidents of the relationship between Mr. Sipma and the corporation, we find that Mr. Sipma is an ‘employee’ of the corporation for ERISA purposes.

The Court then moved on to consider the potential impact of the DOL owner regulation. The Court held that this regulation created a possible exception to the common law rule that a shareholder might be an employee separate from the corporation he owns. However, the Court stated that the regulation on its face was limited to corporations that are wholly owned by one person or that are wholly owned by two persons who are spouses of one another. The Court held that the regulation did not create an exception from the common law rule where a corporate employer is owned by two or more persons who are not spouses and that this interpretation was consistent with the DOL’s own interpretation of the regulation:

[T]he exception on its face is limited to individuals (including spouses) who are sole owners of a business. The exception does not extend to exclude multiple shareholders from the definition of ‘employee’... Additionally, the Department of Labor interprets this subsection as applying ‘only where the stock of the corporation is wholly owned *by one shareholder* and his or her spouse and the shareholder or the shareholder and his or her spouse are the only participants in the plan’... An agency’s interpretation of its own regulations is entitled to deference.

Because Sipma was not the sole shareholder of the corporate employer, the Tenth Circuit held that the DOL regulation did not exclude him from the definition of an “employee” under ERISA. Because Sipma was an employee, he was also considered a “participant” under ERISA, meaning that the disability coverage satisfied the element of an ERISA plan that requires that the plan provide benefits to participants and/or beneficiaries.

Responding to an additional argument by Sipma, the Tenth Circuit also held that the disability plan was “established or maintained” by the Corporation. The Court noted that the purchase of insurance by an employer, including an individual policy of insurance, provides substantial evidence of the existence of an ERISA program. The fact that an employer chooses to insure the program and to delegate much of the administrative responsibility to the insurer does not mean that the employer has not established or maintained a plan. Because the Corporation “took action to provide disability insurance on a regular and long-term basis to Mr. Sipma and Mr. Byron and paid the premiums for the insurance” there was sufficient evidence to demonstrate that the Corporation established and maintained an ERISA benefit plan. Sipma’s state law claims were preempted by ERISA and summary judgment for Massachusetts Casualty was affirmed.

X. Business Owners as Plan Participants: *Yates v. Hendon*

Since shortly after Congress enacted ERISA in the mid-1970s, the Department of Labor has taken the position that a benefit plan cannot be governed by ERISA unless it covers at least one common law employee. However, once the plan does cover an employee, the DOL's position has been that all persons covered by the plan are considered participants under ERISA, including any owners of the business that sponsors the plan. Therefore, when an owner seeks benefits under the plan, the owner's claim is governed by ERISA just like claims filed by non-owner employees.

Given the DOL's clear position on the participant status of owners under ERISA, one would expect that the federal circuits would be consistent on the issue. Not true. For years, the circuits have been split, with the Sixth and First Circuits holding the minority position that owners are not participants under ERISA even when the plan in which they participate is regulated by ERISA. In *Raymond B. Yates, M.D., P.C. Profit Sharing Plan v. Hendon*,⁶⁸ the United States Supreme Court granted certiorari and resolved the circuit split in favor of the DOL's long-held position. Under *Yates*, owners are participants under ERISA when they are covered by an ERISA benefit plan. Any benefit claims filed by owners are therefore governed by ERISA and any attempted state law claims are preempted.

A. Status as a Participant or Beneficiary Impacts Multiple Issues Under ERISA⁶⁹

The owner's participant status in *Yates* arose in a bankruptcy context. Specifically, Dr. Yates' status as a participant under ERISA controlled whether the anti-alienation provision of his ERISA plan applied to his interest in a profit-sharing plan. However, the question of a working owner's status as a participant or a beneficiary more often arises in the context of whether the owner has standing to sue for ERISA plan benefits and the related question of whether any state law claims brought by the owner are preempted by ERISA.

Standing to sue under ERISA is crucial to determining what federal remedies are available to a working owner. ERISA provides federal courts with jurisdiction of ERISA suits, but only where the plaintiff has status as a participant or beneficiary of an ERISA-regulated benefit plan.⁷⁰ ERISA's remedial section provides an express cause of action for the recovery of plan benefits, but such a cause of action is expressly reserved only to participants and beneficiaries.⁷¹ Prior to *Yates*, several lower courts held that working owners did not have standing to sue for benefits under ERISA and that ERISA simply did not apply to an owner's benefit claims even though they arose out of an ERISA-governed benefit plan.⁷² These same courts also held that a working owner's standing to sue under ERISA controlled what state law remedies were available to the working owner. Where a dispute arises out of the administration of benefits under an ERISA plan, the Supreme Court has held that ERISA's remedies are exclusive.⁷³ Any state law claims that purport to supplement or supplant ERISA's

⁶⁸ 124 S. Ct. 1330 (2004).

⁶⁹ Background portions of this article are borrowed in large part from the *amicus curiae* brief filed in *Yates v. Hendon* by UnumProvident Corporation. The brief was jointly written by counsel for UnumProvident, including the author and William J. Kayatta, Jr. and Byrne J. Decker of Pierce Atwood in Portland, Maine.

⁷⁰ 29 U.S.C. §1132(e)(1).

⁷¹ 29 U.S.C. §1132(a)(1)(B).

⁷² See, e.g., *Fugarino v. Hartford Life & Acc. Ins. Co.*, 969 F.2d 178, 186 (6th Cir. 1992); *Kwatcher v. Massachusetts Serv. Employees Pension Fund*, 879 F.2d 957, 965–66 (1st Cir. 1989); *Ritter v. Massachusetts Cas. Ins. Co.*, 439 Mass. 214, 786 N.E.2d 817 (2003).

⁷³ See, e.g., *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987).

exclusive remedies are preempted, even where they are otherwise “saved” from preemption under ERISA’s express preemption clause. Even so, according to some lower courts, where a working owner did not have standing to sue under ERISA’s civil enforcement scheme, state law remedies were not preempted by ERISA.⁷⁴

Although not directly presented in *Yates*, the broader question of a working owner’s standing to sue for plan benefits under §1132(a)(1)(B) and the preemption issues surrounding the participant and beneficiary status of working owners were the most common contexts in which the issue of an owner’s status as a plan participant or beneficiary arose.⁷⁵ These issues affected every ERISA plan that covered working owners.

B. The Department of Labor Determined Long Ago That Working Owners Are Participants When They Are Covered by an ERISA-Governed Employee Benefit Plan

Unlike some federal discrimination statutes such as the Americans With Disabilities Act, ERISA does not include any “small employer exemption” nor is there any other evidence that Congress intended to exclude small employers from ERISA. Consistent with congressional intent that ERISA have broad application even to small employers, the DOL issued a regulation defining the term “employee benefit plan” under ERISA to include plans that covered even one employee:

For purposes of Title I of the Act and this chapter, the term ‘employee benefit plan’ shall not include any plan, fund, or program... under which *no employees* are participants covered under the plan... For example, a so-called ‘Keogh’ or ‘H.R. 10’ plan under which only partners or *only a sole proprietor* are participants covered under the plan will not be covered under Title I. However, a Keogh plan under which one or more common law employees in addition to the self-employed individuals are participants covered under the plan, will be covered under Title I.⁷⁶

For purposes of determining whether a plan covers at least one employee, a sole owner and his/her spouse are not considered employees under the regulation:

⁷⁴ Fugarino, *supra*; Kwatcher, *supra*; Ritter, *supra*.

⁷⁵ Compare *Santino v. Provident Life & Acc. Ins. Co.*, 276 F.3d 772 (6th Cir. 2001) (joint shareholder had standing to sue for benefits as participant); *Sipma v. Mass. Cas. Ins. Co.*, *supra* (same); *Vega v. Nat’l Life Ins. Servs., Inc.*, 188 F.3d 287 (5th Cir. 1999) (*en banc*) (husband and wife, as sole shareholders, had standing to sue for benefits as participants); *Engelhardt v. Paul Revere Life Ins. Co.*, 139 F.3d 1346 (11th Cir. 1998) (joint shareholder has standing to sue for benefits as beneficiary); *Wolk v. Unum Life Ins. Co. of Am.*, 186 F.3d 352 (3d Cir. 1999), *cert. denied*, 528 U.S. 1076 (2000) (partner had standing to sue for plan benefits as beneficiary); *Prudential Ins. Co. of Am. v. Doe*, 76 F.3d 206 (8th Cir. 1996) (joint shareholder has standing to sue for benefits as beneficiary); *Robinson v. Linomaz*, 58 F.3d 365 (8th Cir. 1995) (husband and wife, as sole shareholders, had standing to sue for benefits as beneficiaries); *Peterson v. Am. Life & Health Ins. Co.*, 48 F.3d 404 (9th Cir.), *cert. denied*, 516 U.S. 942 (1995) (partner has standing to sue for benefits as beneficiary); *Madonia v. Blue Cross & Blue Shield of Va.*, 11 F.3d 444 (4th Cir. 1993), *cert. denied*, 511 U.S. 1019 (1994) (sole shareholder had standing to sue for plan benefits as participant); *Harper v. American Chambers Life Ins. Co.*, 898 F.2d 1432 (9th Cir. 1990) (partner has standing to sue for plan benefits as beneficiary) *with* *Agrawal v. Paul Revere*, 205 F.3d 297 (6th Cir. 2000) (sole shareholder does not have standing to sue for plan benefits, either as participant or as beneficiary); *Fugarino v. Hartford*, *supra* (proprietor does not have standing to sue for plan benefits as participant); *Kwatcher v. Mass. Serv.*, *supra* (sole shareholder does not have standing to sue for plan benefits as participant); *Giardono v. Jones*, 867 F.2d 409 (7th Cir. 1989) (proprietor does not have standing to sue for plan benefits as participant).

⁷⁶ 29 C.F.R. §2510.3-3(b) [emphasis added].

For purposes of this section... [a]n individual and his or her spouse shall not be deemed to be employees with respect to a trade or business, whether incorporated or unincorporated, *which is wholly owned by the individual or by the individual and his or her spouse....*⁷⁷

Id. at §2510.3-3(c) [emphasis added].

Once an ERISA plan is established, the DOL consistently concluded that all persons covered by the plan, including working owners, are considered participants in the plan. For example, the DOL was presented with the issue of whether a partner or sole proprietor is subject to ERISA's civil enforcement provision:

[W]hether Title I [including the preemption and claims review procedures] of ERISA applies to group medical programs which provide medical coverage to a sole proprietor or a partner in an unincorporated business, as well as common law employees, and whether the claims made by such a sole proprietor or partner would be subject to the ERISA claims procedure.⁷⁸

After reviewing the breadth of ERISA preemption, the DOL stated that, although sole proprietors and partners are not considered “employees” for purposes of deciding whether a benefit plan has been established, *once a plan is established* (because other employees are covered by the plan in addition to the sole proprietor or partner), sole proprietors and partners are participants and beneficiaries of the plan and are bound by Title I of ERISA, including the preemption and claims review provisions. In other words, once a plan has been established, sole proprietors, partners, and other owners who are covered under the plan are subject to ERISA's claims procedures and are considered beneficiaries and/or participants for purposes of those claims.⁷⁹

The 1992 DOL information letter is consistent with previous agency opinions on the issue. In DOL Advisory Opinion 79-8A, the agency stated that the wife of a partner in a partnership whose employees participated in a multi-employer pension plan was not automatically excluded from participation in the plan merely because the definition of an “employee” in §2510.3-3 is somewhat restrictive. The agency stated that the regulatory definition of “employee” was not intended to dictate a person's status under a plan once an ERISA plan is established. Likewise, in DOL Advisory Opinion 81-54A, the DOL advised as to which individuals would be counted as participants and/or beneficiaries in a scholarship fund for purposes of ERISA's reporting and disclosure requirements. Again, the agency read the terms “participant” and “beneficiary” broadly. It concluded that the term “beneficiary” would include the children of eligible individuals who may become entitled to a scholarship from the fund and that all individuals meeting the eligibility criteria “*of the Fund*” would be participants and/or beneficiaries in accordance with ERISA. In other words, it was the eligibility criteria “*of the Fund*” that controlled participant and beneficiary status. Most recently, the DOL reaffirmed its longstanding position that “the statutory provisions of ERISA, taken as a whole, reveal a clear Congressional design to include ‘working owners’ within the definition of ‘participant’ for purposes of Title I of ERISA.” DOL Advisory Opinion 99-04.

⁷⁷ 29 C.F.R. §2510.3-3(b) [emphasis added].

⁷⁸ Letter from Robert J. Doyle, Director of Regulations and Interpretations, Department of Labor, to Susan Katz Hoffman, at 1 (July 31, 1992) [emphasis added].

⁷⁹ See DOL Reporting and Disclosure Regulations, 40 Fed. Reg. 34525, 34528 (August 15, 1975) (definition of “employee” in §2510.3-3 is for the limited purpose of determining whether a plan has any employees, and thus whether an ERISA plan exists; hence, the regulations are revised to expressly limit the definition of “employee” to §2510.3-3 in order to avoid excluding the “self-employed” from ERISA).

C. *The Majority of Circuit Courts Held That Working Owners Had Standing to Sue for Plan Benefits Under ERISA*

The majority of circuits interpreted ERISA to grant standing to working owners, including sole shareholders of corporate employers. For example, in *Madonia*, *supra*, the Fourth Circuit held that a sole shareholder of a medical corporation had standing to sue as a participant under ERISA. Among other things, the Fourth Circuit held that a working owner's standing to sue under ERISA was consistent with congressional intent for uniform federal regulation of employee benefit plans:

By concluding that sole shareholders can be considered 'participants' in their companies' employee welfare benefit plans, we likewise avoid the situation in which two separate bodies of law would govern a corporation's employee benefits claims. In this particular case, it would seem anomalous to have [the shareholder] seeking recovery under state law theories and [other employees] suing under ERISA. In enacting ERISA, Congress drafted its 'most sweeping federal preemption statute' in order to achieve uniformity and consistency in the law governing employee benefits... Disallowing shareholders such as [the plaintiff] from being plan 'participants' would result in disparate treatment of corporate employees' claims, thereby frustrating the statutory purpose of ensuring similar treatment for all claims relating to employee benefit plans.⁸⁰

The Fifth Circuit, sitting *en banc*, held that where a corporate employer was owned by a husband and wife, and where the corporation sponsored an ERISA health benefits plan, the shareholders were participants under ERISA with standing to sue for plan benefits.⁸¹ As in *Madonia*, the Fifth Circuit held that the health plan was governed by ERISA because it covered at least one employee in addition to the spouse/shareholders. Once an ERISA plan was established, the Fifth Circuit held that the shareholders were considered participants in the plan. The Fifth Circuit was "persuaded by the reasoning in *Madonia*", including that court's statement that such a result "promoted Congress' objective of achieving uniformity through the enactment of ERISA because it fostered consistency in the law governing employee benefits."⁸²

Vega and *Madonia* are part of a long line of circuit court authority holding that working owners of ERISA plan sponsors have standing to sue for plan benefits under ERISA in large part because a contrary holding would frustrate Congress' objective of creating uniform regulation of employee benefit plans.⁸³ Even

⁸⁰ *Id.* at 450.

⁸¹ *Vega v. Nat'l Life Ins. Servs., Inc.*, *supra*.

⁸² 188 F.3d at 294.

⁸³ See, e.g., *Gilbert v. Alta Health & Life Ins. Co.*, 276 F.3d 1292, 1303–04 (11th Cir. 2001) ("This conclusion [that a sole shareholder has standing to sue under ERISA] also comports with common sense... If we accepted [the shareholder's] reading of the [DOL] regulation, then he and his wife would have a different set of rights and remedies than the other employees covered by the same plan."); *Wolk v. Unum Life Ins. Co. of Am.*, 186 F.3d at 357 ("As several courts of appeals have noted, 'to hold otherwise would create the anomaly of requiring some insureds to pursue benefit claims under state law while requiring others covered by the identical policy to proceed under ERISA. Such a scenario would frustrate Congress' intent of achieving uniformity in the law governing employment benefits."); *Prudential v. Doe*, 76 F.3d at 209 (a working owner's standing to pursue ERISA remedies was supported by the policy rationale that avoided the "anomaly of requiring some insureds to pursue benefit claims under state law while requiring others covered by the identical policy to proceed under ERISA."); *Robinson v. Linomaz*, 58 F.3d at 369 (noting that its holding that working owners have standing under ERISA once an ERISA plan is established is consistent with congressional intent and that "it would be anomalous to have those persons benefiting from [the plan] governed by two disparate sets of legal obligations"); *Peterson v. Am. Health*, 48 F.3d at 409 ("To hold [that a working owner does not have standing to sue under ERISA] would

the Sixth Circuit, which was one of two circuits to preclude sole shareholders from participant status under ERISA, acknowledged the patent inconsistency in doing so:

When self-employed individuals are excluded from classification as participant or beneficiary, the self-employed lack standing to enforce their rights under ERISA and can sue under state law theories. ERISA was originally put into place to protect the interests of employees by imposing duties on those who fund and administer the employee benefit plans; with these protections come limitations on employees' rights to recover state law remedies. Although self-employed individuals may not need the protections offered by ERISA, because they are likely to look out for themselves in the administration of the plan, it does not follow that once a self-employed person chooses to participate in an ERISA plan and gain benefits thereunder, she should be free from the limitations imposed upon her employees. Under *Fugarino*, a self-employed individual who participates in a disability plan that covers him and all of his employees will have a unique advantage: the self-employed individual can pursue a parade of state law claims that are withheld from his employees by preemption.⁸⁴

Several of the circuit court holdings that working owners had standing to sue under ERISA were based on the owner's status as a beneficiary, apart from his or her status as a participant. These decisions were based on the plain language of ERISA's definition of a beneficiary, which includes not only persons who are designated by a participant to receive plan benefits (e.g., such as in a life insurance policy), but also includes "a person... designated by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder."⁸⁵ These courts held that this definition is clear and unambiguous and included working owners who were otherwise covered under the terms of the ERISA plan.⁸⁶ Because ERISA's civil enforcement provision permits suits for plan benefits by both participants *and* beneficiaries, these courts held that working owners have standing to sue under ERISA as beneficiaries even if for some reason they are not considered participants.

D. The Circuit Split Created Inconsistency in the Regulation of ERISA Plans

Congress enacted ERISA in order to promote a cost-effective private employee benefit plan system through uniform fiduciary standards and remedies. A single regulatory framework allows simplicity in plan admin-

create the anomaly of requiring some insureds to pursue benefit claims under state law while requiring others covered by the identical policy to proceed under ERISA. Such a scenario would frustrate Congress' intent of achieving uniformity in the law governing employment benefits."); *Harper v. American Chambers*, 898 F.2d at 1434–35 ("[O]ur construction of the statutes defining the [working owners] as ERISA beneficiaries is consonant with the ERISA statutory scheme.").

⁸⁴ *Agrawal v. Paul Revere*, 205 F.3d at 303.

⁸⁵ 29 U.S.C. §1002(8).

⁸⁶ See, e.g., *Gilbert v. Alta Health*, 276 F.3d at 1295 (a sole shareholder has standing as a beneficiary under an ERISA plan where he alleges that he is entitled to benefits under the terms of the plan); *Wolk v. Unum*, 186 F.3d at 356 (a plain language interpretation of ERISA dictates that a partner who alleges that he is entitled to benefits under the terms of an ERISA plan has standing as a beneficiary of that plan); *Prudential v. Doe*, 76 F.3d at 209–10 (a joint shareholder is a beneficiary where he alleges that he is entitled to benefits under an ERISA plan); *Robinson v. Linomaz*, 58 F.3d at 369 (the plain language of the statute dictates that a joint shareholder is a beneficiary); *Peterson v. Am. Life*, 48 F.3d at 409 (because a partner is designated to receive benefits under an ERISA plan, the plain language of the statute dictates that the partner is a beneficiary of the plan); *Harper v. American Chambers*, 898 F.3d at 1434–35 (same). See also *Engelhardt v. Paul Revere*, 139 F.3d at 1351 (a joint shareholder is a beneficiary where he is designated to receive benefits under an ERISA plan).

istration.⁸⁷ A uniform system of benefit plan regulation leads to lower administrative costs and broader availability of benefits to employees. As the Supreme Court stated in *Varity Corp. v. Howe*,⁸⁸ one of the “competing purposes” of Congress was “its desire not to create a system that is so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit plans in the first place.”

The importance of regulatory uniformity within an employee benefit plan is amply illustrated by the decision in *Shaw, supra*. One of the issues in that case was whether state-mandated disability benefits that were otherwise expressly exempted from ERISA fell within federal ERISA regulation where they were administered as part of a plan that also included ERISA-governed benefits. The Supreme Court noted that ERISA was enacted to avoid situations where “one portion of a multibenefit plan would be subject only to state regulation, while other portions would be exclusively within the federal domain.” *Shaw* recognized that “[t]he administrative impracticality of permitting mutually exclusive pockets of federal and state jurisdiction within a plan is apparent.” Accordingly, *Shaw* held that the entire plan was regulated by ERISA, including the “non-ERISA” benefits.

Exclusion of working owners from ERISA’s civil enforcement scheme created a serious dysfunction within ERISA’s civil enforcement scheme. This schism permitted working owners to sue plan fiduciaries, who are required to administer the entire plan under federal law, for violations of state law. Other covered employees were required to sue under federal law. Allowing working owners to maintain state law causes of action outside of ERISA’s preemptive sphere created the “mutually exclusive pockets of federal and state jurisdiction within a plan,” against which the Supreme Court warned in *Shaw*. Such multiplicity of regulation and open-ended administrative and financial burdens are precisely the problems that ERISA was intended to avoid.

Exclusion of working owners from ERISA’s civil enforcement scheme also created an irony that was certainly not anticipated by Congress: because owners would have access to state law damages remedies that are not available under ERISA, working owners had broader remedies than were available to non-owner employees. The availability of state law damages increases the cost of providing benefits, eventually reaching the point of discouraging these same owners from providing benefits to their employees in the first place. This was certainly contrary to the “protection” that Congress intended ERISA to afford working men and women.

Exclusion of working owners from ERISA’s civil enforcement scheme also created a dysfunction between the civil enforcement scheme and ERISA’s other regulatory provisions. Multiple provisions of the statute and corresponding sections of the Internal Revenue Code provide that working owners who participate in ERISA plans are regulated by ERISA. It made no sense if some portions of ERISA regulated owners’ participation in employee benefit plans yet, in some jurisdictions, the civil enforcement provisions were found not to regulate the owners’ claims for benefits under the same plans.

It certainly was not Congress’ intent that ERISA should be so narrow as to allow working owners who are covered under the same benefit plan as other employees to have a better opportunity to collect benefits than their non-owner employees. The intent of Congress was that if the same plan terms apply to all persons

⁸⁷ See, e.g., *Shaw v. Delta Air Lines*, 463 U.S. 85, 99 n. 20 (1983). See also *Ft. Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1, 9 (1987) (simplicity in plan administration is achieved by establishing “a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits”).

⁸⁸ 516 U.S. 489 (1996).

covered under the plan, those terms should be applied consistently to all persons covered by the plan. No other result made any sense.

E. Yates v. Hendon

Dr. Raymond B. Yates was the sole owner of a medical corporation. The corporation sponsored an ERISA-governed profit-sharing plan. Dr. Yates participated in the plan, along with several other non-owner employees of the corporation.

In December 1989, Dr. Yates borrowed money from the benefit plan. However, he failed to comply with the loan repayment terms. In November 1996, Dr. Yates repaid the plan. Three weeks later, an involuntary bankruptcy petition was filed against Dr. Yates. In an adversary proceeding against Dr. Yates, the bankruptcy trustee petitioned the bankruptcy court to set aside the repayment as a preferential transfer. Because ERISA prohibits the alienation of pension benefits, Dr. Yates argued that the bankruptcy trustee was not entitled to money that was paid into the profit-sharing plan. Among other things, the bankruptcy trustee argued that because Dr. Yates was the sole owner of the corporation, he was not considered a participant in the ERISA plan and Dr. Yates' interest in the plan was not protected by ERISA's anti-alienation provision.

Both the bankruptcy court and the district court ruled that Dr. Yates' creditors were entitled to set aside his repayment to the profit-sharing plan. Relying on Sixth Circuit decisions in *Fugarino* and *Agrawal*, *supra*, the bankruptcy court and the district court held that Dr. Yates' interest in the plan was not protected by ERISA's anti-alienation provision because Dr. Yates could not be considered a participant in the plan.

The Sixth Circuit affirmed. Bound by previous panel holdings, the Court held that "our published case-law teaches that 'a sole proprietor or sole shareholder of a business must be considered an employer and not an employee of the business for purposes of ERISA.'"⁸⁹ Accordingly, Dr. Yates would not be considered a participant or beneficiary under ERISA.

The Supreme Court granted *certiorari*. The question was posed as follows: "Does the working owner of a business (here, the sole shareholder and president of a professional corporation) qualify as a 'participant' in a pension plan covered by [ERISA]." The Court summarized its holding:

If the plan covers one or more employees other than the business owner and his or her spouse, the working owner may participate on equal terms with other plan participants. Such a working owner, in common with other employees, qualifies for the protections ERISA affords plan participants and is governed by the rights and remedies ERISA specifies.

According to the Court, several reasons supported this holding. First, the Court referenced several "textual clues" in ERISA and in companion Internal Revenue Code provisions indicating that working owners were intended to be considered participants in ERISA-governed benefit plans. These textual references alleviated any need for the Court to resort to common law definitions of employee status, as it did in *Nationwide Mutual Insurance Co. v. Darden*,⁹⁰ where the Court determined whether an independent contractor could be considered an employee/participant of an ERISA plan. In that case, the Court found no text references in ERISA that would answer the issue of independent contractor participant status and resorted to common law. Textual references to working owners in ERISA and the IRC also caused the Court to distinguish *Clack-*

⁸⁹ 287 F.3d at 525.

⁹⁰ 503 U.S. 318 (1992).

amas Gastroenterology Assocs., P.C. v. Wells,⁹¹ in which the Court held that common law should be used to determine whether working owners are considered employees under the ADA. Having eschewed common law definitions, the Court held that ERISA and IRC textual references “expressly anticipate that a working owner can wear two hats, as an employer and employee.”

The second basis for the Supreme Court’s holding that working owners are participants under ERISA was that such a holding was dictated by the purposes of Congress in enacting ERISA. Treating working owners as participants “avoids the anomaly that the same plan will be controlled by discrete regimes: federal-law governance for the nonowner employees; state-law governance for the working owner.” The Court also noted “excepting working owners from the federal Act’s coverage would generate administrative difficulties and is hardly consistent with a national uniformity goal.”

The DOL’s position on the participant status of working owners provided a third basis for the Court’s holding. The Court held that agency advisory opinions interpreting an agency regulation “merit[] the Judiciary’s respectful consideration” and that the DOL’s view “on the qualification of a self-employed individual for plan participation reflects a ‘body of experience and informed judgment to which courts and litigants may properly resort for guidance.’”⁹²

Finally, the Supreme Court rejected the position of the Sixth Circuit and other courts that ERISA’s “anti-inurement” provision,⁹³ somehow barred owners from being considered participants. This provision prohibits plan assets from inuring to the benefit of employers. However, according to the Supreme Court, “the anti-inurement provision does not preclude [ERISA] coverage of working owners as plan participants”:

The [anti-inurement] provision demands only that plan assets be held for supplying benefits to plan participants... [T]he provision does not address the discrete question whether working owners, along with nonowner employees, may be participants in ERISA-sheltered plans.

In summary, the anti-inurement provision provided “no categorical barrier to working owner participation in ERISA plans.”

Justice Scalia authored a concurring opinion in which he stated that once the Court concluded that agency interpretations on the issue were reasonable, these interpretations are “binding upon us.” He stated that the Court’s approach “denies many agency interpretations their conclusive effect and thrusts the courts into authoritative judicial interpretation,” which “invites lengthy litigation in all the circuits—the product of which (when finally announced by this Court) is a rule of law that only Congress can change.” Justice Thomas also concurred, but for a different reason. He stated that he was not convinced that “textual indications” resolved the issue and that he would resort to common law.

F. Conclusion

Yates provides the long-awaited “bright line” standard needed to administer ERISA-governed plans involving owners. Plan administrators can now provide uniform procedures to claims filed by owners and non-owners alike when they seek benefits under such plans. The position of the Sixth and First Circuits arose in cases that were the some of the earliest to address the issue of an owner’s status under ERISA. These courts’ failure to adhere to DOL interpretation made less and less sense as time went on and as other circuits opted to fol-

⁹¹ 538 U.S. 440 (2003).

⁹² Quoting *Skidmore v. Swift & Co.*, 323 U.S. 134, 140 (1944).

⁹³ 29 U.S.C. §1103(c)(1).

low not only the DOL owner regulation, but also DOL interpretations of that regulation. *Yates* now resolves this problem.

As with many Supreme Court decisions, however, *Yates* leaves several issues open. The Court expressly declined to determine whether working owners may also be considered “beneficiaries” under ERISA, a position that has been confirmed by the vast majority of circuit courts. *Yates* also reveals an apparent split on the Court over the proper amount of deference to be granted to agency interpretive opinions. Ultimately, the Court in *Yates* opted to follow DOL guidance on the issue of the status of working owners and the proper amount of deference was a moot point. It appears that, at least with regard to the DOL’s interpretations of the owner regulation, litigants and lower courts should be safe in relying on the DOL.⁹⁴

An issue not decided in *Yates*, but which is certainly the next issue regarding owners’ participation in benefit plans, is whether plans that cover unmarried joint shareholders but which do not cover non-owner employees are governed by ERISA. The lower courts are split on this issue.⁹⁵ The fact that *Yates* will now have an impact on lower courts’ consideration of this issue is demonstrated by the decision in *Provident Life & Acc. Insurance Co. v. Sharpless*,⁹⁶ in which the Court expressly relied on *Yates* and DOL interpretive guidance to hold that disability policies covering unmarried joint owners of a corporation are governed by ERISA. Whether the Supreme Court will ultimately address this issue or leave it to the lower courts to sort out in the wake of *Yates* remains to be seen.

XI. Individual Insurance Policies and ERISA

It is not uncommon for plaintiffs to argue—and for some defense lawyers to agree—that individual life, health, or disability insurance policies cannot be part of an employee welfare benefit plan governed by the Employee Retirement Income Security Act of 1974, 29 U.S.C. Section 1001, *et seq.* (“ERISA”). Not true. ERISA broadly provides that an employee welfare benefit plan can be funded “through the purchase of insurance or otherwise,” 29 U.S.C. §1002(1), making no distinction between individual insurance and group insurance. Thus, benefits under an ERISA-compliant plan can be funded by one or more group or individual insurance policies, or a combination of group or individual insurance policies.

Several federal district courts have ruled that programs involving individual disability insurance policies are governed by ERISA, even in some instances where the actual structure of the ERISA program expired before an insured filed a claim for benefits under the policy. Two of those decisions—both in California—illustrate the types of arrangements involving individual insurance policies that courts have found to be regulated by ERISA.

⁹⁴ See, e.g., *Pacheco v. Whiting Farms, Inc.*, 365 F.3d 1199 (10th Cir. 2004) (citing *Yates* and holding that agency opinion letters are entitled to deference).

⁹⁵ Compare *Kennedy v. Allied Mut. Ins. Co.*, 952 F.2d 262 (9th Cir. 1991); *Ritter v. Massachusetts Cas. Ins. Co.*, 439 Mass. 214, 786 N.E.2d 817 (2003); and *Tierney v. Unum Life Ins. Co. of Am.*, 97 S.W.3d 842 (Tex. App. 2003) (plans covering unmarried joint shareholders are not governed by ERISA) with *Leckey v. Stefano*, 263 F.3d 267 (3d Cir. 2001); *Santino v. Provident Life & Acc. Ins. Co.*, 276 F.3d 772 (6th Cir. 2001); and *Sipma v. Mass. Cas. Ins. Co.*, 256 F.3d 1006 (10th Cir. 2001) (plans covering unmarried joint shareholders of corporate plan sponsors are governed by ERISA).

⁹⁶ 364 F.3d 634 (5th Cir. 2004).

A. *Indicia of an ERISA Plan*

The ultimate question in determining whether any insurance policy—individual or group—is regulated by ERISA, is whether the policy is part of an employment relationship. That necessarily requires the establishment of an employer-employee relationship, *i.e.*, there must be an employer and at least one covered employee/participant. *See, e.g.*, 29 C.F.R. §2510.3-3(b) and (c) (every ERISA plan must cover at least one common law employee). It also requires evidence that the insurance policy is part of the employment relationship.

In a typical *group* insurance arrangement, a group insurance policy is issued to an employer who determines that it will provide coverage to a select group of employees. The employer also typically contributes at least part of the cost of the employee's coverage and/or performs other functions or actions indicating that the employer endorses the program and/or has adopted the policies as part of its overall employee benefit program.

A typical program involving *individual* policies of insurance is not so different. Examples of some of the common practices involving individual insurance policies can include the following:

- A multi-life program, sometimes exhibited in a written agreement between an employer and an insurer.
- The employer selects the broker, the insurer, and sometimes the types of policies that will make up the program.
- The employer may agree to accept certain responsibilities for establishing and/or maintaining the program, such as payment of all or a portion of the premiums.
- Premiums are subject to a discount as a result of the agreement between the employer and the insurer.
- There may be other benefits such as abbreviated underwriting procedures or higher than coverage limits.
- Billings are made directly to the employer, sometimes referred to as a “list bill.”
- Individual policies are issued to a select group of employees, many times including one or more owner/employees of the employing entity (frequently a professional corporation).
- The employer maintains ongoing communication with the insurer, including administrative tasks such as informing the insurer when new employees are hired or existing employees are terminated.
- The employer facilitates payment of the premiums. The actual financial responsibility for the premiums may occur in a number of ways, *e.g.*, the employer may absorb the cost, the employer may pass on some or all of the cost on to the employees (such as through payroll deductions or via a flexible benefits program), the employer may ask the employees to pay the premiums directly and may reimburse the employees through a bonus program, or the cost of the premiums may be deducted from various expense accounts available to the employees. Many times the purpose of passing on the costs to the employees is to ensure that any benefits would not be subject to income taxes.

B. *Structure of an ERISA Plan*

The structure of an ERISA welfare benefit plan is statutory and requires five elements: (a) a plan, fund, or program; (b) established or maintained; (c) by an employer (or an employee organization); (d) for the purpose of providing statutory benefits (including life, health, and disability insurance); (e) to participants and beneficiaries. 29 U.S.C. §1002(1). In the context of group or group-type insurance programs, courts also look to whether the program falls within the “safe harbor” regulation, which excludes any program from ERISA where the employer is a mere advertiser of the program. In order to satisfy the regulatory safe harbor, a plan

must satisfy several elements. Two of these elements are most often in dispute when one is attempting to determine whether a plan is exempt from ERISA: (a) whether the employer contributes to the program; and (b) whether the employer has endorsed the program. Satisfaction of either of these elements removes a plan from the safe harbor exemption. 29 C.F.R. §2510.3-1(j).

C. Case Study: Zide v. Provident Life & Acc. Ins.

The employer in *Zide v. Provident Life & Acc. Ins. Co.*, 2011 U.S. Dist. Lexis 153777 (C.D. Cal. Apr. 13, 2011) signed a salary allotment agreement with Provident Life & Accident Insurance Company whereby the employer represented that it would pay the entire premium cost in consideration for Provident to issue individual disability policies to select employees of a medical corporation, some of whom were also shareholders of the corporation. The salary allotment agreement was in effect for many years. During that time, various doctors were covered under the plan. Some of the doctors were employees when first covered, but later became shareholders. Premiums were billed via periodic list bills sent to the corporation and the corporation paid the premiums. The corporation then charged the premiums back to the various doctors. There was a substantial premium discount as well as other benefits which continued even if a doctor left the corporation and continued to pay the policy premiums. By the time Dr. Zide filed a claim for benefits under his policy, he was the only insured left at the corporation and he was the sole owner of the corporation. When Provident terminated Dr. Zide's benefits, he sued under California state law and alleged bad faith, seeking compensatory and punitive damages. Provident alleged, among other things, that Dr. Zide's policy was governed by ERISA and that his bad faith claim was preempted.

The district court granted judgment to Provident, ruling that the insurance program was an ERISA plan and that Dr. Zide's state law claims were preempted. Applying the statutory five-factor test, the district court concluded:

- Although there was no formal plan document apart from the insurance policy, there was an established plan, fund, or program in that the plan was a reality and not a mere promise of future potential coverage.
- The program was established and maintained by the employer corporation: premiums were paid initially by the employer; the employer performed other ongoing administrative services, including maintaining contact with the insurer over a period of years; and the employees received a substantial discount and other benefits from the arrangement.
- The corporation was an employer and was identified as such in the salary allotment agreement with the insurer.
- The program provided statutory benefits (benefits in the event of disability).
- There were participants in the program in that the program covered at least one non-owner employee of the corporation at least some point during the program's existence.

The district court also concluded that the program fell outside of the safe harbor exemption. Even though the employees bore the ultimate cost of the premiums, the availability of a discount through the efforts and commitment of the employer and which was in existence solely by virtue of the employment relationship, constituted an employer contribution to the program. Finally, the court ruled that even though the program might not satisfy all of the ERISA requirements at the time Dr. Zide filed his benefit claim because it no longer covered at least one non-owner employee, the fact that the program had at one time been governed by ERISA meant that Dr. Zide's policy continued to be governed by ERISA as he continued to reap the various

benefits (discounted premiums and higher levels of coverage) made available to him by the employment relationship and the employer's commitments to the insurer.

D. Case Study: Masteler v. Paul Revere Life Ins.

Another recent example of an individual disability insurance policy being governed by ERISA is the case of *Masteler v. Paul Revere Life Ins. Co.*, 2012 U.S. Dist. Lexis 21725 (S.D. Cal. Feb. 22, 2012). In that case, a large national employer entered into an "employee security program" with Paul Revere whereby the insurer agreed to issue individual disability income policies to a select group of executive employees with favorable coverage options and substantial premium discounts, in exchange for the employer's promise to pay the premiums. The program was in effect for several years and multiple policies were issued to executive employees of the employer during that time. When the plaintiff applied for his policy, he represented to the insurer that his employer would pay the entire premium cost. The evidence indicated that the employer did pay the first annual premium for his policy, but several months after the policy was issued, the plaintiff left his employment. He continued the policy, agreeing to pay future premiums himself.

The plaintiff became disabled due to a heart condition and was paid benefits for several years. When benefits were about to reach the maximum pay period under the policy, the plaintiff argued that his heart condition was an injury rather than a sickness, triggering the lifetime benefit clause of the policy. The insurer disagreed, benefits were terminated, and the plaintiff sued under California state law, alleging bad faith and seeking compensatory and punitive damages. Among other things, Paul Revere argued that the policy was governed by ERISA and that the plaintiff's state law claims were preempted.

The district court agreed with Paul Revere and dismissed the plaintiff's state law complaint. The court held that where an employer enters into an agreement with an insurer to make individual disability policies available to employees at discounted premiums and higher coverage levels and pays the premiums, the employer has established an ERISA plan. The court ruled that the regulatory safe harbor did not apply because the employer paid the premium cost. Finally, the court ruled that where the employee elected to continue his coverage under the same policy and under the same terms after he left his employment, the fact that the plaintiff took over the premium payments did not remove the policy from ERISA. The plaintiff's claim was governed exclusively by ERISA and his state law claims were preempted.

E. Conclusion

The *Zide* and *Masteler* decisions are just a couple of examples of situations where individual insurance policies were held to be governed by ERISA. These decisions dispel the myth that only group insurance policies can be part of an ERISA plan and that individual insurance is subject to state law. Of course, in order for ERISA to apply, there must be a nexus to an employment relationship, but once that nexus is established, many fact scenarios may bring individual policy coverage under ERISA and outside of state law.

Preemption of State Law

ERISA has three provisions relating to its preemptive effect on state law: (1) the “Preemption Clause”; (2) the “Saving Clause”; and (3) the “Deemer Clause.” These provisions and their interplay with one another have provided the basis for much litigation under ERISA, including several key United States Supreme Court decisions. In some areas, preemption law is clear. In others, one wonders if what was described by Congress as ERISA’s “crowning achievement”—establishment of benefit plan regulation as exclusively a federal concern—has been accomplished.¹

I. The Statute

Congress provided for the preemption of all state laws that “relate to” employee benefit plans. The “Preemption Clause” provides as follows:

Except as provided in [the Saving Clause]... [ERISA shall] supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan....²

Congress did allow for some exceptions to this broad preemption provision. The “Saving Clause” provides as follows:

[N]othing in this subparagraph shall be construed to exempt or relieve any person from any law of any state which regulates insurance, banking, or securities.³

However, to prevent the Saving Clause from becoming an escape hatch for state regulation of most benefit plans, particularly those that were self-funded (*i.e.*, those plans not funded by insurance policies), Congress prohibited states from “deeming” self-funded plans to be subject to state insurance regulations. This “Deemer Clause” provides as follows:

Neither an employee benefit plan... nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer... or to be engaged in the business of insurance... for purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts....⁴

The mechanics of these provisions can be summarized as follows: First, in order to be preempted, a state law must “relate to” an employee benefit plan. Second, even if the law “relate[s] to” an employee benefit plan, it is not preempted if the law “regulates insurance, banking, or securities.” Even so, the Deemer Clause makes clear that employee benefit plans may not be deemed to be an “insurance company or other insurer” for purposes of state insurance laws. Given the statutory complexity of these three clauses, as well as the wide variety of state statutory and decisional law arguably affected by them, it is not surprising that the Supreme Court has been called upon several times to interpret these provisions.

¹ See 120 Cong. Rec. 29197 (1974).

² ERISA, §514(a) (the “Preemption Clause”).

³ *Id.* §514(b)(2)(A) (the “Saving Clause”).

⁴ *Id.* §514(b)(2)(B) (the “Deemer Clause”).

II. Supreme Court Applications

In several key decisions, the Supreme Court has given a broad reading to ERISA's preemption provision.⁵ This, in turn, is based in part on the Court's broad reading of whether a law "relates to" an employee welfare benefit plan. The Court has held that a state law "relates to 'a benefit plan... if it has a connection with or reference to such a plan.'"⁶ The Court has also "emphasized that the pre-emption clause is not limited to 'state laws specifically designed to affect employee benefit plans.'"⁷

In *Pilot Life*, the Supreme Court held that when a plaintiff claims benefits under an employee benefit plan, ERISA provides the *exclusive* remedy. The plaintiff based his claim on state common law "tortious breach of contract" and "the Mississippi law of bad faith." The plaintiff requested damages allegedly resulting from a denial of benefits under an insured employee benefit plan.⁸ The Court held that this claim was preempted because the state law at issue "related to" an employee benefit plan.⁹

In a case decided the same day as *Pilot Life*, the Supreme Court gave a further broad reading to ERISA's preemption provision by holding that ERISA's preemption of state law is so complete that any complaint seeking benefits under an employee benefit plan is "necessarily federal in nature" and may be removed to federal court. This is so even though the complaint is phrased entirely in terms of state law and fails to make any mention of ERISA.¹⁰ Thus, even the "well-pleaded complaint" rule (a rule that requires a complaint phrased entirely under state law to remain in state court) will not prevent removal of that case to federal court.

The fact that a state law "relate[s] to" employee benefits, however, is not sufficient to trigger application of ERISA's preemption provision. Rather, the state law must "relate to" an employee benefit *plan*. The Supreme Court made this point in the case of *Ft. Halifax Packing Co., Inc. v. Coyne*.¹¹ In that case, a state law was challenged as being preempted by ERISA where the law mandated a one-time severance payment to employees at the time of a plant closure. The Court held that this state law was *not* preempted, in part because it did not relate to a *plan*. The Court noted that not all state laws regulating benefits were preempted; only those laws that relate to benefit *plans* are preempted:

ERISA's preemption provision does not refer to state laws relating to "employee benefits," but to state laws relating to "employee benefit *plans*"... We have held that the words "relate to" should be construed expan-

⁵ See, e.g., *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 45–46 (1987) ("the express pre-emption provisions of ERISA are deliberately expansive"); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983) ("the breadth of [29 U.S.C. §1144(a)'s] pre-emptive reach is apparent....").

⁶ *Shaw*, 463 U.S. at 96–97.

⁷ *Pilot Life*, 481 U.S. at 47–48; *accord*, *D.C. v. Greater Wash. Bd. of Trade*, 113 S. Ct. 580 (1992) (a state law refers to or has a connection with benefit plans even if the law is not specifically designed to affect such plans, or the effect is only indirect and the law is consistent with ERISA's substantive requirements); *Shaw*, 463 U.S. at 98 (pre-emption clause not "interpreted to pre-empt only state laws dealing with the subject matters covered by ERISA—reporting, disclosure, fiduciary responsibility, and the like.")

⁸ *Pilot Life*, 481 U.S. at 51.

⁹ *Accord*, *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987) (suit for breach of contract, reinstatement of benefits, and mental anguish preempted by ERISA). See also *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990) (common-law wrongful discharge claim preempted by ERISA where it "relates to" an employee benefit plan and conflicts with ERISA's exclusive civil enforcement provision).

¹⁰ *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987).

¹¹ 482 U.S. 1 (1987).

sively.... Nothing in our case law, however, supports [the] position that the word “plan” should in effect be read out of the statute.¹²

Under the statute, all state laws that relate to employee benefit *plans* are preempted by ERISA unless they fall within the Saving Clause. Thus, “[t]he saving clause excepts from the preemption clause laws that ‘regulat[e] insurance.’”¹³ According to the Supreme Court, it is not sufficient that a law merely falls within the Saving Clause. A state law is not exempt from ERISA preemption if the law conflicts with a substantive ERISA provision.¹⁴ Thus, the Saving Clause functions to preserve state law claims *only if*: (1) the state law upon which the claim is based regulates insurance; *and* (2) the state law upon which the claim is based does not conflict with a substantive ERISA provision.^{15,16}

The test employed by the Supreme Court in determining whether a state law “regulates insurance” involves two steps.¹⁷ First, the law must “regulate[] insurance” under a “common sense view.” Under this commonsense interpretation, “a law must not just have an impact on the insurance industry, but must be specifically directed toward that industry.”¹⁸ Second, the law in question must regulate the “business of insurance” as that phrase is defined by the McCarran-Ferguson Act.¹⁹ Under the McCarran-Ferguson Act, three criteria are used to determine if the practice at issue constitutes the “business of insurance” and is therefore subject to state regulation:

First, whether the practice has the effect of transferring or spreading a policyholder’s risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry.²⁰

Even if a law “regulates insurance,” it is still preempted where the remedies sought by the plaintiff conflict with ERISA’s civil enforcement provisions. The most important consideration in determining whether a state law will be preempted is Congress’s clear intent that the civil enforcement scheme of ERISA be exclusive, not whether the state laws at issue “regulate insurance.”²¹ ERISA provides a comprehensive and exclusive mechanism for employees to enforce their rights, bring claims, and monitor their fiduciaries, as well as specific remedies for parties that prevail.²² The comprehensive enforcement schemes set out in ERISA, §502(a) “represent a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans.”²³

¹² *Id.* at 8.

¹³ *Pilot Life*, 481 U.S. at 45.

¹⁴ *Id.*

¹⁵ *Id.*

¹⁶ *Ingersoll-Rand*, 498 U.S. at 139.

¹⁷ *Pilot Life*, 481 U.S. at 48–52.

¹⁸ *Id.* at 50.

¹⁹ 15 U.S.C. §1011, *et seq.*

²⁰ *Pilot Life*, 481 U.S. at 48–49 (quoting *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1982)) [emphasis added].

²¹ *Pilot Life* 481 U.S. at 51–57. *See also* *Ingersoll-Rand*, 498 U.S. at 142–43.

²² *Id.* at 52–56.

²³ *Id.* at 54.

The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA.²⁴

According to the Supreme Court, the legislative history of ERISA provides further support for the conclusion that state, common, and statutory laws are preempted by the civil enforcement provisions of ERISA even though they may “regulat[e] insurance”:

The deliberate care with which ERISA’s civil enforcement remedies were drafted and the balancing of the policies embodied in its choice of remedies argues strongly for the conclusion that ERISA’s civil enforcement remedies were intended to be exclusive. This conclusion is fully confirmed by the legislative history of the civil enforcement provision.²⁵

Finally, even if a state law is one that regulates insurance within the meaning of ERISA, the law is not applicable to self-funded benefit plans (e.g., plans funded other than by an insurance policy) by virtue of the Deemer Clause. The Supreme Court has held that “the deemer clause... exempt[s] self-funded ERISA plans from state laws that ‘regulat[e] insurance’ within the meaning of the saving clause.”²⁶ Thus, state laws that regulate insurance are not applicable to a self-funded benefit plan:

[S]elf-funded ERISA plans are exempt from state regulation insofar as that regulation “relate[s] to” the plans. State laws directed toward the plans are pre-empted because they relate to an employee benefit plan but are not “saved” because they do not regulate insurance. State laws that directly regulate insurance are “saved” but do not reach self-funded employee benefit plans because the plans may not be deemed to be insurance companies, other insurers, or engaged in the business of insurance for purposes of such state laws.²⁷

The reach of the Deemer Clause is clear:

If a plan is insured, a State may regulate it indirectly through regulation of its insurer and its insurer’s insurance contract; *if the plan is uninsured, the State may not regulate it.*²⁸

Several general rules of application may be drawn from this line of Supreme Court authorities on ERISA’s preemption provision.

- 1) The courts should interpret ERISA’s “relate to” language expansively, giving broad application to ERISA’s preemption provision.
- 2) In order to be “saved” from ERISA preemption as a law that “regulates insurance,” a state law not only must regulate insurance in the “common sense” of the term, but must also meet the standards of the McCarran-Ferguson Act as a law that regulates the “business of insurance.”

²⁴ *Id.*; *accord*, *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987) (ERISA provides an exclusive federal cause of action for the resolution of disputes involving a claim for benefits under an employee benefit plan); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. at 145 (“[w]hen it is clear or may fairly be assumed that the activities that a State purports to regulate are protected” by... ERISA, “due regard for the federal enactment requires that state jurisdiction must yield”).

²⁵ *Pilot Life*, 481 U.S. at 54.

²⁶ *FMC v. Holliday*, 498 U.S. 52, 61 (1990).

²⁷ *Id.*

²⁸ *Id.* at 368.

- 3) Even if a state law is one that “regulates insurance” within the meaning of ERISA, it is still preempted if it purports to provide remedies or procedures that conflict with the exclusive civil enforcement scheme of ERISA.
- 4) A state law is not saved from preemption as one that “regulates insurance” where it is applied to a self-funded benefit plan.

ERISA’s preemption clause was further interpreted in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*²⁹ The United States Supreme Court held that ERISA does not preempt state provisions for surcharges on bills of patients whose commercial insurance coverage is purchased by employee health care plans governed by ERISA and for surcharges on HMOs insofar as their membership fees are paid by an ERISA plan.

New York state law regulates hospital rates for all in-patient care, except for services provided to Medicare beneficiaries. Patients with Blue Cross/Blue Shield coverage, Medicaid patients, and HMO participants are billed at rates determined under Diagnostic Related Groups. Patients served by commercial insurers providing in-patient hospital on an expense-incurred basis, by self-insured funds directly reimbursing hospitals, and by certain workers’ compensation, volunteer firefighters’ benefit, ambulance workers’ benefit, and no-fault motor vehicle insurance funds are billed at the DRG rate plus a 13 percent surcharge to be retained by the hospital.

The Supreme Court agreed that the surcharges would have a significant effect on commercial insurers and HMOs that do or could provide coverage for ERISA plans and thus lead, at least indirectly, to an increase in plan costs. The Court also reiterated its previous statements in several cases that the governing text of ERISA’s preemption provision is “clearly expansive.” Nevertheless, the Court held that the state law did not sufficiently “relate to” employee benefit plans so as to require preemption. The indirect economic influence on the choices plans must make in determining how to purchase funding for health benefits does not bind plan administrators to any particular choice and does not function as a regulation of an ERISA plan itself; it simply bears on the cost of benefits and the relative costs of competing insurance to provide them. The Court noted that cost uniformity was almost certainly not an object of preemption under ERISA and that state laws that have only an indirect economic effect on the relative costs of various health insurance packages in a given state are “a far cry” from state laws that Congress meant to insulate ERISA plans.

The Supreme Court was careful to note that it did not hold that ERISA preempts only direct regulation of ERISA plans. The Court acknowledged that “a state law might produce such acute, albeit indirect, economic effects, by intent or otherwise, as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers, and that such a state law might indeed be preempted under ERISA.” However, the court held that New York’s surcharges did not fall into either category: “They affect only indirectly the relative prices of insurance policies, a result no different from myriad state laws in areas traditionally subject to local regulation, which Congress could not possibly have intended to eliminate.”

One area where the Supreme Court did determine that state law imposed the kind of regulation that leads to preemption was in *Gobeille v. Liberty Mutual Ins. Co.*, 2016 WL 782861 (U.S. Sup. Ct. March 1, 2016). The State of Vermont required certain entities, including health insurers and self-funded health plans, to report payments related to health care claims and other information related to health care services. The State then compiled the information in a health care database. The Supreme Court held that the state law was preempted by ERISA. The Court ruled that preemption was necessary to prevent multiple jurisdictions from

²⁹ 131 L. Ed. 2d 695 (1995).

imposing differing or parallel requirements that would create wasteful administrative costs and that could also subject ERISA-governed health plans to potential liability in multiple states. The Court noted that the U.S. Secretary of Labor, not the states, is authorized to decide whether to exempt ERISA plans from reporting requirements or to report the kind of data required by Vermont.

III. Lower Court Applications of ERISA's Preemption Rules

In light of the number of Supreme Court decisions regarding ERISA's preemptive effect, a multitude of state laws have been held to be preempted by ERISA. For example, state law claims of bad faith are preempted, whether based on common law or on statute, regardless of whether or not the statute is in the insurance code or in a state's Deceptive Trade Practices Act.³⁰ Tort and contract claims, including tortious breach of contract, are preempted.³¹ State law claims of emotional distress arising out of the administration of an employee benefit plan are preempted.³² Claims of estoppel and oral representations are preempted.³³ State law claims of fraud and detrimental reliance are preempted by ERISA.³⁴ State law claims of wrongful death are preempt-

³⁰ See, e.g., *Pilot Life*, 481 U.S. 41 (1987); *Pitts v. American Security Life Ins. Co.*, 931 F.2d 351 (5th Cir. 1991); *Ramirez v. Inter-Continental Hotels*, 890 F.2d 760 (5th Cir. 1989); *In re Life Ins. Co. of Am.*, 857 F.2d 1190 (8th Cir. 1988); *Reilly v. Blue Cross & Blue Shield United of Wis.*, 846 F.2d 416 (7th Cir. 1988); *Cantrell v. Great Republic Ins. Co.*, 873 F.2d 1249 (9th Cir. 1989); *Kanne v. Connecticut Gen. Life Ins. Co.*, 867 F.2d 489 (9th Cir. 1988); *Howard v. Parisian*, 807 F.2d 1560 (11th Cir. 1987).

³¹ See, e.g., *Fitzgerald v. Codex Corp.*, 882 F.2d 586 (1st Cir. 1989); *Smith v. Dunham-Bush*, 959 F.2d 6 (2d Cir. 1992); *Shiffler v. Equitable Life Assur. Soc'y*, 838 F.2d 78 (3d Cir. 1988); *Makar v. Health Care Corp. of Mid-Atlantic*, 872 F.2d 80 (4th Cir. 1989); *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987); *Harms v. Cavenham Forest Indus., Inc.*, 984 F.2d 686 (5th Cir. 1993); *Fisher v. Combustion Eng'g, Inc.*, 976 F.2d 293 (6th Cir. 1992); *Cromwell v. Equicor-Equitable HCA Corp.*, 944 F.2d 1272 (6th Cir. 1991); *Maciosek v. Blue Cross & Blue Shield of Wis.*, 930 F.2d 536 (7th Cir. 1991); *Harper v. R.H. Macy & Co., Inc.*, 920 F.2d 544 (8th Cir. 1990); *Dytrt v. Mountain State Tel. & Tel. Co.*, 921 F.2d 889 (9th Cir. 1990); *Kelso v. General Am. Life Ins. Co.*, 967 F.2d 388 (10th Cir. 1992); *Swerhun v. Guardian Life Ins. Co. of Am.*, 979 F.2d 195 (11th Cir. 1992).

³² See, e.g., *Pane v. RCA Corp.*, 868 F.2d 631 (3d Cir. 1989); *Hughes v. K-Mart Corp.*, 1993 U.S. App. Lexis 1333 (6th Cir. 1993) (unpublished); *Reilly v. Blue Cross*, 846 F.2d 416 (7th Cir. 1988); *Kuhl v. Lincoln Nat'l Health Plan of Kansas City*, 999 F.2d 298 (8th Cir. 1993); *Johnson v. District 2 Marine Eng'rs Beneficial Ass'n*, 857 F.2d 514 (9th Cir. 1988); *Howard v. Parisian*, 807 F.2d 1560 (11th Cir. 1987). *But see* *Drinkwater v. Metro. Life Ins. Co.*, 846 F.2d 821 (1st Cir. 1988) (spouse's claim of emotional distress based upon her husband's employer's conduct does not relate to an ERISA plan).

³³ *Cleary v. Graphic Commc'ns Int'l Union*, 841 F.2d 444 (1st Cir. 1988); *Smith v. Dunham-Bush*, 959 F.2d 6 (2d Cir. 1992); *Berger v. Edgewater Steel*, 911 F.2d 911 (3d Cir. 1990); *Coleman v. Nationwide Life Ins. Co.*, 969 F.2d 54 (4th Cir. 1992); *Harms v. Cavenham Forest Indus., Inc.*, 984 F.2d 686 (5th Cir. 1993); *Cromwell v. Equicor*, 944 F.2d 1272; *Kraut v. Wisconsin Laborers' Health Fund*, 1993 U.S. App. Lexis 9502 (7th Cir. 1993); *Consol. Beef Indus. v. N.Y. Life Ins. Co.*, 949 F.2d 960 (8th Cir. 1991); *Anderson v. John Morrell & Co.*, 830 F.2d 872 (8th Cir. 1987); *Peterson v. Soo Line R.R. Co.*, 1992 U.S. App. Lexis 2665 (9th Cir. 1992); *Straub v. Western Union Tel. Co.*, 851 F.2d 1262 (10th Cir. 1988); *Peckham v. GEM State Mut. of Ohio*, 964 F.2d 1043 (10th Cir. 1992); *Nachwalter v. Christie*, 805 F.2d 956 (11th Cir. 1986). *But see* *Memorial Hosp. Sys. v. Northbrook Life Ins. Co.*, 904 F.2d 236 (5th Cir. 1990) (estoppel and other state law claims are not preempted by ERISA where brought by party that is not a participant or beneficiary of the employee benefit plan).

³⁴ See, e.g., *Diduck v. Kaszycki & Sons Contractors, Inc.*, 974 F.2d 270 (2d Cir. 1992); *Memorial Hosp. Sys. v. Northbrook Life Ins. Co.*, 904 F.2d 236 (5th Cir. 1990); *Reilly v. Blue Cross*, 846 F.2d 416 (7th Cir. 1988); *Olson v. General Dynamics Corp.*, 960 F.2d 1418 (9th Cir. 1991); *Johnson v. District 2 Marine Eng'rs Beneficial Ass'n*, 857 F.2d

ed.³⁵ State law wrongful discharge claims are also preempted insofar as plaintiff alleges that his or her discharge was motivated by an intent to avoid or otherwise circumscribe plaintiff's attainment or accumulation of benefits under an employee benefit plan.³⁶

Some federal courts have held that preemption may depend on whether the matter involves a dispute between "ERISA entities" such as the employer, the employee, the plan insurer, plan fiduciaries, and the like. For example, in *Memorial Hospital System v. Northbrook Life Insurance Co.*,³⁷ the Court held that an estoppel claim brought by a medical provider against a plan insurer was not preempted by ERISA because the plaintiff medical provider was not a plan entity. More recently, the Fifth Circuit held that a fraudulent inducement claim against an independent insurance agent was not preempted because the defendant was a non-ERISA entity.³⁸ It has also been held that a similar claim against the plan insurer is preempted by ERISA because the insurer is an ERISA entity.³⁹

As noted above, the Saving Clause does not exempt all state insurance code provisions from preemption. For example, it has been held that a state statute dealing with notice of the right to convert from a group policy to an individual policy does not "regulate insurance" and is preempted by ERISA.⁴⁰ However, where state statutes mandate that certain provisions be included in group insurance policies and/or that certain types of coverage be provided to insureds, such statutes are not usually preempted, since such laws are saved from preemption as laws that "regulate insurance."⁴¹ Even so, a state may not regulate the types of provisions to be included in a self-funded benefit plan.⁴²

Finally, the Supreme Court has held that state garnishment laws specifically aimed at employee benefit plans and that proscribe garnishment of benefits under such plans are preempted by ERISA.⁴³ On the other hand, state garnishment laws of general application are not preempted.⁴⁴

514 (9th Cir. 1988); *Sanson v. General Motors Corp.*, 966 F.2d 618 (11th Cir. 1992); *Amos v. Blue Cross/Blue Shield of Ala.*, 868 F.2d 430 (11th Cir. 1989).

³⁵ See, e.g., *Spain v. Aetna Life Ins. Co.*, 11 F.3d 129 (9th Cir. 1993); *Settles v. Golden Rule Ins. Co.*, 927 F.2d 505 (10th Cir. 1991).

³⁶ See *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990); *Fitzgerald v. Codex*, 882 F.2d 586 (1st Cir. 1989); *Pizzlo v. Bethlehem Steel Co.*, 884 F.2d 116 (4th Cir. 1989); *Nishimoto v. Federman-Bachrach & Assocs.*, 903 F.2d 709 (9th Cir. 1990).

³⁷ 904 F.2d 236 (5th Cir. 1990).

³⁸ *Morstein v. Nat'l Ins. Servs., Inc.*, 93 F.3d 715 (11th Cir. 1996).

³⁹ *Perkins v. Time Ins. Co.*, 898 F.2d 470 (5th Cir. 1990). See also *Stevenson v. Bank of New York Company, Inc.*, 609 F.3d 56 (2d Cir. 2010) (employee's claim that his employer failed to provide promised pension and other benefits was not preempted by ERISA because the claims were solely a means of describing the consideration underlying an employment contract). But see *Dobbs v. Anthem Blue Cross and Blue Shield*, 600 F.3d 1275 (10th Cir. 2010) (an employer's claims against its insurer arising from pre-contractual representations may not be preempted although a beneficiary's fraudulent inducement claims are preempted where the allegedly improper conduct related to the insurer's failure to abide by the terms of the plan).

⁴⁰ See *Howard v. Gleason Corp.*, 901 F.2d 1154 (2d Cir. 1990).

⁴¹ See, e.g., *Metro. Life Ins. Co. v. Mass.*, 471 U.S. 724 (1985).

⁴² *FMC v. Holliday*, 498 U.S. 52.

⁴³ *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825 (1988).

⁴⁴ *Id.*

IV. Focus on the Insurance Saving Clause: *UNUM v. Ward*

The issues on which the United States Supreme Court granted *certiorari* in *UNUM Life Insurance Co. of America v. Ward*⁴⁵ were relatively narrow and well defined: (1) whether California's common law notice-prejudice rule was saved from preemption under ERISA as a law that "regulates insurance"; and (2) whether California's common law of agency "relate[d] to" an employee benefit plan and was preempted by ERISA. However, as practitioners awaited the Supreme Court's decision, there was much speculation as to whether *Ward* would merely follow the analytical framework previously utilized by the Supreme Court in *Metro-politan Life Insurance Co. v. Massachusetts*⁴⁶ and *Pilot Life Insurance Co. v. Dedeaux*⁴⁷ to apply ERISA's preemption clauses or whether the Court would use *Ward* as a vehicle to open the door to state law causes of action as a supplement to ERISA's civil enforcement remedies, a possibility that the Supreme Court expressly rejected in *Pilot Life, Ingersoll-Rand Co. v. McClendon*,⁴⁸ and other decisions.

As finally decided, *Ward* did not lead to the dramatic changes expected by some observers, but instead reiterated the preemption analysis that the Supreme Court used in *Pilot Life* and other cases while also offering some important clarification as to the precise application of *Pilot Life* criteria. The parties in *Ward* agreed that the *notice-prejudice rule* "relate[d] to" the benefit plan and was preempted by ERISA unless it was "saved" as a law that "regulates insurance." The parties disputed whether the *agency rule* "relate[d] to" the benefit plan, although *Ward* agreed that if it was preempted, it did not "regulate insurance" and would not be "saved" from preemption. The Supreme Court held that, as historically applied in California, the notice-prejudice rule is a law that "regulates insurance" under the *Pilot Life* criteria and is saved from preemption. The Court also held that California's common law of agency "relates to" the employee disability plan at issue and is preempted by ERISA.

A. Factual Background

John Ward was an employee of Management Analysis Company and was a participant in his employer's group long term disability program. Benefits under the program were funded by a policy of insurance issued to the employer by UNUM Life Insurance Company of America. The policy provided that proofs of disability were to be provided to UNUM no later than one year and 180 days after the onset of disability. There was no dispute that the program was governed by ERISA.

In December 1992, Ward was diagnosed with diabetic neuropathy. Approximately three months later, he qualified for California state disability benefits. He informed his employer of this fact and asked about continuing health coverage. In July 1993, Ward qualified for Social Security disability benefits and forwarded a copy of the determination letter to his employer. In April 1994, Ward discovered among his papers a copy of the plan booklet related to the UNUM policy. After his employer told him that he was covered under the UNUM policy, Ward completed an application for benefits and it was forwarded to UNUM. UNUM ultimately denied the claim because it was untimely under the policy.

⁴⁵ 1999 U.S. Lexis 2839 (Apr. 20, 1999).

⁴⁶ 471 U.S. 724 (1985).

⁴⁷ 481 U.S. 41 (1987).

⁴⁸ 498 U.S. 133 (1990).

B. Legal Issues and Rulings in the Lower Courts

Ward filed suit in federal court to recover benefits under ERISA. Among other things, Ward argued that his employer was an agent of UNUM for purposes of administering the disability program under California common law. Because Ward timely informed his employer of his disability, Ward argued that this notice was imputed to UNUM. The district court rejected Ward's argument, holding that the state agency rule "relate[d] to" the disability program and was therefore preempted. The district court granted summary judgment to UNUM.

Ward appealed, and the Ninth Circuit reversed the summary judgment. The appellate court relied on two grounds. First, the court applied California's notice prejudice rule to hold that UNUM was required to show actual prejudice from the delayed notice before it could deny Ward's claim as untimely. The Ninth Circuit held that although the notice-prejudice rule "relate[d] to" the disability program and was preempted by ERISA, it was ultimately "saved" from preemption because it was a state law that "regulates insurance." Second, the Ninth Circuit held that California's agency rule did not "relate to" the disability program and was not preempted by ERISA. The Ninth Circuit remanded the matter to the district court to determine whether UNUM suffered actual prejudice because of the untimely filing and/or whether under California agency principles Ward's late claim was timely filed with Ward's employer as agent for UNUM.

C. Supreme Court Ruling

1. California's Notice-Prejudice Rule Is Saved from Preemption

The Supreme Court granted *certiorari* to resolve whether the state notice-prejudice and agency rules were preempted under ERISA. In reviewing the notice-prejudice rule, the Supreme Court immediately left no doubt that it would not plow new ground, stating that "[o]ur precedent provides a framework for resolving whether a state law 'regulates insurance' within the meaning of the saving clause" and expressly relying on its previous decisions in *Pilot Life* and *Metro. Life v. Mass.* The Court then applied the established two-prong analysis to determine whether the notice-prejudice rule was preempted by ERISA: (1) the Court looked at whether the state common law rule regulates insurance from a commonsense perspective; and (2) the Court considered whether the rule regulated insurance under the three McCarran-Ferguson Act factors.

The Supreme Court held that California's notice-prejudice rule regulated insurance from a commonsense perspective. The Court deferred to the Ninth Circuit's determination that the state law rule "controls the terms of the insurance relationship by 'requiring the insurer to prove prejudice before enforcing proof-of-claim requirements'" and that the rule "by its very terms, 'is directed specifically at the insurance industry and is applicable only to insurance contracts.'" Accordingly, the Supreme Court held that "[t]he rule thus appears to satisfy the common-sense view as a regulation that homes in on the insurance industry and does 'not just have an impact on [that] industry.'"

The Supreme Court rejected UNUM's argument that the notice-prejudice rule was not directed specifically at the insurance industry because it was merely an industry-specific application of general principles regarding forfeiture of contracts. The Court agreed that the notice-prejudice rule was an application of the general contract law maxim that "the law abhors a forfeiture." However, the Court held that in California the notice-prejudice rule was a unique form of that principle, applied solely to insurance contracts: "[I]t is an application of a special order, a rule mandatory for insurance contracts, not a principle a court may plially employ when the circumstances so warrant." Specifically, the Court noted that there was a major distinction in California law between application of the forfeiture principle with respect to noninsurance contracts and

the application of the notice-prejudice rule to insurance contracts: “Outside the notice-prejudice context, the burden of justifying a departure from a contract’s written terms generally rests with the party seeking the departure.” Analyzing the history of the adoption and application of the notice-prejudice rule by the California state courts, the Supreme Court held that California’s distinctive application of the notice-prejudice rule in the context of insurance policies was the very basis for its conclusion that the rule regulated insurance from a commonsense perspective:

California’s insistence that insurers show prejudice before they may deny coverage because of late notice is grounded in policy concerns specific to the insurance industry.... That grounding is key to our decision.

Thus, the Court concluded that “the notice-prejudice rule is distinctive most notably because it is a rule firmly applied to insurance contracts, not a general principle guiding a court’s discretion in a range of matters.”

The Supreme Court also held that California’s notice-prejudice rule “regulated insurance” when analyzed under the McCarran-Ferguson Act factors. The Court held that a law need not satisfy all three of the factors in order to be deemed a state law that “regulates insurance” under ERISA:

Preliminarily, we reject UNUM’s assertion that a state regulation must satisfy all three McCarran-Ferguson factors in order to “regulate insurance” under ERISA’s saving clause. Our precedent is more supple than UNUM conceives it to be. We have indicated that the McCarran-Ferguson factors are “considerations [to be] weighed” in determining whether a state law regulates insurance... and that “none of these criteria is necessarily determinative in itself.”

The McCarran-Ferguson factors are “checking points or ‘guideposts, not separate essential elements... that must be satisfied’ to save the State’s law.”

With regard to the first McCarran-Ferguson factor, the Ninth Circuit had ruled that the notice-prejudice rule did not have the effect of transferring or spreading policyholder risk because it did not alter the allocation of risk for which the parties contracted, that is, the risk of lost income due to disability. As *amicus curiae* before the Supreme Court, the United States argued that this ruling was incorrect based on the contention that the notice-prejudice rule shifted the risk of late notice and stale evidence to the insurer. The Supreme Court, however, found it unnecessary to resolve this dispute over application of the first McCarran-Ferguson factor because it held that the state law rule met the other two factors.

The Supreme Court held that the notice-prejudice rule did meet the second McCarran-Ferguson factor because it became an integral part of the policy relationship between the insurer and the insured:

California’s rule changes the bargain between insurer and insured: it “effectively creates a mandatory contract term” that requires the insurer to prove prejudice before enforcing a timeliness-of-claim provision...

As the Ninth Circuit stated: “The [notice-prejudice] rule dictates the terms of the relationship between the insurer and the insured, and consequently, is integral to that relationship.”

The Court also held that a state insurance law that regulates the administration of insurance policies can be an integral part of the policy relationship, rejecting UNUM’s argument that only those laws that regulate the substantive content of insurance policies can be an integral part of that relationship.

The Court also held that the notice-prejudice rule satisfied the third McCarran-Ferguson factor because the rule was limited in its application to entities within the insurance industry. California’s rule focused on the insurance industry and did not merely have an impact on the insurance industry.

The Supreme Court disagreed with UNUM's position that California's notice-prejudice rule conflicted with ERISA's exclusive civil enforcement provision.⁴⁹ The Court noted that Ward sued under ERISA, and there was no issue raised in the case as to whether Ward was able to pursue a separate state law cause of action. In a footnote, the Court noted that the United States had argued that the exclusivity of ERISA's civil enforcement provisions should be qualified by the insurance saving clause. The Court also noted that this position was diametrically opposed to the position taken by the United States 12 years earlier in *Pilot Life* and that the Court had agreed with the United States' position in *Pilot Life*. The Court then declined to address the issue, finding in unnecessary in light of the fact that Ward was suing under ERISA and not under any state law.

Finally, the Supreme Court rejected UNUM's argument that the notice-prejudice rule was preempted because it conflicted with ERISA's provision regarding notice and review of denied claims.⁵⁰ The Court held that "[b]y allowing a longer period to file than the minimum filing terms mandated by federal law, the notice-prejudice rule complements rather than contradicts ERISA and the regulations."

2. California Agency Rule Is Preempted by ERISA

In addition to relying on the notice-prejudice rule, Ward also relied on California's common law rule that an employer can act as the agent of an insurer in administering a group insurance policy. Specifically, he argued that timely notice of his disability to his employer was imputed to UNUM because the employer was acting as an agent for UNUM. The Ninth Circuit agreed with Ward and held that the state agency rule was not preempted because it did not dictate the manner in which the plan would be administered. The Supreme Court found the Ninth Circuit to be "mistaken" and stated that the Ninth Circuit's reasoning was "not firmly grounded."

As persuasively urged by the United States... deeming the policyholder-employer the agent of the insurer would have a marked effect on plan administration. It would "force the employer, as plan administrator, to assume a role, with attendant legal duties and consequences, that it has not undertaken voluntarily"; it would affect "not merely the plan's bookkeeping obligations regarding to whom benefits checks must be sent, but [would] also regulate the basic services that a plan may or must provide to its participants and beneficiaries"... Satisfied that the [state law agency] rule "relates to" ERISA plans, we reject the Ninth Circuit's contrary determination.

Ward did not argue that the state law agency rule was "saved" from preemption as a law that "regulates insurance," and so the Supreme Court did not address that issue.

D. Precedential Impact of Ward

One can draw several conclusions from the Supreme Court's decision in *Ward*.

- *Ward* did not create any new analytical framework for determining when a state law "regulates insurance" under ERISA. Instead, the Court applied the same tests first adopted by the Court in 1985 in *Metro. Life v. Mass.* and reiterated in 1987 in *Pilot Life*. Thus, *Ward* does not appear to signal any sea change in Supreme Court preemption precedent but instead serves to reemphasize that its previous decisions still represent binding law.

⁴⁹ 29 U.S.C. §1132(a).

⁵⁰ *Id.* §1133.

- *Ward* implies that a state law must meet both the commonsense aspect of the *Pilot Life* analysis as well as at least some of the McCarran-Ferguson factors. *Ward* clarifies, however, that a state law need not satisfy all of the McCarran-Ferguson factors in order to be saved from preemption.
- *Ward* also clarifies that a determination of whether a particular state law “regulates insurance” requires a state-specific analysis of the historical underpinnings of the law at issue. In its analysis of the notice-prejudice rule, the Court continually looked to California’s historical application of the rule specifically to insurance companies and insurance policies. This leaves open the possibility that while California’s notice-prejudice rule was deemed to be a state law that “regulates insurance” in *Ward*, the same or similar state law rules might not “regulate insurance” as applied in other states.
- Contrary to what some believed would happen, *Ward* provides no authority for the creation of state law causes of action that would purport to supplement the causes of action in ERISA. The Supreme Court took care to state that *Ward* does not represent a change in the Supreme Court’s previously stated position that ERISA’s civil enforcement scheme was intended to be exclusive. Accordingly, even though a state law cause of action might constitute a law that “regulates insurance” under ERISA, it will still be preempted if it purports to supplement and/or contradict ERISA’s civil enforcement provisions.
- *Ward* holds that the saving clause does not apply only to state substantive laws, but may also apply to state procedural rules. However, this is nothing new. For example, the Supreme Court implied in *FMC Corp. v. Holliday*⁵¹ that state insurance laws regulating subrogation rights might be saved from preemption. The only reason that the Court did not directly address the issue in that case was that the plan in that case was self-funded and not subject to state insurance regulation.
- *Ward* reemphasizes that state laws are preempted by ERISA even though they are not specifically created to regulate ERISA plans and even though they are applied to insurance policies in some contexts. The Court held that California’s agency rule was preempted merely because it “relate[d] to” the plan by altering the administration of the plan.

V. Preemption of State Law Bad Faith Claims: *Rush Prudential v. Moran*

The health insurance industry anxiously awaited the Supreme Court’s decision in *Rush Prudential HMO, Inc. v. Moran*,⁵² because it promised to resolve whether ERISA preempted state laws mandating third party review of certain health coverage decisions. However, the preemption issue affecting the health insurance industry in *Moran* hinged on a much broader issue affecting all life, health, and disability insurance carriers: whether a state law purporting to expand ERISA’s civil remedies, such as a state bad faith law, was exempt from preemption to the extent it was a state law that regulated insurance. While much has been written on the impact of the *Moran* holding on health insurers and state third party review laws, little has been said about the broader holding in that case, which reaffirmed the exclusivity of ERISA’s remedies and the preemption of state laws that purport to alter ERISA’s exclusive remedies, including state bad faith laws.

After *Pilot Life*, most courts and ERISA practitioners understood that suits for plan benefits were limited to the remedies found in ERISA and that state law remedies—including bad faith tort claims—were preempted. This changed dramatically following language in *Ward*. In footnote 7 of that case, the Court

⁵¹ 498 U.S. 52 (1990).

⁵² 122 S. Ct. 2151 (2002).

responded to an argument by the solicitor general suggesting that ERISA's remedies were not intended to exclude state insurance laws, even where those laws purport to supplement the remedies available under ERISA. After noting that the solicitor general's position in *Ward* flatly contradicted the position that the federal government took in *Pilot Life*, the Court refused to address the issue, saying that Ward's claim was brought under ERISA and there was no allegation of extra-ERISA remedies at issue in that case.

Remarkably, several lower federal courts interpreted the Supreme Court's footnote in *Ward* as a sea change in ERISA preemption law and allowed the resurrection of state law bad faith claims on the ground that such laws "regulate insurance." When the Supreme Court granted *certiorari* in *Moran*, several of plaintiffs' *amici* urged the Court to use *Moran* as a vehicle to turn the footnote in *Ward* into an express holding and thereby overturn *Pilot Life*. With some jurisdictions allowing ERISA cases to proceed to trial as bad faith claims and with no post-*Ward* authority at the circuit court level until shortly before the *Moran* decision was issued, insurers were concerned that ERISA benefit claims would mushroom into multimillion-dollar state law tort claims.

It was with this background that insurers awaited *Moran*. Fortunately for defendants and for plan participants and beneficiaries generally, the Supreme Court in *Moran* reaffirmed the exclusivity of ERISA's remedies in no uncertain terms and erased any doubt that state law bad faith and extra-contractual damages claims are preempted by ERISA, regardless of whether they "regulate insurance."

A. Express Preemption and Conflict Preemption Under ERISA

In order to appreciate the framework in which *Moran* was decided, it is necessary to understand that ERISA involves two types of preemption: (1) statutory or "express" preemption and (2) "conflict" preemption. Under ERISA's "express" preemption provision, §514(a), ERISA preempts all state laws that "relate to" employee benefit plans except state laws that regulate insurance, banking, or securities. Under this "express preemption" provision, state laws are preempted even if they do not directly conflict with ERISA.⁵³

The second form of preemption under ERISA is "conflict" preemption. This occurs when state laws conflict with the provisions of ERISA or operate to frustrate ERISA's purposes.^{53,54} "Conflict" preemption is a creature of the Supremacy Clause, which provides that the laws of the United States "shall be the supreme Law of the Land... any Thing in the Constitution or Laws of any State to the Contrary notwithstanding."⁵⁵ Thus, "conflict" preemption applies even to state laws that do not fall within the parameters of ERISA's express preemption provision.⁵⁶

The Supreme Court in *Pilot Life* applied both "express" preemption and "conflict" preemption principles to hold that state law claims, including bad faith claims, are preempted by ERISA. The Court determined that

⁵³ See, e.g., *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825 (1988); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983).

⁵⁴ *Boggs v. Boggs*, 520 U.S. 833, 841 (1997); *Engelhoff v. Engelhoff*, 532 U.S. 141 (2001).

⁵⁵ U.S. Cons., art. VI, cl. 2. See also *McCulloch v. Maryland*, 17 U.S. 316, 4 Wheat. 316, 427 (1819) ("It is of the very essence of supremacy, to remove all obstacles to its action within its own sphere, and so to modify every power vested in subordinate governments").

⁵⁶ See *John Hancock Mut. Life Ins. Co. v. Harris Trust & Savs. Bank*, 510 U.S. 86, 99 (1993) ("State law governing insurance generally is not displaced, but 'where [that] law stands as an obstacle to the accomplishment of the full purposes and objectives of Congress,' federal preemption occurs").

Mississippi's bad faith law, while certainly "identified with the insurance industry," was not a law that regulates insurance within the meaning of §514(b). Thus, the law was not saved from preemption under ERISA's "express" preemption provision.

The Court also held that the bad faith claim was preempted because it conflicted with ERISA. Allowing ERISA beneficiaries to bring varying state causes of action for claims that were within the scope of ERISA's civil enforcement provision "would pose an obstacle to the purposes and objectives of Congress."⁵⁷ ERISA contains a civil enforcement provision that includes a panoply of remedies for ERISA plan participants, beneficiaries, and fiduciaries, §502(a). The civil enforcement scheme of ERISA "is one of the essential tools for accomplishing the stated purposes of ERISA." Examining the language and structure of ERISA's civil enforcement provision, and reviewing the legislative history of that provision, this Court concluded "that ERISA's civil enforcement remedies were intended to be exclusive." The Court expressly endorsed the solicitor general's position that Congress intended "the civil enforcement provisions of ERISA §502(a) [to] be the exclusive vehicle for actions by ERISA plan participants and beneficiaries asserting improper processing of a claim for benefits." Any analysis of the impact of the insurance saving clause must be based on an analysis of "the role of the saving clause in ERISA as a whole." Thus, even if the Mississippi law of bad faith was saved from preemption under ERISA's "express" preemption provision because it was a state law that regulates insurance, it was still preempted under principles of "conflict" preemption because it would interfere with the exclusivity of ERISA's civil enforcement provision by creating supplemental remedies to ERISA.⁵⁸

Several other Supreme Court decisions reinforce the distinction between "conflict" preemption and "express" preemption under ERISA. In *Metropolitan Life Insurance Co. v. Taylor*, decided the same day as *Pilot Life*, the Court held that preemption by virtue of ERISA's exclusive remedy provisions was so strong as to override the removal jurisdiction concept of the "well pleaded complaint rule." In other words, a state law complaint arising out of a dispute over the processing of ERISA plan benefits is so completely preempted that the state law claims are converted into federal claims under ERISA. In *Ingersoll-Rand Co. v. McClendon*, the Supreme Court held that the exclusivity of ERISA's civil enforcement provision, §502(a), supplemented "express" preemption under ERISA and provided an independent basis for preemption of a state law wrongful discharge claim: "Even if there were no express preemption in this case, the Texas cause of action would be preempted because it conflicts directly with an ERISA cause of action." Finally, in *John Hancock*, the Court found that a state law that regulated insurance and was thus saved from "express" preemption was still preempted because it conflicted with one of ERISA's purposes.

B. Post-Ward Developments in the Lower Courts

The primary issue in *Ward* was whether a state notice-prejudice rule was saved from preemption as a law that "regulates insurance." The notice-prejudice rule generally stated that an insurer could not deny a claim for benefits as untimely unless it could show that it was prejudiced by the delay. *Ward* did not involve a bad faith claim nor did it involve any other state law that purported to alter or supplement ERISA's remedies. Nevertheless, the solicitor general argued that the Court should use *Ward* to limit the decision in *Pilot Life* by holding that state remedy laws, to the extent they regulate insurance, are not preempted by ERISA. The *Ward* Court responded as follows:

⁵⁷ *Id.* at 52.

⁵⁸ *Id.*

We discussed this issue in *Pilot Life*... That case concerned Mississippi common law creating a cause of action for bad faith breach of contract, law not specifically directed to the insurance industry and therefore not saved from ERISA preemption. In that context, the Solicitor General, for the United States as *amicus curiae*, urged the exclusivity of §502(a), ERISA’s civil enforcement provision... The Court agreed with the Solicitor General’s submission....

In the instant case, the Solicitor General... has endeavored to qualify the argument advanced in *Pilot Life*... [T]he Solicitor General now maintains that the discussion of §502(a) in *Pilot Life* “does not in itself require that a state law that ‘regulates insurance,’ and so comes within the terms of the savings clause, is nevertheless preempted if it provides a state-law cause of action or remedy”... We need not address the Solicitor General’s current argument, for Ward has sued under §502(a)(1)(B) for benefits due, and seeks only the application of saved state insurance law as a relevant rule of decision in his §502(a) action.⁵⁹

Plaintiffs relied on the position of the solicitor general and the above language in *Ward* to argue that state law bad faith was no longer preempted so long as the law “regulates insurance.” Several district courts around the country agreed with this argument. An early example is the case of *Lewis v. Aetna Life Insurance Co.*,⁶⁰ in which a district court held that Oklahoma’s bad faith cause of action was a state law that “regulate[d] insurance” and was saved from preemption under ERISA’s express preemption clause. Similar decisions followed *Lewis*.⁶¹ By and large, these decisions failed to consider ERISA’s exclusive remedies and ignored the conflict preemption issue altogether. State law bad faith claims that were thought to be dead under ERISA after *Pilot Life*, were resurrected.

C. The Decision in Moran

Like *Ward*, the *Moran* case also did not involve a state law bad faith claim. The state law at issue in *Moran* required that certain health plan decisions involving “medical necessity” be subject to review by an independent third party after they were denied by the plan fiduciary and prior to any court action. One of the arguments advanced for preemption of the third party review law was that it conflicted with the exclusive remedies of ERISA. Thus, the exclusivity of ERISA’s remedies was again at the heart of a preemption dispute, leading many courts and practitioners to look to *Moran* as an opportunity to resolve the uproar over bad faith claims that followed *Ward*.

1. The District Court and the Seventh Circuit

Debra Moran’s doctor recommended surgery for her medical condition. Her HMO disagreed, ruling that the recommended surgery was not medically necessary and suggesting an alternative procedure. Moran underwent the surgery recommended by her doctor and then sued the HMO under an Illinois state law that required health plan decisions involving medical necessity decisions to be submitted to an independent physician review panel. The trial court ruled that the state law was preempted by ERISA.

⁵⁹ 526 U.S. at 377, n.7.

⁶⁰ 78 F. Supp. 2d 1202 (N.D. Okla. 1999).

⁶¹ See, e.g., *Colligan v. Unum Life Ins. Co. of Am.*, 2001 U.S. Dist. Lexis 8103 (D. Colo. 2001); *Gilbert v. Alta Health & Life Ins. Co.*, 122 F. Supp. 2d 1267 (N.D. Ala. 2000); *Hill v. Blue Cross & Blue Shield*, 117 F. Supp. 2d 1209 (N.D. Ala. 2000).

The Seventh Circuit reversed. *Moran v. Rush Prudential HMO, Inc.*⁶² The appellate court held that the Illinois state law “regulate[d] insurance” and was therefore saved from preemption under ERISA’s express preemption clause. The court then moved to the conflict preemption issue, observing that ERISA’s civil remedies are exclusive and that the federal remedies cannot be supplemented or supplanted by state law remedies. However, the Seventh Circuit held that the state third party review law did not purport to supplement ERISA’s remedies and was therefore not in conflict with ERISA. In fact, the court held that Moran’s claim under the third party review statute was enforceable *solely through ERISA*, §502(a).

The result in *Moran* was in conflict with an earlier decision by the Fifth Circuit in *Corporate Health Insurance, Inc. v. Texas*,⁶³ even though much of the reasoning in the two cases was consistent. *Corporate Health* also involved a state statute that mandated third party review of certain medical plan coverage decisions. Like the Seventh Circuit in *Moran*, the Fifth Circuit held that the state law “regulated insurance” within the meaning of ERISA and was “saved” from express preemption. Also like the Seventh Circuit, the Fifth Circuit held that ERISA’s remedies are intended to be exclusive and that state laws that purport to supplement ERISA’s remedies are exclusive:

[E]ven if the provisions would otherwise be saved, they may nonetheless be preempted if they conflict with a substantive provision of ERISA. In *Pilot Life v. Dedeaux*, the Supreme Court held that “our understanding of the saving clause must be informed by the legislative intent concerning [ERISA’s] civil enforcement provisions.” The Court interpreted Congress’s intent regarding the exclusivity of ERISA’s enforcement scheme very broadly, concluding that the scheme preempts not only directly conflicting remedial schemes, but also supplemental state law remedies. Thus, the saving clause does not operate if the state law at issue creates an alternative remedy for obtaining benefits under an ERISA plan.⁶⁴

The Fifth Circuit took a different route than the Seventh Circuit and held that the state third party review law purported to provide a state law remedy not otherwise available under ERISA and was therefore preempted under conflict preemption principles.

2. The Position of Plaintiff’s *Amici* at the Supreme Court

Against the above background, the Supreme Court granted *certiorari* in *Moran*. Several *amici* supporting Moran saw the case as a chance to convince the Supreme Court to limit or even overturn *Pilot Life* and thereby open the door to state law bad faith claims in ERISA cases.⁶⁵ Such a result would have dramatic consequences for benefit plan insurers: it would allow awards of compensatory and punitive damages and most likely require jury trials in cases in which extracontractual damages and jury trials are not currently permitted. Such a result would also have an impact on employers, participants, and beneficiaries of ERISA plans by dramatically increasing the costs of providing ERISA plan benefits.

While *Moran* was pending, another case made its way to the Supreme Court on a petition for *certiorari* in which the bad faith preemption issue was directly in dispute. In *Patrick v. Unum Life Insurance Co. of America*,⁶⁶ the plaintiff sought review of a California state court of appeal decision holding that California’s

⁶² 230 F.3d 959 (7th Cir. 2000).

⁶³ 215 F.3d 526 (5th Cir. 2000).

⁶⁴ *Id.* at 538–39.

⁶⁵ See, e.g., Brief of United Policyholders at *Amicus Curiae* in *Rush v. Moran*, No. 00-1021.

⁶⁶ 122 S. Ct. 2619 (2002).

common law of bad faith is preempted by ERISA because it conflicts with ERISA's exclusive remedies. In her petition for *certiorari*, Patrick urged the Court to use *Moran* and *Patrick* as vehicles to overturn *Pilot Life*.

3. The Supreme Court Decision in *Moran*

After granting *certiorari*, the Supreme Court invited the solicitor general to weigh in on the issue of whether the state third party review law at issue in *Moran* was a state law that “regulate[d] insurance” and, if so, whether it conflicted with ERISA's civil remedy scheme. The solicitor general argued that the state third party review law “regulate[d] insurance” and was saved from “express” preemption. The solicitor general also argued that the state law did not provide a remedy that purported to supplement ERISA's remedies. If it did provide such a remedy, the solicitor general argued that ERISA's remedies are exclusive and that the exclusivity of those remedies would certainly preempt state laws that allowed for remedies not otherwise available under ERISA:

After noting that causes of action outside of Section 502(a) would lead to the award of judicial remedies, such as compensatory and punitive damages, that Congress had rejected... the Court [in *Pilot Life*] concluded that “[t]he policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA,”... *That reasoning clearly prevents a State from adopting causes of action under state law to enforce the terms of an ERISA plan (including incorporating provisions of state law) as an alternative to the cause of action under federal law in Section 502(a)(1)(B). For the same reasons, a State could not under any circumstances make a plan or its insurer liable to the participant or beneficiary for punitive damages.* Such a requirement would be far removed from what private parties might ordinarily contract for and would directly upset the policy choices reflected in Congress—inclusion of certain remedies and the exclusion of others.⁶⁷

The Supreme Court ultimately adopted the solicitor general's position and held that the state third party review law was not preempted. It held that the law was a state insurance law and was therefore “saved” from express preemption. The Court then considered whether the law was in conflict with ERISA's remedies. The Supreme Court reconfirmed that ERISA's remedies are exclusive, even to the extent that they “override” state remedies:

In ERISA law, we have recognized one example of this sort of overpowering federal policy in the civil enforcement provisions, 29 U.S.C. §1132(a), authorizing civil actions for six specific types of relief. In *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134 (1985), we said those provisions amounted to an “interlocking, interrelated, and interdependent remedial scheme,” *id.* at 146, which *Pilot Life* described as “representing a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans,” 481 U.S. at 54. So, we have held, the civil enforcement provisions are of such extraordinarily preemptive power that they override even the “well-pleaded complaint” rule for establishing the conditions under which a cause of action may be removed to federal court.⁶⁸

The Court noted that it had previously held in *Ingersoll-Rand*, *supra*, that state remedy laws are preempted by ERISA where “the law provide[s] a form of ultimate relief in a judicial forum that add[s] to the judicial remedies provided by ERISA.”⁶⁹ This is because “[a]ny such provision patently violates ERISA's policy of inducing

⁶⁷ Brief of the United States as *Amicus Curiae* in *Rush v. Moran*, No. 00-1021 at Part III(B)(1)(f) [emphasis added].

⁶⁸ 122 S. Ct. at 2164–65.

⁶⁹ *Id.* at 2166.

employers to offer benefits by assuring a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards when a violation has occurred.”⁷⁰

The Supreme Court went on to hold that the overriding preemptive effect of ERISA’s civil enforcement provision applies, even to the point of preempting state laws that “regulate insurance” and that otherwise would fall outside of express preemption:

Although we have yet to encounter a forced choice between the congressional policies of exclusively federal remedies and the “reservation of the business of insurance to the States”... we have anticipated such a conflict, *with the state insurance regulation losing out if it allows plan participants ‘to obtain remedies... that Congress rejected in ERISA....*

In *Pilot Life*, an ERISA plan participant who had been denied benefits sued in state court on state tort and contract claims. He sought not merely damages for breach of contract, but also damages for emotional distress and punitive damages, both of which we had held unavailable under relevant ERISA provisions... We not only rejected the notion that these common-law claims “regulated insurance”... but went on to say that, *regardless, Congress intended a “federal common law of rights and obligations” to develop under ERISA... without embellishment by independent state remedies...* [W]e said the saving clause had to stop short of subverting congressional intent, clearly expressed “through the structure and legislative history[,] that the federal remedy... displace state causes of action....”⁷¹

Having established the premise for its decision that ERISA’s remedies cannot, under any circumstances, be supplemented by state law, the issue before the Court in *Moran* was whether the state third party review law purported to grant remedies that were not otherwise available under ERISA. If it did grant such remedies, it would be preempted because it would conflict with the exclusivity of ERISA’s civil enforcement provisions. The Court held that the third party review law did not conflict with ERISA’s remedies and was not preempted.

The Court cited two bases for distinguishing the third party review law in *Moran* from the state remedial laws that were held preempted in *Pilot Life* and other decisions of the Court. First, the Court held that the third party review law “provides no new cause of action under state law and authorizes no new form of ultimate relief.”⁷² Specifically, the state law “does not enlarge the claim beyond the benefits available in any action brought under §1132(a).”⁷³ Although the third party reviewer’s determination might reverse the plan fiduciary’s decision, the Court held that the state law did not create any new remedy for ERISA plan participants because “the relief ultimately available would still be what ERISA authorizes in a suit for benefits under §1132(a).”⁷⁴ Thus, the state third party review law “does not involve the sort of additional claim or remedy exemplified in *Pilot Life*, *Russell*, and *Ingersoll-Rand*.”⁷⁵

The second reason relied on by the Court to hold that the state third party review law was not a remedy law that conflicted with ERISA’s exclusive civil enforcement scheme was that the state law in *Moran* regulated

⁷⁰ *Id.*

⁷¹ *Id.* at 2165 [emphasis added].

⁷² *Id.* at 2167.

⁷³ *Id.*

⁷⁴ *Id.*

⁷⁵ *Id.*

only the internal administrative claim review process and did not regulate the formal adjudication process.⁷⁶ Rejecting the HMO's argument that the state law was akin to mandatory arbitration, the Court held that it was more like an informal "second opinion."⁷⁷ The Court left open the possibility that "a State might provide for a type of 'review' that would so resemble an adjudication as to fall within *Pilot Life's* categorical bar."⁷⁸

D. Follow-up to Moran

The same reasoning relied on by the Supreme Court for holding that the third party review law in *Moran* did not conflict with ERISA's remedies dictates that state law bad faith claims are preempted because they *do* conflict with the exclusivity of ERISA's remedies. Unlike the third party review law in *Moran*, a state law bad faith claim purports to enlarge the remedies that are otherwise available under ERISA.⁷⁹ In fact, the entire reason that plaintiffs attempt to use bad faith claims is to obtain damages that are not available under ERISA.

State law bad faith causes of action also do not meet the second criterion cited in *Moran* for avoiding preemption. Unlike state third party review laws that regulate only the internal insurance claim review process, state law bad faith claims regulate the formal adjudication process. In fact, there is no available means of obtaining punitive damages under state law other than through formal adjudication. Once a state law purports to regulate the formal judicial process, it crosses the preemption line drawn in *Moran*. At that point, the state law conflicts with ERISA's exclusive remedies and is preempted, regardless of whether or not it also "regulates insurance."

The holding in *Moran* reconfirming the exclusivity of ERISA's remedies was foreseen by some federal circuit courts that held in the months leading up to the *Moran* decision that state law statutory and common law bad faith actions not only did not "regulate insurance" so as to fall within ERISA's saving clause, but that such claims also conflicted with ERISA's exclusive remedies.⁸⁰ Less than a week after the *Moran* decision, the Supreme Court denied *certiorari* in *Patrick v. Unum*, dealing the final blow to attempts to pursue bad faith claims as a remedy for the denial of ERISA benefits.

Despite the clarity of the Supreme Court's holdings on the exclusivity of ERISA's remedies, including its decision in *Moran*, one district court has since ruled that Pennsylvania's state statutory bad faith cause of action is saved from preemption because it is a law that "regulates insurance."⁸¹ Once again, the court failed to even address the exclusive remedy/conflict preemption issue. At this writing, the case is under advisement on a petition for reconsideration.

Moran makes it clear that debates as to whether state bad faith causes of action "regulate insurance" are ultimately irrelevant because those same causes of action are superseded by federal law under the concept of conflict preemption. The exclusive remedy argument ought to be the first argument in response to bad faith claims in ERISA cases. There should be no question following *Moran* that such claims conflict with ERISA and are preempted.

⁷⁶ *Id.* at 2168.

⁷⁷ *Id.*

⁷⁸ *Id.*

⁷⁹ §1132(a).

⁸⁰ See, e.g., *Hotz v. Blue Cross & Blue Shield of Mass.*, 292 F.3d 57 (1st Cir. 2002); *Moffett v. Halliburton Energy Servs.*, 291 F.3d 1227 (10th Cir. 2002); *Gilbert v. Alta Health & Life Ins. Co.*, 276 F.3d 1292 (11th Cir. 2001).

⁸¹ *Rosenbaum v. Unum Life Ins. Co. of Am.*, 2002 U.S. Dist. Lexis 14155 (E.D. Pa. 2002).

VI. Reconfirmation of Conflict Preemption: *Aetna Health v. Davila*

In *Aetna Health, Inc. v. Davila*,⁸² the Supreme Court reaffirmed the exclusiveness of ERISA's remedies in the context of a state law suit for extra contractual damages arising out of health plan medical necessity determinations.

Aetna Health was the result of a consolidation of cases on certiorari from the Fifth Circuit. Specifically, the plaintiffs sought various damages arising under Texas statutory provisions as a result of their health plans' decisions to deny certain benefits based on lack of medical necessity. The issue was whether the state law causes of action were completely preempted by ERISA's civil enforcement scheme. The Supreme Court held that the state causes of action were preempted.

There are two points that should be made regarding the *Aetna Health* decision. First, whatever questions may have remained, if any, regarding the viability of state bad faith claims, *Aetna Health* makes it clear that such claims are foreclosed by ERISA's civil enforcement scheme. In fact, the Supreme Court specifically held that even if one could argue that a state law claim, such as a bad faith claim, is "saved" from statutory preemption as a state law that regulates insurance, such a claim would still be preempted by ERISA because it conflicts with the exclusivity of ERISA's remedial provisions. As the Supreme Court held, "Even a state law that can arguably be characterized as 'regulating insurance' will be pre-empted if it provides a separate vehicle to assert a claim for benefits outside of, or in addition to, ERISA's remedial scheme."

The second major point in *Aetna Health* was the Court's clarification of its previous decision in *Pegram v. Herdrich*.⁸³ In *Pegram*, the Supreme Court held that a decision regarding a surgical procedure made by a doctor who was a part-owner of an HMO constituted a mixed benefit eligibility/treatment decision and was not regulated by ERISA's fiduciary provisions. The implication seemed to be that such decisions are regulated by state law (e.g., state medical malpractice law). In *Aetna Health*, the Supreme Court held that a decision can only be a "mixed eligibility and treatment decision" when the person making the decision is a treating professional. Thus, decisions made by health plans that are not actually treating the claimant (e.g., non-HMO health plans) by definition cannot be "mixed eligibility and treatment" decisions under *Pegram*. Such decisions would not be governed by state law and would only be considered health plan eligibility decisions governed by ERISA.

VII. The Supreme Court Revisits the Saving Clause: *Kentucky v. Miller*

In yet another recent case, the Supreme Court again revisited the saving clause in *Kentucky Ass'n of Health Plans, Inc. v. Miller*.⁸⁴ The state law at issue in *Miller* requires HMOs to allow noncontracting health care providers to provide services to members of the HMO so long as the provider agreed to accept payments in accordance with the HMO's fee schedule for contract providers. The parties agreed that the AWP law "related to" ERISA plans that were funded by HMO arrangements but disagreed as to whether the AWP law was a state law that "regulates insurance" so as to fall within the boundaries of the saving clause.

In deciding the saving clause issue, the Supreme Court noted that in its previous saving clause decisions, it held that while the "commonsense" test always applied, not all of the McCarran-Ferguson Act criteria

⁸² 124 S. Ct. 2488 (2004).

⁸³ 530 U.S. 211 (2000).

⁸⁴ 123 S. Ct. 1471 (2003).

were applied in every case. In fact, depending on the state law at issue, different McCarran-Ferguson criteria became important in each case, resulting in inconsistent application of the McCarran-Ferguson factors. To clarify its position and presumably to provide clearer guidance to lower courts, the Court collapsed the various factors and held that in order for a law to be “saved” as a law that “regulates insurance” under ERISA, the law must meet both of the following factors:

- 1) The law must be directed toward entities engaged in insurance; and
- 2) The law must substantially affect the risk pooling arrangement between the insurer and the insured.

The Supreme Court held that the AWP law satisfied both factors and was saved from preemption under ERISA.

First, the Court held that the AWP law was directed toward entities engaged in insurance. The Court held that “[i]t is well established” that a state law must be specifically directed toward the insurance industry, rather than directed only toward insurers, in order to fall under the saving clause. This factor appears to be a reiteration of the “commonsense” test. Applying this factor in *Miller*, the Court held that the state AWP law was specifically directed toward the insurance industry “by imposing conditions on the right to engage in the business of insurance.”

Second, the Court held that even though the AWP law was directed specifically toward the insurance industry, it would not be saved unless it also substantially affected the risk-pooling arrangement between the insurer and the insured. By way of example, the Court noted that a state law that sets minimum wages for janitors employed by insurance companies might place a condition on the right to engage in the business of insurance, such a law would not be saved under ERISA because it would not substantially affect the risk-pooling arrangement. However, the Court held that the AWP law did substantially affect the risk-pooling arrangement. The mere fact that the AWP law did not mandate certain language to be included in insurance policies did not prevent the AWP law from satisfying the second prong of the saving clause test. Rather, because the AWP law expanded the scope of providers from whom an insured may receive services, the law altered the scope of permissible bargains between insurers and insureds in a manner similar to laws previously held “saved” under ERISA. Thus, applying the two-prong analysis, the Court held that the AWP law was exempt from preemption under ERISA.

VIII. Application of ERISA in Foreign Courts

Most defense counsel rightly assume that the laws of the forum country govern disputes filed in the courts of that country. However, there are situations when a court is required to apply non-forum law. One such situation potentially requiring the application of foreign law involves a United States law known as the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. §1001, *et seq.* (“ERISA”). ERISA regulates most privately sponsored employee benefit programs in the U.S. However, ERISA can also apply in foreign jurisdictions, such as when an employee of a U.S.-based company files suit outside of the U.S. to recover benefits under his employer’s plan. Because ERISA has its own substantive and procedural rules, counsel defending these suits should consider the possible application of ERISA and should seek advice from counsel knowledgeable in this area of law.

The ERISA statute makes only brief reference to foreign benefit plans. At 29 U.S.C. §1003(b)(4), the statute provides that ERISA does not apply “to any employee benefit plan if... such plan is maintained outside of the United States primarily for the benefit of persons substantially all of whom are nonresident aliens....” There is little case law interpreting this provision, but the cases that do exist interpret the statutory exemp-

tion narrowly. See, e.g., *Lefkowitz v. Arcadia Trading Co. Ltd. Ben. Pension Plan*, 996 F.2d 600 (2d Cir. 1993) (benefit plans established by Hong Kong corporations were not exempt from ERISA where the sole beneficiary was an American citizen and the corporations were engaged in interstate commerce in the U.S.).

Not surprisingly, nowhere does the statute address application of ERISA in foreign courts. However, the question sometimes arises in connection with multi-national companies. For example, a U.S. company may maintain a single benefit plan for its employees, including employees who work at facilities located in foreign countries. There is no question that, in the U.S., the benefit plan would be governed by ERISA and if a U.S.-based employee sues for benefits under the plan, the suit will be governed by ERISA, applying all of the special procedural and substantive rules applicable under that body of law. But what happens if an employee working in a foreign country files a suit for benefits under the same plan in his home country? A recent case in Ontario provides an answer to this question, holding that ERISA law applies. Although the discussion is brief, the holding is based primarily on contract choice-of-law principles.

In *Stickel v. Unum Provident Corp.*, 2011 Carswell Ont 5783 (Ont. S.C.J. 2010), *aff'd*, 2011 Carswell Ont 2294 (Ont. C.A. 2011), the plaintiff lived in Toronto but was employed by a company with its head office in New York. The employee was enrolled in his employer's long term disability plan. Benefits under the plan were funded by a group policy of disability insurance issued to the employer in New York. The plaintiff was involved in an automobile accident and filed a disability claim under his employer's plan. The claim was initially approved but monthly disability benefits were later terminated when the insurer determined that the plaintiff was no longer disabled. The plaintiff filed suit against the insurer in Ontario, Canada. The court ruled that U.S. ERISA law governed the dispute:

The parties are in agreement that the law that is applicable to the subject insurance policy is the law of New York. That law provides that the *Employee Retirement Income Security Act* ("ERISA"), a federal statute enacted to provide a high degree of uniformity to insurance law throughout the states of the United States of America, applied and was supreme. Accordingly, it was incumbent on the parties to prove the foreign law to the extent required for a proper determination of this motion.

2010 Carswell Ont. at para. 14. The ruling was affirmed on appeal without any further discussion.

The *Stickel* case illustrates a very straightforward principle of contract choice-of-law principles. Most insurance policies issued in the U.S. contain choice-of-law provisions, including policies that are issued to fund benefits under ERISA-governed programs (e.g., life, health, and disability insurance policies). Most policies specify the law of the state in which the policy is issued, even though the policy might also apply to employees in other states and/or employees in foreign countries. In jurisdictions that enforce contract choice-of-law provisions, including jurisdictions outside of the U.S., disputes under such policies may be governed by ERISA. In these cases, foreign courts will be required to import ERISA principles that in some situations can substantially alter the procedural and substantive rules of the case. Counsel defending such cases should not automatically assume that the forum jurisdiction's laws will apply to the case and should be aware of the potential application of ERISA even when suit is filed outside of the U.S.

Standard of Review

I. Introduction

The applicable standard governing a court's review of a fiduciary's benefit decision continues to be one of the most litigated topics in employee benefits cases. This standard governs the deference to be granted to the fiduciary's decision, if any. It also dictates the scope of evidence a court may consider in reviewing the fiduciary's decision, which in turn impact the breadth of discovery. Courts have wrestled with how the review standard must be altered where there is evidence of a conflict of interest on the part of the plan fiduciary. More recently, courts have also begun to discuss the nature and extent of the evidentiary proof that is necessary to show the existence of such a conflict. Case law discussion of these issues continues to reinforce one unalterable principle: *a participant's suit for benefits is essentially a request for judicial review of a plan fiduciary's benefits decision.*

II. The Law Before *Firestone*

Prior to the United States Supreme Court's decision in *Firestone v. Bruch*,¹ the law was well established that where a court was reviewing a benefit decision, a high level of deference was granted to decisions made by plan fiduciaries under ERISA.² However, although the federal courts were uniform in applying a deferential standard of review, they were not entirely consistent in applying a specific standard or as to the applicable factors to consider when evaluating a fiduciary's decision.

The courts generally agreed that the basic standard of judicial review for a fiduciary's decision was the arbitrary and capricious standard. However, there was some inconsistency regarding the application of this standard. For example, some courts held that a decision was not arbitrary and capricious where it was supported by substantial evidence.³ Other courts required that the decision be made in good faith.⁴ Other courts overturned a fiduciary's decision if it was based on an erroneous interpretation of law.⁵ The Eighth

¹ 489 U.S. 101 (1989).

² *Reuda v. Seafarers Int'l Union*, 576 F.2d 939 (1st Cir. 1978); *Riley v. MEBA Pension Trust*, 570 F.2d 406 (2d Cir. 1977); *Shiffler v. Equitable Life Assur. Soc'y*, 838 F.2d 78 (3d Cir. 1988); *LeFebre v. Westinghouse Elec. Corp.*, 747 F.2d 197 (4th Cir. 1984); *Denton v. First Nat'l Bank*, 765 F.2d 1295 (5th Cir. 1985); *Cook v. Pension Plan for Salaried Employees of Cyclops Corp.*, 801 F.2d 865 (6th Cir. 1985); *Van Boxel v. Journal Co. Employees' Pension Trust*, 836 F.2d 1048 (7th Cir. 1987); *Bueneman v. Central States, Southeast & Southwest Areas Pension Fund*, 572 F.2d 1208 (8th Cir. 1978); *Jung v. FMC Corp.*, 755 F.2d 708 (9th Cir. 1985); *Peckham v. Board of Trustees*, 653 F.2d 424 (10th Cir. 1981); *Anderson v. Ciba-Geigy Corp.*, 759 F.2d 1518 (11th Cir. 1985), *cert. denied*, 474 U.S. 995 (1985); *Maggard v. O'Connell*, 671 F.2d 568 (D.C. Cir. 1982).

³ *LeFebre*, 747 F.2d at 208; *Wardle v. Central States, Southeast and Southwest Areas Pension Fund*, 627 F.2d 820, 824 (7th Cir. 1980), *cert. denied*, 449 U.S. 1112 (1981); *Music v. Western Conference of Teamsters Pension Fund*, 712 F.2d 413, 418 (9th Cir. 1983).

⁴ *Adcock v. Firestone Tire & Rubber Co.*, 822 F.2d 623, 626 (6th Cir. 1987); *Music*, 712 F.2d at 418.

⁵ *Wardle*, 627 F.2d at 824; *Music*, 712 F.2d at 418.

Circuit added a requirement that the decision would be overturned not only if it was “arbitrary or capricious” but also where it was an “abuse of discretion.”⁶ Finally, the Second and Eleventh Circuits abandoned the “arbitrary and capricious” language altogether and defined the judicial standard of review as “determining whether the fiduciary’s interpretation was made rationally and in good faith, not whether it was right.”⁷ Although the language used to describe the standard varied from circuit to circuit, all courts gave a high degree of deference to a fiduciary’s decision.

Courts considered a wide range of factors in applying a deferential standard. The most common factor was consideration of the plan language itself and a determination of whether the fiduciary’s decision or interpretation was consistent with the plan language and whether the language had been interpreted or applied uniformly.⁸ Another common factor was whether the fiduciary had adequate evidence or factual development to support his decision.⁹ Some courts considered whether the fiduciary’s decision was consistent with prior practice,¹⁰ and others considered whether the fiduciary was acting in bad faith.¹¹ The Fourth Circuit would not consider ERISA procedural violations in evaluating a benefit decision,¹² but other courts held that egregious violations may be relevant.¹³ Another area of disagreement among the circuits was the cost factor. For example, a fiduciary might properly limit benefits if an alternative decision would result in unanticipated costs to the plan so as to potentially limit resources available to the proper beneficiaries.¹⁴ Similarly, a court could consider the fiduciary’s decision in light of his responsibility to all beneficiaries of the plan.¹⁵ Conversely, some courts considered avoidance of a substantial outlay to be indicative of a fiduciary’s bad faith.¹⁶

Finally, some courts did not perceive the deferential standard of review as being the same for each case. Rather, the standard might vary from case to case, depending on the fiduciary’s interest in the outcome of the benefit decision.¹⁷

III. The Supreme Court Speaks: *Firestone v. Bruch*

The United States Supreme Court’s landmark decision in *Firestone v. Bruch* established new ground rules regarding the appropriate level of deference, if any, to be accorded benefit determinations by an ERISA plan

⁶ Bueneman, 572 F.2d at 1209.

⁷ Riley, 570 F.2d at 410 [citations omitted]; Anderson, 759 F.2d at 1522 (citing *Griffis v. Delta Family Care Disability*, 723 F.2d 822, 825 (11th Cir.), *cert. denied*, 467 U.S. 1242 (1981)).

⁸ Bayles v. Central States, Southeast & Southwest Areas Pension Fund, 602 F.2d 97, 100 (5th Cir. 1979); Blakeman v. Mead Containers, 779 F.2d 1146, 1151 (6th Cir. 1985); Jung, 755 F.2d at 713.

⁹ Brown v. Retirement Committee of the Briggs and Stratton Retirement Plan, 797 F.2d at 521, 532 (7th Cir. 1986), *cert. denied*, 479 U.S. 1094 (1987).

¹⁰ Jung, 755 F.2d at 713.

¹¹ Cook, 801 F.2d at 871.

¹² Holland v. Burlington Indus., Inc., 772 F.2d 1140, 1149 (4th Cir. 1985).

¹³ Barry v. Dymo Graphic Sys., Inc., 394 Mass. 830, 478 N.E.2d 707, 714 (1985); Wolfe v. J.C. Penney Co., Inc., 710 F.2d 388, 393 (7th Cir. 1983); Blau v. Del Monte Corp., 748 F.2d 1348, 1353 (9th Cir. 1984), *cert. denied*, 474 U.S. 865 (1985).

¹⁴ Bayles, 602 F.2d at 100.

¹⁵ Reuda, 576 F.2d at 942.

¹⁶ Jung, 755 F.2d at 711.

¹⁷ See Van Boxel, 836 F.2d at 1052–53; see also Jung, 755 F.2d at 711–12.

fiduciary. Rejecting the wholesale importation of the arbitrary and capricious standard into the review of ERISA benefit decisions, the Court held:

[A] denial of benefits challenged under §1132(a)(1)(B) is to be reviewed under a *de novo standard unless* the benefit plan gives the administrator or fiduciary *discretionary authority* to determine *eligibility for benefits* or to *construe* the terms of the plan.¹⁸

The Supreme Court noted that its holding neither distinguished between types of plans nor focused on the motivations of plan administrators and fiduciaries.¹⁹ However, the Court stated that if an administrator or fiduciary was operating under a conflict of interest, then that conflict might be weighed as a factor in determining whether there is an abuse of discretion.²⁰

The Court set forth two main reasons for not applying the “arbitrary and capricious” standard across the board. First, the Court noted the applicability of trust law principles in ERISA, and that under the common law principles of trusts, courts do not always give deference to a fiduciary’s determination. The Court cited the following settled principles of trust law as examples.

- 1) “Trust principles make a deferential standard of review appropriate when a trustee exercises discretionary powers.”²¹
- 2) “A trustee may be given power to construe disputed or doubtful terms, and in such circumstances the trustee’s interpretation will not be disturbed if reasonable.”²²
- 3) “[When] ‘trustees are in existence, and capable of acting, a court of equity will not interfere to control them in the exercise of a *discretion vested in them by the instrument* under which they act.’”²³
- 4) If a trust does not confer discretion upon the trustees, “courts construe terms in trust agreements *without* deferring to either party’s interpretation.”²⁴

The second reason for rejecting the blanket use of a deferential standard was the Court’s belief that the widespread use of this standard would frustrate ERISA’s manifest purposes of (1) promoting the interests of employees and their beneficiaries in employee benefit plans and (2) protecting contractually defined benefits. However, the Court was careful to point out that “[n]either general principles of trust law nor a concern for impartial decision making, however, *forecloses parties from agreeing upon a narrower standard of review.*”²⁵

In summary, the Supreme Court in *Firestone* rejected uniform application of a deferential review standard and held that such a standard would be applicable only where the benefit plan grants discretion to the decision maker to determine eligibility for plan benefits or to construe the terms of the benefit plan. However, while the Supreme Court formulated this new rule regarding judicial review of benefit decisions, the Court failed to delineate specific guidelines as to what types of plan language would be sufficient to confer discretionary authority upon plan administrators and/or fiduciaries such that their benefit determinations would be accorded deference by the courts. The Court also failed to define the degree of deference and the

¹⁸ *Id.* at 956 [emphasis added].

¹⁹ *Id.*

²⁰ *Id.* at 956–57.

²¹ *Id.*

²² *Id.*

²³ *Id.* at 954 [emphasis in original] (citing *Nichols v. Eaton*, 91 U.S. 716, 724–25 (1875)).

²⁴ *Id.* at 955 [emphasis added].

²⁵ *Id.* at 956 [emphasis added].

standard necessary to overturn these benefit determinations. Consequently, in the nearly ten years since *Firestone* was decided, the circuits have developed their own rules as to the interpretation and application of the *Firestone* holding.

IV. The Circuits Respond: Discretionary Language After *Firestone*

A. General Power-Granting Clauses

Many plans have clauses that grant certain general powers to the plan administrator and/or fiduciary. Most courts have held that *overly general, nonspecific* power-granting clauses are not sufficient to grant the decision maker the requisite discretionary authority referenced in *Firestone*. For example, in *Michael Reese Hospital v. Solo Cup Employee Health Benefit Plan*,²⁶ the Seventh Circuit was faced with a plan that had the following general power-granting clause: “The Company shall have authority to control and manage the operation and administration of the Plan.”²⁷ The Seventh Circuit held that this language was *not* a sufficient grant of discretionary authority entitling the fiduciary’s determination to be given deference. The Court noted that there was no *express* discretionary authority to determine eligibility for benefits or to construe the terms of the plan within the general power-granting clause. Other courts have followed this same line of reasoning.²⁸

²⁶ 899 F.2d 639 (7th Cir. 1990).

²⁷ *Id.* at 641.

²⁸ See, e.g., *Criss v. Hartford Acc. & Indem. Co.*, 1992 U.S. App. Lexis 13288 (6th Cir. 1992) (unpublished) (*de novo* standard applies where plan does not grant express or implied discretion to interpret the terms of the plan); *Masella v. Blue Cross*, 936 F.2d 98 (2d Cir. 1991) (authority to establish initial terms of plan not equivalent to discretion to interpret terms once established); *Reinking v. Philadelphia Am. Life Ins. Co.*, 910 F.2d 1210 (4th Cir. 1990) (authority to decide what information is necessary for a benefits decision not sufficient to grant discretionary authority as to decision itself); *Cathey v. Dow Chem. Co. Med. Care Program*, 907 F.2d 554 (5th Cir. 1990) (language granting administrator “authority to correct any defect, supply any omission or reconcile any inconsistency in, and to control and manage” the plan not sufficient to avoid *de novo* standard); *Brown v. Ampco-Pittsburgh Corp.*, 876 F.2d 546 (6th Cir. 1989) (absent clear grant of discretion, abuse of discretion standard not applicable); *Petrilli v. Drechsel*, 910 F.2d 1441 (7th Cir. 1990) (no discretion granted where there is no language granting administrator power to construe the plan); *Baxter v. Lynn*, 886 F.2d 182 (8th Cir. 1989) (language granting discretion to determine eligibility not sufficient to grant discretion to interpret plan terms as well); *Hamilton v. Air Jamaica, Ltd.*, 750 F. Supp. 1259 (E.D. Pa. 1990) (reservation of power to amend not sufficient to grant discretion in benefits decisions); *Carland v. Metro. Life Ins. Co.*, 727 F. Supp. 592 (D. Kan. 1989) (language stating fiduciary is to direct the overall administration of the plan does not grant discretion); *but see Bernstein v. Capitalcare, Inc.*, 70 F.3d 783 (4th Cir. 1995) (discretion where plan administrator is authorized to adopt reasonable policies and procedures); *O’Shea v. First Manhattan*, 55 F.3d 109 (2d Cir. 1995) (discretion where plan states “trustees shall determine any questions arising... [under] the plan”); *Kirwan v. Marriott Corp.*, 10 F.3d 784 (10th Cir. 1994) (discretion where plan gives fiduciary authority to control and manage the plan); *Gust, Jr. v. Coleman Co.*, 1991 U.S. App. Lexis 15203 (10th Cir. 1991) (language authorizing administrator to determine eligibility grants discretion); *Cargile v. Confederated Life Ins. Group Plans*, 748 F. Supp. 874 (N.D. Ga. 1990) (deferential standard applies where plan states that plan administrator “is responsible for the administration of the plan” and the functions of the administrator include “determination of eligibility of individual claimants for receipt of benefits”).

B. “Power to Interpret” and “Power to Construe”

The circuits have been fairly consistent in holding that power-granting clauses with such phrases as “*power to interpret*” and “*power to construe*” grant the discretionary authority referenced by *Firestone*. The reasoning is best explained by the Fourth Circuit in *DeNobel v. Vitro Corp.*²⁹ In holding that language authorizing the fiduciary to determine all benefits and resolve all questions of interpretation is a sufficient grant of authority, the Fourth Circuit noted:

[T]here are obviously *no magic words required* to trigger the application of one or another standard of judicial review. In this setting, it instead *need only appear on the face of the plan documents* that the fiduciary has been ‘given [the] power to construe disputed or doubtful terms’—or to resolve disputes over benefits eligibility....³⁰

²⁹ 885 F.2d 1180 (4th Cir. 1989).

³⁰ *Id.* at 1187 [emphasis added] (quoting *Firestone*, 109 S. Ct. at 954). *See also* *Hutchins v. Champion Int’l Corp.*, 110 F.3d 1341 (8th Cir. 1997) (deference where plan provides fiduciary with “sole, absolute and uncontrolled” discretion); *Moos v. Square D Co.*, 72 F.3d 39 (6th Cir. 1995) (“discretion to interpret” requires deference); *Jordan v. Rensselaer Polytechnic Inst.*, 46 F.3d 1264 (2d Cir. 1995) (“discretion to construe” requires deferential review); *Abnathya v. Hoffman-LaRoche, Inc.*, 2 F.3d 40 (3d Cir. 1993) (“power to interpret” grants discretion); *Crosby v. Crosby*, 986 F.2d 79 (4th Cir. 1993) (power to construe disputed or doubtful terms); *Anderson v. Operative Plasters’ Pension and Welfare Plans*, 991 F.2d 356 (7th Cir. 1993) (trustees have power to reconcile, determine, interpret, and construe any question or dispute under the plan); *Kotrosits v. GATX Corp.*, 970 F.2d 1165 (3d Cir. 1992) (language providing that fiduciary has “power to construe... and to determine” and that decisions shall be “final and binding” is sufficient for deferential review); *Wildbur v. Arco Chem. Co.*, 974 F.2d 631 (5th Cir. 1992) (absence of the word “discretion” does not call for *de novo* review; discretionary authority is granted where plan states that fiduciary’s decisions shall be “final and conclusive”); *Fought v. Evans Prods. Co. Racine Pension Plan Agreement*, 966 F.2d 304 (7th Cir. 1992) (plan authorizing fiduciary “to construe the Plan” grants deferential review); *Arfsten v. Frontier Airlines, Inc.*, 967 F.2d 438 (10th Cir. 1992) (discretion is granted where fiduciary is given authority “to construe the Plan and to determine all questions of fact that may arise thereunder”); *Curtis v. Noel*, 877 F.2d 159 (1st Cir. 1989) (plan language providing that administrator shall determine “eligibility”... and shall provide... interpretation[s] of plan provisions” is sufficient to grant discretionary authority); *Cotter v. Eastern Conference of Teamsters*, 898 F.2d 424 (4th Cir. 1990) (plan language granting fiduciary “the duty to interpret and construe” plan provisions entitles fiduciary’s decision to be awarded deference); *Jordan v. Cameron Ironworks*, 900 F.2d 53 (5th Cir. 1990) (language stating that the fiduciary has “all powers necessary to administer... including... to construe all terms... [and] to determine eligibility,” clearly gives the fiduciary broad powers such that its determinations are entitled to deference); *Fuller v. CBT Corp.*, 905 F.2d 1055, 1058 (7th Cir. 1990) (language granting the fiduciary the power “to construe and interpret the plan” entitles the fiduciary’s decision to be accorded deference); *Lakey v. Remington Arms*, 874 F.2d 541 (8th Cir. 1989) (language that fiduciary has “power to interpret” plan entitles fiduciary’s decision to deference); *Pratt v. Petroleum Prod. Mgmt. Inc. Employee Sav. Plan & Trust*, 920 F.2d 651 (10th Cir. 1990) (“power to construe and interpret the plan” is sufficient to grant discretion); *Anderson v. Blue Cross/Blue Shield of Ala.*, 907 F.2d 1072 (11th Cir. 1990) (plan language giving administrator “the right to determine which services and supplies are medically necessary,” as well as the “reasonable and customary fee” for such services and supplies was sufficient to grant discretion); *Hermann v. E.W. Wilie Corp.*, 1991 U.S. Dist. Lexis 8681 (N. Dak. 1991) (power to construe grants discretion); *Bogue v. Ampex Corp.*, 750 F. Supp. 424 (N.D. Cal. 1990) (language granting authority to determine questions of eligibility and coverage creates a duty and right to evaluate and invokes a judgmental function). *But see* *Dzingliski v. Weirton Steel Corp.*, 875 F.2d 1075 (4th Cir. 1989) for a seemingly different result.

C. “Power to Determine” and “Due Proof”

Some courts have also held that plans granting authority to determine issues that inherently require discretion are sufficient to require application of a deferential review standard. The Ninth Circuit’s holding in *Bogue v. Ampex Corp.*,³¹ provides an example. The plaintiff in *Bogue* sought severance benefits. Plaintiff’s recovery turned on whether he was given a “substantially equivalent position.” According to the plan, “[t]he determination of ‘Substantially equivalent’ position will be made by [the defendant].”³² Focusing on the fact that the plan authorized the defendant to determine benefit eligibility and that the defendant was responsible for funding benefits under the plan, the Ninth Circuit held that the plan granted discretionary authority to the defendant such that the decision at issue was reviewed under the arbitrary and capricious standard:

[T]he program stated that [defendant] would make the determination of eligibility for benefits, and the program clearly placed on [defendant] the ultimate responsibility for funding those benefits. We find that the program imposes on [defendant]... discretionary authority to determine eligibility for benefits or to construe the terms of the plan.³³

Clearly, no “magic words” are necessary to confer the discretion necessary for application of a deferential standard of review. Rather, whatever words are used, the plan need only make it clear that the defendant has the authority to make the decision at issue.³⁴

Likewise, some federal courts have also held that language that requires the participant to submit due proof or satisfactory proof of his claim is sufficient to require a deferential review standard. For example, the Ninth Circuit held in *Snow v. Standard Insurance Co.*,³⁵ that the deferential arbitrary and capricious standard of review applies where the plan provides for payment of disability benefits only upon submission of “satisfactory written proof” to the plan insurer. The Seventh Circuit also held in *Patterson v. Caterpillar, Inc.*,³⁶ that a requirement that benefits are payable upon receipt of “due proof” is sufficient to require discretionary review.³⁷ The very nature of a requirement that the participant *prove* that he is entitled to plan benefits implies discretion:

³¹ 976 F.2d 1319 (9th Cir. 1992), *cert. denied*, 123 L. Ed. 2d 471 (1993).

³² 976 F.2d at 1324.

³³ *Id.*

³⁴ See, e.g., *Hunt v. Hawthorne Assocs., Inc.*, 119 F.3d 888 (11th Cir. 1997) (discretion where plan gives fiduciary authority to “initially determine all questions” under the plan); *Bernstein v. Capitalcare, Inc.*, 70 F.3d 783 (4th Cir. 1995) (application of a deferential review standard was supported by plan language that stated that benefits were payable “only if Capitalcare determines” that certain conditions are met under the plan); *Chambers v. Family Health Plan Corp.*, 100 F.3d 818, 825 (10th Cir. 1996) (arbitrary and capricious standard of review is applicable where plan expressly gives discretion for exclusion of coverage for services “which in the judgment of [the decision maker] are experimental.”); *Bali v. Blue Cross & Blue Shield*, 873 F.2d 1043 (7th Cir. 1989) (similar language provided the insurer with discretion to determine what evidence may be required to provide a basis for a benefits decision under the employee benefit plan).

³⁵ 87 F.3d 327 (9th Cir. 1996).

³⁶ 70 F.3d 503 (7th Cir. 1995).

³⁷ See also *Donato v. Metropolitan Life Ins. Co.*, 19 F.3d 375, 379 (7th Cir. 1994) (policy that stated that plan insurer would provide disability benefits “upon receipt of proof... satisfactory to us” required the reviewing court to grant deference to insurer’s decision to deny Plaintiff’s claim for benefits); *Bollenbacher v. Helena Chem. Co.*, 926 F. Supp. 781, 787 (N.D. Ind. 1996) (“plan language which requires a claimant to submit ‘proof’ of a claim does, by its very nature, grant discretion to the plan administrator to determine eligibility for benefits”); *Caldwell v. Life*

“Proof” has been defined as “[T]he effect of evidence... [A]ny fact or circumstance *which leads the mind* to the affirmative or negative of any proposition”... [Proof] is logically defined as the sufficient reason for assenting to a proposition as true, and in its larger sense it is defined as meaning *satisfying fair men* by fair means of what was done... A plan administrator that requests “proof” of a claimant’s disability must out of necessity examine the evidence submitted by the claimant to determine whether or not it amounts to “proof” of the alleged disability. Obviously, if the proof is sufficient, the administrator will (or at least should) determine that the claimant is eligible for benefits; if the proof is not sufficient, eligibility will be denied. *In short, plan language which requires a claimant to submit “proof” of a claim does, by its very nature, grant discretion to the plan administrator to determine eligibility for benefits.*³⁸

More recently, the Ninth and Seventh Circuits have limited their holdings in *Bogue*, *Snow*, and *Patterson*, respectively. For example, the Ninth Circuit has held regarding *Bogue*: “In *Bogue*... we held that an administrator had discretion only where discretion was ‘unambiguously retained’ by the administrator.”³⁹ The court then went on to hold that an ERISA-governed insurance policy that required the claimant to submit “satisfactory proof that you have become disabled” did not “unambiguously retain” discretion because the phrase was subject to at least two reasonable constructions. Similarly, the Seventh Circuit limited the breadth of its holding in *Patterson* in *Herzberger v. Standard Insurance Co.*⁴⁰ Specifically, the court held that where a plan required that benefits shall be paid upon the submission of proof (or satisfactory proof), the plan did not unambiguously grant discretion to the insurer. The Seventh Circuit then established a “safe harbor” form of discretionary language:

“Benefits under this plan will be paid only if the plan administrator decides in his discretion that the applicant is entitled to them.”... An ERISA plan that contains such language will not be open to being characterized as entitling the applicant for benefits to plenary judicial review of a decision turning him down.... Equally clearly, the presumption of plenary review is not rebutted by the plan’s stating merely that benefits will be paid only if the plan administrator determines they are due, or only if the applicant submits satisfactory proof of his entitlements to them.⁴¹

Despite their recent holdings apparently limiting the circumstances under which deferential review will apply in ERISA benefits cases, it appeared that the Ninth and Seventh Circuits agreed that a plan grants discretion if it requires that “proof” of disability be “satisfactory to the insurer.” The phrase “to the insurer” or “to us” appears to require a subjective determination by the insurer as to the quality of the “proof” submitted by the claimant and thereby grant discretion. For example, in *Herzberger*, the Seventh Circuit acknowledged the continued viability of its earlier holding in *Donato v. Metropolitan Life Insurance Co.*⁴² where the court held that a policy requiring that proof of disability be “satisfactory to us [*i.e.*, the insurer]” granted discretion. Similarly in *Thomas v. Oregon Fruit Co.*,⁴³ the Ninth Circuit implied that similar language would be sufficient

Ins. Co. of N. Am., 959 F. Supp. 1361, 1365 (D. Kan. 1997) (plan stating that benefits will be paid upon receipt of due proof requires application of arbitrary and capricious standard of review).

³⁸ *Bollenbacher v. Helena Chem. Co.*, 926 F. Supp. 781, 787 (N.D. Ind. 1996) [emphasis added].

³⁹ *Kearney v. Standard Ins. Co.*, 175 F.3d 1084 (9th Cir. 1999).

⁴⁰ 205 F.3d 327 (7th Cir. 2000).

⁴¹ *See also* *Federal v. Paul Revere Life Ins. Co.*, 228 F.3d 518 (4th Cir. 2000) (plan requiring submission of due proof of loss did not grant discretion). *Contra* *Perez v. Aetna Life Ins. Co.*, 130 F.3d 550 (6th Cir. 1998) (plan requiring submission of satisfactory proof does grant discretion).

⁴² 19 F.3d 375 (7th Cir. 1994).

⁴³ 228 F.3d 991 (9th Cir. 2000).

to grant discretion. Likewise, in *Walke v. Group Long Term Disability Insurance*,⁴⁴ the Eighth Circuit suggested that if the phrase “to us” modifies the word “satisfactory,” discretion is granted. Furthermore, in *Pinto v. Reliance Standard Life Insurance Co.*,⁴⁵ the Third Circuit assumed that similar language granted discretion so as to require a deferential standard of review.

The Seventh Circuit decision in *Diaz v. Prudential Insurance Co. of America*, 424 F.3d 635 (7th Cir. 2005) seems to further limit the circumstances in which plan language requiring that the claimant submit proof that is “satisfactory” to the insurer or claim administrator, grants discretion. The plan in that case stated that a claimant would be considered disabled when “Prudential determines that” the claimant is disabled and that the claimant was required to submit proof “satisfactory to Prudential” in order to receive continued disability benefits under the plan. The Court held that this language was not sufficient to grant discretion after *Herzberger*. In the wake of *Diaz*, the Ninth Circuit held that language in a disability policy requiring the claimant to submit proof of disability and stating that such proof “must be satisfactory to [the insurer]” did not grant discretionary authority and that the insurer’s decision to terminate disability benefits was subject to *de novo* review. See *Feibusch v. Integrated Device Technology, Inc.*, 463 F.3d 880, 884–85 (9th Cir. 2006). In another decision, the Ninth Circuit, sitting *en banc* in *Abatie v. Alta Health & Life Insurance Co.*, 458 F.3d 955 (9th Cir. 2006) reiterated its longstanding position that the word “discretion” need not appear in the plan because there are no “magic words” required to grant discretion. Specifically, the court held that language granting the insurer “responsibility for full and final determinations of eligibility for benefits; interpretation of terms; determinations of claims; and appeals of claims denied in whole or in part under the [insurance] policy rests exclusively with [the claim administrator.]” *Id.* at 963.

D. “Final,” “Conclusive,” “Binding”

In addition to power-granting clauses, many plans specify that the fiduciary’s decision is “final,” “conclusive,” “binding,” or “exclusive.” In some cases, plans containing this type of language have been held to grant the fiduciary discretionary authority entitling its benefits determinations to deference. A prime example of how courts view plan-related documents with this language is the Fourth Circuit’s opinion in *Richards v. United Mine Workers of America Health and Retirement Fund*.⁴⁶ In *Richards*, the court was faced with plan language that granted the trustees “full and final determination as to all issues concerning eligibility for benefits” and specified that its rules and regulations would be “binding upon all persons.”⁴⁷ The court noted that the above-cited language “explicitly grants the Trustees broad discretionary authority.”⁴⁸ Many courts have followed this line of reasoning.⁴⁹

⁴⁴ 256 F.3d 835 (8th Cir. 2001).

⁴⁵ 214 F.3d 377 (3d Cir. 2000).

⁴⁶ 895 F.2d 133 (4th Cir. 1990).

⁴⁷ *Richards* at 135 [emphasis added].

⁴⁸ *Id.* at 135.

⁴⁹ See, e.g., *Cozzie v. Metropolitan Life Ins. Co.*, 140 F.3d 1104 (7th Cir. 1998) (deference applies where plan states that fiduciary “determines conclusively for all parties all questions arising in the administration of the Program”); *Sargent v. Holland*, 114 F.3d 33 (4th Cir. 1997) (deference where plan gives authority to fiduciary to make “full and final determinations as to all issues”); *Dowden v. Blue Cross & Blue Shield of Tex.*, 126 F.3d 641 (5th Cir. 1997) (“authority to make a final and conclusive determination of the claim” granted discretion); *Pagan v. NYNEX Pension Plan*, 52 F.3d 438 (2d Cir. 1995) (“determine conclusively” grants discretion); *Duhon v. Texaco*,

E. No Deference to Legal Determinations

Most courts have held that if the fiduciary is making decisions involving statutory interpretation, a *de novo* standard is mandated regardless of plan language. For example, in *Penn v. Howe-Baker Engineers, Inc.*,⁵⁰ the issue confronting the fiduciary was whether the claimant was an employee or an independent contractor. The Fifth Circuit reviewed the fiduciary's decision under a *de novo* standard, holding that a fiduciary's conclusions involving statutory interpretation were not entitled to deference.⁵¹ The court noted, however, that it would grant deference to the fiduciary's *factual* determinations necessary to the review of law questions.⁵²

Inc., 15 F.3d 1302 (5th Cir. 1994) ("final and conclusive" grants discretion); *Lockhart v. UMW 1974 Pension Plan*, 5 F.3d 74 (4th Cir. 1993) ("full and final determination" grants discretion); *Russo v. Health, Welfare & Pension Fund*, 984 F.2d 762 (7th Cir. 1993) (decisions of trustees are binding on all persons); *Winchester v. Prudential Life Ins. Co.*, 975 F.2d 1479 (10th Cir. 1992) (discretion is granted where insurer is given "exclusive" right to "interpret" the plan and its decision is "conclusive and binding"); *Jordal v. Simmons*, 926 F.2d 223 (2d Cir. 1991) (language granting fiduciaries full and exclusive authority to determine eligibility and all questions of coverage vests fiduciary with discretion); *Stoetznier v. U.S. Steel Corp.*, 897 F.2d 115, 119, n.5 (3d Cir. 1990) (language that "decisions... shall be final and conclusive" grants discretionary authority to the administrator); *DeWitt v. State Farm Ins. Cos. Retirement Plan for U.S. Employees*, 905 F.2d 798 (4th Cir. 1990) ("power to construe and interpret the plan" where the administrator's "determinations, constructions and interpretation... shall be binding" grants discretion); *Morales v. Pan Am. Life Ins. Co.*, 914 F.2d 83 (5th Cir. 1990) (deferential standard applies where "plan document grants [administrator] discretion to construe the Plan, to determine eligibility, to authorize all disbursements... and to perform all other such other duties required by the Plan"); *Davis v. Kentucky Fin.*, 887 F.2d 689 (6th Cir. 1989), *cert. denied*, 110 S. Ct. 1924 (1990) (plan stating that "[a]ll determinations shall be final, conclusive and binding" grants "great discretion"); *Exbom v. Central States, Southeast & Southwest Area Health & Welfare Fund*, 900 F.2d 1138 (7th Cir. 1990) (plan giving administrator "power to construe the provisions of the [plan]" and that "any construction adopted by the [administrator] in good faith is binding" granted administrator discretionary authority to determine eligibility and the proper construction of the plan's terms); *Johnson v. Enron Corp.*, 906 F.2d 1234 (8th Cir. 1990) (plan language stating that fiduciary's decision is "binding and conclusive" falls under the exception articulated by the court in *Firestone*); *Jones v. Laborers Health & Welfare Trust Fund*, 906 F.2d 480 (9th Cir. 1990) (plan stating that administrator's "construction adopted... in good faith shall be binding" grants discretion); *Madden v. ITT Long Term Disability Plan for Salaried Employees*, 914 F.2d 1279 (9th Cir. 1990) (plan giving administrator "the exclusive right... to interpret the Plan and to decide any and all matters arising thereunder" where administrator's decisions "shall be final, conclusive and binding on all parties" grants discretion); *Jett v. Blue Cross*, 890 F.2d 1137 (11th Cir. 1989) (language specifying that "determinations [are] final and conclusive [and that] Blue Cross... has the exclusive right to interpret... [the plan]" meets the *Firestone* test for discretionary authority); *Brown v. Blue Cross & Blue Shield of Ala., Inc.*, 898 F.2d 1556-59 (11th Cir. 1990) (plan language that "determinations [by Blue Cross]... shall be final and conclusive" grants discretionary authority); *Retirement & Sec. Program v. Oglethorpe*, 712 F. Supp. 223 (D.D.C. 1989); *McConnell v. Texas*, 727 F. Supp. 751 (D. Mass. 1990) ("final and conclusive" grants discretion upon administrator); *Eley v. Boeing Co.*, 742 F. Supp. 566 (W.D. Wash. 1990) (discretion granted to administrator where plan gives administrator full authority and responsibility for all aspects of the plan).

⁵⁰ 898 F.2d 1096 (5th Cir. 1990).

⁵¹ *Id.* at 1100.

⁵² *Id.* at 1100 n.3. See also *Izzeralli v. Rexene Prods. Co.*, 24 F.3d 1506 (5th Cir. 1994); *Counts v. Kissack Water & Oil Serv., Inc.*, 986 F.2d 1322 (10th Cir. 1993); *Weil v. Retirement Plan Admin. Comm. of the Terson Co., Inc.*, 913 F.2d 1045 (2d Cir. 1990); *Penn v. Howe-Baker Eng'rs, Inc.*, 898 F.2d 1096 (5th Cir. 1990); *Seaway Port Auth. of Duluth v. Duluth-Superior ILA Marine Ass'n Restated Pension Plan*, 920 F.2d 503 (8th Cir. 1990); *Arnold v. Arrow Transp.*, 926 F.2d 782 (9th Cir. 1991); *Adams v. Ampco-Pittsburgh Corp.*, 733 F. Supp. 998, 1000 (W.D. Pa.

F. Deference by Some to Factual Determinations

Not all courts have given *Firestone* blanket application in reviewing a fiduciary's decision regarding a claim for benefits. The Supreme Court in *Firestone* seemingly limited its discussion to "actions challenging denials of benefits based on plan interpretations."⁵³ The Fifth Circuit has seized upon this language to hold that the *de novo* standard enunciated in *Firestone* is applicable only in cases involving issues of plan interpretation and that where the court is reviewing a purely factual determination by the fiduciary (e.g., whether a participant is disabled), the court should grant the fiduciary's factual determination deference and reverse that determination only where it is arbitrary and capricious or in bad faith.

In *Pierre v. Connecticut General Life Insurance Co.*,⁵⁴ the plaintiff sought accidental death benefits under an employee benefit plan. When the defendant denied the claim, the plaintiff asked the court to overturn the decision and to apply a *de novo* standard of review. The Fifth Circuit held that the Supreme Court's application of *de novo* review in *Firestone* applies only to fiduciary decisions involving plan interpretation, and that the fiduciary's *factual* determination that the death was not "accidental" within the meaning of the plan would be granted deference regardless of whether the plan granted discretion to the decision maker, and would be reversed only if it constituted an abuse of discretion.⁵⁵

Limiting the *Firestone* holding to cases involving plan interpretation questions allows application of a deferential standard of review to the large number of cases where the fiduciary's decision is purely factual. However, this reading of *Firestone* has not been universally accepted. Several circuits have expressly rejected such a limitation, holding that deference is granted to a fiduciary's factual determinations only where the plan grants discretion to the fiduciary to make such decision.⁵⁶

G. The Applicable Standard: "Arbitrary and Capricious" vs. "Abuse of Discretion"

Prior to *Firestone*, although courts were fairly uniform in applying a high level of deference to decisions by ERISA plan administrators and fiduciaries, they were *not* in uniformity as to the specific standard of deferential review or as to the factors to consider when evaluating a fiduciary's decision. After *Firestone*, the circuits

1989). *But see* Collins v. Central States Welfare Fund, 18 F.3d 556 (8th Cir. 1994) (fiduciary's legal determination that decedent was not an employee was granted deference).

⁵³ 489 U.S. at 108 [emphasis added].

⁵⁴ 932 F.2d 1552 (5th Cir. 1991).

⁵⁵ *See also* Southern Farm Bureau Life Ins. Co. v. Moore, 993 F.2d 98 (5th Cir. 1993) (factual determinations of plan fiduciary are reviewed under abuse of discretion standard); Harms v. Cavenham Forest Indus., Inc., 984 F.2d 686 (5th Cir. 1993) (court must defer to a plan fiduciary's factual determinations made in the course of determining benefits eligibility, unless those determinations reflect an abuse of discretion). *See also* Cox v. Mid-America Dairymen, Inc., 965 F.2d 569 (8th Cir. 1992) (noting that the Eighth Circuit "has apparently sided with" the holding in *Pierre* that "the deferential standard of review applies to a trustee's fact-based benefits determination" even though the plan does not expressly provide that such determinations are discretionary).

⁵⁶ *See, e.g.,* Riedel v. General Am. Life Ins. Co., 248 F.3d 753 (8th Cir. 2001); Rowan v. UNUM Life Ins. Co., 119 F.3d 433 (6th Cir. 1997) (absent discretionary plan language, factual determinations are subject to *de novo* review); Ramsey v. Hercules, Inc., 77 F.3d 199 (7th Cir. 1996) (same standard of review applies to factual determinations as plan interpretations); Luby v. Teamsters Health, Welfare & Pension Trust Funds, 944 F.2d 1176 (3d Cir. 1991) (*Firestone* mandate of *de novo* review based on plan interpretation extends as well to fiduciary decisions based upon purely factual questions); Reinking v. Philadelphia Am. Life Ins. Co., 910 F.2d 1210 (4th Cir. 1990) (*Firestone* applies to plan interpretation as well as to factual determinations by fiduciaries).

have continued to struggle with application of a deferential review standard. Many courts have applied the old familiar terminology of the pre-*Firestone* cases. Most circuits have, in one or more decisions, stated that where plan language grants a fiduciary discretionary authority, his decision is entitled to deference under an *arbitrary and capricious* standard. However, several circuit courts have at other times referred to it as an *abuse of discretion* standard. Some courts have stated that the arbitrary and capricious and abuse of discretion standards are the same.⁵⁷ Other courts have stated that they are not equivalent.⁵⁸

In applying the deferential standard, courts have developed different analytical frameworks. The courts agree that the standard grants some deference to the fiduciary's decision, be it a decision based on facts or an interpretation of ambiguous plan terms. For example, one court referred to the arbitrary and capricious standard as "extremely deferential and has been described as the least demanding form of judicial review."⁵⁹ Most courts have held that under the deferential review standard, a fiduciary's decision must be upheld if it is "reasonable."

Where the disputed decision involves questions of plan interpretation, some circuits have defined specific factors to be analyzed in determining whether the decision meets the "reasonableness" threshold. For example, the Eighth Circuit has applied a five-factor test to determine whether a fiduciary's interpretation is reasonable, including: (1) whether the fiduciary's interpretation is consistent with the goals of the plan; (2) whether the interpretation renders any language in the plan meaningless or makes the plan internally inconsistent; (3) whether the interpretation conflicts with ERISA; (4) whether the interpretation has been consistent; and (5) whether the interpretation is contrary to the clear language of the plan.⁶⁰ No single factor is necessarily determinative nor do the factors need to be examined in any particular order.⁶¹ The Fifth Circuit has followed a similar test. Although the Fifth Circuit applies a deferential standard of review to factual determinations, it defers to a fiduciary's plan interpretations only where the plan grants discretionary authority. In applying this standard to plan interpretation issues, the Fifth Circuit first determines whether the fiduciary's interpretation is legally correct. If so, the inquiry is at an end and the benefit denial must be upheld.⁶² If the interpretation is not legally correct, a court must weigh several factors, none of which are alone determinative, including: (1) whether the fiduciary has given the plan a uniform construction; (2) whether the interpretation is consistent with a fair reading of the plan; and (3) whether a different interpretation would result in unanticipated costs to the plan.⁶³

Some courts have also held that the usual summary judgment standard does not apply in the context of reviewing an ERISA benefit determination. Specifically, the usual inferences in favor of a non-moving

⁵⁷ *Anderson v. Cytec Industries, Inc.*, 619 F.3d 505 (5th Cir. 2010); *Holmstrom v. Metropolitan Life Ins. Co.*, 615 F.3d 758 (7th Cir. 2010); *Taft v. Equitable Life Assurance Soc'y*, 9 F.3d 1469 (9th Cir. 1993) (distinction without a difference); *Penn v. Howe-Baker Eng'rs, Inc.*, 898 F.2d 1096 (5th Cir. 1990); *Jett v. Blue Cross*, 890 F.2d 1137 (11th Cir. 1989).

⁵⁸ *See Rizzo v. Caterpillar, Inc.*, 914 F.2d 1003 (7th Cir. 1990); *Richards v. United Mine Workers of Am.*, 895 F.2d 133 (9th Cir. 1990); *Pierre v. Connecticut Gen. Life Ins. Co.*, 932 F.2d 1552 (5th Cir. 1991) ("the arbitrary and capricious standard... may be interpreted and applied in a manner that is 'too stringent'").

⁵⁹ *Cozzie v. Metropolitan Life Ins. Co.*, 140 F.3d 1104, 1107 (7th Cir. 1998).

⁶⁰ *Hutchins v. Champion Int'l Corp.*, 110 F.3d 1341 (8th Cir. 1997); *Finley v. Special Agents Mut. Benefit Ass'n*, 957 F.2d 617, 621 (8th Cir. 1992).

⁶¹ *Hutchins*, 110 F.3d at 1343.

⁶² *Tolson v. Avondale Indus., Inc.*, 141 F.3d 604, 607 (5th Cir. 1998).

⁶³ *Id.*

party do not apply because the district court sits more as an appellate court than a trial court.⁶⁴ This analysis applies whether or not a court is applying deferential review.⁶⁵

V. Conflicts of Interest

The Supreme Court's holding in *Firestone* did not distinguish between types of plans, the manner in which the plans were funded, or the motivations of plan administrators and fiduciaries. 489 U.S. at 115. However, the Court did hold that if an administrator or fiduciary was operating under a conflict of interest, then that conflict "must be weighed as a 'facto[r]' in determining whether there is an abuse of discretion." *Id.*

The Supreme Court's holding regarding a decision maker's conflict of interest was in direct response to the overturned Third Circuit decision in that case. The Third Circuit held that deferential review would apply only where the fiduciary was completely impartial. Thus, in the Third Circuit's view, whether or not an arbitrary and capricious review standard would apply in an ERISA judicial review proceeding turned entirely on whether the decision maker had a conflict of interest. The Supreme Court expressly rejected this approach and instead decided that the question of what review standard to apply would be a matter of contract between the parties.

A. Early Circuit Responses to *Firestone* on the Conflict of Interest Issue

To some extent before *Firestone*, and to a greater extent after *Firestone*, the circuits were in general agreement that where a deferential review standard was applicable and where the decision maker had a conflict of interest, the amount of deference would be reduced. However, here the agreement ended, with the circuits divided on two key questions: (1) when and under what circumstances does a conflict of interest exist? and (2) if a conflict exists, how much impact does it have on the deferential review standard?

One of the earliest cases to discuss the conflict of interest issue after *Firestone* addressed both of these questions. In *Brown v. Blue Cross & Blue Shield of Alabama, Inc.*, 898 F.2d 1556 (11th Cir. 1990), *cert. denied*, 498 U.S. 1040 (1991), the Eleventh Circuit reviewed a health benefit determination made by a plan insurer. According to the Eleventh Circuit, where an insurer paid benefits out of its own assets, there is an inherent conflict of interest for the insurer every time it makes a benefit determination.

Having decided that an insurer has a perpetual conflict, the Eleventh Circuit addressed the impact of the conflict on the deferential review standard. In attempting "to develop a coherent method for integrating [the]... self-interest [factor] into the legal standard for reviewing [the insurer's] benefits determinations," the court concluded that "[t]he inherent conflict between the fiduciary role and the profit-making objective of an insurance company makes a highly deferential standard of review inappropriate." *Id.* at 1561, 1562. Accordingly, it chose to apply a "heightened deferential standard of review" rather than a "highly deferential" standard of review, with the following factors to be considered in determining whether benefit denial decision is arbitrary and capricious: (1) the extent of the discretion conferred upon the decision maker by the terms of the trust; (2) the purposes of the plan; (3) the nature of the power; (4) the existence or non-existence, the definiteness or indefiniteness, of an external standard by which the reasonableness of the decision maker's conduct can be judged; (5) the motives of the decision maker in exercising the power; (6) the existence or nonexistence of an interest in the decision maker conflicting with that of the beneficiaries. *Id.* at 1564–65.

⁶⁴ *Cusson v. Liberty Life Assur. Co. of Boston*, 592 F.3d 215 (1st Cir. 2010).

⁶⁵ *Richards v. Hewlett-Packard Corp.*, 592 F.3d 232 (1st Cir. 2010) (applying *de novo* review standard).

The *Brown* court held that any conflict of interest analysis did not apply where a deferential review standard was not applicable. Thus, before a court looked at the conflict of interest question, the first step in the *Brown* analysis was to determine whether the fiduciary's decision was objectively "wrong" under a *de novo* standard. If the decision was not "wrong," it must be upheld. On the other hand, assuming that the interpretation was wrong under a *de novo* standard, once it was determined that a fiduciary was in a position where his personal interest *might* conflict with that of the beneficiary, a heightened deferential standard of review was mandated. Under this heightened standard, once a *potential* conflict of interest was *identified*, the burden of proof shifted to the fiduciary to prove that his or her determination was *not* tainted by self-interest. In the Court's words, "a wrong but apparently *reasonable interpretation* is *arbitrary and capricious* if it *advances the conflicting interest* of the fiduciary at the expense of the affected beneficiary or beneficiaries *unless the fiduciary justifies* the interpretation on the ground of its benefit to the class of all participants and beneficiaries." *Id.* at 1566–67 (emphasis added). If a fiduciary met this burden, then a "normal" deferential standard of review would apply. *Id.*

B. Development of Circuit Law Re: When Does a Conflict of Interest Exist?

Several circuits, including the Third, Fourth, and Fifth Circuits, agreed with the Eleventh Circuit that where an insurer decides benefit claims under a fully insured ERISA plan, the "apparent" or "inherent" conflict arising from the insurer's dual roles as insurer and claim payer, automatically resulted in an "actual" conflict of interest that must be considered by courts applying the arbitrary and capricious review standard. *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 388–89 (3d Cir. 2000) (where an insurer makes a benefit determination, the court may engage in "implicit assumptions about economic behavior," alleviating the need for plaintiffs to bear the burden of submitting evidence of "actual self dealing"); *Vega v. Nat'l Life Ins. Servs., Inc.*, 188 F.3d 287, 295 (5th Cir. 1999) (court assumes that an insurer "has a disincentive to grant claims"); *Doe v. Group Hospitalization & Med. Servs.*, 3 F.3d 80, 86 (4th Cir. 1993) ("To the extent that Blue Cross has discretion to avoid paying claims, it thereby promotes the potential for its own conflict"). The Sixth Circuit adopted similar reasoning in some cases, but not in all cases, and that circuit suffered from an internal split of authority. Compare *Miller v. Metropolitan Life Ins. Co.*, 925 F.2d 979, 984 (6th Cir. 1991) (assuming that all insurers have a perpetual conflict between their profit-making role as a business and their role as an ERISA fiduciary) with *Carr v. Reliance Standard Life Ins. Co.*, 363 F.3d 604, 606 & n.2 (6th Cir. 2004) (suggesting that an insurer's inherent conflict will not alter the standard of review, absent proof of an actual impact on the decision under review).

Unlike the circuits that assumed a conflict of interest where an insurer decides ERISA claims, most circuits opted not to make such an assumption, even where an ERISA plan was fully insured. Several circuits held that a plaintiff had the burden to show the existence of an actual conflict (as contrasted with an "inherent" or "apparent" conflict) before such a conflict would have an impact on the court's application of the arbitrary and capricious review standard. For example, the Seventh Circuit held that an insurer is presumed to be "acting neutrally unless a claimant shows by providing specific evidence of actual bias that there is a significant conflict." *Mers v. Marriott Int'l Group Accidental Death & Dismemberment Plan*, 144 F.3d 1014, 1020 (7th Cir. 1998). This presumption arose out of the economic and competitive realities that drive insurance company decisions: "Companies... who choose group insurance policies... have the sophistication and bargaining power necessary to take their business elsewhere if an insurer... consistently denies valid claims." *Id.* at 1021. The First Circuit adopted the same rationale, noting that "an employer would not want to keep an overly tight-fisted insurer. The [insurer's] conflict is not as serious as it might appear at first blush." *Doyle v. Paul Revere Life Ins. Co.*, 144 F.3d 181, 184 (1st Cir. 1998). Thus, before a court would apply less deference to

an insurer's decision, the plaintiff was required to demonstrate "that the decision was improperly motivated." Mere proof that a benefit award would be paid from the insurer's funds was not sufficient for the court to lessen the amount of deference applied in reviewing the insurer's benefit determination. *Id.*

Other circuits also required a plaintiff to prove the existence of an actual conflict of interest, although not necessarily based on an economic/competition rationale. For example, the Eighth Circuit noted that "not every funding conflict of interest per se warrants heightened review" under ERISA. In order to achieve "heightened" review, the plaintiff was required to present "material probative evidence" tending to show that there was a palpable conflict of interest and that this conflict caused a serious breach of the claim administrator's duties. *Woo v. Deluxe Corp.*, 144 F.3d 1157, 1160–61 & n.2 (8th Cir. 1998). Other circuits applied a similar procedure. *See, e.g., Whitney v. Empire Blue Cross & Blue Shield*, 106 F.3d 475, 477 (2d Cir. 1997) (an ERISA plaintiff must "show not only that a potential conflict of interest exists... but that the conflict affected the reasonableness of the [insurer's] decision"); *Atwood v. Newmont Gold Co.*, 45 F.3d 1317, 1323 (9th Cir. 1995) (decisions by "apparently" conflicted insurers are accorded full deference except where the plaintiff produces specific evidence "indicating that the conflicting interest caused a breach of the administrator's duty to the beneficiary").

Finally, the Tenth Circuit carved out its own niche on this issue. The circuits that assumed a conflict generally allowed the insurer to present evidence to rebut the presumption that the conflict had any actual impact on the decision under review. *See, e.g., Brown*, 898 F.2d at 1556–57. However, the Tenth Circuit adopted a rationale that appeared to create an irrebutable presumption of conflict where an insurer made a benefit determination under an ERISA plan, apparently giving no consideration to the precise funding of the plan, the procedures applied in rendering the decision, or the substantive basis for the decision. *Fought v. Unum Life Ins. Co. of America*, 379 F.3d 997 (10th Cir. 2004).

C. Development of Circuit Law Re: What Impact Does a Conflict of Interest Have on the Arbitrary and Capricious Review Standard?

As with the question of when a conflict exists, the circuits were also split on what impact a conflict of interest should have on the arbitrary and capricious review standard. In other words, circuits charted different routes in applying the Supreme Court's holding in *Firestone*, that a conflict of interest should be "weighed as a factor" in determining whether the decision under review was arbitrary and capricious.

Again, it is helpful to start with the Eleventh Circuit decision in *Brown*. Once the court in that case determined that the insurer had an inherent conflict of interest by virtue of its dual role as decision maker and claim payer, it held that the burden shifted to the insurer to show that its "wrong but apparently reasonable" determination was not tainted by self-interest. *Brown*, 898 F.2d at 1566. This approach came to be known as the "presumptively-void" test because, under *Brown*, the insurer's decision was presumed to be biased and therefore invalid, unless the insurer could show otherwise. If the decision maker failed to satisfy its burden, the decision would be overturned, unless of course the decision was "correct" under the *de novo* standard.

The Second Circuit applied a slightly different test, which may be a variation of the "presumptively-void" test. In that circuit, where the plaintiff demonstrated that an actual conflict of interest existed and that the decision under review was impacted by bias, the arbitrary and capricious standard was abandoned and the court applied a *de novo* standard. *See, e.g., Sullivan v. LTV Aerospace & Defense Co.*, 82 F.3d 1251, 1256 (2d Cir. 1996). In effect, this approach was the same as the "presumptively-void" standard in that a decision mak-

er's demonstrated bias essentially forfeited the decision maker's right to rely on the arbitrary and capricious standard, although a "correct" decision would still be upheld, even where the decision was biased.

Most circuits declined to follow either the "presumptively-void" or the "de novo" tests and instead applied a version of the pre-*Firestone* test applied in the Seventh Circuit's *Van Boxel* decision, where the court ruled that the arbitrary and capricious standard was flexible and could be adjusted to take into account a decision maker's bias. This standard became known as the "sliding scale" analysis. The sliding-scale standard was applied in the First, Third, Fourth, Fifth, Sixth, Seventh, and Eighth Circuits. The Ninth Circuit applied a similar standard, although it declined to call it a "sliding-scale" standard. *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955 (9th Cir. 2006) (*en banc*).

Generally, the standard "integrate[s] conflicts as factors in applying that standard, approximately calibrating the intensity of [the] review to the intensity of the conflict." *Pinto*, 214 F.3d at 393. *See also Pari-Fasano v. ITT Hartford Life & Acc. Ins. Co.*, 230 F.3d 415, 419 (1st Cir. 2000) (a conflict of interest "would necessarily affect the court's determination of what was reasonable conduct by the insurer under the circumstances"); *Vega*, 188 F.3d at 297 ("The greater the evidence of conflict on the part of the administrator, the less deferential our abuse of discretion standard will be."); *Woo*, 144 F.3d at 1161–62 (The 'sliding scale' approach "more closely comports with *Firestone* because it requires the courts to apply an abuse of discretion analysis, taking into consideration the conflict."); *Donato v. Metropolitan Life Ins. Co.*, 19 F.3d 375, 380 n.3 (7th Cir. 1994) ("[T]he arbitrary and capricious standard of review is a sliding scale standard that should be 'more penetrating the greater is the suspicion of partiality, less penetrating the smaller that suspicion is.'"); *Doe*, 3 F.3d at 87 ("deference will be lessened to the degree necessary to neutralize any untoward influence"); *Miller*, 925 F.2d at 984 ("application of the [abuse of discretion] standard should be shaped by the circumstances of the inherent conflict of interest"). In its application, this highly flexible and mainly subjective standard gave courts much leeway in upholding a fiduciary's decision.

Finally, the Tenth Circuit again stood alone in its application of a decision maker's conflict of interest to the arbitrary and capricious review standard. Prior to *Fought*, the Tenth Circuit was an adherent to the sliding-scale approach. *See, e.g., Nance v. Sun Life Assur. Co. of Canada*, 294 F.3d 1263, 1269 (10th Cir. 2002). *Fought* purported to follow the same analysis, but appeared to be more closely aligned with the "presumptively-void" jurisdictions. For example, where an insurer denied ERISA plan benefits under a fully insured plan, the insurer's decision was presumed to be biased and the burden of proof shifted to the insurer to prove that its decision was not arbitrary and capricious (*i.e.*, that its factual determinations were supported by substantial evidence).

D. Supreme Court Tackles the Conflict of Interest Issue: Met Life v. Glenn

After rebuffing dozens of requests over several years, the Supreme Court finally attempted to resolve the multi-faceted conflict of interest issues in *Metropolitan Life Insurance Company v. Glenn*, 128 S. Ct. 2343 (2008). The facts of *Glenn* were pretty typical of a long term disability dispute: Glenn filed a claim for benefits under the employer's plan, which was insured by Metropolitan Life Insurance Company. Met Life approved benefits during the initial 24-month own occupation period and referred Glenn to a law firm to assist her with an application for Social Security disability benefits, which were approved following a hearing with an Administrative Law Judge. Thereafter, Met Life denied benefits during the any occupation period, which the Supreme Court majority characterized as a "Social-Security-type standard," determining that Glenn was capable of sedentary work. The district court upheld the denial, but was reversed by the Sixth Circuit. The appellate court ruled that Met Life's decision was arbitrary and capricious in light of a combination of several

factors, including Met Life's inherent conflict of interest; Met Life's failure to reconcile its conclusions with those of the Social Security ALJ; Met Life's focus on one favorable medical report at the expense of other, more detailed, reports; Met Life's failure to provide all of the treating physician reports to its own hired experts; and Met Life's failure to take into account evidence that stress aggravated Glenn's heart condition.

The Supreme Court granted Met Life's petition for certiorari to address two issues: (1) whether dual role claim fiduciaries have a conflict of interest under ERISA; and, if so, (2) the impact of such a conflict on a court's application of a deferential standard of review. The Court declined to grant Met Life's request that it address the appropriate application of Social Security disability decisions to private disability claims under ERISA.

1. Foundational Legal Principles

To anyone familiar with the oral argument in *Glenn*, it was clear that, whatever the Supreme Court was to decide, the decision would heavily rely on its previous ruling in *Firestone*. Indeed, the majority opinion prefaced its decision in *Glenn* on four legal principles, all of which were established in *Firestone*: (1) a benefit determination under ERISA is a fiduciary act and the appropriate standard of review of such a decision should be guided by principles of trust law; (2) trust law requires a *de novo* review unless the plan provides to the contrary; (3) when the plan does provide to the contrary, a deferential standard of review is appropriate; and (4) if a claim fiduciary operates under a conflict of interest, that conflict must be weighed as a factor in determining whether the fiduciary abused its discretion. One of the upshots of these foundational principles, which should not be overlooked, is that where a plan does not grant discretion and *de novo* review is applicable, then a decisionmaker's conflict of interest is irrelevant.

2. Do Dual Role Claim Administrators Have a Conflict of Interest?

Following oral argument, the Court's decision on the first issue in *Glenn* did not seem to be in doubt: a dual role claim administrator has a conflict of interest. Moreover, although much of the discussion in *Glenn* focused on insured ERISA plans, the Court also held that the same rule would apply in the context of non-insured ERISA plans where the same entity both funds the plan and makes claim determinations under the plan. Forecasting that the "existence of a conflict" issue will now slide into the background, the Court ruled that various factors that Met Life argued would militate against the existence of a conflict could instead be considered in diminishing the existence or severity of a conflict on deferential review. These factors included market forces that encourage insurance companies to pay benefit claims even though against their own immediate financial interests where payment of claims makes the insurer more competitive.

3. What Impact Does a Conflict Have on Deferential Review?

The more interesting question entertained by the Supreme Court in *Glenn* was what impact a dual role claim administrator's conflict of interest has on a court's application of the arbitrary and capricious review standard. Here the Court was less clear but did base its decision firmly on *Firestone*'s holding that a conflict of interest should "be weighed as a 'factor in determining whether there is an abuse of discretion.'" The Court reiterated what was the basic holding in *Firestone*, *i.e.*, that a conflict does not change the review standard from deferential to *de novo*. The Court expressly rejected suggestions by several plaintiffs' *amici* that it overturn *Firestone*: "Nor would we overturn *Firestone* by adopting a rule that in practice could bring about near universal review by judges *de novo*—*i.e.*, without deference—of the lion's share of ERISA plan claims denials." The Court also

expressly rejected the position taken in several circuits that a conflict requires a shifting of the burden of proof in ERISA benefit cases, reasoning that such holdings focus too narrowly upon the evaluator/payor conflict.

Having said what it would not do, the Court finally rested its decision squarely on *Firestone* by holding that a conflict of interest should be taken into account as one factor, along with all other factors, in applying a deferential review standard. While a conflict, like any other factor, might serve as a “tiebreaker” where all other factors are “closely balanced,” in some cases, it might not carry much weight at all:

The conflict of interest at issue here, for example, should prove more important (perhaps of great importance) where circumstances suggest a higher likelihood that it affected the benefits decision, including, but not limited to, cases where an insurance company administrator has a history of biased claims administration... It should prove less important (perhaps to the vanishing point) where the administrator has taken active steps to reduce potential bias and to promote accuracy, for example, by walling off claims administrators from those interested in firm finances, or by imposing management checks that penalize inaccurate decisionmaking irrespective of whom the inaccuracy benefits.

The Court declined to dictate any specific set of instructions on how a conflict should be applied or what weight to assign a conflict of interest in a given case. However, the Court did rule that the manner in which the Sixth Circuit applied deferential review in *Glenn* was appropriate:

The Court of Appeals gave the conflict weight to some degree; its opinion suggests that, in context, the court would not have found the conflict alone determinative... The court instead focused more heavily on other factors. In particular, the court found questionable the fact that Met Life had encouraged Glenn to argue to the Social Security Administration that she could do no work, received the bulk of the benefits of her success in doing so (the remainder going to the lawyers it recommended), and then ignored the agency’s finding in concluding that Glenn could in fact do sedentary work... This course of events was not only an important factor in its own right (because it suggested procedural unreasonableness), but also would have justified the court in giving more weight to the conflict (because Met Life’s seemingly inconsistent positions were both financially advantageous). And the court furthermore observed that Met Life had emphasized a certain medical report that favored a denial of benefits, had deemphasized certain other reports that suggested a contrary conclusion, and had failed to provide its independent vocational and medical experts with all of the relevant evidence... All these serious concerns, taken together with some degree of conflicting interests on Met Life’s part, led the court to set aside Met Life’s discretionary decision.

4. Minority Opinions

Chief Justice Roberts agreed that dual role claim administrators have a conflict of interest, but wrote a concurring opinion, stating that he would consider a claim administrator’s conflict only “where there is evidence that the benefits denial was motivated or affected by the administrator’s conflict.” Justice Kennedy stated that he would remand the case to the lower court to reconsider it in light of the Court’s decision. Specifically, Justice Kennedy indicated that Met Life should be given the opportunity to demonstrate that it “employed structural safeguards to avoid conflicts of interest, safeguards the Court says can cause the importance of a conflict to vanish.” Finally, Justices Scalia and Thomas dissented, arguing that the majority’s “totality-of-the-circumstances” or “gestalt reasonableness” test was “painfully opaque.” The dissenters urged that “the notion that there are degrees of deference is absurd,” leaving lower courts with much latitude to apply whatever standard a court feels is appropriate to reach a given result. Ultimately, the dissenters argued that the reasonableness of a decision should be determined without regard to the existence of a conflict of interest. In other words, a reasonable decision is still reasonable, regardless of whether a decisionmaker is conflicted.

5. Highlights of the *Glenn* Decision

Despite its vagueness, there are several conclusions that one can draw from *Glenn*. First, whether or not a conflict of interest exists, it has no impact on a court's review where the review standard is *de novo*. A correct decision is still correct no matter how conflicted a decision maker is in a given case.

Second, dual role claim administrators are presumed to have a conflict of interest. This overturns the law in some circuits (*e.g.*, First, Second, some Sixth Circuit cases, Seventh, and Eighth Circuits) to the effect that a plaintiff must prove an actual conflict before the conflict will have any impact on a deferential review standard.

Third, while a structural conflict is now presumed, it should have little or no impact on a deferential review standard unless the plaintiff proves that it actually had an impact on the decision. The majority's statement that the impact of a conflict may vary greatly in a given case is proof of this point. In essence, plaintiffs now have the burden to prove not that the conflict exists, but that it had an impact on the decision, before that conflict will have any real affect on a court's application of the arbitrary and capricious review standard. The first question answered by *Glenn* will now be largely irrelevant.

Fourth, there will be no burden-shifting to the claim administrator nor will there be any presumption that a decision by a conflicted administrator is void. Case law in "presumptively-void" jurisdictions (*e.g.*, Tenth and Eleventh Circuits) is now overturned. In fact, as noted above, plaintiffs will be saddled with the burden to establish that a conflict actually had an affect on the claim decision before a court will accord the conflict any weight whatsoever.

Fifth, regarding the Court's reference to a conflict as a "tiebreaker," it is clear that it will act as such only where all other factors are closely balanced. In fact, it stands to reason that any factor may be a "tiebreaker" in a particular case where all other factors are closely balanced.

Finally, it may be argued *Glenn* will require courts to allow more discovery than previously. However, this is not at all clear. Many courts already allow supplementation of the administrative record where discovery is limited to the conflict of interest issue. Other courts have long applied a conflict in a "sliding scale" context (which appears to be very similar to *Glenn*'s multiple factor test) without allowing much, if any, discovery or consideration of evidence outside of the administrative record. Furthermore, additional discovery may not be all bad where it gives the claim administrator the opportunity to rebut any presumption of a tainted decision, a point that is emphasized by the *Glenn* majority as well as by Justice Kennedy's concurring opinion.

Circuit courts applying *Glenn* have been relatively uniform in considering conflict merely as a factor. Circuits that previously applied "heightened scrutiny" in the face of a conflicted claim administrator no longer apply additional scrutiny in reviewing the decision.⁶⁶ The circuits are also fairly consistent in holding that the weight to be given a conflict will vary depending on the circumstances of a given case.⁶⁷ For example, one court has held that a conflict is not shown where a disability denial letter quoted from a summary report of surveillance where the claim examiner viewed the surveillance tapes personally.⁶⁸ The same court also held that a failure to address a favorable Social Security disability award was not evidence of a conflict where the

⁶⁶ See, *e.g.*, *Howley v. Mellon Financial Corp.*, 625 F.3d 788 (3d Cir. 2010); *Capone v. Aetna Life Ins. Co.*, 592 F.3d 1189 (11th Cir. 2010).

⁶⁷ See, *e.g.*, *Holmstrom v. Metropolitan Life Ins. Co.*, 615 F.3d 758 (7th Cir. 2010); *Mitchell v. C.B. Richard Ellis Long Term Dis. Plan*, 611 F.3d 1192 (9th Cir. 2010); *Darvell v. Life Ins. Co. of N. America*, 597 F.3d 929 (8th Cir. 2010).

⁶⁸ *Cusson v. Liberty Life Assur. Co. of Boston*, 592 F.2d 215 (1st Cir. 2010).

award did not occur until after the insurer denied disability benefits.⁶⁹ Another court has held that the use of in-house medical reviewers is not evidence of a conflict.⁷⁰ On the other hand, where there is evidence of procedural unreasonableness, a court may give more weight to the conflict.⁷¹ A court may also give more weight to the conflict where a claim administrator dismisses the report of the claimant's vocational expert where the report is vastly more detailed and particularized than the report of the administrator's expert.⁷²

VI. Scope of Admissible Evidence

A. Deferential Review

Before *Firestone*, all courts were in agreement that in reviewing a fiduciary's decision under the arbitrary and capricious standard, a trial court was limited to the evidence before the fiduciary at the time of the fiduciary's final decision. After *Firestone*, the circuit courts are still uniform in holding that under a deferential standard of review, a court is allowed to consider only the evidence presented to the fiduciary at the time of his final decision.⁷³ However, some courts have created a narrow exception to the limited evidence rule by allowing the admission of evidence outside of the administrative record that relates to the issue of the existence and extent of a conflict of interest.⁷⁴ This exception has expanded somewhat since the Supreme Court decision in *Met Life v. Glenn*, where courts have granted limited discovery and admission of evidence to determine what weight to apply to a conflict in a given case.⁷⁵

Some courts that limit the admission of evidence to the administrative record also limit discovery based on the idea that if evidence outside of the administrative record is not admissible, then there is no purpose to discovery of evidence outside of the administrative record.⁷⁶ For example, in *Perlman v. Swiss Bank Corp. Comprehensive Dis. Protection Plan*, 195 F.3d 975 (7th Cir. 1999), the Seventh Circuit specifically criticized a district court for allowing depositions and other discovery, stating: "There should not have been any inquiry

⁶⁹ *Id.*

⁷⁰ *Estate of Blanco v. Prudential Ins. Co. of America*, 606 F.3d 399 (7th Cir. 2010).

⁷¹ *Holmstrom v. Metropolitan Life Ins. Co.*, 615 F.3d 758 (7th Cir. 2010); *Schexnayder v. Hartford Life and Acc. Ins. Co.*, 600 F.3d 465 (5th Cir. 2010).

⁷² *Durakovic v. Building Service 32 BJ Pension Fund*, 609 F.3d 133 (2d Cir. 2010).

⁷³ *See, e.g.*, *Lopes v. Metropolitan Life Ins. Co.*, 332 F.3d 1 (1st Cir. 2003); *Gooden v. Provident Life & Acc. Ins. Co.*, 250 F.3d 329 (5th Cir. 2001); *Heaser v. Toro Co.*, 247 F.3d 826 (8th Cir. 2001); *Univ. Hosps. of Cleveland v. Emerson Elec. Co.*, 202 F.3d 839 (6th Cir. 2000); *Martin v. Blue Cross & Blue Shield of Va.*, 115 F.3d 1201 (4th Cir. 1998); *Layes v. Mead Corp.*, 132 F.3d 1246 (8th Cir. 1998); *Thibodeaux v. Continental Cas. Ins. Co.*, 138 F.3d 593 (5th Cir. 1998); *Mitchell v. Eastman Kodak Co.*, 113 F.3d 433 (3d Cir. 1997); *Bernstein v. Capitalcare, Inc.*, 70 F.3d 783 (4th Cir. 1995); *Donato v. Metropolitan Life Ins. Co.*, 19 F.3d 375 (7th Cir. 1994); *Southern Farm Bureau Life Ins. Co.*, 993 F.2d 98 (5th Cir. 1993); *Miller v. Metro. Life Ins. Co.*, 925 F.2d 979 (6th Cir. 1991); *Oldenburger v. Central States, Southeast & Southwest Areas Teamster Pension Fund*, 934 F.2d 171 (8th Cir. 1991); *Winters v. Costco Wholesale Corp.*, 49 F.3d 550 (9th Cir. 1995); *Sandoval v. Aetna Life & Cas. Co.*, 967 F.2d 377 (10th Cir. 1992); *Jett v. Blue Cross & Blue Shield of Ala.*, 890 F.2d 1137 (11th Cir. 1989).

⁷⁴ *See, e.g.*, *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377 (3d Cir. 2000); *Tremain v. Bell Indus., Inc.*, 196 F.3d 970 (9th Cir. 1999); *Wilkins v. Baptist Healthcare System, Inc.*, 150 F.3d 609 (6th Cir. 1998).

⁷⁵ *See, e.g.*, *Murphy v. Deloitte & Touche Group Ins. Plan*, 619 F.3d 1151 (10th Cir. 2010); *Jones v. Reliastar Life Ins. Co.*, 615 F.3d 941 (8th Cir. 2010); *Denmark v. Liberty Life Assur. Co.*, 566 F.3d 1 (1st Cir. 2009).

⁷⁶ *See, e.g.*, *Perlman v. Swiss Bank Corp. Comprehensive Disability Protection Plan*, 195 F.3d 975 (7th Cir. 1999).

into the thought processes of [the insurer's], the training of those who considered Perlman's claim, and in general who said what to whom within [the insurer]—all of which Perlman was allowed to explore at length by depositions and interrogatories....” *Id.* at 982. More recently, the Seventh Circuit again addressed the permissible scope of discovery in a deferential review case under ERISA in *Semien v. Life Insurance Co. of North America*, 436 F.3d 805 (7th Cir. 2006), adopting the following standard:

A claimant must demonstrate two factors before limited discovery becomes appropriate. First, a claimant must identify a specific conflict of interest or instance of misconduct. Second, a claimant must make a prima facie showing that there is good cause to believe limited discovery will reveal a procedural defect in the plan administrator's determination.

Id. at 815. The Seventh Circuit noted that “this standard essentially precludes discovery without an affidavit or factual allegation” and that “this standard presents a high bar for individuals whose claims have been denied by a plan administrator with discretionary authority.” *Id.* However, the court stated that such a standard is consistent with the underpinnings of the ERISA statutory scheme:

Congress has not provided Article III courts with the statutory authority, nor the judicial resources, to engage in a full review of the motivations behind every plan administrator's discretionary decisions. To engage in such a review would usurp plan administrators' discretionary authority and move toward a costly system in which Article III courts conduct wholesale reevaluations of ERISA claims. Imposing onerous discovery before an ERISA claim can be resolved would undermine one of the primary goals of the ERISA program: providing ‘a method for workers and beneficiaries to resolve disputes over benefits inexpensively and expeditiously.’... While claimants who believe they are the victims of arbitrary and capricious benefits decisions should feel free to seek relief in federal court, trial judges must exercise their discretion and limit discovery to those cases in which it appears likely that the plan administrator committed misconduct or acted with bias.

Id. at 815–16. However, again, discovery on the conflict issue seems to be broader post-*Glenn*, at least in some jurisdictions.⁷⁷

B. De Novo Review

Although the courts have been fairly uniform in limiting the scope of review to the evidence that was before the fiduciary at the time of its decision when applying a deferential standard, two lines of authority have developed over the extent of admissible evidence under the *de novo* standard. The lead case holding that when reviewing a fiduciary's decision under a *de novo* standard a court is limited to the evidence before the fiduciary at the time of his decision is *Perry v. Simplicity Engineering*.⁷⁸ In *Perry*, the court noted that *Firestone* did not require district courts to hear and consider evidence not presented to the plan administrator in connection with a claim. Rather, the court stated that the *de novo* review required by *Firestone* is a *de novo* review of the record before the administrator or fiduciary. The court noted that permitting or even requiring district courts to consider evidence from both parties that was not presented to the administrator would seriously impair the achievement of a primary goal of ERISA to provide an inexpensive and expeditious method for workers and beneficiaries to resolve disputes over benefits. The Sixth Circuit reaffirmed its position with

⁷⁷ See cases cited above.

⁷⁸ 900 F.2d 963 (6th Cir. 1990).

respect to this issue in *Wulf v. Quantum Chemical Corp.*⁷⁹ and *Miller v. Metropolitan Life Insurance Co.*,⁸⁰ stating that a court may consider only the evidence available to the administrator at the time the final decision was made, and that this limitation was applicable to either an arbitrary and capricious or *de novo* standard of review.⁸¹ The Sixth Circuit again reaffirmed its position in *Wilkins v. Baptist Healthcare System, Inc.*⁸²

The opposing line of authority holds that a trial court has discretion to consider new evidence in addition to the administrative record when reviewing a fiduciary's benefit decision. The earliest case in this area was the Eleventh Circuit's decision in *Moon v. American Home Assurance*,⁸³ wherein the court stated the following:

[Any] contention that a court conducting a *de novo* review must examine only such facts as were available to the plan administrator at the time of the benefits denial is contrary to the concept of a *de novo* review.⁸⁴

According to the reasoning in *Moon*, to adopt a rule that would limit admissible evidence to the administrative record would “require us to propose a standard of review that would afford less protection to employees and their beneficiaries than [they enjoyed] before ERISA was enacted [contrary to *Firestone*].”⁸⁵

This second line of cases does not create unlimited authority to admit additional evidence. Several courts have expressly cautioned that additional evidence may be admitted under the *de novo* standard only where the administrative record is not adequate for the trial court to conduct its review. For example, in *Davidson v. Prudential Insurance Co.*,⁸⁶ the Eighth Circuit held that the district court did not abuse its discretion by limiting its review to the administrative record where the additional evidence proffered by the plaintiff to support his claim for disability benefits was known or should have been known to the plaintiff during the administrative review process.⁸⁷ More recently, the Eighth Circuit held in *Brown v. Seitz Foods, Inc.*,⁸⁸ that “additional evidence gathering is... discouraged on *de novo* review to ‘ensure expeditious judicial review of ERISA benefit decisions and to keep district courts from becoming substitute plan administrators.’”⁸⁹ The court then went on to hold that “[a] district court may admit additional evidence in an ERISA benefit-denial case... if the plaintiff shows good cause for the district court to do so.”⁹⁰ Likewise, the Fourth Circuit has held that *de novo* review of a benefits claim should be limited to the administrative record unless exceptional circumstances exist. Examples of exceptional circumstances include: claims that require consideration of conflicts; medical questions regarding the credibility of medical experts; the availability of very limited administrative review procedures with little or no evidentiary record; the necessity of evidence regarding interpretation of the terms of the plan

⁷⁹ 26 F.3d 1368 (6th Cir. 1994).

⁸⁰ 925 F.2d 979 (6th Cir. 1991).

⁸¹ See also *Wulf v. Quantum Chem. Corp.*, 26 F.3d 1368 (6th Cir. 1994) (again reaffirming the Sixth Circuit position).

⁸² 150 F.3d 609 (6th Cir. 1998).

⁸³ 888 F.2d 86 (11th Cir. 1989).

⁸⁴ *Moon* at 89.

⁸⁵ *Id.* at 89.

⁸⁶ 953 F.2d 1093 (8th Cir. 1992).

⁸⁷ See also *Donatelli v. Home Ins. Co.*, 992 F.2d 763 (8th Cir. 1993) (if it is necessary for adequate *de novo* review, the trial court may allow the parties to introduce evidence in addition to that presented to the fiduciary; however, the court should not exercise this discretion absent good cause to do so).

⁸⁸ 140 F.3d 1198 (8th Cir. 1998).

⁸⁹ *Id.* at 1200.

⁹⁰ *Id.*

rather than specific historical facts; instances where the payor and the administrator are the same entity and the court is concerned about impartiality; claims that would have been insurance contract claims prior to ERISA; and circumstances in which there is additional evidence that the claimant could not have presented in the administrative process.⁹¹ Finally, although the Third Circuit, in *Luby v. Teamsters Health, Welfare & Pension Trust Funds*,⁹² expressly sided with the *Moon* line of reasoning and rejected the holding in *Perry*, the court noted that where the administrative record is sufficiently developed, a court exercising *de novo* review may, in its discretion, limit its review to the record before the plan fiduciary at the time of his decision.⁹³

Several policy arguments are important in determining the scope of review concerning a fiduciary's benefit decision. For example, it would make little sense to require a claimant and the plan fiduciary to expend substantial time and effort submitting and reviewing evidence in determining the validity of a claim if the parties may merely "start from scratch" when the matter goes to court. It would also contravene the exhaustion requirement where a court is permitted to reverse a plan's determination based on evidence that the plan never had an opportunity to consider. As noted in *Perry* and *Brown*, such a result would relegate the federal courts to the role of "substitute plan administrators." Where the administrative record is substantial and sufficient to enable the court to conduct an adequate review of the fiduciary's decision, there is no sound policy reason to admit additional evidence in court, and in fact very good reasons why this ought not to be allowed.

For a time, it looked as if the Seventh Circuit might be taking a different approach to the admission of evidence in *de novo* cases. In *Krolnik v. The Prudential Ins. Co. of America*, 570 F.3d 841 (7th Cir. 2009), the plaintiff sought to overturn a decision by Prudential to terminate his long term disability benefits after he received the maximum benefit amount for a mental disability. *Krolnik v. The Prudential Ins. Co. of America*, 2007 U.S. Dist. Lexis 96847 (E.D. Wis. 2007). He launched a wide volley of discovery requests, including requests to depose a variety of doctors and Prudential employees, discovery of Prudential's claims handling procedures, charts, and documents of other disability claimants, and depositions of Prudential's consulting doctors. Noting that Krolnik bore the burden of demonstrating that the benefits of the discovery outweighed the associated costs, and relying on existing Seventh Circuit authority, the district court concluded that Krolnik failed to satisfy this burden. On summary judgment, Krolnik submitted medical affidavits, but the district court declined to consider them and granted summary judgment to Prudential.

The Seventh Circuit criticized both the district court's discovery decision and its decision not to consider the medical affidavits. The Court characterized Krolnik's discovery requests as being limited to "generat[ing] evidence about his medical conditions, and the extent (if any) to which his mental condition affects his ability to work," when even a cursory reading of the district court's discovery order reveals that Krolnik's discovery was far broader. The Seventh Circuit also described the excluded evidence as "[doctor] affidavits describing his condition and prognosis," without any mention of whether the affidavits contained information that duplicated what was already in the record or even whether Krolnik had the opportunity to submit the information during the claim review process. Despite these obvious defects, the Court held that the district judge should have allowed the discovery and admitted the additional evidence.

⁹¹ *Quesinberry v. Life Ins. Co. of N. Am.*, 987 F.2d 1017 (4th Cir. 1993).

⁹² 944 F.2d 1176 (3d Cir. 1991).

⁹³ See also *Walke v. Group Long Term Disability Ins.*, 256 F.3d 835 (8th Cir. 2001) (under *de novo* standard, a court has some discretion to admit evidence outside of the administrative record); *Dishman v. UNUM Life Ins. Co. of Am.*, 250 F.3d 1272 (9th Cir. 2001) (same); *Fitts v. Federal Nat'l Mortgage Ass'n*, 236 F.3d 1 (D.C. Cir. 2001) (same); *Juliano v. Health Maintenance Org. of N.J.*, 221 F.3d 279 (2d Cir. 2000).

The Seventh Circuit panel began its analysis by stating that “*de novo review*” is a misnomer and that courts and lawyers should stop referring to “review” and start referring to such a case as an “independent decision.” The Court also stated that such a proceeding is not unlike a breach of contract action where a judge “won’t ask what evidence the insurer considered,” but instead “will decide for itself where the truth lies.” According to *Krolnik*, in such cases, “the court decides on the record made in the litigation.” [Footnote: 570 F.3d at 843.]

The Court allowed that some ERISA *de novo* cases might still be limited to the administrative record: “Medical evidence presented to the plan or its insurer may be placed in the judicial record, and when this evidence is ample it may in principle constitute the whole record.” *Id.* The Court also stated that “[i]f the administrative record contains comprehensive medical evidence, then duplicative discovery may be limited to avoid ‘undue burden or expense.’” However, the Court also held that “[d]iscovery may be curtailed to the extent that the Rules of Civil Procedure allow” and “we cannot imagine any justification for refusing to admit evidence that one party has procured at its own expense.” *Id.*

Ultimately, the Seventh Circuit remanded the matter for trial. The Court characterized the dispute as whether Krolnik could work even with his physical and mental problems. The Court instructed the district court to make an “independent decision” in which it “must weigh *all* of the medical evidence” and that at trial, Krolnik would be free to offer medical evidence of his own and cross-examine the physicians whose reports supported Prudential’s decision.

A more recent Seventh Circuit decision raises questions about the viability of Krolnik and whether it represents a change in Circuit law. In *Estate of Blanco v. Prudential Ins. Co. of America*,⁹⁴ a claim for disability benefits was denied based on a pre-existing condition exclusion. During review in the district court, the plaintiff submitted his own affidavit and affidavits from two of his treating physicians that were not included in the administrative record. The district court excluded the affidavits, concluding that the administrative record was adequate for it to make an informed and independent judgment.

On appeal, the Seventh Circuit affirmed the evidentiary ruling. Significantly, it relied almost solely on the pre-Krolnik decision in *Patton v. MFS/Sun Life Fin. Distribs., Inc.*,⁹⁵ and did not even mention *Krolnik*. The Court held that the “most important factor” in determining whether to admit new evidence on *de novo* review is “whether the new evidence is necessary to make an informed and independent judgment.” The Court noted that “affidavits, which were created months after the [medical] examinations and with an eye toward litigation, do not add much to the record,” especially where the administrative record already contains the treating physicians’ medical records. The Court held that the exclusion of such evidence “discourages sandbagging and pays tribute to the goal of requiring the exhaustion of administrative remedies.”

The *Blanco* court did suggest that there might be circumstances where new evidence is admissible in a *de novo* proceeding. For example, such evidence might concern important plan terms rather than historical facts about the claimant, or the district court might consider whether the administrator faced a conflict of interest and whether the parties had a chance to present their evidence in the administrative proceeding. The reference to conflict of interest evidence in a *de novo* proceeding was *dictum*, because the Court went on to hold that no such conflict existed because prior Seventh Circuit case law held that reliance on in-house medical personnel to review medical records does not create a conflict of interest.⁹⁶

⁹⁴ 606 F.3d 399 (7th Cir. 2010).

⁹⁵ 480 F.3d 490 (7th Cir. 2007).

⁹⁶ See, e.g., *Davis v. Unum Life Ins. Co. of America*, 444 F.3d 569 (7th Cir. 2006).

VII. Contract Interpretation Principles

Regardless of the applicable standard of review, courts will apply the clear and unambiguous terms of an ERISA plan as written. Courts interpret such terms in their ordinary and popular sense as would a person of average intelligence and experience.⁹⁷

Where the terms of a plan are determined to be ambiguous, a question has arisen as to what rules of interpretation should be applied to determine whether the plan fiduciary's interpretation was reasonable. In *Kunin v. Benefit Trust Life Insurance Co.*,⁹⁸ the Ninth Circuit stated that its opinion (1) assumed that arbitrary and capricious was the proper standard, and (2) ignored the insurer's conflict of interest. Even so, the court held that the rule of *contra proferentum* applies (*i.e.*, ambiguities in insurance contracts are construed against the insurer) *irrespective* of any grant of discretionary authority to interpret policy terms. In fact, the Ninth Circuit went so far as to state affirmatively that *Firestone* dictates that "disputed provisions [be interpreted] *de novo*, not defer[ring] to the administrator's interpretation."⁹⁹

Some thought that the ultimate application of the *Kunin* decision would be affected by the subsequent Ninth Circuit decision (by a different panel) in *Evans v. Safeco Life Insurance Co.*¹⁰⁰ In *Evans*, unlike *Kunin*, the fiduciary had not been granted discretionary authority. The issue was the definition of the term "children" in the policy. The court held that federal law controlled the interpretation of an ERISA plan. The court then stated that under federal common law, "ERISA insurance policies" were to be interpreted "in an ordinary and popular sense" as would a person "of average intelligence and experience." It noted that a court should not artificially create ambiguity where none exists. According to the court, "[i]f a reasonable interpretation favors the insurer and any other interpretation would be strained," there is no reason not to yield to the insurer's interpretation. It appeared that the somewhat more deferential analysis used in *Evans* indicated a retreat from the approach used in *Kunin*.

However, a more recent Ninth Circuit opinion did not continue along the *Evans* line. In *Stewart v. Mutual Benefit Life*,¹⁰¹ the Ninth Circuit reaffirmed its holding in *Kunin* by noting that with respect to ERISA cases, "we follow the rule of *contra proferentum* in insurance contracts."

Although *Stewart* was an unpublished opinion, the Ninth Circuit again reaffirmed its *Kunin* holding, this time in a published format. According to the court:

Although *contra proferentum* is strictly applied in the interpretation of insurance contracts, it is not automatically or universally applied to other contracts [such as a self-funded ERISA plan].¹⁰²

Because the plan in *Eley* was self-funded, the Ninth Circuit expressly refused to find *Kunin* applicable. Thus, instead of determining what level of deference is to be accorded benefit decisions based upon whether a fiduciary has been granted discretionary authority, the Ninth Circuit seems to suggest that it is based upon

⁹⁷ See, e.g., *Pizzuti v. Polaroid Corp.*, 985 F.2d 13 (1st Cir. 1993).

⁹⁸ 910 F.2d 534 (9th Cir. 1990).

⁹⁹ *Id.*

¹⁰⁰ 916 F.2d 1437 (9th Cir. 1990).

¹⁰¹ 1991 U.S. App. Lexis 21125 (9th Cir. 1991) (unpublished).

¹⁰² *Eley v. Boeing Co.*, 945 F.2d 276 (9th Cir. 1991).

the funding of the plan. This seems to fly in the face of the Supreme Court's statement that *Firestone* did "not distinguish between types of plans."¹⁰³

The Eighth Circuit has completely rejected the *Kunin* approach.¹⁰⁴ When faced with the issue of the applicability in ERISA cases of the rule of *contra proferentum*, the Eighth Circuit held that the rule was *not* applicable. The court noted that the rule was preempted since it affected benefit plans, was *not* directed specifically toward the insurance industry, and was violative of the provisions of ERISA. The court then went on to discuss the appropriate rule for ERISA cases where the fiduciary is not granted discretion. Using a commonsense approach, the court noted that ERISA required that plans issue plan summaries to participants that are written in a manner calculated to be understood by the average plan participant. The Eighth Circuit reasoned that "[t]his requirement provides a source from which we may fashion a federal common law rule; the terms should be accorded their ordinary, and not specialized, meanings...."¹⁰⁵ Accordingly, neither party's interpretation of plan terms should be granted deference.¹⁰⁶ The Eighth Circuit reaffirmed its *Brewer* holding in *Prudential Insurance Co. of America v. Doe*.¹⁰⁷

Currently, most circuits apply the *contra proferentum* rule in cases where the *de novo* standard is applicable, particularly where the plan is funded by insurance.¹⁰⁸ At the same time, most courts have rejected application of the rule in cases where a deferential standard is applicable, particularly where the fiduciary is granted express discretion to construe the terms of the plan.¹⁰⁹ Some courts have noted that the *contra proferentum* rule should be applied only as a last resort after all other means of interpreting the ambiguous plan provision have been exhausted.¹¹⁰ Finally, at least one court has held that the *contra proferentum* rule will apply only where the beneficiary can show that he actually relied on the ambiguous plan language to his detriment.¹¹¹

¹⁰³ *Firestone* at 115. See also *Routt v. Lincoln Nat'l Life Ins. Co.*, 1992 U.S. App. Lexis 7928 (9th Cir. 1992) (unpublished) (when the policy at issue is an employer-purchased and employer-funded policy drafted solely by the insurer, the rule of *contra proferentum* applies).

¹⁰⁴ *Brewer v. Lincoln Nat'l Life Ins. Co.*, 921 F.2d 150 (8th Cir. 1990).

¹⁰⁵ *Id.* [emphasis added].

¹⁰⁶ *Maxa v. John Alden Life Ins. Co.*, 972 F.2d 980 (8th Cir. 1992) (the rule of *contra proferentum* violates the provisions of ERISA and cannot be used to interpret the plan's terms); *Doe v. General Am. Life Ins. Co.*, 815 F. Supp. 1281 (E.D. Mo. 1993) (ambiguous terms in a benefit plan are construed against the drafter only if all other attempts to interpret the plan are unsuccessful).

¹⁰⁷ 140 F.3d 785 (8th Cir. 1998).

¹⁰⁸ See, e.g., *Bailey v. Blue Cross & Blue Shield of Va.*, 67 F.3d 53 (4th Cir. 1995); *Babikian v. Paul Revere Life Ins. Co.*, 63 F.3d 837 (9th Cir. 1995); *Pagan v. NYNEX Pension Plan*, 52 F.3d 438 (2d Cir. 1995); *Smith v. Hartford Ins. Group*, 6 F.3d 131 (3d Cir. 1993).

¹⁰⁹ See, e.g., *I.V. Servs. of Am., Inc. v. Trustees of the Am. Consulting Eng'rs Council Ins. Trust Fund*, 136 F.3d 114 (2d Cir. 1998); *Hightshue v. AIG Life Ins. Co.*, 135 F.3d 1144 (7th Cir. 1998); *Morton v. Smith*, 91 F.3d 867 (7th Cir. 1996); *Winters v. Costco Wholesale Corp.*, 49 F.3d 550 (9th Cir. 1995); *O'Neil v. Retirement Plan*, 37 F.3d 55 (2d Cir. 1994).

¹¹⁰ See, e.g., *Hughes v. Boston Mut. Life Ins. Co.*, 26 F.3d 264 (1st Cir. 1994); *Delk v. Durham Life Ins. Co.*, 959 F.2d 104 (8th Cir. 1992).

¹¹¹ *Collins v. American Cast Iron Pipe Co.*, 105 F.3d 1368 (11th Cir. 1997).

VIII. The Rise and Fall of the Treating Physician Rule

The Ninth Circuit follows the minority view in applying the conflict of interest factor in cases involving the deferential review standard. Specifically, the Ninth Circuit holds that where the participant submits probative evidence of a conflict of interest and that the conflict affected the decision, there is a rebuttable presumption that deference should not be granted to the claims administrator's decision. The burden then shifts to the administrator to prove that the conflict did not affect the decision. If the claims administrator fails in this burden, the court grants no deference and reviews the benefit determination *de novo*.

In *Regula v. Delta Family Care Disability Survivorship Plan*,¹¹² the Ninth Circuit held that a claims administrator's decision not to follow the opinion of the treating physician in an ERISA disability case constitutes evidence of an actual conflict of interest, shifting the burden to the claims administrator to prove that the conflict did not affect the decision. While *Regula* was before the Supreme Court on petition for writ of *certiorari*, the Ninth Circuit decided *Nord v. Black & Decker Disability Plan*.¹¹³ The Ninth Circuit reiterated its position that a disability claims administrator's decision not to follow the opinion of a treating physician is evidence of a conflict. The Ninth Circuit also held that the claims administrator failed to show that its decision was not affected by the conflict. Applying a *de novo* review standard, the Ninth Circuit then went on to hold that because the claims administrator failed to present substantial evidence contradicting the treating physician's opinion, Nord was disabled under the benefit plan and entitled to benefits.

The Supreme Court granted *certiorari* and reversed the Ninth Circuit in *Black & Decker Disability Plan v. Nord*.¹¹⁴ The Supreme Court thereafter vacated the Ninth Circuit decision in *Regula*. The Supreme Court held that the rule granting automatic deference to treating physicians is inapplicable to private benefit determinations under ERISA, thus overturning the Ninth Circuit's holding that Black & Decker's denial was incorrect. Although the respondent and some of his *amici* asked the Court to review the lower courts' conflict of interest analysis that had developed since *Firestone*, the Court declined to do so, stating that it would limit its determination to the Ninth Circuit's holding "that an ERISA disability plan administrator's determination of disability is subject to the 'treating physician rule.'" Nevertheless, it is clear that the Supreme Court's decision also prevents courts from "penalizing" claims administrators by reducing the amount of deference under some form of conflict of interest analysis where the claims administrator rejects the treating physician's opinion.

A. Adoption of the Treating Physician Rule: *Regula v. Delta*

1. Background Facts and Administrative History

Frank Regula was a participant in the Delta disability plan. He originally filed a claim for disability benefits in 1985 based on a "cervical disc injury." He was awarded benefits that continued to be paid until 1995. At that time, the Delta plan required Regula to prove that he was prevented from performing any type of work. Regula submitted two medical reports regarding his current condition. A report from a psychologist stated that it was "very probable" that Regula was disabled as a result of "combined physical and emotional symptom complex." A report from Regula's medical doctor stated that Regula was "permanently disabled" due to the "undesirable effects of multiple surgeries."

¹¹² 266 F.3d 1130 (9th Cir. 2001).

¹¹³ 296 F.3d 823 (9th Cir. 2002).

¹¹⁴ 538 U.S. 822 (2003).

The Delta plan set up an independent medical examination with a doctor who specialized in physical and rehabilitative medicine. The IME doctor concluded that Regula was “definitely capable of gainful employment performing some type of work” and noted several specific activities that Regula was able to perform. Thereafter, Delta referred Regula for an independent psychiatric review. The psychiatrist concluded that Regula was “consciously exaggerating his psychological and orthopedic difficulties” and stated that Regula “can return to work immediately.” Delta denied further benefits and affirmed this decision on administrative appeal.

2. Court Procedure and Rulings

Regula filed suit under ERISA. All parties agreed in the district court that the court’s review was governed by a deferential review standard. Under this standard, the district court denied Regula’s motion for summary judgment and ultimately entered judgment in the plan’s favor. Regula appealed.

The Ninth Circuit refused to accept the parties’ stipulation regarding the applicable review standard, holding that it involved a question of law to which the parties could not bind the court. The Ninth Circuit then discussed its application of a conflict of interest analysis in the context of ERISA’s judicial review standards. A court must first determine whether the participant has submitted material, probative evidence that an apparent conflict (*e.g.*, that the decision maker is also the source of benefit funding under the plan) has “caused a breach of the administrator’s fiduciary obligations to the beneficiary.” Such evidence creates a rebuttable presumption that the decision was contrary to the administrator’s fiduciary duties to the participant. At that point, the burden shifts to the administrator to produce evidence that the conflict did not affect the decision to terminate benefits. If the plan fails to meet this burden, the decision is reviewed *de novo*.

The Ninth Circuit cited various factors that could indicate bias on the part of Delta. For example, the plan’s termination of benefits after a long period of paying benefits where there was no evidence of a significant change in Regula’s condition was cited as evidence of a conflict. However, according to the court, the strongest evidence of conflict was the plan’s rejection of Regula’s treating doctors’ opinions in favor of the opinions of two nontreating doctors. Adopting the “treating physician rule” from Social Security disability cases, the Ninth Circuit held that “we add deviation from the treating physician rule to the short list of factors by which a court may determine that an apparent conflict of interest has ripened into an actual, serious conflict, thereby permitting the court to engage in *de novo* review.” At that point, the burden shifted to the plan to show that its decision was not affected by any conflict. The Ninth Circuit remanded the case to the district court to allow Delta to submit evidence in an attempt to rebut its conflict. Delta filed a petition for writ of *certiorari* with the Supreme Court.

B. Further Application of the Treating Physician Rule: Nord v. Black & Decker

1. Background Facts and Administrative History

Kenneth Nord was employed in a sedentary occupation with Black & Decker. Black & Decker maintained an employee disability plan. In 1997, Nord filed for benefits under the plan due to intermittent hip and low back pain. Nord was required to prove that he could not perform his regular job. Nord’s doctor opined that Nord was disabled. Nevertheless, the claims administrator for the plan denied Nord’s claim.

Nord pursued an administrative appeal. As part of its review on appeal, Black & Decker obtained an independent medical evaluation. The IME doctor opined that Nord should be able to perform sedentary work with no material limitations. A representative of the Black & Decker human resources department completed

a form in which she stated that Nord would not be able to perform his job as a result of chronic pain. Black & Decker rejected the opinion of its human resources representative and of Nord's doctor and affirmed its denial.

2. Court Procedure and Rulings

Nord sued the plan for benefits under ERISA. The district court reviewed the decision under a deferential review standard because the plan expressly gave the claims administrator discretionary authority to determine eligibility for plan benefits. The district court granted summary judgment in favor of Black & Decker, holding that the denial was not arbitrary and capricious. Nord appealed.

The Ninth Circuit overturned the district court judgment and ordered summary judgment in favor of Nord. The appellate court applied the same reasoning that it used in *Regula*. The court held that under the treating physician rule, "the plan administrator can reject the conclusions of the treating physicians only if the administrator gives 'specific, legitimate reasons for doing so that are based on substantial evidence in the record.'" Because rejection of the treating physician's opinion was sufficient to allow the apparent conflict of interest to ripen into an actual conflict of interest, the burden shifted to Black & Decker to rebut the conflict. The Ninth Circuit held that Black & Decker failed to do so.

Applying a *de novo* review standard, the Ninth Circuit went on to hold that summary judgment should be entered against Black & Decker. Black & Decker relied solely on the IME opinion. However, the Ninth Circuit ruled that the IME opinion was "overwhelmed by substantial evidence in the record," including the opinions of the treating doctor and the opinion of the human resources representative. Essentially, the treating physician rule resulted in an adverse judgment against the plan, even though strictly speaking, it was applied only in determining whether the claims administrator had a conflict of interest.

C. The Supreme Court Slays the Treating Physician Rule

The Supreme Court granted *certiorari* in *Nord* to review the Ninth Circuit's holding "that an ERISA disability plan administrator's determination of disability is subject to the 'treating physician rule.'" The Court withheld a ruling on a petition for *certiorari* in *Regula*, pending its decision in *Nord*. During briefing and at argument in *Nord*, the respondent and its *amici* encouraged the Court to use *Nord* as a vehicle to clarify application of the conflict of interest element in applying the ERISA judicial review standards. The Supreme Court declined to decide the conflict of interest issue directly, although it certainly decided that the treating physician rule was not an appropriate means of determining the existence of a conflict, as is discussed below.

The Supreme Court characterized the Ninth Circuit decision in *Nord* as holding Nord was entitled to judgment as a matter of law because "the Ninth Circuit emphasized that Black & Decker fell short under the treating physician rule: The plan administrator had not provided adequate justification, the Court of Appeals said, for rejecting opinions held by [the treating doctor] and others treating Nord...." Reversing the Ninth Circuit, the Supreme Court held that there was no justification for requiring blanket deference to the treating doctor under ERISA, citing several reasons:

There is no statutory language requiring a treating physician rule. The ERISA statute requires reasonable procedures for evaluating benefit claims and mandates a "full and fair review" of those decisions. However, "[n]othing in the Act itself... suggests that plan administrators must accord special deference to the opinions of treating physicians. Nor does the Act impose a heightened burden of explanation on administrators when they reject a treating physician's opinion."

The Department of Labor, as the agency with authority to regulate ERISA, had not mandated a treating physician rule. The DOL has issued detailed procedure regulations governing ERISA benefit claims that contain no treating physician rule. In fact, the DOL expressly opposed such a rule under ERISA in its *amicus* brief filed in support of the petitioner in *Nord*.

There is no basis for federal courts to mandate a treating physician rule as a matter of ERISA policy. The Supreme Court held that courts are not in a position to make policy determinations, particularly determinations that are based on assumptions by the Ninth Circuit that a treating physician is never biased in favor of the claimant and that *independent* reviewing doctors are always biased in favor of the plan:

[T]he assumption that the opinions of a treating physician warrant greater credit than the opinions of plan consultants may make scant sense when, for example, the relationship between the claimant and the treating physician has been of short duration, or when a specialist engaged by the plan has expertise the treating physician lacks. And if a consultant engaged by a plan may have an “incentive” to make a finding of “not disabled,” so a treating physician, in a close case, may favor a finding of “disabled.” Intelligent resolution of the question whether routine deference to the opinion of a claimant’s treating physician would yield more accurate disability empirical investigation of the kind courts are ill equipped to conduct.

Finally, “and of prime importance,” the Court cited substantial differences between the Social Security disability system and private disability plans governed by ERISA that counseled against importation of the treating physician rule into ERISA. The Social Security system is an “obligatory, nationwide... program” which the Social Security Administration has determined can be administered only via the application of various evidentiary presumptions, including the treating physician rule. ERISA, on the other hand, neither requires employers to adopt disability plans nor does the statute dictate the terms or benefits of such plans. “Rather, employers have large leeway to design disability and other welfare plans as they see fit.” This leeway granted to employers in designing and administering their private benefit programs prevents importation of the treating physician rule.

The Supreme Court closed by observing that a claims administrator may not arbitrarily reject credible evidence favoring benefit eligibility, including opinions from the treating doctor. However, “courts have no warrant to require administrators automatically to accord special weight to the opinions of a claimant’s physician; nor may courts impose on plan administrators a discrete burden of explanation when they credit reliable evidence that conflicts with a treating physician’s evaluation.” The Court also rejected the respondent’s argument for a distinction in the use of the treating physician requirement between a “procedural rule” and a “substantive rule.” The Court held that “ERISA does not support judicial imposition of a treating physician rule, whether labeled ‘procedural’ or ‘substantive.’” The Court vacated the Ninth Circuit opinion and remanded the case. Subsequently, the Court also vacated the decision in *Regula* and remanded that case as well.

IX. Once Deferential, Always Deferential

“People make mistakes.” *Conkright v. Frommert*, 130 S. Ct. 1640 (2010).

So begins the decision that is, to date, the strongest statement by the United States Supreme Court of the importance of the deferential review standard to the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. §1001, *et seq.* (“ERISA”). In the end, the Court held that even where a claim administrator with discretionary authority interprets a benefit plan in a way that is determined to be arbitrary and capricious, the claim administrator’s second alternative interpretation must also be granted deference. Why? Because deferential review is part and parcel of ERISA’s core, part of the very balancing and compromise

that Congress intended when it enacted ERISA. These are strong words about a review standard that does not even appear in the statute and that is entirely court-created.

A. Background

Prior to the Supreme Court's decision in *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101 (1989), most of the circuit courts applied a deferential review standard when reviewing claims determinations by ERISA plan administrators. In *Firestone*, the Supreme Court relied on trust law principles to institutionalize deferential review by holding that where an ERISA plan grants discretionary authority to determine eligibility for benefits or to interpret the terms of a benefit plan, a court is obligated to defer to the claim administrator's judgment and can overturn that judgment only where the decision is arbitrary and capricious or an abuse of discretion.

Nineteen years after *Firestone*, the Supreme Court again addressed deferential review in *Metropolitan Life Ins. Co. v. Glenn*, 128 S. Ct. 2343 (2008). The issues in that case were: (a) whether a dual-role fiduciary (*i.e.*, one who is both the decision maker and the payor of benefits) has a conflict of interest; and, if so, (b) what impact that conflict has on the application of a deferential review standard to that fiduciary's benefit determination. Among other arguments, the respondent and its amici argued that the presence of a conflict should void any discretionary authority and eliminate deferential review. However, the Supreme Court rejected that argument and held that while a dual-role fiduciary does have a conflict of interest, deferential review must still apply with the conflict being one factor in determining whether the fiduciary's decision was arbitrary and capricious.

B. Factual Background and Procedural History of Konkright

The plaintiffs were former employees of Xerox who left the company in the 1980's and received lump sum distributions from their pension plan. Later, they were rehired and began to accumulate additional credits under the plan. The plan granted discretionary authority to the plan administrator to interpret the terms of the plan. When the plaintiffs retired a second time, Xerox was required to interpret the plan to determine the appropriate offset applicable to the original lump sum distribution in order to avoid double dipping by the plaintiffs. Of course, the plaintiffs disagreed with the plan administrator's interpretation and filed suit, alleging that the interpretation was arbitrary and capricious.

The district court granted summary judgment to the plan. The Second Circuit reversed, holding that the plan administrator's interpretation was unreasonable. The court remanded the matter to the district court.

On remand, the district court considered other approaches to the offset issue. The plan administrator submitted an affidavit proposing an alternative interpretation and argued that its alternative interpretation should also be granted deference. The district court disagreed and adopted an interpretation of the plan other than what was proposed by the administrator. The Second Circuit affirmed, holding that "a court need not apply a deferential standard 'where the administrator ha[s] previously construed the same [plan] terms and we found such a construction to have violated ERISA.'"

C. Supreme Court Decision

The Supreme Court reversed, holding that a "single honest mistake" does not rob an ERISA plan administrator of discretion and that the district court should have deferred to Xerox's alternative interpretation. The Supreme Court rejected what it described as a "one-strike-and-you're-out" rule.

The Court reviewed its prior decisions on deferential review, including *Firestone* and *Glenn*, describing the latter as an “expansion” of *Firestone*. Noting that not even a “systemic conflict of interest” robs an administrator of discretion, the Court held that a previous mistake in interpreting a plan does not prevent continued application of a deferential review standard to additional alternative interpretations.

The Supreme Court first looked to the terms of the Xerox pension plan for guidance. It noted that the plan expressly granted discretion to construe the plan terms and that “[n]othing in that provision suggests that the grant of authority is limited to first efforts to construe the Plan.”

The Court next looked to trust law, but found it not very helpful. The Court noted that under trust law a fiduciary who fails to exercise discretion honestly and fairly can be divested of discretion. However, there was no evidence that Xerox failed to exercise its discretion in good faith and there was no indication in trust law that “one good-faith mistake” would be sufficient to remove discretion.

Finally, the Court looked to the underlying principles of ERISA which it found to support continued application of deferential review. Citing previous decisions, the Court held that ERISA was the product of a careful balancing between ensuring a fair and prompt claim settlement process and encouraging the creation of ERISA plans. Deferential review protects these interests:

- Deference encourages efficient resolution of claim disputes through an administrative process rather than costly litigation.
- Deference encourages predictability because an employer can rely on the expertise of the claim administrator rather than unpredictable decisions under de novo review by the courts.
- Deference promotes uniformity because it allows claim administrators to apply interpretations of plan terms rather than relying on varied interpretations by different courts.

The Supreme Court rejected the position of the plaintiffs and the Department of Labor that deference should not apply to subsequent interpretations by an administrator whose initial interpretation was determined to be unreasonable:

[T]he interests in efficiency, predictability, and uniformity—and the manner in which they are promoted by deference to reasonable plan construction by administrators—do not suddenly disappear simply because a plan administrator has made a single honest mistake.

The Court also rejected the DOL’s argument that the application of deference to subsequent interpretations of the plan should turn on whether the administrator is interpreting the “same terms.” The Court noted that such a requirement would only require more litigation, further destroying the careful balance struck by Congress when it enacted ERISA. Finally, the Court rejected the DOL’s argument that continued application of deference would only encourage administrators to adopt unreasonable interpretations knowing that they can always fall back on an alternative interpretation if their first interpretation is deemed to be arbitrary. The Court found this argument to be “overblown,” saying that in an extreme situation, trust law supports stripping a trustee of deference if the trustee does not exercise its discretion “honestly and fairly.”

D. Conclusion

Deferential review was originally applied by the lower courts as a carryover from pre-ERISA pension law, which in turn was based on trust law concepts. The Supreme Court relied on trust law to uphold the application of deferential review in *Firestone*. The Supreme Court again applied trust law concepts in *Glenn* to hold that deferential review applies even where the decision maker has a patent conflict of interest. Stepping away

from trust law principles in *Conkright*, for the first time, the Supreme Court held that the core principles of ERISA support deferential review. This is a significant point because it places deferential review squarely in the lap of Congress and its intent in enacting ERISA. Deferential review is no longer merely a court-made concept with antecedents outside of ERISA, but is instead a basic premise of the statute.

One question that is raised by the decision is what trust law principles are still applicable to deferential review. The Court acknowledged that under trust law, discretion may be removed in extreme situations where a trustee does not exercise its discretion fairly and honestly. Does this open up ERISA cases to bad faith discovery? Will plaintiffs be allowed to argue that deference should not be applied in a given case because the fiduciary has failed to exercise its discretion “fairly and honestly” in other cases? More than likely, the Court saw this as a highly unusual situation and not one that would automatically lead to fishing expeditions searching for “bad faith.”

Another question is whether *Conkright* applies when a fiduciary uses its discretion to make factual determinations rather than to interpret ambiguous plan terms. More ERISA benefits cases turn on fact determinations rather than plan interpretation issues. It would seem that a “single honest mistake” in determining disputed facts ought not to rob a fiduciary of plan-granted discretion.

A final observation is the Court’s rejection of the position taken by the DOL. Historically, the DOL has held strong sway with the Court insofar as ERISA issues are concerned. The Court’s rejection of the DOL’s position could be a sign of the future or at least a sign that under the current administration, the DOL may not have as much influence on the Court’s ERISA jurisprudence as it has in the past.

X. Prohibition of Discretion

Starting in early 2004 in California and continuing in several states, various state insurance commissioners, as well as the National Association of Insurance Commissioners have made efforts to limit or even prohibit discretionary clauses in insurance policies that fund ERISA plans. These actions have been challenged in court, but to date, courts have generally rejected arguments that such prohibitions are preempted by ERISA.¹¹⁵ Specifically, these courts have held that such prohibitions constitute state laws that regulate insurance and that they are saved from preemption under ERISA. These courts have also held that such prohibitions do not conflict with ERISA’s civil enforcement provisions.¹¹⁶ One court held that a state regulatory limitation on the form of discretionary clauses did *not* constitute a state law that regulates insurance and *was* preempted by ERISA, but stated in dicta that if such a regulation was a blanket prohibition of discretion, then it would be saved from preemption.¹¹⁷

¹¹⁵ *Standard Insurance Company v. Morrison*, 584 F.3d 837 (2009); *American Council of Life Insurers v. Ross*, 558 F.3d 600 (6th Cir. 2009).

¹¹⁶ *Id.*

¹¹⁷ *Hancock v. Metropolitan Life Insurance Company*, 590 F.3d 1141 (10th Cir. 2009).

Fiduciaries and Nonfiduciaries

I. Fiduciary Status

The touchstone under ERISA for determining if one is a fiduciary is whether one has any discretionary authority or control regarding administration or management of a plan or authority or control over disposition of its assets. ERISA defines a *fiduciary* as follows:

[A] person is a fiduciary with respect to a plan to the extent (i) he exercises any *discretionary authority* or *discretionary control* respecting *management* of such plan or exercises any authority or control respecting management or disposition of its *assets*, (ii) he renders investment advice for a fee or other compensation direct or indirect, with respect to any moneys or other property of such plan, or has any authority or *discretionary responsibility* in the *administration* of such plan.¹

However, according to the DOL, there is a wide range of activities an entity may engage in without being considered a fiduciary. Specifically, the DOL has promulgated the following regulation:

D-2 Q: Are persons who have no power to make any decisions as to plan policy, interpretations, practices or procedures, but who perform the following administrative functions for an employee benefit plan, within a framework of policies, interpretations, rules, practices and procedures made by other persons, fiduciaries with respect to the plan:

- (1) Application of rules 11 determining eligibility for participation or benefits;
- (2) Calculation of service and compensation credits for benefits;
- (3) Preparation of employee communications material;
- (4) Maintenance of participants' service and employment records;
- (5) Preparation of reports required by government agencies;
- (6) Calculation of benefits;
- (7) Orientation of new participants and advising participants of their rights and options under the plan;
- (8) Collection of contributions and application of contributions as provided in the plan;
- (9) Preparation of reports concerning participants' benefits;
- (10) Processing of claims; and
- (11) Making recommendations to others for decisions with respect to plan administration?

A: No. Only persons who perform one or more of the functions described in section 3(21)(A) of the Act with respect to an employee benefit plan are fiduciaries. Therefore, a person who performs purely ministerial functions such as the types described above for an employee benefit plan within a framework of policies, interpretations, rules, practices and procedures made by other persons is not a fiduciary because such person does not have discretionary authority or discretionary control respecting management of the plan, does not exercise any authority or control respecting management or disposition of the assets of the plan,

¹ 29 U.S.C. §1002(21)(A).

and does not render investment advice with respect to any money or other property of the plan and has no authority or responsibility to do so....²

Courts have stressed that the definition of fiduciary is to be broadly construed and includes anyone with discretionary authority over the plan.³ In determining who is a fiduciary, courts focus on a person's responsibility, authority and discretion rather than on the person's title:

To decide whether [a party's] actions fall within the statutory definition of 'fiduciary' acts, we must interpret the statutory terms which limit the scope of fiduciary activity to discretionary acts of plan 'management' and 'administration'.⁴

The Supreme Court has held that a person is a fiduciary under ERISA only when fulfilling certain defined functions such as discretionary control over plan management or administration.⁵ Thus, one is a fiduciary *only when, and to the extent*, that he has discretion.⁶ The Supreme Court has held that in making decisions with regard to plan design, employers do not act in a fiduciary capacity and thus are not subject to ERISA's fiduciary standards.⁷ However, when the employer participates in the administration of a plan, fiduciary status attaches.⁸

In *Varity Corporation*, the Supreme Court addressed the issue of whether an employer who allegedly misrepresented the future status of its subsidiary's employee benefit plan was acting as an employer or as an ERISA fiduciary. The Court cited three factors that convinced it that the employer representatives were administering the plan and therefore acting in a fiduciary capacity when they made the misrepresentations to the participants:

- the transmission of plan information in order to help participants decide whether to remain with the plan was a plan-related activity;
- the persons who made the misrepresentations had authority to communicate with plan participants as plan fiduciaries; and
- the factual context in which the misrepresentations were made was such that reasonable participants could have thought that the employer was communicating with them in both its capacity as an employer and as the plan administrator.⁹

In holding that Varity Corporation's representations were subject to scrutiny under ERISA's fiduciary standards, the Court rejected three defenses raised by the employer. The Court held that:

² 29 C.F.R. 2509.75-8, D-2, Q&A.

³ Brock v. Hendershott, 840 F.2d 339 (6th Cir. 1988); Donovan v. Mercer, 747 F.2d 304 (5th Cir. 1984).

⁴ Varity Corporation v. Howe, 516 U.S. 489 (1996). *See also* Blatt v. Marshall & Lassman, 812 F.2d 810 (2d Cir. 1987) (a person is a fiduciary where the person has authority and responsibility with respect to the matter in question, regardless of their formal title).

⁵ Lockheed Corporation v. Spink, 517 U.S. 882 (1996).

⁶ Varity Corporation v. Howe, *supra*; Payonk v. HMW Industries, Inc., 883 F.2d 221 (3d Cir. 1989); Barnes v. A.S. Lacy, 927 F.2d 539 (11th Cir. 1991).

⁷ Lockheed Corporation v. Spink, 135 L. Ed. 2d 153 (1996); Varity Corporation v. Howe, *supra*; Curtiss-Wright Corporation v. Schoonejongen, 131 L. Ed. 2d 94 (1995).

⁸ *See, e.g.*, Varity Corporation v. Howe, *supra*; Nazay v. Miller, 1991 U.S. App. Lexis 28566 (3d Cir. 1991).

⁹ 134 L. Ed. 2d at 143.

- plan administration is not limited to duties that are mandated by the plan but also includes discretionary duties;
- general statements about a company's future potential are not protected from scrutiny under ERISA where they are intentionally false and linked to plan benefits; and
- communications about the future of an employee benefit plan do not constitute decisions by an employer to amend the plan, which decisions are not subject to ERISA's fiduciary standards.¹⁰

A third-party claim administrator of a self-funded benefit plan is a fiduciary where the claim administrator manages and administers the plan.¹¹ The extent of the fiduciary status depends on the latitude the claims administrator has in determining claims.¹² For example, the performance of purely ministerial functions, including the filing of reports required by government agencies, may not be sufficient to qualify a person as a fiduciary under the statute.¹³

In summary, a fiduciary is anyone with discretionary authority or control regarding plan management, plan administration, or plan assets. However, one is a fiduciary only when and to the extent that he has discretion. In making this determination, it is clear that courts apply a functional test looking not just at formal titles and duties set forth in documents, but also at the day-to-day realities of how the plan operates.

II. Fiduciary Duties and Responsibilities

ERISA, §404(a)(1) imposes four specific statutory duties upon fiduciaries, stating that a fiduciary must act solely in the interests of participants and beneficiaries and:

- a. for the exclusive purpose of:
 - (i) providing benefits to participants and beneficiaries
 - (ii) defraying reasonable expenses of administering the plan;
- b. with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims;
- c. by diversifying the investments of a plan so as to minimize risks of large losses; *and*
- d. acting in accordance with plan documents.¹⁴

III. Prohibited Transactions

In addition to setting forth the affirmative duties in §404, ERISA further provides that fiduciaries may not engage in certain prohibited transactions. ERISA prohibits certain transactions between a plan and a party in interest as follows:

- (a) Except as provided in section 408:

¹⁰ *Id.* at 144.

¹¹ *Reilly v. Blue Cross & Blue Shield United of Wisconsin*, 846 F.2d 416 (7th Cir. 1988).

¹² *Gelardi v. Pertec Computer Corporation*, 761 F.2d 1323 (9th Cir. 1985).

¹³ *Anoka Orthopedic Associates v. Lechner*, 910 F.2d 514 (8th Cir. 1990).

¹⁴ ERISA §404(a)(1)(A)–(D).

- (1) A fiduciary with respect to a plan shall not cause the plan to engage in a transaction, if he knows or should know that such transaction constitutes a direct or indirect—
 - (A) sale or exchange or leasing of any property between the plan and a party in interest;
 - (B) lending of money or other extension of credit between the plan and a party in interest;
 - (C) furnishing of goods, services, or facilities between the plan and a party in interest;
 - (D) transfer to, or use by or for the benefit of, a party in interest, of any assets of the plan; or
 - (E) acquisition, on behalf of the plan, of any employer security or employer real property in violation of section 407(a) of this title.
- (2) No fiduciary who has authority or discretion to control or manage the assets of a plan shall permit the plan to hold any employer security or employer real property if he knows or should know that holding such security or real property violates section 407(a).¹⁵

ERISA also prohibits certain transactions between a plan and a fiduciary. A fiduciary is not permitted to:

- (1) deal with the assets of the plan in his own interest or for his own account;
- (2) in his individual or in any other capacity act in any transaction involving the plan on behalf of a party (or represent a party) whose interests are adverse to the interests of the plan or the interests of its participants or beneficiaries; or
- (3) receive any consideration for his own personal account from any party dealing with such plan in connection with a transaction involving the assets of the plan.¹⁶

Finally, ERISA forbids a transfer of real or personal property by a party in interest to a plan “if it is subject to a mortgage or similar lien which a party-in-interest placed on the property within the 10-year period ending on the date of the transfer.”¹⁷

There are some limitations to the application of ERISA’s prohibited transaction provision. In determining when a particular transaction constitutes a “prohibited transaction” under §406(a), the Supreme Court has held that “to sustain an alleged transgression of §406(a), a plaintiff must show that a fiduciary caused the plan to engage in the allegedly unlawful transaction.”¹⁸ Transactions that are not “caused by fiduciaries” are not impermissible under ERISA, §406(a).¹⁹ In addition, certain actions, even if “caused” by fiduciaries, are not considered “transactions” forbidden by §406(a) if they do not constitute “uses of plan assets that are potentially harmful to the plan.”²⁰ Accordingly, the Supreme Court has held that a plan administrator’s payment of early retirement benefits in exchange for a release of potential ERISA and other discrimination claims is wholly outside the scope of §406(a).

Certain transactions are also expressly exempt from ERISA, §406. The most common exemptions permit (1) contracts with parties in interest for necessary services reasonably compensated;²¹ and (2) fiduciaries to

¹⁵ ERISA, §406(a).

¹⁶ ERISA, §406(b).

¹⁷ ERISA, §406(c).

¹⁸ *Lockheed Corporation v. Spink*, 517 U.S. at 888.

¹⁹ *Id.* at n.3.

²⁰ *Id.* at 165.

²¹ ERISA, §408(b)(2).

receive reasonable compensation for services rendered or for the reimbursement of expenses properly and actually incurred in the performance of their duties with respect to the plan.²²

IV. Fiduciary Liability/Damages

There are several ways for a fiduciary to incur liability under ERISA. A fiduciary may have liability pursuant to (1) ERISA, §409 (enforced through §502(a)(2)); (2) §502(a)(3); or (3) as a co-fiduciary under ERISA, §405.

A fiduciary's failure to meet the specific requirements of ERISA is not merely evidence of imprudent action, but may, in and of itself, be a basis for liability under ERISA. ERISA, §409 provides as follows:

- (a) Any person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by this subchapter shall be personally liable to make good to such plan any losses to the plan resulting from each such breach, and to restore to such plan any profits of such fiduciary which have been made through use of assets of the plan by the fiduciary, and shall be subject to such other equitable or remedial relief as the court may deem appropriate; including removal of such fiduciary...
- (b) No fiduciary shall be liable with respect to a breach of fiduciary duty under this subchapter if such breach was committed before he became a fiduciary or after he ceased to be a fiduciary.

ERISA, §409 is enforced through ERISA's civil enforcement section, §502(a)(2). This section authorizes the Secretary of Labor and any participant, beneficiary or other fiduciary to seek "appropriate relief" under ERISA, §409. An action under this section may only be brought against a plan fiduciary.²³

In *Massachusetts Mutual Life Insurance Co. v. Russell*, the Supreme Court held that an action under ERISA, §409 and §502(a)(2) may only be brought on behalf of the plan itself.²⁴ There is no private cause of action by a participant for compensatory or punitive damages under these sections.²⁵ However, more recently in *LaRue v. DeWolff, Boberg & Associates, Inc.*,²⁶ the Supreme Court expanded on its holding in *Russell* and held that a participant in an individual account pension plan (e.g., an IRC 401(k) plan) could bring an action for losses to his account allegedly resulting from the plan fiduciary's failure to carry out his investment instructions. The Supreme Court deemed such an action as being on behalf of the pension plan and therefore cognizable under §§409 and 502(a)(2) even though any damages would inure solely to the benefit of the participant's own account and not to the plan generally.

The measure of loss is the restoration of the plan to the position it would have achieved but for the breach.²⁷ It has been held that where a fiduciary's acts are not dishonest, but merely imprudent, and the acts have not resulted in a financial loss to the plan nor a financial gain to the fiduciary, injunctive relief rather than monetary relief may be appropriate.²⁸ Under the recent Supreme Court holding in *LaRue v. DeWolff, supra*, a fiduciary may be personally liable for investment losses (or possibly, for missed opportunity costs)

²² ERISA, §408(a)(2).

²³ *Geller v. County Line Auto Sales, Inc.*, 86 F.3d 18 (2d Cir. 1996).

²⁴ 473 U.S. 134 (1985).

²⁵ *Id.*

²⁶ 552 U.S.248 (2008).

²⁷ *Donovan v. Bierwirth*, 754 F.2d 1049 (2d Cir. 1985).

²⁸ *Brock v. Robbins*, 830 F.2d 640 (7th Cir. 1987).

to an individual participant's own account when those losses occur in the context of an individual account pension plan.

The Supreme Court resolved a split in the federal courts as to whether there is a private cause of action against a fiduciary under ERISA, §502(a)(3) for one or more breaches of ERISA's fiduciary duties in *Varity Corporation v. Howe*. The Supreme Court held that §502(a)(3) provides a private cause of action for appropriate equitable relief to remedy fiduciary breaches.²⁹ The Court cautioned, however, that §502(a)(3) only operates where other portions of ERISA's civil enforcement scheme do not provide a remedy for such breaches. For example, the Supreme Court held that where the dispute involves issues as to benefit plan interpretation and the payment of benefits, an action for appropriate equitable relief under §502(a)(3) would not be available because ERISA elsewhere provides a remedy to recover plan benefits under §502(a)(1)(B).³⁰

The holding in *Varity Corp.* became the basis for a recent *en banc* decision by the Sixth Circuit in *Rochow v. Life Ins. Co. of N. America*.³¹ In that case, the plaintiff sought judicial review of the defendant's decision to deny his claim for long term disability benefits under ERISA. After obtaining a judgment that the denial was arbitrary and capricious, which was affirmed on appeal, the trial court awarded nearly \$1 million in past due benefits pursuant to §502(a)(1)(B) and then allowed the plaintiff to pursue additional equitable remedies of equitable accounting and disgorgement of profits under §502(a)(3). After extensive discovery and a bench trial, the trial court awarded over \$3 million in disgorged profits to the plaintiff.

On appeal, a split panel of the Sixth Circuit affirmed the trial court, but the panel decision was vacated and on March 5, 2015, the Sixth Circuit sitting *en banc* voted to overturn the disgorgement decision. The court held that, under *Varity Corp.*, a plaintiff is not permitted to bring parallel actions for benefits under §502(a)(1)(B) and equitable relief under §502(a)(3) unless the plaintiff demonstrates that under the circumstances of the case (a) relief under §502(a)(1)(B) is inadequate, or (b) the plaintiff has sustained a separate injury remediable under §502(a)(3). The court also held that plaintiff's allegations of defendant's delay in deciding his claim for benefits, which formed the basis for his disgorgement claim, were part of his claim for denied benefits under §502(a)(B) and did not constitute a separate injury justifying additional relief under §502(a)(3) nor did it demonstrate that the relief afforded by §502(a)(1)(B) was inadequate. The court remanded the matter to the district court for consideration of an award of prejudgment interest, which the court held is part of the remedy for denied benefits under §502(a)(1)(B).

Under certain circumstances, fiduciaries may be liable for the breaches by their co-fiduciaries, particularly where the fiduciary participated in, enabled, or knew of the co-fiduciary's breach. See ERISA, §405. According to ERISA, §405, a fiduciary will be liable if he has knowledge of a breach by another fiduciary, unless he makes reasonable efforts under the circumstances to remedy the breach.³² It should be noted that liability for breach by a co-fiduciary is not limited to only those areas in which one has fiduciary duties. It has been held that while ERISA does not make a fiduciary an insurer against a co-fiduciary's conduct, it does require the fiduciary to use reasonable care in entering into an agreement allocating specific responsibilities

²⁹ For discussion regarding the types of remedies available under §502(a)(3), see Chapter 8.

³⁰ *Forsyth v. Humana, Inc.*, 99 F.3d 1504 (9th Cir. 1996) (no remedy available for breach of fiduciary duty under §502(a)(3) where plaintiffs had a cause of action under other sections of ERISA); *Wald v. Southwestern Bell Corporation Customcare Medical Plan*, 83 F.3d 1002 (8th Cir. 1996) (same).

³¹ 2015 WL 925794 (6th Cir. March 5, 2015)

³² *Id.*

among fiduciaries.³³ If co-fiduciaries choose to specifically provide for procedures allocating various fiduciary responsibilities, then they will only be liable to the extent that (a) they have violated ERISA, §404(a)(1), or (b) they have knowledge of the other's breach.³⁴

Often when fiduciaries are sued for breach of fiduciary duties, co-fiduciaries will look to one another, under federal common law, and seek contribution and indemnity for liability incurred as a result of the co-fiduciary's breaches. Federal courts are split as to the validity of this cause of action.³⁵

Other times, fiduciaries will attempt to limit their liability by written agreement, providing that certain parties must indemnify them if they are sued for certain acts. In determining both the validity and extent of possible liability posed by this type of arrangement, the first issue one must face is a choice of law question. In other words, will this written agreement constitute a plan document such that ERISA will govern, or will state law prevail? Under ERISA, §410, any agreement that purports to relieve a fiduciary from responsibility is void as against public policy.

V. Non-Fiduciary Liabilities

A. Benefit Claims

Several courts have held non-fiduciaries liable under state common law theories for their improper processing of claims under an employee welfare benefit plan. These theories directly impact insurance companies and others who administer claims pursuant to administrative service contracts. Under an administrative service contract, an insurance carrier or some other entity may agree to handle benefit claim processing for an employer who maintains a self-funded benefit plan. Thus, the carrier pays claims within guidelines usually set forth by the employer. Therefore, the claims administrator (*i.e.*, carrier) may have little, if any, discretion in paying claims, and the claims are paid by the employer with the employer's money.

The potential ramifications of these opinions allowing state common law claims against non-fiduciaries are enormous, because if ERISA does not preempt such claims, parties who are deemed to be non-fiduciaries under ERISA may find themselves facing "bad faith" punitive damage claims in state court for improper processing of an ERISA benefit claim. Thus, where insurers act as claims administrators under an administrative services contract, if they are deemed to be non-fiduciaries, then they may be sued in state court under state common law theories, and their cases will be tried before a jury.

What many courts have failed to recognize is that even under an administrative service arrangement, where an insurer's sole function is that of a claims administrator, the insurer may nonetheless still be a fidu-

³³ *Free v. Briody*, 732 F.2d 1331 (7th Cir. 1984); ERISA, §405(b).

³⁴ *Id.*

³⁵ *Compare* *Free v. Briody*, *supra* (general principles of trust law provide for indemnification under appropriate circumstances) *with* *Call v. Sumitomo Bank of California*, 881 F.2d 626 (9th Cir. 1989) (ERISA does not authorize an action for contribution among co-fiduciaries).

ciary under ERISA.³⁶ If the insurer is a fiduciary, then obviously ERISA would still apply and preempt any and all state law claims.³⁷

B. Aiding and Abetting Fiduciary Breaches

In the United States Supreme Court decision in *Mertens v. Hewitt Associates*,³⁸ the Court was faced with the issue of whether a nonfiduciary who knowingly participates in the breach of a fiduciary duty imposed by ERISA is liable for monetary losses that an employee benefit plan suffers as a result of the breach. Although the Court sidestepped the issue of nonfiduciary liability somewhat, deciding that a nonfiduciary could not be held liable for *monetary* damages under ERISA's equitable relief section, §502(a)(3), the Court expressed doubt as to whether a nonfiduciary could be held liable for participating with a fiduciary in breaches of the duties imposed by ERISA because there is no express authorization for such relief under ERISA:

[W]hile ERISA contains various provisions that can be read as imposing obligations upon nonfiduciaries, including actuaries, no provision explicitly requires them to avoid participation (knowing or unknowing) in a fiduciary's breach of fiduciary duty.³⁹

The Court noted that such an omission was the result of choices and compromises made by Congress when it enacted ERISA:

ERISA... defines "fiduciary" not in terms of formal trusteeship, but in *functional* terms of control and authority over the plan... Professional service providers such as actuaries become liable for damages when they cross the line from advisor to fiduciary; must disgorge assets and profits obtained through participation as parties-in-interest in transactions prohibited by [ERISA] and pay related civil penalties... may be enjoined from participating in a fiduciary's breaches, compelled to make restitution, and subjected to other equitable decrees. All that ERISA has eliminated, on these assumptions, is the common law's joint and several liability, for all direct and consequential damages suffered by the plan, on the part of persons who had no real power to control what the plan did.⁴⁰

³⁶ Compare *Flacche v. Sun Life Assurance Company of Canada*, 958 F.2d 730 (6th Cir. 1992) (the mere payment of claims is insufficient to give defendant discretionary control over the management of plan assets or the administration of the plan) with *Libbey-Ovens-Ford Company v. Blue Cross and Blue Shield Mutual of Ohio*, 982 F.2d 1031 (6th Cir. 1993) (our main concern in order to determine the response of fiduciary duty is whether the insurance company has discretionary authority; the result is the same whether the insurance company is the carrier administering claims under an insurance policy or whether the insurance company is administering claims for a fee under a self insured plan); *Kerns v. Benefit Trust Life Ins. Co.*, 992 F.2d 214 (8th Cir. 1993) (where insurance company did nothing more than perform its normal contractual claims handling function under a group policy that was part of an ERISA plan, we conclude that an insurer that performs this limited function is not a fiduciary with respect to a plan); *Kyle Railways, Inc. v. Pacific Administration Services, Inc.*, 990 F.2d 513 (9th Cir. 1993) (where administrative services agreement prescribes only ministerial functions for defendant and expressly requires defendant to refer all discretionary questions regarding payment of claims to the employer for final decision, the defendant is not a fiduciary).

³⁷ *Reilly v. Blue Cross*, *supra*.

³⁸ 508 U.S. 248 (1993).

³⁹ *Id.* at 255.

⁴⁰ *Id.* at 262.

The Supreme Court revisited the issue of nonfiduciary liability under ERISA in *Harris Trust and Sav. Bank v. Salomon Smith Barney*.⁴¹ Harris Trust, a fiduciary, sued Salomon, a nonfiduciary party in interest, under ERISA, §502(a)(3), alleging violations of ERISA's prohibited transaction requirements and seeking rescission of the transaction at issue and restitution, as well as other equitable remedies. Salomon moved to dismiss the action, which motion was denied. On appeal, the Seventh Circuit reversed, holding that a nonfiduciary cannot be held liable under §502(a)(3) for participating in a prohibited transaction because ERISA's prohibited transaction provisions only impose duties on fiduciaries, not nonfiduciaries.

The Supreme Court reversed. The Supreme Court agreed that ERISA's prohibited transaction provisions do not impose substantive duties on nonfiduciaries acting in concert with fiduciaries. However, the Court held that §502(a)(3) also creates certain substantive duties and that liability under that provision does not depend on whether ERISA's prohibited transaction provisions also create such duties:

[The language of §502(a)(3)], to be sure, 'does not... authorize 'appropriate equitable relief' at large, but only 'appropriate equitable relief' for the purpose of 'redress[ing any] violations or... enforcing any provisions' of ERISA or an ERISA plan... But §502(a)(3) admits of no limit... on the universe of possible defendants. Indeed, §502(a)(3) makes no mention at all of which parties may be proper defendants—the focus, instead, is on redressing the 'act or practice which violates any provision of ERISA'....

The Supreme Court went on to hold that the type of remedy sought by Harris Trust was appropriate under ERISA:

The common law of trusts, which offers a 'starting point for analysis [of ERISA]... [unless] it is inconsistent with the language of the statute, its structure, or its purposes... plainly countenances the sort of relief sought by petitioners against Salomon here. As petitioners and *amicus curiae* United States observe, it has long been settled that when a trustee in breach of his fiduciary duty to the beneficiaries transfers trust property to a third person, the third person takes the property subject to the trust, unless he has purchased the property for value and without notice of the fiduciary's breach of duty. The trustee or beneficiaries may then maintain an action for restitution of the property (if not already disposed of) or disgorgement of proceeds (if already disposed of), and disgorgement of the third person's profits derived therefrom...

Importantly, that a transferee was not 'the original wrongdoer' does not insulate him from liability for restitution... Only a transferee of ill-gotten trust assets may be held liable, and then only when the transferee (assuming he has purchased for value) knew or should have known of the existence of the trust and the circumstances that rendered the transfer in breach of trust. Translated to the instant context, the transferee must be demonstrated to have had actual or constructive knowledge of the circumstances that rendered the transaction unlawful. Those circumstances, in turn, involve a showing that the *plan fiduciary*, with actual or constructive knowledge of the facts satisfying the elements of a §406(a) transaction, caused the plan to engage in the transaction.

In response to Salomon's argument that potential liability of nonfiduciaries would require nonfiduciaries to monitor the plan for ERISA violations, the Court held that in considering whether or not to impose liability, "it may be that such concerns should inform the courts' determinations of what a transferee should (or should not) be expected to know when engaging in a transaction with a fiduciary."

⁴¹ 530 U.S. 238 (2000).

VI. Fiduciary Liability Case Examples: Retirement Savings Plan Stock Disputes

Stock Drop cases are actions against eligible individual account plans (EIAPs) (including employee stock ownership plans (ESOPs)) alleging that plan fiduciaries breached their ERISA duty of prudence by failing to remove employer stock as an investment option from such plans. These allegations arise in the face of declines in the value of employer stock and usually involve allegations of employer misconduct that leads to a decline in stock value. Although there are several types of claims in Stock Drop cases, at their heart is the allegation that a prudent fiduciary would have known or should have known of the decline in stock price and would have removed the stock from the plan. In reviewing such claims, several circuits adopted what was known as the *Moench* Presumption, after a Third Circuit decision by that name, which held that a fiduciary's decision not to remove employer stock from EIAPs and ESOPs was presumed to be prudent absent rebuttal of the presumption.

In *Fifth Third Bancorp v. Dudenhoeffer*,⁴² the United States Supreme Court rejected application of the *Moench* presumption in ERISA cases. The Court held that employee stock ownership plan fiduciaries are subject to the same duty of prudence that applies to all ERISA fiduciaries and are not entitled to any special presumption of prudence. The Court held that, to state a breach of the duty of prudence, a complaint must plead an alternative legal action that the fiduciary could have taken and that a prudent fiduciary in similar circumstances would not have viewed as more likely to harm the fund than to help it. The Court made several suggestions that should inform a lower court's analysis of this issue: (a) a fiduciary is not required to break the law, so a fiduciary cannot be imprudent by failing to buy or sell stock in violation of insider trading laws; (b) a court should consider the impact of various corporate disclosure and securities laws on the fiduciary's decision; and (c) the court should consider whether stopping trade on a company stock might do more harm to the fund than continuing to allow trades. The Court also held that where a stock is publicly traded, allegations that a fiduciary should have recognized that stock was overvalued or undervalued based on public information would generally be implausible.

Another type of retirement plan stock dispute is a suit over allegedly excessive fees paid by plan participants for various investment options in their 401(k) savings plans. There are several variations on this theme and the law continues to evolve as this is being written, but one type of claim, especially against larger 401(k) plans, is that the plan fiduciaries failed to include less expensive mutual fund offerings where such offerings were available and the plan was large enough to demand the less expensive offerings. This was the heart of the dispute in *Tibble v. Edison International*, 191 S. Ct. 795 (2015). The plaintiffs in that case were plan participants who alleged that Edison could have and should have offered institutional share classes rather than retail classes of various mutual funds in the Edison 401(k) plan. Edison argued that the lawsuit was too late because the suit was not filed until more than six years after the decision was made to include the retail share classes in the plan and after ERISA's fiduciary breach limitations period had expired. The plaintiffs argued that the duty to monitor fund offerings is an ongoing duty. The Supreme Court agreed and held that a plan fiduciary has a continuing duty to monitor investments and to remove imprudent investments separate and apart from the duty of prudence in selecting investment options at the outset.

⁴² 134 S. Ct. 2459 (2014).

Reporting and Disclosure

I. The Summary Plan Description (“SPD”)

ERISA requires the “plan administrator” to furnish each participant and beneficiary receiving benefits under an ERISA plan with a current summary plan description (“SPD”). A summary plan description is a written summary of the provisions of an employee benefit plan. The information contained in the SPD is strictly regulated by ERISA.

By statute, the party responsible for providing a summary plan description is the “plan administrator”:

Publication of the summary plan descriptions... shall be made to participants and beneficiaries of the particular plan as follows:

- (1) The *administrator* shall furnish to each participant, and each beneficiary receiving benefits under the plan, a copy of the summary, plan description....¹

The term “administrator” means:

- (i) the person specifically designated by the terms of the instrument under which the plan is operated;
- (ii) if an administrator is not so designated, the *plan sponsor*....²

A “plan sponsor” under ERISA means *the employer*.³ The term “plan administrator” should not be confused with a claims administrator. Often, a claims administrator is the party responsible for claim review and approval of claims. Although this role may confer upon a decisionmaker fiduciary status, it does not confer the status “plan administrator” upon that entity.

The fact that the *plan administrator* is solely responsible for complying with ERISA’s disclosure requirements was underscored in *Davis v. Liberty Mutual Insurance Company*.⁴ In *Davis*, the plaintiff argued that his health plan insurer had failed to provide accurate information regarding plan benefits in the summary plan description. After quoting at length from section 104, the court of appeals rejected the argument that the plan insurer was liable for this alleged defect:

From these provisions, it is manifest that [the insurer] *cannot be the target of such a claim because*, as the insurer, *it is not the plan “administrator”* within the meaning of ERISA. As the [plaintiffs’] counsel forthrightly acknowledged at oral argument, [the insurer] is nowhere designated by the plan as “administrator,” nor has it been suggested that [the insurer] fits within the statutory definition of “plan sponsor.”⁵

¹ ERISA, §104(b). *See also* Lee v. Union Electric Company, 789 F.2d 1303, 1307 (8th Cir. 1986) (“ERISA requires *plan administrators* to provide plan participants and beneficiaries a summary plan description....”); Childers v. Northwest Airlines, Inc., 688 F. Supp. 1357, 1361 (D. Minn. 1988) (“[ERISA’s] narrow disclosure requirements... impose a duty to disclose *only* upon the *plan administrator*....”).

² ERISA, §3(16)(A) [29 U.S.C. §1002(16)(A)] [emphasis added].

³ *Id.* at §3(16)(B).

⁴ 871 F.2d 1134 (D.C. Cir. 1989).

⁵ *Id.* at 1138 [emphasis added].

The appellate court also rejected plaintiffs' argument that because the insurer was a "fiduciary" it, too, had a duty to comply with ERISA's disclosure requirements:

We are unmoved by the [plaintiffs'] argument that [the insurer] should be held liable, as a fiduciary, for failure to supply a summary plan description. In particular, the [plaintiffs] urge that, since [the insurer] was possessed of the information to be conveyed by the plan description, it would be unfair to saddle [the employer] with full responsibility for the failure to furnish this information. The simple answer to this is that *the statute contains nothing to indicate that fiduciaries have an obligation to provide summary plan information*. The [plaintiffs] thus ask us, in effect, to tailor the statute to the 'equities', as they perceive them, of this situation. *Respect for our proper role requires that we decline this invitation to substitute our notions of fairness for the duties which Congress has specifically articulated by imposing liability on the "administrator"*.⁶

Courts have held that provisions in an SPD satisfy ERISA where they provide information about the *general circumstances* in which benefits could be lost or denied and cause the ordinary employee to sense when there is a danger that benefits can be lost or diminished.⁷ Thus, it has been held that where a plan explicitly sets forth that early retirement benefits would be based upon "mutually satisfactory conditions" to both employer and employee, the plan met the requirements as set forth in ERISA, §102.⁸ Courts have also upheld the recovery of retroactive Social Security awards by ERISA plans where such plans provide for the reduction of benefits by such awards, even though the plan did not specifically provide for such retroactive reimbursement.⁹

It should be emphasized that the SPD is only required to discuss general rules, and there is no requirement that it provide specific advice to every employee.¹⁰

A more interesting question regarding SPDs involves the consequences a plan faces if it does not distribute an SPD or if the SPD that is distributed does not meet the requirements of ERISA, §102. This issue has been litigated often and the circuits have used various approaches in attempting to cope with this issue. Most courts agree that technical noncompliance with these requirements is not sufficient for relief.¹¹ Several circuits

⁶ *Id.* at 1134 n.5 [emphasis added]. See also *Pappas v. Buck Consultants, Inc.*, 923 F.2d 531 (7th Cir. 1991) (suit against non-administrators for various reporting requirements not included among the mechanisms for civil enforcement under ERISA).

⁷ See, e.g., *Arnold v. Arrow Transportation Co. of Delaware*, 926 F.2d 782 (9th Cir. 1991).

⁸ *Dzingliski v. Weirton Steel Corporation*, 875 F.2d 1075 (4th Cir. 1989).

⁹ See, e.g., *Madden v. ITT Long Term Disability Plan for Salaried Employees*, 914 F.2d 1279 (9th Cir. 1990); *Stuart v. Metropolitan Life Ins. Co.*, 664 F. Supp. 619, 623–24 (D. Me. 1987), *aff'd*, 849 F.2d 1534 (1st Cir.), *cert. denied*, 488 U.S. 968, 109 S. Ct. 496, 102 L. Ed. 2d 533 (1988) (failure to provide for recoupment of retroactive payments does not prevent such reimbursement where clear language of plan anticipates reductions in benefits upon receipt of Social Security award).

¹⁰ *Stahl v. Tony's Building Materials, Inc.*, 875 F.2d 1404 (9th Cir. 1989); *Childers v. Northwest Airlines*, 688 F. Supp. 1357 (D. Minn. 1988) (ERISA does not impose a fiduciary duty to provide individualized notices of the effect a particular event may have on a participant or beneficiary's eligibility to receive benefits); *Kyrouc v. Northern Illinois Gas Co. Retirement Plan*, 1991 U.S. Dist. Lexis 11920 (N.D. Ill. 1991) (plan summary is not required to anticipate every possible idiosyncratic contingency that might affect a particular participant's or beneficiary's status).

¹¹ *Simmons v. Diamond Shamrock Corp.*, 844 F.2d 517 (8th Cir. 1988). See also *Crocker v. Southern Bell Telephone and Telegraph*, 887 F.2d 1078 (4th Cir. 1989) (unpublished opinion) (as a general rule, procedural violations of ERISA do not entitle an employee to a substantive remedy); *Brown v. Ampco-Pittsburgh Corp.*, 876 F.2d 546 (6th Cir. 1989) (failure to comply with ERISA's procedural requirements is not ordinarily a basis for substantive relief).

have held that in order to recover on the basis of a faulty SPD, a claimant must show significant reliance on, or possible prejudice flowing from, the defect.¹² Other courts have approached the issue from the standpoint of whether or not procedural defects would affect the standard of review, and whether or not the fiduciary's decision is arbitrary and capricious. These courts have affirmatively stated that reporting and disclosure violations are irrelevant in determining a plaintiff's entitlement to benefits, and thus such violations do not comprise arbitrary and capricious behavior.¹³ Although some courts are willing to consider procedural violations in determining whether or not a denial of benefits was arbitrary, the overwhelming majority of courts have held that compliance with ERISA's procedural requirements does *not* exempt a plan from ERISA's coverage.¹⁴

A final issue regarding "faulty" summary plan descriptions arises when the language in the SPD conflicts with language in other plan-related documents. The issue is which document is controlling. Some decisions have hinged on whether either document expressly defers (*i.e.*, has a disclaimer of some sort) to the other.¹⁵ Other courts have given deference to the SPD where claimants have been able to prove reliance

¹² *Govoni v. Bricklayers, Masons and Plasterers*, 732 F.2d 250 (1st Cir. 1984); *Baker v. Lukens Steel Co.*, 793 F.2d 509 (3d Cir. 1986); *Gentile v. The Youngstown Steel Door Company and National Bank*, 802 F.2d 457 (6th Cir. 1986) (unpublished opinion); *Anderson v. Alpha Portland Industries, Inc.*, 836 F.2d 1512 (8th Cir. 1988); *Hancock v. Montgomery Ward Long Term Disability Trust*, 787 F.2d 1302 (9th Cir. 1986) (plaintiff must show "substantive harm"); *Ellenburg v. Brockway, Inc.*, 763 F.2d 1091 (9th Cir. 1985) (same). *But cf.* *Gridley v. Cleveland Pneumatic Co.*, 924 F.2d 1310 (3d Cir. 1991) (violation cannot provide basis for equitable estoppel).

¹³ *Hozier v. Midwest Fastener, Inc.*, 908 F.2d 1155 (3d Cir. 1990) (reporting and disclosure violations irrelevant in determining plaintiff's entitlement to benefits under the terms of a written plan); *Crocker v. Southern Bell Telephone and Telegraph Co., Inc.*, 887 F.2d 1078 (4th Cir. 1989) (before a court disturbs a challenged benefits determination on the ground that it constituted an abuse of discretion, something more than run-of-the-mill or even flagrant mismanagement must appear); *Holland v. Burlington Industries, Inc.*, 772 F.2d 1140 (4th Cir. 1985) (no reason to vary the standard based on procedural violations); *Simmons v. Diamond Shamrock Corp.*, 844 F.2d 517 (8th Cir. 1988) (technical non-compliance does not constitute arbitrary and capricious behavior); *Sage v. Automation, Incorporated Pension Plan and Trust*, 845 F.2d 885 (10th Cir. 1988) (plan decision not upset where right even if procedural defects); *Anderson v. Ciba-Geigy, Corp.*, 759 F.2d 1518 (11th Cir. 1985) (even where ERISA's provisions were "flouted" in a "wholesale and flagrant manner", the arbitrary and capricious standard still applies).

¹⁴ *See, e.g.*, *Orozco v. United Airlines, Inc.*, 887 F.2d 949 (9th Cir. 1989); *Scott v. Gulf Oil Corp.*, 754 F.2d 1499 (9th Cir. 1985); *Williams v. Wright, Jr.*, 927 F.2d 1540 (11th Cir. 1991); *Clay v. ILC Data Device Corp.*, 1991 U.S. Dist. Lexis 11942 (E.D.N.Y. 1991); *Purser v. Enron Corp.*, 1988 U.S. Dist. Lexis 15516 (W.D. Pa. 1988); *Bourg, Jr. v. N.M. Investors Life Insurance Co.*, 1991 U.S. Dist. Lexis 14630 (E.D. La. 1991); *Ada v. Ralston Purina Company*, 772 F. Supp. 46 (D. Puerto Rico 1991).

¹⁵ *See, e.g.*, *DeNobel v. Vitro Corporation*, 885 F.2d 1180 (4th Cir. 1989) (observing that courts have repeatedly upheld provisions stating that in the case of a conflict between the summary and the plan, the plan will control); *Gelardi v. Pertec Computer Corp.*, 761 F.2d 1323 (9th Cir. 1985) (same).

or prejudice flowing from the summary.¹⁶ Still other courts have taken the position that the SPD controls in cases of conflict *irrespective* of any “reliance.”¹⁷

The Supreme Court tackled some of the issues surrounding SPDs in *CIGNA Corporation v. Amara*.¹⁸ CIGNA converted its traditional defined benefit pension plan into a cash balance plan. A class of participants alleged that CIGNA misrepresented and/or failed to disclose certain aspects of the plan in its SPD and other communications, although they were fully disclosed in the master plan document. The class sought benefits under ERISA, §502(a)(1)(B) [29 U.S.C. §1132(a)(1)(B)] based on the plan as represented in the summary communications. In other words, the participants alleged that the language in the SPD and other summary communications constituted “plan terms” that could be enforced via §502(a)(1)(B). The district court agreed and awarded benefits based on the plan as described in the SPD pursuant to §503(a)(1)(B). The district court also held that “likely harm” rather than detrimental reliance, was a sufficient level of proof on which to award relief.

The Supreme Court disagreed and held that communications in an SPD do not have the same status as the plan itself and cannot be enforced as “plan terms” under §502(a)(1)(B): “we cannot agree that the terms of statutorily required plan summaries (or summaries of plan modifications) necessarily may be enforced (under §502(a)(1)(B)) as the terms of the plan itself.” The Court cited two reasons for this conclusion. First, the terms of the statutory provision mandating the creation and distribution of SPDs “suggests that information *about* the plan provided by those disclosures are not itself *part* of the plan.” Second, the Court noted that while a plan is created by the plan sponsor, SPDs and other summary communications are the responsibility of the plan administrator, which may or may not be the same entity, but even if the same, the entity is acting in different capacities. A plan sponsor is generally viewed as a settlor in trust terminology, and is not subject to ERISA’s fiduciary standards because a settlor does not act as a fiduciary. In contrast, a plan administrator is a fiduciary and is subject to ERISA’s fiduciary requirements. The Court concluded:

For these reasons taken together we conclude that the summary documents, important as they are, provide communication with beneficiaries *about* the plan, but that their statements do not themselves constitute the *terms* of the plan for purposes of §502(a)(1)(B). We also conclude that the District Court could not find authority in that section to reform CIGNA’s plan as written.

The Supreme Court went on to suggest that a remedy for CIGNA’s reporting and disclosure violations might be available under §502(a)(3) [29 U.S.C. §1132(a)(3)], the section that provides for injunctive or other appropriate equitable relief to remedy violations of ERISA or the terms of an ERISA plan. Here, the Court

¹⁶ See, e.g., *Genter v. Acme Scale & Supply Co.*, 776 F.2d 1180 (3d Cir. 1985) (where SPD provides only one method of computing coverage, but plan provides for two, district court should consider whether the employee would have taken advantage of the second option had he known of it); *Fuller v. CBT Corp.*, 905 F.2d 1055 (7th Cir. 1990) (in event of discrepancy, participant may rely on SPD); *Anderson v. Alpha Portland Industries, Inc.*, 836 F.2d 1512 (8th Cir. 1988) (to secure relief plaintiff must show significant reliance on, or possible prejudice flowing from, the summary); *McKnight v. Southern Life and Health Insurance Co.*, 758 F.2d 1566 (11th Cir. 1985) (employees justified in relying on SPD in case of conflict); *Chiles v. Ceridian Corp.*, 95 F.3d 1505 (10th Cir. 1996) (employee must show significant reliance or a possible prejudice flowing from defective SPD); *Coar v. Kazimir*, 990 F.2d 1413 (3d Cir. 1993) (same); *Stiltner v. Beretta USA Corp.*, 74 F.3d 1473 (4th Cir. 1996) (same).

¹⁷ See, e.g., *Bachelder v. Communications Satellite Corp.*, 657 F. Supp. 423 (D. Me. 1987); *Heidgerd v. Olin Corp.*, 906 F.2d 903 (2d Cir. 1990); *Edwards v. State Farm Mutual Automobile Insurance Company*, 851 F.2d 134 (6th Cir. 1988). *But, cf.*, *Bryant v. International Fruit Products Co.*, 793 F.2d 111 (6th Cir. 1986) (handbook cannot be relied upon to modify or alter plan).

¹⁸ 131 S. Ct. 1866 (2011).

reached the issue on which it had granted review and that had long split the lower courts, i.e., the level of proof necessary for participants to obtain relief for a plan administrator's disclosure violations. Limiting its discussion to equitable relief under §502(a)(3), the Court held that under the law of equity, there was no general requirement for detrimental reliance, although the Court acknowledged that some remedies, such as estoppel, do require such a showing: "when a court exercises its authority under §502(a)(3) to impose a remedy equivalent to estoppel, a showing of detrimental reliance must be made."

The Court said that other forms of equitable relief do not require detrimental reliance. The requisite showing depends on the theory of relief sought. For example, if a court is considering a surcharge remedy, because a court of equity would not surcharge a trustee for a nonexistent harm, "a fiduciary can be surcharged under §502(a)(3) only upon a showing of actual harm – proved (under the default rule for civil cases) by a preponderance of the evidence." Addressing the district court ruling, the Supreme Court held that "likely harm" was not sufficient to obtain the remedy awarded by the district court, but that to obtain a remedy for CIGNA's disclosure violations, "a plan participant or beneficiary must show that the violation injured him or her." To do so, each participant must show harm and causation, but not necessarily detrimental reliance.¹⁹

II. Obligation to Provide Plan Documents

ERISA imposes an obligation upon the plan administrator to furnish, upon written request of any participant or beneficiary, a copy of the latest updated summary plan description, or other instruments under which the plan is established or operated.²⁰ ERISA permits an aggrieved participant or beneficiary to bring an action to enforce these rights under ERISA, §502(c) [29 U.S.C. §1132(c)]. In pertinent part, ERISA, §502(c) states:

Any administrator... who fails or refuses to comply with a request for any information which such administrator is required by this subchapter to furnish to a participant or beneficiary (unless such failure or refusal results from matters reasonably beyond the control of the administrator) by mailing the material requested to the last known address of the requesting participants or beneficiary within 30 days after such request may *in the court's discretion* be *personally liable* to such participant or beneficiary in the amount of up to \$100 a day from the date of such failure or refusal, and the court may in its discretion order such other relief as it deems proper.

As with the dissemination of the summary plan description under ERISA, §102, the party responsible for compliance with ERISA, §104(b) is the "plan administrator."²¹

There are several important issues that have arisen under this subsection. *First*, as noted above, the request must be made to the *plan administrator*.²² *Second*, the request must be *in writing*.²³ Furthermore, in some cases courts have been rather particular about the form of the request. For example, in *Fisher v. Metro-*

¹⁹ See additional discussion of the *Amara* decision in Chapter 8.

²⁰ ERISA, §104(b) [29 U.S.C. §1024(b)].

²¹ See, e.g., *Pappas v. Buck Consultants, Inc.*, 923 F.2d 531 (7th Cir. 1991); *Moran v. Aetna Life Insurance Co.*, 872 F.2d 296 (9th Cir. 1989); *Bass v. The Prudential Insurance Co.*, 1991 U.S. Dist. Lexis 7720 (D. Kan. 1991); *Davis v. Liberty Mutual*, *supra*.

²² *Id.*

²³ ERISA, §104; *Tracey v. Heublin, Inc.*, 1991 U.S. Dist. Lexis 13442 (D. Conn. 1991); *Porcellini v. Strassheim Printing Co.*, 578 F. Supp. 605 (E.D. Pa. 1983); *Anderson v. Mortell*, 722 F. Supp. 462 (N.D. Ill. 1989). See also *Kleinhans v. Lisle Savings Profit Sharing Trust*, 810 F.2d 618 (7th Cir. 1987) (statutory penalty limited to participant who has "affirmatively requested" information).

politan Life Ins. Co.,²⁴ the court held that where plaintiff's "written request" for a copy of the plan description was nothing more than a scribbled note at the bottom of a Social Security award certificate requesting not plan documents, but rather a "copy of the policies," there was nothing to suggest to the administrator that the plaintiff was really requesting a copy of a document relating to the ERISA plan.

Third, with respect to recovery, it has been held that ERISA, §502(c) only refers to violations of statutorily imposed regulations and does not embrace violations of regulations promulgated pursuant to the statute.²⁵

Fourth, with respect to recovery under ERISA, §502(c), most courts have held that a plaintiff need *not* necessarily show prejudice in order to recover monetary relief under this section.²⁶ However, courts have held that an absence of bad faith or deliberate failure on the part of the administrator may be considered by the court in determining the amount of penalty levied on the administrator.²⁷

Finally, there is a split in the circuits as to whether an entity other than the actual plan administrator, as defined by the statute, can be liable for these plan administrator obligations. Under ERISA, the plan administrator is defined as the person specifically designated by the terms of the plan, and if no one is designated, the statute deems it to be the plan sponsor-employer. Despite the statute's clarity that the plan administrator must be designated by the plan in writing, and if it is not then it is the employer, several courts have held that an insurer that undertakes plan administrator responsibilities becomes a *de facto* plan administrator and can be liable under §502(c).²⁸ There is also some authority that a plan administrator can be held liable under ERISA for the actions of another party on its behalf.²⁹

III. Benefit Plan Amendments

ERISA does not mandate the establishment of employee benefit plans, nor does it require the provision of any particular benefits or level of benefits.³⁰ Accordingly, barring plan language forbidding amendments to the

²⁴ 895 F.2d 1073 (5th Cir. 1990).

²⁵ *Wilczynski v. Lumbermens Mutual Casualty Co.*, 93 F.3d 387 (7th Cir. 1996); *Groves v. Modified Retirement Plan*, 803 F.2d 109 (3d Cir. 1986).

²⁶ *See, e.g., Zaiee v. West*, 916 F.2d 1204 (7th Cir. 1990) (liquidated damages provision in §502(c) dispenses with proof of injury); *Woolsey v. Marian Laboratories, Inc.*, 1991 U.S. App. Lexis 11126 (10th Cir. 1991) (penalty may be imposed where plan representatives are indifferent to requests); *Curry v. Contract Fabricators Inc. Profit Sharing Plan*, 891 F.2d 842 (11th Cir. 1990) (monetary loss not a prerequisite to civil penalty); *Garred v. General American Life Ins. Co.*, 1991 U.S. Dist. Lexis 13511 (W.D. Ark. 1991) (prejudice not a prerequisite); *Starr v. JCI Processing, Inc.*, 1991 U.S. Dist. Lexis 9939 (D. N.J. 1991) (prejudice not required where claim for benefits is colorable and administrator displayed lack of good faith by ignoring plaintiff's request). *But see First Atlantic Leasing Corp. v. Tracey*, 738 F. Supp. 863 (D. N.J. 1990) (plaintiff must show prejudice).

²⁷ *Daniel v. Eaton Corp.*, 839 F.2d 263 (6th Cir. 1988).

²⁸ *See, e.g., Law v. Ernst*, 956 F.2d 364 (1st Cir. 1992) (defendant who assumed and controlled plan administrator's function of furnishing required information and held itself out as plan administrator may be properly regarded as the plan administrator for purposes of section 502(c)); *Rosen v. TRW, Inc.*, 979 F.2d 191 (11th Cir. 1992) (same). *But see Lee v. Burkhart*, 991 F.2d 1004 (2d Cir. 1993) (only the statutory plan administrator can be responsible under §502(c)); *McKinsey v. Sentry Ins.*, 986 F.2d 401 (10th Cir. 1993) (same).

²⁹ *Taylor v. Peoples Natural Gas Company*, 49 F.3d 982 (3d Cir. 1995).

³⁰ *Lockheed Corporation v. Spink*, 517 U.S. 882 (1996); *Curtiss-Wright v. Schoonejongen*, 514 U.S. 73 (1995); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 91 (1983); *Ershick v. United Missouri Bank of Kansas City*, 948 F.2d 660, 668

plan,³¹ a plan sponsor (or other specifically authorized person) may freely amend or terminate a welfare plan. ERISA provides no regulation concerning the substance of welfare plan amendments. The fact that a plan amendment may be to the employer's or the insurer's advantage is irrelevant and does not affect the validity of the amendment in any way.³² However, plan amendments must be enacted both in accordance with ERISA and plan procedures.

There are several statutory provisions that refer to and otherwise impact the plan amendment process. Relevant portions of the statute are quoted below. In essence, ERISA provides:

Each employee benefit plan shall *provide a procedure for amendment* of the plan *and designate the persons with authority* to amend the plan [ERISA, §402(b)(3)];

The administrator must furnish plan modifications and changes to new participants within 90 days after participation begins under the plan and to a new beneficiary within 90 days after he/she first receives benefits under the plan [ERISA, §104(b)(1)];

If there is a modification or change other than a material reduction in covered services or benefits provided in the case of a group health plan, the administrator must furnish a summary description of the modification or change to participants/beneficiaries within 210 days after the end of the plan year in which the change is adopted [ERISA, §104(b)(1)]; and

Under amendments enacted in 1996, if the modification or change is a material reduction in services or benefits provided in a group health plan, the administrator must provide a summary description of such modification or change to participants and beneficiaries not later than 60 days after the date of the adoption of the modification or change or, in the alternative, plan sponsors may provide such descriptions at regular intervals of not more than 90 days [ERISA, §104(b)(1)].

ERISA has no specific provision dictating who may or may not have authority to amend an employee benefit plan. ERISA, §402(b)(3) [29 U.S.C. §1022(b)(3)] requires that “[e]very employee benefit plan shall... provide a procedure for amending such plan, and for identifying the persons who have authority to amend the plan...”³³ ERISA, §102(a)(1) [29 U.S.C. §1002(a)(1)] provides that a summary of “material modifications” must be written in a manner calculated to be understood by the average participant “and shall be furnished in accordance with section 104(b)(1).” ERISA, §104(b)(1) [29 U.S.C. §1004(b)(1)] states that the *administrator* shall

(10th Cir. 1991) (“[u]nder ERISA, private parties, not the government, control the level of the benefits [provided by a plan]”).

³¹ It is possible for a plan sponsor to include language in the benefit plan that contractually obligates the sponsor to waive its right to amend the plan:

Although ERISA generally allows employers to modify or discontinue [welfare] plans at will so long as the procedure followed is consistent with the plan and [ERISA], we have held that an employer's welfare plan itself may designate a vested benefit.

Wise v. El Paso Natural Gas Co., 986 F.2d 929, 937 (5th Cir. 1993).

³² See e.g., Lockheed Corp. v. Spink, *supra*, (employers are free to amend pension plans without scrutiny under ERISA's fiduciary duty requirements); Curtiss-Wright v. Schoonejongen, *supra* (“[e]mployers or other plan sponsors are generally free under ERISA, for any reason at any time, to adopt, modify, or terminate welfare plans”); Wise v. El Paso Natural Gas Co., 986 F.2d 929 (5th Cir. 1993) (“Employers need not abandon prudent business behavior when the marketplace forces compel them to rethink earlier offers of contingent, non-vested benefits”).

³³ ERISA broadly defines a “person” as “an individual, partnership, joint venture, corporation, mutual company, joint-stock company, trust, estate, unincorporated organization, association, or employee organization.” ERISA, §3(9) [29 U.S.C. §1002(9)].

furnish to each participant and beneficiary receiving benefits under the plan a copy of the summary plan description, and all modifications and changes referred to in §102(a)(1).³⁴ This subsection goes on to state that the modifications and changes shall be provided to a participant within 90 days after he/she becomes a participant and to a beneficiary within 90 days after he/she first receives benefits. The subsection further states:

If there is a modification or change described in section 102(a)(1) (other than a material reduction in covered services or benefits provided in the case of a group health plan (as defined in section 706(a)(1)), a summary description of such modification or change shall be furnished not later than 210 days after the end of the plan year in which the change is adopted to each participant, and to each beneficiary who is receiving benefits under the plan.

In 1996, §104(b)(1) was amended to add the following:

If there is a modification or change described in section 102(a)(1) that is a material reduction in covered services or benefits provided under a group health plan (as defined in section 706(a)(1)), a summary description of such modification or change shall be furnished to participants and beneficiaries not later than 60 days after the date of the adoption of the modification or change. In the alternative, the plan sponsors may provide such description at regular intervals of not more than 90 days.

Until recently, most of the litigation concerning welfare plan amendments centered around the issue of retiree health benefits, and usually involved interpretation of a collective bargaining agreement in addition to the plan. However, the Supreme Court recently addressed the issue of plan amendment procedure in *Curtiss-Wright v. Schoonejongen*.³⁵

The benefit plan at issue in *Schoonejongen* was amended to terminate health benefits for a certain class of retirees of the plan sponsor. The plan documents contained broad language in which the plan sponsor reserved the right to modify, revoke, suspend, change or terminate the plan in whole or in part. The issue was whether this language complied with ERISA, §402(b)(3) and, if not, what impact that defect might have on the plan amendment at issue.

The Third Circuit held that a general reservation of a right to amend did not comply with §402(b)(3), which mandates that plan participants and beneficiaries be informed how a plan may be amended and by whom. The Court also held that a simple reservation did not provide a procedure “identifying the persons who have authority to amend the plan.” According to the Third Circuit, the purpose of §402(b)(3) is to ensure that all interested parties will know *how* a plan may be altered *and who* may make such alternation.”

The United States Supreme Court reversed. The Supreme Court held that the general statement that the plan could be amended “by the Company” *did* comply with §402(b)(3). The Court remanded the matter for a “fact-intensive inquiry, under applicable corporate law principles, into what persons or committees within Curtiss-Wright possessed plan amendment authority, either by express delegation or impliedly, and whether

³⁴ ERISA defines administrator as “the person specifically so designated by the terms of the instrument under which the plan is operated” or, where no such person is designated, the administrator is “the plan sponsor.” ERISA, §3(16)(A). ERISA defines the “plan sponsor” as “(i) the employer in the case of an employee benefit plan established or maintained by a single employer, (ii) the employee organization in the case of a plan established or maintained by an employee organization, or (iii) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan.” *Id.* at §3(16)(B).

³⁵ 131 L. Ed. 2d 94 (1995).

those persons or committees actually approved the new plan provision.” Several important points appear in the Court’s unanimous opinion:

- ERISA does not create any substantive right to welfare benefits. A welfare benefit plan may be amended or terminated at any time for any reason absent some contractual commitment to continued benefits. The fact that a welfare plan is amended does not impact ERISA’s fiduciary duty provisions and is not sufficient, in and of itself, to form the basis for a cause of action under ERISA. A participant *can* challenge the validity of the amendment based on whether it was adopted in accordance with the plan’s amendment procedure.
- A statement that the plan may be amended at any time “by the Company” is sufficient to comply with ERISA’s requirement that the plan specify “the person” with amendment authority. ERISA defines the term “person” broadly to include not only natural persons, but also “companies.” In order to determine whether a particular amendment is valid, courts must look to whether the particular person or group of persons who approved the amendment had authority to do so under general principles of corporate law.
- A statement that the plan may be amended at any time “by the Company” is also sufficient to comply with ERISA’s requirement that the plan specify a procedure for amendment. Such a statement implies that the plan may be amended by a unilateral company decision as opposed to a joint decision by the company and a union or other party (such as an insurer). Again, the Court held that general principles of corporate law provide the necessary guidelines for determining whether a particular amendment procedure employed by the plan sponsor in a given situation is adequate to lawfully amend the plan. The Court also noted that the amendment procedure adopted by Curtiss-Wright was the simplest of procedures because the plan was the simplest of plans: a voluntary plan established, maintained and funded by a single employer. The Court states that more complicated plans might require more complicated amendment procedures. (For example, a plan that is insured or maintains stop-loss coverage might require an amendment procedure that takes into account the input of an insurer into the plan amendment process.)
- The Court suggested that in some cases a more detailed plan amendment provision might succeed in alleviating litigation costs. For example, the general reservation provision adopted by Curtiss-Wright had already resulted in years of litigation as to whether the person(s) who promulgated the plan amendment at issue had authority to do so and whether the procedure they employed was sufficient to satisfy the plan’s requirement that the plan only be amended “by the Company.” The Supreme Court remanded the matter for a “fact-intensive inquiry, under applicable corporate law principles, into what persons or committees within Curtiss-Wright possessed plan amendment authority, either by express delegation or impliedly, and whether those persons or committees actually approved the new plan provision.” Obviously, a more detailed plan amendment procedure that specifically identified the persons with authority to amend the plan and the procedures by which amendments were to be adopted might have alleviated many of the issues on remand.
- Although not specifically stated by the Court, it is clear that if the participants succeed in proving on remand that the plan was not properly amended, the plan amendment is invalid. The Court did note, however, that even if the amendment was not proper, the lower court could look to whether subsequent actions by persons with authority to act on behalf of the company served to ratify the provision.
- Although the Third Circuit held that Curtiss-Wright’s failure to comply with ERISA, §402(b)(3) made the plan amendment null and void, the Supreme Court declined to address this issue because it concluded

that Curtiss-Wright did, in fact, comply with that section. Lower federal courts are split over the effect of a plan's failure to comply with §402(b)(3).³⁶

Although ERISA specifies the manner in which plan amendments are to be communicated to participants and beneficiaries, neither ERISA nor *Schoonejongen* mandates any particular method to be utilized for amending a plan, nor do they specify which person(s) are to have authority to amend the plan. It is important to realize, however, that plan amendment procedures and the person(s) authorized to amend the plan will differ depending on the type of plan involved. For example, under a fully insured plan, the insurer might be the party with authority to amend the plan terms, while under a self-funded plan the plan sponsor might have plan amendment authority. Once a decision is made as to the appropriate plan amendment procedures and the person(s) with authority to amend the plan, the plan should also state the procedure for communicating amendments to participants and beneficiaries. Because ERISA provides such procedures, the statutory language should be used in the plan. Furthermore, the best practice is to include the plan amendment procedure in all plan documents, especially those documents distributed to participants and beneficiaries. These documents include the plan, the summary plan description, the policy or the administrative services agreement, and any wraparound documents. In this way, there should be no question that the communication test discussed in *Schoonejongen* will be satisfied.

³⁶ Compare *Schoonejongen v. Curtiss-Wright Corp.*, 18 F.3d 1034 (3d Cir. 1994) (amendment is null and void where plan document does not comply with §402(b)(3)) with *Aldridge v. Lily-Tulip, Inc. Salaried Retirement Plan*, 40 F.3d 1202 (11th Cir. 1994) (plan amendment is valid unless participants can show detrimental reliance on plan's failure to comply with §402(b)(3)).

ERISA's Claim Procedures

I. “Full and Fair Review”

ERISA, §503 [29 U.S.C. §1133] provides that every employee benefit plan must provide adequate notice in writing to any participant and beneficiary whose claims for benefits have been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant. This section also provides that each participant or beneficiary must be afforded a reasonable opportunity for a “full and fair review” by the appropriate named fiduciary of the decision denying the claim.¹ Thus, ERISA, §503 sets forth two distinct and important duties for employee benefit plans: (1) to provide participants and beneficiaries whose claim has been denied with “proper” notices of the denial, and (2) to provide parties whose claims have been denied with an opportunity to have the decision reviewed.

A. *Department of Labor Claim Regulations Prior to 2002*

Although the statute itself only specifies that the notice be “adequate,” set forth the reasons for denial, and be written in a manner to be understood by the claimant, Department of Labor Regulations specify in detail the scope, purpose, contents and time deadlines applicable for claims procedures.² This section discusses the regulations as they applied to claims filed on or before January 1, 2002 (for disability and other welfare and pension plans except health plans) and July 1, 2002 (for health plans).

With respect to notification to a claimant of a claims decision, Department of Labor Regulations specify that if a denial of a claim is not furnished within a “reasonable period of time,” the claim will be deemed denied.³ A period of time is deemed to be “unreasonable” if it exceeds 90 days after receipt of the claim by the plan, unless “special circumstances” require an extension of time for processing the claim.⁴ Where an extension is required, the Regulations state that “written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period”.⁵ However, under the Regulations, in no event

¹ ERISA, §503 [29 U.S.C. §1133] states in full:

In accordance with regulations of the Secretary, every employee benefit plan shall—

- (1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and
- (2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

² See 29 C.F.R. §2560.503-1(a)–(j).

³ 29 C.F.R. §2560.503-1(e)(2). *See also*, *Sheppard & Enoch Pratt Hosp., Inc. v. Travelers Ins. Co.*, 32 F.3d 120 (4th Cir. 1994).

⁴ 29 C.F.R. §2560.503-1(e)(3).

⁵ *Id.*

may the extension exceed a period of 90 days from the end of the initial period (*i.e.*, 180 days from receipt of the claim).⁶

The content of the notice, in addition to being written in a manner calculated to be understood by the claimant, should also contain the following information:

- (1) The specific reason or reasons for the denial[;]
- (2) Specific reference to pertinent plan provisions on which the denial is based[;]
- (3) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and
- (4) Appropriate information as to the steps to be taken if the participant or beneficiary wishes to submit his or her claim for review.⁷

Where a plan altogether fails to provide any notice to a claimant within 90 days of receipt of the claim, the only “remedy” available to a participant is that “[his] claim shall be deemed denied,” and the claimant may then proceed to request an administrative review of the “denial.”⁸ The United States Supreme Court has stated that nothing in the statute or regulations provides for a recovery from the plan itself or from its administrators if a benefit determination is not made within the time frame provided by ERISA.⁹

Although strict compliance regarding the content of a denial letter is not necessary, many courts have held that *substantial* compliance is necessary.¹⁰ Courts have also held that when the content of the claim denial letter does not meet with ERISA’s regulations regarding content, the appropriate “remedy” is to remand the decision back to the plan for new consideration.¹¹ However, the Tenth Circuit has held that a plan decision will not be upset where decided correctly.¹² On the other hand, the Ninth Circuit has taken an opposite viewpoint.¹³

As stated previously, §503(2) mandates that all employee benefit plans provide a reasonable opportunity to a participant or beneficiary whose claim has been denied a “full and fair review” of the decision denying benefits. The DOL regulations regarding a “full and fair review” can be found at 29 C.F.R. §2560.503-1(S). In pertinent part, the Regulations specify that the review procedure include, but not be limited to, provisions that allow a claimant to: “(1) Request a review upon written application to the Plan; (2) Review pertinent documents; and (3) Submit issues and comments in writing.”¹⁴ Plans may, if they wish, establish a limited period

⁶ *Id.*

⁷ 29 C.F.R. §2560.503-1(f).

⁸ 29 C.F.R. §2560.503-1(e)(2).

⁹ *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134 (1985).

¹⁰ *See, e.g., Wolfe v. J.C. Penney Company, Inc.*, 710 F.2d 388 (7th Cir. 1983); *Brown v. Retirement Committee of the Briggs and Stratton Retirement Plan*, 797 F.2d 521 (7th Cir. 1986); *Burdette v. Mees*, 1991 U.S. App. Lexis 10403 (4th Cir. 1991) (unpublished) (letter that simply concludes claim is denied without giving reasons is insufficient); *McDonough v. Lever Brothers Co.*, 1991 U.S. App. Lexis 13231 (9th Cir. 1991) (unpublished) (same).

¹¹ *See, e.g., Burdette v. Mees*, 1991 U.S. App. Lexis 10403 (4th Cir. 1991) (unpublished); *Wolfe v. J.C. Penney Company, Inc.*, 710 F.2d 388 (7th Cir. 1983); *McDonough v. Lever Brothers Co.*, 1991 U.S. App. Lexis 13231 (9th Cir. 1991) (unpublished).

¹² *Sage v. Automation, Incorporated Pension Plan and Trust*, 845 F.2d 885 (10th Cir. 1988).

¹³ *Hancock v. Montgomery Ward Long Term Disability Trust*, 787 F.2d 1302 (9th Cir. 1986).

¹⁴ 29 C.F.R. §2560.503-1(g)(1).

within which a claimant must file any request for review of a denied claim. The minimum period of time must be no less than 60 days.¹⁵ The decisions on review must ordinarily be made within 60 days of the plan's receipt of a request for review, but in no event may it exceed 120 days.¹⁶ Where a fiduciary fails to render a decision within these time frames, the claim is deemed denied on review.¹⁷

The meaning of a "full and fair review" does not necessarily require a trial-like atmosphere complete with attorneys for both sides. In fact, the decisionmaker need not hear *any* oral testimony; a written record will suffice. *Brown v. Retirement Committee of the Briggs and Stratton Retirement Plan*.¹⁸ The persistent "core" requirements of a "full and fair review" within the meaning of ERISA, §503 include (1) knowing what evidence the fiduciary relied upon, (2) having an opportunity to address the accuracy and sufficiency of that evidence, and (3) having the fiduciary consider all evidence presented.¹⁹ It is *not* a violation of ERISA's requirement of a "full and fair review" to have the same fiduciary who initially denied the claim also be the person to review it upon appeal.²⁰

It has been held that where a plan fails to provide a claimant with a "full and fair review," the appropriate recourse is to seek review by the district court.²¹ According to the Sixth Circuit, even where this happens, the standard of review remains the same.²²

¹⁵ 29 C.F.R. §2560.503-1(g)(3).

¹⁶ *Id.*

¹⁷ *Id.*

¹⁸ 797 F.2d 521 (7th Cir. 1986).

¹⁹ *Id.*

²⁰ DOL Regulation 29 C.F.R. §2560.503-1(g)(1) and (2) states:

(g) *Review procedure.*

- (1) Every plan shall establish and maintain a procedure by which a claimant or his duly authorized representative has a reasonable opportunity to appeal a denied claim to an appropriate named fiduciary or to a person designated by such fiduciary, and under which a full and fair review of the claim and its denial may be obtained. Every such procedure shall include but not be limited to provisions that a claimant or his duly authorized representative may:
 - (i) Request a review upon written application to the plan;
 - (ii) Review pertinent documents; and
 - (iii) Submit issues and comments in writing.
- (2) To the extent that benefits under an employee benefit plan are provided or administered by an insurance company, insurance service, or other similar organization that is subject to regulation under the insurance laws of one or more States, the claims procedure pertaining to such benefits may provide for review of and decision upon denied claims by such company, service or organization. In such case, that company, service, or organization shall be the "appropriate named fiduciary" for purposes of this section. In all other cases, the "appropriate named fiduciary" for purposes of this section may be the plan administrator or any other person designated by the plan, provided that such plan administrator or other person is either named in the plan instrument or is identified pursuant to a procedure set forth in the plan as the person who reviews and makes decisions on claim denials.

²¹ *Daniel v. Eaton Corp.*, 839 F.2d 263 (6th Cir. 1988).

²² *Id.*

B. Department of Labor Claim Regulations Effective January 1, 2002

For nearly a quarter of a century, claim administrators followed the same federally mandated procedures for processing benefit claims under plans governed by ERISA. These procedures applied alike to all types of benefit plans including pension, life, health, and disability plans. In 1998, the DOL proposed significant revisions to the claim procedure regulations, moved largely by calls for more stringent regulation of managed health care. The proposed regulations drew volumes of written commentary which led the DOL to hold public hearings with testimony from groups representing all aspects of the benefit plan industry.

Although the hearings took place in February 1999, the DOL delayed issuing final regulations pending expected managed health care legislation from Congress. When that legislation did not materialize, President Clinton ordered the DOL to finalize the procedural regulations. The DOL issued the final regulations in November 2000.²³ The new regulations were applicable to claims filed on or after January 1, 2002 for disability and other plans except health plans. The DOL extended the effective date for health plans to July 1, 2002.

1. New Terminology

The regulations incorporated several new terms and/or give old terms new meanings unique to the new ERISA claim procedures:

- *Urgent Care Claim*: A claim for health care benefits where application of non-urgent care procedures could seriously jeopardize the life or health of a claimant or the ability of a claimant to regain maximum function or where, in the opinion of a physician with knowledge of the claimant's condition, non-urgent care procedures would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. In the case of a dispute whether a claim involves urgent care, the regulations appear to give the treating doctor the ultimate power to determine whether or not a claim is an urgent care claim.²⁴
- *Pre-Service Claim*: A claim for a health care benefit where the payment of the benefit is conditioned on advance approval of the medical care.²⁵
- *Post-Service Claim*: Any claim for health care that is not a pre-service claim.²⁶
- *Group Health Plan*: This is a term borrowed from the HIPAA amendments to ERISA and means an employee welfare benefit plan to the extent that the plan provides medical care... to employees or their dependents... directly or through insurance, reimbursement, or otherwise. ERISA, §733(a). A group health plan is governed by the new regulations whether it is insured or self-funded.²⁷
- *Health Care Professional*: A physician or other health care professional licensed, accredited, or certified to perform specified health care services. Generally, one must be licensed or certified in the substantive area applicable to the claim under review.²⁸

²³ The new regulations replace the former regulations and are codified at 29 C.F.R. §2560.503-1. 65 Fed. Reg. 70246 (November 21, 2000).

²⁴ 29 C.F.R. §2560.503-1(m)(1).

²⁵ *Id.* at §2560.503-1(m)(2).

²⁶ *Id.* at §2560.503-1(m)(3).

²⁷ 29 C.F.R. §2560.503-1(m)(6).

²⁸ *Id.* at §2560.503-1(m)(7).

- *Concurrent care decision*: A claim for additional health care benefits where the plan has approved an ongoing course of treatment.²⁹
- *Relevant*: This term is used in conjunction with requirements for the plan to produce “relevant” documents as part of the claim procedure. A document is relevant if it is relied on in making the decision, or if it is submitted, generated, or considered as part of the claim review process, or if the document demonstrates consistency in claim determinations among similarly situated claimants. For group health plans and disability plans, a document is also relevant if it constitutes a statement of policy or procedure for the plan concerning the benefit at issue regardless of whether the policy was relied on in the processing the specific claim at issue.³⁰

2. General Claim Procedures—All Plans

All benefit plans of any type must comply with the regulations.³¹ All claim procedures applied by the plan, including applicable deadlines, must be disclosed in the summary plan descriptions distributed to participants and beneficiaries.³² In situations where the claim administrator that carries out the claim processing functions and the plan administrator that prepares the plan documents are different entities, the regulations do not state who is ultimately held responsible if the plan’s claim procedures are not included in the plan summary or who is responsible if the procedures followed by the claim administrator do not exactly parallel the claim procedures spelled out in the summary plan description.

Probably the most startling requirement in the rules was that the claim procedures must contain administrative processes and safeguards designed to ensure and to verify that benefit claims determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants.³³ In the comments accompanying the new regulations, the DOL stated that this requirement merely formalizes what courts have long required.³⁴ This most likely came as a surprise to most claim administrators. Indeed, the DOL referenced only two federal courts out of thousands of ERISA benefit cases in support of this proposition.³⁵ The regulations also fail to provide any guidance as to the nature of these administrative processes and safeguards, the DOL being of the opinion that “plans should have flexibility and are capable of monitoring their internal decisionmaking effectively and efficiently.”³⁶

Certainly, the regulations created more questions than they resolved: There was no guidance as to the nature and extent of the administrative processes and safeguards. There was no guidance as to what types of claimants are similarly situated. Presumably claimants who do not participate in the same employer-sponsored benefit plan are not similarly situated, although this is not completely clear. The DOL also pro-

²⁹ *Id.* at §2560.503-1(f)(2)(ii).

³⁰ *Id.* at §2560.503-1(m)(8).

³¹ *Id.* at §2560.503-1(a) and (b).

³² *Id.* at §2560.503-1(b).

³³ *Id.* at §2560.503-1(b)(5).

³⁴ 65 Fed. Reg. 70246, 70251 (November 21, 2000).

³⁵ *Id.*

³⁶ *Id.* at 70252.

vided no guidance as to how claim administrators processing disability claims would be able to comply with this requirement when disability claims are each unique on their own facts.

Several other new requirements appeared in the final regulations. Group health plans and disability plans may only require a maximum of two mandatory appeals in order for a claimant to exhaust administrative remedies and pursue an action in court.³⁷ Moreover, plans are permitted to mandate arbitration, but only if it constitutes one level of the two-level appeal process and if it does not preclude the claimant from pursuing an action for benefits under ERISA.³⁸ The plan is permitted to offer additional voluntary levels of appeal, but only if the plan waives any exhaustion defense that could be asserted in court, agrees that the applicable limitations period is tolled, the voluntary levels of appeal are only available after the mandatory appeal procedures have been exhausted, and if the claimant is provided with sufficient information regarding the voluntary appeals so as to make an informed decision whether to pursue additional appeals.³⁹

3. Deadlines for the Initial Claim Decision

Claim review deadlines were changed dramatically for group health plans and disability plans as compared to the former rules. Under the old rules (which are still applicable to benefit plans other than group health plans and disability plans), the plan had 90 days to decide the claim. An extension of up to an additional 90 days was available where special circumstances required additional time to decide the claim.⁴⁰ The new rules required plans to specifically notify the claimant of the need for the extension and the special circumstances that justify the extension.⁴¹ The new rules also stated that all deadlines constitute maximum allowable periods and that all claims must be decided within a reasonable period of time under the circumstances.⁴² The introductory comments to the new regulations stated as follows:

Decisions are required to be made, generally, within a reasonable period of time appropriate to the circumstances. Accordingly, in some cases, delaying a decision until the end of the maximum period may be unreasonable under the circumstances and thus a violation of the procedural standards.⁴³

In other words, it may be at least theoretically possible to violate the claim procedure regulations even when the plan acts within the mandated maximum time periods.

The most dramatic change in deadlines applied to *urgent health care claims*. Where the claimant submits adequate information, the plan must decide the claim “as soon as possible, taking into account the medical exigencies,” but not later than 72 hours from receipt of the claim.⁴⁴ If the claim is deficient in some way, the plan has only 24 hours to notify the claimant that he/she has failed to follow proper plan procedures for filing the claim or that the claimant has submitted insufficient information.⁴⁵ The claimant then has 48 hours to

³⁷ *Id.* at §2560.503-1(c)(2) and (d).

³⁸ *Id.* at §2560.503-1(c)(4) and (d).

³⁹ *Id.* at §2560.503-1(c)(3) and (d).

⁴⁰ *Id.* at §2560.503-1(f)(1).

⁴¹ *Id.*

⁴² *Id.* at §2560.503-1(f)(1); 65 Fed. Reg. 70246, 70248.

⁴³ 65 Fed. Reg. 70246, 70248, n. 8.

⁴⁴ *Id.* at §2560.503-1(f)(2)(i).

⁴⁵ *Id.*

provide the necessary information.⁴⁶ The plan then has 48 hours to decide the claim, running from either the receipt of the additional information or, if the claimant fails to submit the additional information or to correct the deficient claim, from the end of the period for the claimant to do so.

Where the health care claim involves a termination or reduction of *concurrent care*, the plan must notify the claimant of its decision sufficiently in advance of the reduction or termination so as to allow the claimant to appeal and obtain a final decision before the reduction or termination occurs.⁴⁷ If the concurrent care decision involves a request to extend urgent health care beyond the original approved benefit, the plan has 24 hours to decide the claim if the request is made at least 24 hours before the originally approved treatment expires.⁴⁸ If a request for extension of treatment is not made at least 24 hours prior to the expiration of the approved treatment and involves urgent care, the request must be treated as a claim involving urgent care and decided in accordance with the urgent care deadlines (*i.e.*, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt).⁴⁹ If the request is not made at least 24 hours prior to the expiration of the approved treatment period and does not involve urgent care, the request may be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim, *i.e.*, as a pre-service claim or a post-service claim.⁵⁰

The deadlines for all other health care claims (*i.e.*, claims that do not involve urgent care or concurrent care), are divided into two categories. Where the request for benefits is a *pre-service claim*, the plan has 15 days to decide the claim. This period may be extended for an additional 15 days if the plan notifies the claimant before the initial period expires that the extension is necessary because of matters beyond the plan's control. If the extension is necessary because more information is required from the claimant, the claimant must be allowed at least 45 days from receipt of the notice to submit the requested information.⁵¹ Where the claim involves a *post-service claim*, the plan has up to 30 days to deny the claim with the possibility of one 15-day extension where the extension is necessary due to circumstances beyond the control of the plan. Again, the claimant has 45 days to provide the necessary additional information.⁵²

Finally, if the claim is for a *disability benefit*, the plan has 45 days to decide the claim. Two 30-day extensions are available if the plan notifies the claimant prior to the expiration of each 30-day period that an extension is necessary and if the plan explains the following: (1) the standards on which entitlement to benefit is based; (2) the unresolved issues that prevent a decision at that time; and (3) any additional information needed to resolve the issues. The claimant must be provided at least 45 days to submit the additional information.⁵³

The DOL regulation provided a general tolling rule: the deadline for a decision is tolled from the date a notice of extension and request for additional information is sent to the claimant to the date the claimant

⁴⁶ *Id.*

⁴⁷ *Id.* at §2560.503-1(f)(2)(ii).

⁴⁸ *Id.*

⁴⁹ *Id.* at §2560.503-1(f)(2)(i) and (ii)(B).

⁵⁰ *Id.* at §2560.503-1(f)(2)(iii).

⁵¹ *Id.* at §2560.503-1(f)(2)(iii)(A).

⁵² *Id.* at §2560.503-1(f)(2)(iii)(B).

⁵³ *Id.* at §2560.503-1(f)(3).

responds to the request for additional information.⁵⁴ If the claimant fails to respond, decision deadlines run from the outside date on which the claimant is required to submit the information.⁵⁵

4. Manner and Content of the Initial Denial Notice

Denial notices may be in writing or electronic, so long as any electronic notices comply with separate DOL regulations regarding such notices. Where the claim involves urgent health care, the notice may be oral so long as a written or electronic notice follows within no more than 3 days.⁵⁶

The denial notice for all types of benefit plans must include the following information: (1) the reasons for the decision; (2) references to the plan provisions on which the denial is based; (3) a description of any additional materials that may be necessary to prove entitlement to benefits and why the materials are necessary; (4) a description of the applicable appeal procedures and (5) a statement that the claimant can sue for benefits under ERISA, §502(a).⁵⁷ If the claim is for a health or disability benefit, additional information is required: (1) the notice must identify any internal rule, guideline, or protocol that was relied on in denying the claim and must either provide the claimant with a copy of the rule, guideline, or protocol or state that a copy is available on request; (2) if the denial is based on lack of medical necessity or that the requested service is experimental, the notice must explain the scientific or clinical judgment utilized to make the decision and how it applied to the claim; and (3) although not entirely clear in the regulations, it appears that the denial notice must identify any health care professionals who were consulted during review of the claim, whether or not the plan relied on their advice.⁵⁸ If the claim is for urgent health care, the denial notice must also describe the plan's expedited appeal process for urgent health care claims.⁵⁹

5. Appeal Deadlines

The rules continued the statutory requirement that all benefit plans must provide at least one level of review beyond the initial claim decision pursuant to ERISA, §503.⁶⁰ All plans except group health and disability plans must provide a claimant with at least 60 days from the claimant's receipt of the denial notice to request an appeal.⁶¹ Group health and disability plans must provide the claimant at least 180 days to request an appeal.⁶²

Deadlines for deciding the appeal begin to run when the request for appeal is filed with the plan.⁶³ The time period is tolled during any period in which the plan is waiting for additional information after giving proper notice to the claimant.⁶⁴ All plans except group health and disability plans must decide the appeal

⁵⁴ *Id.* at §2560.503-1(f)(4).

⁵⁵ *Id.*

⁵⁶ *Id.* at §2560.503-1(g).

⁵⁷ *Id.* at §2560.503-1(g)(1)(i)–(iv).

⁵⁸ *Id.* at §2560.503-1(g)(1)(v). *See also* 29 C.F.R. §2560.503-1(h)(3)(iv) and (4).

⁵⁹ *Id.* at §2560.503-1(g)(1)(vi).

⁶⁰ *Id.* at §2560.503-1(h)(1).

⁶¹ *Id.* at §2560.503-1(h)(2).

⁶² *Id.* at §2560.503-1(h)(3) and (4).

⁶³ *Id.* at §2560.503-1(i)(4).

⁶⁴ *Id.*

within a maximum period of 60 days.⁶⁵ If special circumstances exist that require additional time to decide the appeal, the plan may extend the decision date up to an additional 60 days.⁶⁶ Disability plans may follow the same rules, except that the maximum periods for making appeal decisions are 45 days rather than 60 days.⁶⁷

If the claim involves health care, different deadlines are applicable depending on the nature of the claim. If the claim involves *urgent health care*, the plan must make its decision “as soon as possible, taking into account the medical exigencies,” but no longer than 72 hours after receipt of the appeal. If the claim involves a *pre-service request* for approval of treatment, the plan must decide the appeal within 30 days if the plan allows one level of appeal; if the plan allows two levels of appeal, the plan has no more than 15 days for each appeal level to make its decision. For *post-service claims*, where the plan provides one level of appeal, the plan has up to 60 days to decide the appeal; if the plan allows two levels of appeal, the plan has no more than 30 days for each level of appeal.

6. Regulations Governing the Appeal Process

Where an appeal is requested, all plans, including group health and disability plans, are required to give the claimant adequate opportunity to submit written comments and documents supporting his/her appeal.⁶⁸ The plans must also provide the claimant with access to and copies of all “relevant” (as defined by the DOL) documents, including but not limited to any applicable internal rules, guidelines, and protocols as well as information demonstrating that the fiduciary has adequately complied with the plan documents and has consistently applied plan terms.⁶⁹ The review process must also take into account all information submitted by the claimant.⁷⁰

Additional requirements apply to appeals involving group health and disability claims. The person deciding the appeal cannot be the same person who made the initial decision nor can he/she be a subordinate to the person who made the initial decision.⁷¹ The person deciding the appeal is also forbidden from giving any deference to the initial decision.⁷² If the appeal involves a decision based on medical judgment, the person deciding the appeal must consult with an appropriate health care professional with appropriate training and experience in the relevant medical field.⁷³ The health care professional consulted on appeal must be different from any health care professional consulted during the initial claim review and must not be a subordinate to that health care professional.⁷⁴ The plan must also identify any health care professionals consulted, whether or not the plan relied on their advice.⁷⁵ If the claim involves *urgent health care*, the plan must provide an expedited appeal process whereby an appeal request may be submitted orally or in writing

⁶⁵ *Id.* at §2560.503-1(i)(1).

⁶⁶ *Id.*

⁶⁷ *Id.* at §2560.503-1(i)(3).

⁶⁸ *Id.* at §2560.503-1(h)(2).

⁶⁹ *Id.*

⁷⁰ *Id.*

⁷¹ *Id.* at §2560.503-1(h)(3)(ii) and (4).

⁷² *Id.*

⁷³ *Id.* at §2560.503-1(h)(3)(iii) and (4).

⁷⁴ *Id.* at §2560.503-1(h)(3)(v) and (4).

⁷⁵ *Id.* at §2560.503-1(h)(3)(iv) and (4).

and where all information shall be transmitted between the plan and the claimant via telephone, facsimile, or some other expeditious method.⁷⁶

7. Content of the Appeal Decision Notice

As with the original denial notice, the notice of decision on appeal may be transmitted in writing or electronically.⁷⁷ The notice must include: (1) the reasons for the decision; (2) references to pertinent plan provisions; (3) a statement that the claimant may have access to and copies of all relevant documents; (4) a description of voluntary appeal procedures, if any; and (5) a statement that the claimant has a right to sue for benefits under ERISA, §502(a).⁷⁸ Notices of decisions on appeal involving group health and disability claims must also include: (1) a description of any rule, guideline, or protocol relied on as well as a statement that the rule, guideline, or protocol is available free of charge upon request; (2) if the decision is based on a medical necessity or experimental treatment or similar exclusion, the notice must either explain the scientific or clinical basis for the decision or a statement that such an explanation will be provided free of charge upon request; and (3) the notice must include the following statement: “You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local United State Department of Labor office and your State insurance regulatory agency.”⁷⁹

8. Other Requirements

At the close of the regulations, the DOL commented on two issues. First, the DOL stated that state insurance laws are not preempted by ERISA or the new claim procedure regulations if they do not prevent application of a requirement of the DOL claim procedure rules.⁸⁰ Specifically, the DOL stated that a state law that establishes a review procedure to resolve group health claim disputes does not prevent application of the DOL regulation “so long as the review procedure is conducted by a person or entity other than the insurer, the plan, plan fiduciaries, employer, or any employee or agent of any of the foregoing.”⁸¹ This appears to be a response to laws passed by several states in the last couple of years that require a third-party review process and other procedures to resolve health claim disputes.⁸²

Second, the DOL regulations suggested certain “penalties” for failing to follow the new claim procedure regulations.⁸³ If a plan fails to comply with the regulations, the claimant will be deemed to have exhausted all applicable administrative remedies and is not subject to an exhaustion of remedies defense in court.⁸⁴ The claimant may also argue that he/she is entitled to pursue available remedies under ERISA, §502(a) “on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the

⁷⁶ *Id.* at §2560.503-1(h)(3)(vi).

⁷⁷ *Id.* at §2560.503-1(j).

⁷⁸ *Id.* at §2560.503-1(j)(1)–(4).

⁷⁹ *Id.* at §2560.503-1(j)(5).

⁸⁰ *Id.* at §2560.503-1(k)(1).

⁸¹ *Id.* at §2560.503-1(k)(2).

⁸² See *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002) (upholding Illinois third-party review law against ERISA preemption challenge).

⁸³ 29 C.F.R. §2560.503-1(l).

⁸⁴ *Id.*

merits of the claim.”⁸⁵ It remains to be seen whether the courts will adopt these options in reviewing claim decisions under ERISA.

C. Proposed Amendments to Claim Regulations: Disability Claims

In November 2015, the Department of Labor issued proposed amendments to the disability claim procedure regulations applicable to ERISA plans. There are three stated reasons for the Department’s decision to revise the disability claim regulations. The Department announced that it wished to bring the disability regulations into line with changes to the health care regulations necessitated by the Affordable Care Act. Another stated purpose is to counter perceived increases in disability claim litigation. Finally, the Department announced that claim procedure amendments are intended to reduce the cost and perceived delays in processing disability claims. Unfortunately, the goal of bringing disability claim procedures into line with medical procedures is misguided because of the dramatic differences between medical and disability benefit claims. Moreover, the Department’s proposals will not accomplish the remaining goals of reducing costs and litigation and—more likely—will lead to increased administrative costs and delays and increased litigation because of several additional layers of review and other requirements imposed on an already complicated process. The purpose of this article is to analyze some of the key proposed amendments and to suggest modifications as the proposals work their way through the regulatory process.

1. Proposals to Amend Disability Claim Regulations

The amendment proposals do not eliminate any of the current requirements imposed by the 2020 amendments. Instead, the 2015 proposals add new and different requirements that will supplement the amount of work involved in processing a disability benefit claim, that will cause resulting delays in making decisions, and that will increase the cost of such claims and the amount of litigation that arises from such claims.

a. Right to Review New Evidence and Rationales

The current rules do not require a plan to disclose evidence received or generated during the appeal phase until after a final decision is rendered. Efforts by plaintiffs to convince courts to add such a requirement and to also require plans to give claimants a chance to respond to the new evidence have been largely for naught. *See, e.g., Metzger v. UNUM Life Ins. Co. of Am.*, 476 F.3d 1661, 166 (10th Cir. 2007). This is primarily based on court’s conclusion that no such requirement exists in the current regulations. *Id.* Court have also expressed concern that such a requirement would result in an endless back-and-forth between the plan and the claimant, delaying the decision process as well as increasing the cost of the appeal process. *Id.*

The proposed regulations add a new requirement applicable during the claim appeal phase that a plan must permit a claimant a reasonable time to review and respond to “new or additional evidence.” That in and of itself is probably not an issue to the extent it is intended to reflect what is already a common practice by many disability insurance carriers. It is not unusual for plans to provide a copy of an independent medical examination report or other significant medical review to the claimant and/or the claimant’s treating doctor for comment before rendering an appeal decision.

What makes the proposal problematic, however, is that the Department places no limits on the amount of back-and-forth required nor does it propose to adjust the decision period to accommodate this addi-

⁸⁵ *Id.*

tional procedure. One would hope that this process happens once during the appeal phase such that all new evidence is forwarded to the claimant and the claimant is given an adequate time to respond to all of the evidence at one time. When the claimant does respond, if the response prompts further review by a medical professional, which is likely (and may be required by the current regulations), the plan ought not be required to send the matter for another response, and so on.

As for timing, the Department should impose a deadline for a claimant's response and should toll the decision deadline while the plan waits for the response or the response time expires with no response. There is no way that this added requirement can be accomplished under the current time frames. The Department should also allow for a minimum decision period after a claimant's response is received.

Part of the problem is the Department's failure to define what constitutes "new evidence." New evidence might mean new facts or it might mean a new medical opinion on the same facts. If the latter, there is a much greater chance of the repeated back-and-forth that the courts have warned about. In that case, the claim process could extend indefinitely and administrative appeal costs will skyrocket, all of which is contrary to the Department's express goals.

b. Deemed Exhausted Requirement

One of the more interesting proposals is the Department's proposal that a plan must strictly comply (as opposed to substantially comply) with the claim procedures and a rule that would allow claimants to call an end to the claim process at any time for any perceived error. Claimants have the option to provide advance notice to the plan, but are not required to do so. Otherwise, claimants can apparently go directly to court where the court will be faced with deciding whether the alleged error was "*de minimis*." This is a technical term under the proposed amendments that takes into account a host of factors, including prejudice, good faith, whether the parties are engaging in ongoing communication, whether the error is part of a pattern and practice, and so on.

There are so many problems with this proposal that it is hard to know where to begin. The most obvious is that it promises to establish a veritable cottage industry of claim procedure litigation. There are no limits to the number of times a claimant can terminate the claim process nor are there any apparent restrictions on what a claimant determines are the proper bases for alleging a claim violation. There is also no penalty to a claimant for filing a groundless lawsuit. To the contrary, if the claimant is wrong, the claimant is merely allowed to return to the claim process as if nothing happened.

The possibility of gamesmanship is without a doubt. Claimants' attorneys who want to extort a settlement will launch premature litigation on the pretext of a claim violation in order to force the plan to incur litigation costs and incentivize it to settle a disputed and potentially doubtful claim. At the very least, they will threaten to do so. Even where there is a legitimate procedural issue, it still makes no sense to truncate the claim process. What if the plan were to ultimately approve the claim? By taking the claim into litigation before there is a claim determination, the claimant may suffer months or years of delay in receiving benefits.

This "deemed exhausted" provision should be jettisoned. If the Department insists on imposing such a requirement, it should at least require advance notice and allow the plan an opportunity to respond. That will not prevent unscrupulous lawsuits, but will at least help avoid misunderstandings that can ultimately lead to delays and unnecessary costs. Finally, where a claimant does pursue a frivolous suit, there ought to be a penalty of some kind, including forfeiting the right to further pursue the claim.

Finally, the Department opines that where a plan does not strictly comply with the claim regulations, then a court should not apply deferential review. With all due respect to the Department, this is not the Department's call. The decision on what judicial review standard to apply rests solely with the courts. The Department's position also ignores binding United States Supreme Court case law. In *Conkright v. Frommert*, 130 S. Ct. 1640 (2010), Chief Justice Roberts recognized the obvious when he opened the majority decision by stating "People make mistakes." In that case, the Court held that an honest mistake does not to deprive a plan fiduciary of plan-granted discretionary authority. But that is exactly what the Department is attempting to do in the proposed amendments and it has no authority to impose such a rule on the federal courts.

c. Disclosure Requirements

The proposed claim amendments also require a plan that is denying a claim to affirmatively respond to contrary recommendations or decisions by treating doctors, and other third party payers, including Social Security. It is common practice for disability plans to discuss treating physician opinions and to distinguish contrary Social Security decisions, so the proposal really adds nothing new on that front. A requirement to discuss opinions of other third party payers, however, will greatly increase costs. For example, if another disability or pension plan has made a disability benefit determination, the plan will be required to determine the criteria for that decision, the bases for the third party decision, and to obtain the record evidence in the possession of the third party payer in order to evaluate the decision. Not only that, but unlike Social Security files which are fairly static once a decision is rendered, private disability plans typically require ongoing review, which means that the files are dynamic and constantly changing, and which also means the plan will be required to constantly request updates from the third party payer. Finally, so what if a third party payer disagrees with the plan? If both plans are granted discretionary authority, by its nature that means there is room for disagreement among reasonable people. Certainly the Department should not be suggesting that a plan abdicate its decision making responsibility simply because a third party has decided to approve a disability claim.

The proposal also requires disclosure of any "new rationale" for an adverse benefit determination before the appeal decision is rendered. Under current practice, where a new basis for a disability claim denial is raised for the first time in the appeal denial letter, the claimant is given the option of an additional appeal in order to address the new issue. The Department is now proposing that the claimant be given an opportunity to respond to this "new rationale" before the appeal decision is rendered. The problem with such a proposal is that it not only delays the decision process, but also requires the plan to predict what it may do in advance of the decision and in sufficient time to give the claimant time to respond so that the plan still has time to issue a timely decision.

Again, the proposed process and the timing are both problematic. The Department should leave the process the way it currently applies, *i.e.*, if the plan ultimately relies on a new basis for affirming a denied disability claim, the plan should provide the claimant with the option of requesting an additional appeal. That way the claimant can respond to a complete record and a final decision, not a preliminary thought that may be based on incomplete information and that may not even be adopted when the appeal decision is issued.

The Department is also proposing that a notice of an adverse benefit determination include disclosure of any rules or guidelines used in denying the claim or a statement that there are no rules or guidelines. The primary problem with this requirement is the Department's failure to recognize some of the fundamental differences between medical claims and disability claims. Medical plans typically have detailed guidelines

to decide such things as medical necessity or whether treatment is experimental. In contrast, disability plans rarely have such specific guidelines. Disability claims are highly fact-specific and rarely follow the patterns seen in medical claims. Typically, the disability policy language is the primary guideline for claim administrators and plans are already required to include applicable policy language in their denial letters. It is one thing to require disclosure where there is a guideline actually used in denying a claim; however, it is quite another thing to require disability plans to guess whether some term in a company's claim manual might possibly be construed as being applicable so that the plan can accurately deny that no such guideline exists.

d. Independence and Impartiality

According to the Department, disability plans cannot make hiring or other employment decisions based on the likelihood that the person will support a denial of benefits. That seems rather innocuous as far as it goes and probably reflects current industry practice. The proposal then goes on to state that medical experts cannot be retained based on "reputation for outcomes." The Department does not define what "reputation" entails and it is far from clear. Reputation from whose perspective? The plaintiff? The disability plan? The Department also fails to address how this information will be disclosed or whether it will lead to unnecessary discovery. Will discovery require an expert's opinions regarding other claimants so one can determine the expert's "reputation"? Would this be limited to claimants under the same plan or would it extend to other plans and programs? The questions are endless. This proposal needs to be deleted or clarified, but again, the strong possibility that it will create confusion and add costs defeats the very purposes espoused by the Department and the reasons for issuing the proposals in the first place.

e. Notices for Contractual Limitations Periods

The Department also asks for comments about whether disability plans should be required to disclose contractual limitations periods in denial letters. Not only that, but the Department is also suggesting that plans be required to compute and disclose the actual deadline to file suit and to update that deadline as circumstances change and tolling applies, etc.

The circuits are split on whether contractual limitations periods need to be disclosed. Disclosure of a plan's limitations language, if any, is probably not too burdensome. However, asking disability claim personnel to essentially practice law by evaluating, interpreting, and calculating lawsuit deadlines is a bit over the top. Asking the same personnel to update their calculations, especially if it means doing so for closed claims, accomplishes nothing and unduly complicates the process.

f. Implementation Date

The Department proposes that any final regulations go into effect 60 days after finalization. This is not realistic. When the 2000 regulations were finalized in November 2000, they were made applicable to claims filed on or after January 1, 2002. That gave plans time to adjust procedures, revise plan documents and obtain insurance department approval for same where necessary, hire and train personnel, and so forth. That kind of lead time is also required for the current proposals unless the Department pulls back significantly from the proposals when it issues the final regulations.

ERISA's Civil Enforcement Scheme: Causes of Action and Remedies

I. Statutory Claims and Parties Plaintiff

ERISA's detailed civil enforcement section lists several causes of action related to employee benefit plans, prescribes the parties who may bring each type of action, and sets forth the available remedies under each type of action.

The statute is limited to four types of plaintiffs: the Secretary of Labor, plan participants, plan beneficiaries, and plan fiduciaries.¹ The types of individuals and entities included within the term "fiduciary" are discussed at Chapter 5.² A plan *participant* is defined by ERISA as:

[A]ny employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan... or whose beneficiaries may be eligible to receive any such benefit.³

The Supreme Court has held that a former employee does not fall within the "may become eligible" language of this definition unless he has a reasonable expectation of returning to covered employment or a colorable claim to vested benefits.⁴ A plan *beneficiary* is defined as:

[A] person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder.⁵

Most courts have held that the parties specifically enumerated in ERISA's civil enforcement section are the only parties authorized to bring the actions delineated therein.⁶ However, this is not a unanimous view.⁷

¹ ERISA, §502 [29 U.S.C. §1132].

² *Supra*.

³ ERISA, §3(7) [29 U.S.C. §1002(7)].

⁴ *Firestone v. Bruch*, 489 U.S. 101, 117 (1989).

⁵ *Id.* at §3(8).

⁶ *See, e.g., Allstate Ins. Co. v. The 65 Security Plan*, 879 F.2d 90 (3d Cir. 1989); *Hermann Hospital v. MEBA Medical & Benefits Plan*, 845 F.2d 1286 (5th Cir. 1988); *Teagardener v. Republic-Franklin, Inc. Pension Plan*, 909 F.2d 947 (6th Cir. 1990).

⁷ *See Amalgamated Clothing & Textile Workers' Union v. Murdock*, 861 F.2d 1406 (9th Cir. 1988) (allowing a non-enumerated party to bring an action under ERISA where the party can demonstrate that he has suffered an injury in fact, that he arguably falls within the zone of interests protected by the statute, and where the statute does not preclude the party from bringing suit).

The civil enforcement section makes several types of actions available to the parties listed above in connection with an employee welfare benefit plan, including the following:

- 1) A *participant* or *beneficiary* may bring an action for the statutory penalty applicable to an administrator or an employer's failure to comply with certain procedural requirements of the statute [ERISA, §502(a)(1)(A)];
- 2) A *participant* or *beneficiary* may bring an action to recover benefits due to him under the terms of the plan, to enforce rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan [ERISA, §502(a)(1)(B)];
- 3) The *Secretary* or a *participant*, *beneficiary* or *fiduciary* may bring an action for appropriate relief for a breach of fiduciary duties (discussed in more detail at Chapter 5)⁸ [ERISA, §502(a)(2)];
- 4) The *Secretary* or a *participant*, *beneficiary* or *fiduciary* may bring an action to
 - enjoin “any act or practice” that violates ERISA or the terms of the plan; *or*
 - obtain “other appropriate equitable relief” to redress such violations or to enforce ERISA or the terms of the plan [ERISA, §502(a)(3) and (5)];
- 5) The *Secretary*, or a *participant*, *beneficiary* or *fiduciary* may bring an action for violations of ERISA's reporting requirements [ERISA, §502(a)(4)];
- 6) The *Secretary* may bring an action to collect any civil penalty
 - for a plan administrator's failure or refusal to file an annual report;
 - for a party in interest's participation in a prohibited transaction; *or*
 - against a “fiduciary or other person” for any breach of fiduciary duty or any knowing participation in such breach [ERISA, §502(a)(6)].

II. Benefit Claims and Parties Defendant

By far the most common type of civil enforcement remedy under ERISA is an action for benefits under a plan. Such an action may be brought by a participant or a beneficiary of the plan.⁹ The plaintiff may seek benefits presently due to him/her under the terms of the plan, may seek to enforce his/her right to present benefits under the plan, or may seek to clarify his/her right to future benefits under the plan. The term “benefits” in this case includes all types of employee benefits governed by ERISA, including pension and welfare benefits. Although the statute does not specify the proper defendant, it does state that a plan may be sued as an entity. ERISA, §502(d)(1).

III. Compensatory and Punitive Damages

Aside from the appropriate standard of review, discussed at Chapter 4,¹⁰ the most common issue raised in an action under ERISA's civil enforcement section concerns the type and scope of damages available to the plaintiff in addition to the disputed benefits themselves. In *Pilot Life*, the Supreme Court held that state law

⁸ *Supra.*

⁹ ERISA, §502(a)(1)(B).

¹⁰ *Supra.*

“bad faith” claims and damages are not available to plaintiffs because they are preempted and because ERISA’s civil enforcement scheme is exclusive.¹¹

Much of the debate as to the scope of damages under ERISA has arisen since the *Russell* decision. In that case, the Supreme Court held that there is no private cause of action for extracontractual damages in an action for breach of fiduciary duties under §§409 [29 U.S.C. §1109] and 502(a)(2).¹² In *Russell*, a plan participant sought extracontractual compensatory and punitive damages as a result of the plan administrator’s alleged breach of fiduciary duties under ERISA. The plaintiff based her claim on §409 and its companion enforcement subsection, §502(a)(2). The Court held that there was no *express* private cause of action for damages under §409 or §502(a)(2) and that any recovery for breach of fiduciary duties was intended to inure to the benefit of the plan as a whole rather than to a particular individual:

[T]he entire text of [§1109] persuades us that Congress did not intend that section to authorize any relief except for the plan itself. In short... we do not find in [§1109] express authority for an award of extra-contractual damages to a beneficiary.¹³

The Court also concluded that there was no *implied* right of action for such damages under ERISA. This conclusion was based in large part on a review of the civil enforcement provision of ERISA [§502] and the absence in that provision of any reference to extracontractual or punitive remedies:

The six carefully integrated civil enforcement provisions found in [§1132(a)] of the statute as finally enacted... provide strong evidence that Congress did not intend to authorize other remedies that it simply forgot to incorporate expressly. The assumption of inadvertent omission is rendered especially suspect upon close consideration of ERISA’s interlocking, interrelated, and interdependent remedial scheme, which is in turn part of a ‘comprehensive and reticulated statute.’

...

In contrast to the repeatedly emphasized purpose to protect contractually defined benefits, there is a stark absence—in the statute itself and in its legislative history—of any reference to an intention to authorize the recovery of extra-contractual damages.¹⁴

Accordingly, the Court held that there is no express or implied private cause of action for extracontractual compensatory or punitive damages for breach of fiduciary duties under ERISA, §409 and its corresponding civil enforcement provision, §502(a)(2).

Although the Supreme Court did not expressly decide whether extracontractual damages are recoverable under ERISA’s general equitable relief section, §502(a)(3),¹⁵ several circuit court decisions have held that they are not. Prior to *Russell*, the Eighth Circuit expressed strong doubts as to the availability of an award of extracontractual damages under §§502(a) and 510 [29 U.S.C. §1140]:

We do not think punitive damages are provided for in ERISA. Ordinarily punitive damages are not presumed; they are not the norm; and nowhere in ERISA are they mentioned. If Congress had desired to provide for punitive damages, it could have easily so stated, as it has in other acts. However, we need not

¹¹ See also, *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134 (1985).

¹² *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134 (1985).

¹³ 473 U.S. at 144.

¹⁴ *Id.* at 146–48.

¹⁵ In *Russell*, *supra*, the Court expressly reserved decision on whether extracontractual damages could be recovered under §502(a)(3). 473 U.S. at 139 n.5.

decide this issue, because we find that punitive damages are inappropriate in this case under either 29 U.S.C. §1132(a) or §1140... We believe that, as a matter of federal common law, an award of punitive damages is inappropriate to a claim of interference with employee benefit plans.¹⁶

After the Supreme Court decision in *Russell*, virtually every circuit court that has addressed the issue has applied the framework and guidelines in *Russell* to hold that extracontractual compensatory and punitive damages were not recoverable under §502(a).¹⁷

A rather large body of case law developed in this area in connection with claims under ERISA's interference with employee benefit rights section, §510. In *Drinkwater v. Metropolitan Life Ins.*, the First Circuit held that a violation of §510 did not entitle a plaintiff to extracontractual damages:

The compensatory and punitive damages sought by [plaintiff] are extracontractual in that this relief is not within the terms of... [the] benefit plan... It is clear that the comprehensive provisions of ERISA were intended by Congress to be the exclusive remedy for beneficiaries under ERISA-authorized plans. In light of that history, we cannot conclude that Congress intended to authorize any form of relief other than what was expressly granted.¹⁸

In *Bishop v. Osborn Transportation*, the Eleventh Circuit held that punitive damages were not available as a result of a violation of §510 as enforced under §502(a)(3):

Punitive damages are just that, damages, and are not ordinarily incorporated by the term 'equitable relief'... The restriction of §502(a)(3)(B) to equitable relief shows Congress did not intend the recovery of punitive damages under §502(a)...

...

The [plaintiff] does not cite any case in which a court explicitly authorized the recovery of punitive damages under §502(a). On the other hand, the Fourth, Fifth, Sixth, Seventh, Eighth and Ninth Circuits have all held that §502(a)(3) does not authorize the recovery of punitive or extra-contractual damages.¹⁹

Likewise, in *Pane v. RCA Corp.*, the Third Circuit held that punitive damages could not be awarded for a violation of §510 where "[i]t has been consistently held that §502(a) of ERISA... does not authorize such relief."²⁰

Like the Supreme Court holding in *Russell*, this line of authority was founded to a great extent on the fact that ERISA's civil enforcement provisions are exclusive and that those provisions make no reference to the recovery of extracontractual compensatory or punitive damages. The Supreme Court expressed reluctance to

¹⁶ *Dependahl v. Falstaff Brewing Corp.*, 653 F.2d 1208, 1216 (8th Cir. 1981).

¹⁷ *Pane v. RCA Corp.*, 868 F.2d 631 (3d Cir. 1989); *Drinkwater v. Metropolitan Life Ins. Co.*, 846 F.2d 821 (1st Cir. 1988); *Sage v. Automation, Inc. Pension Plan & Trust*, 845 F.2d 885 (10th Cir. 1988); *Bishop v. Osborn Transportation*, 838 F.2d 1173 (11th Cir. 1988); *Varhola v. Doe*, 820 F.2d 809 (6th Cir. 1987); *Kleinhans v. Lisle Savings Profit Sharing Trust*, 810 F.2d 618 (7th Cir. 1987); *Sokol v. Bernstein*, 803 F.2d 532 (9th Cir. 1986); *Sommers Drug Stores v. Corrigan Enterprises, Inc.*, 793 F.2d 1456 (5th Cir. 1986); *Powell v. Chesapeake & Potomac Tel. Co. of Va.*, 780 F.2d 419 (4th Cir. 1985).

¹⁸ 846 F.2d at 824.

¹⁹ 838 F.2d at 1174.

²⁰ 868 F.2d at 635 n.2.

“tamper with an enforcement scheme crafted with such evident care as the one in ERISA,”²¹ and stated that “Congress did not intend to authorize other remedies that it simply forgot to incorporate expressly.”²²

Despite the unanimity of the federal courts, the issue of the availability of extracontractual compensatory and punitive damages was resurrected after the Supreme Court’s decision in *Ingersoll-Rand v. McClendon*.²³ In that case, the Supreme Court held that ERISA provided the exclusive remedy for plaintiff’s wrongful discharge claim, where plaintiff alleged that the purpose of his discharge was to avoid the vesting of his pension. The plaintiff sought compensatory and punitive damages, but not plan benefits, because it was discovered during the course of the litigation that the discharge did not affect plaintiff’s vesting in the pension plan. The lower court had held that ERISA did not apply to plaintiff’s claim because plaintiff was not seeking ERISA benefits under the benefit plan. The Supreme Court held that this fact was not sufficient to avoid preemption because plaintiff’s claim still “relate[d] to” an employee benefit plan and was therefore subject to the exclusive remedies of ERISA, §502(a). At the end of the Court’s opinion, in a passing comment, the Court noted that “the relief requested here is well within the power of federal courts to provide.”²⁴ The Court did not specify what “relief” it was referring to in this vague statement.

Plaintiffs attempted to argue that this bald statement permitted a claim for extracontractual damages under ERISA; in fact, some lower courts accepted this argument.²⁵ However, the circuit courts did not. For example, in *McRae v. Seafarers’ Welfare Plan*,²⁶ the Eleventh Circuit held that extracontractual compensatory and punitive damages were not available under ERISA, §502(a)(3) and rejected the plaintiff’s argument that the above language in *Ingersoll-Rand* would permit the recovery of extracontractual damages:

We find that our holding in this case does not conflict with the recent Supreme Court decision in *Ingersoll-Rand Co. v. McClendon*.... In *Ingersoll-Rand*, the Supreme Court stated: ‘Not only is §502(a) the exclusive remedy for vindicating §510 protected rights, there is no basis in §502(a)’s language for limiting ERISA actions to only those which seek ‘pension benefits’. It is clear that the relief requested here is well within the power of federal courts to provide.’.... We do not interpret these statements to mean that the remedies which the plaintiff in *Ingersoll-Rand* was seeking—future lost wages, mental anguish and punitive damages—are necessarily available under ERISA §502(a). The Supreme Court was stating that federal law provides relief for ERISA actions other than those that seek to recover pension benefits, such as the plaintiff’s cause of action for wrongful termination. The Supreme Court is not holding that the specific *remedies* this plaintiff had sought under state law are necessarily the remedies that will be afforded him should he be granted *relief* under ERISA §502.²⁷

Likewise, in *Harsch v. Eisenberg*, the Seventh Circuit stated that “we are not rash enough to believe that the [Supreme] Court [in *Ingersoll-Rand*] intended to overrule settled law in most of the circuits, as well as narrowly limit—if not overrule—its own decision in [*Massachusetts Mutual v.*] *Russell* in such an off-hand

²¹ *Russell*, 473 U.S. at 147.

²² *Id.* at 146; *see also*, *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987) (holding that a common law action for bad faith was preempted by ERISA’s exclusive civil remedy provision).

²³ 498 U.S. 133 (1990).

²⁴ *Id.* at 145.

²⁵ *See, e.g.*, *Blue Cross and Blue Shield of Alabama v. Lewis*, 753 F. Supp. 345 (N.D. Ala. 1990).

²⁶ 920 F.2d 819 (11th Cir. 1991).

²⁷ 920 F.2d at 821 n.7. *Accord* *Zimmerman v. Sloss Equipment, Inc.*, 72 F.3d 822 (10th Cir. 1995).

manner.”²⁸ The *Harsch* Court went on to hold that “[w]e will continue to doubt the availability of extracontractual damages under ERISA until a more plausible signal reaches us from above.”²⁹

Any issue as to the availability of compensatory and punitive damages under ERISA was finally laid to rest by the Supreme Court in *Mertens v. Hewitt Associates*.³⁰ In that case, the plaintiff sought common-law damages from a nonfiduciary based on the allegation that the nonfiduciary had participated in various breaches by plan fiduciaries. Plaintiff pursued his damage action under ERISA’s general equitable relief provision, §502(a)(3). Expressing doubt as to whether any claim could be made against a party that was not a fiduciary of the plan, the Supreme Court went on to hold that damages were not available under ERISA.

The Court noted that the availability of “other equitable relief” under §502(a)(3) could mean the availability of relief that was generally available in courts of equity or, on the other hand, the phrase could be limited to those types of relief generally considered to be equitable. The Court held that Congress intended the availability of “other equitable relief” under ERISA to mean that a party may only obtain those types of relief generally considered to be equitable (*e.g.*, restitution, injunction, or mandamus), but that damages are not available under §502(a)(3). After the decision in *Mertens*, federal circuit courts continued to uniformly hold that extracontractual compensatory and punitive damages are not available under ERISA’s exclusive civil enforcement scheme and that a plaintiff pursuing an action under ERISA may only obtain equitable relief.³¹

IV. Fiduciary Duty Claims Under §§409 and 502(a)(2)

In *Massachusetts Mutual Life Insurance Co. v. Russell*, *supra*, the Supreme Court held that a claim for breach of fiduciary duties under §§409 and 502(a)(2) may only be brought on behalf of the plan and not for individual relief. However, in *LaRue v. DeWolff, Boberg & Associates, Inc.*,³² the Court narrowed its holding in *Russell* somewhat. The plaintiff in *LaRue* was a participant in an individual account (IRC 401(k)) pension plan. *LaRue* alleged that the plan fiduciary failed to carry out his investment instructions and that his account was damaged in the amount of \$150,000. The record did not reflect whether this amount represented the decline in value of assets that the fiduciary should have sold or the increase in value of assets that the fiduciary should have purchased (*i.e.*, missed opportunity costs). The participant sought to recover this amount from the fiduciary as “make whole” relief under the general equitable relief provision of ERISA, §502(a)(3), as well as relief under the fiduciary breach provisions of ERISA, §§409 and 502(a)(2). The question under §502(a)(3) was whether equitable relief includes monetary “make whole” relief. The question under §§409 and 502(a)(2) was whether the participant was seeking relief on behalf of the plan, which is authorized by §§409 and 502(a)(2), or whether he was seeking relief on his own account, which is not authorized by those provisions.

Analyzing the question under §§409 and 502(a)(2), the Supreme Court noted the dramatic change in pension plan design since *Russell*. When *Russell* was decided, most employers sponsored traditional defined benefit plans, under which a guaranteed pension amount is paid from a common fund. By the time *LaRue*

²⁸ 956 F.2 651, 660 (7th Cir. 1992).

²⁹ *Id.*

³⁰ 124 L. Ed. 2d 161 (1993).

³¹ *Godfrey v. BellSouth*, 89 F.3d 755 (11th Cir. 1996); *Zimmerman v. Sloss Equipment*, 72 F.3d 822 (10th Cir. 1995); *Kemmerer v. ICI Americas, Inc.*, 70 F.3d 281 (3d Cir. 1995); *Filipowicz v. American Stores*, 56 F.3d 807 (7th Cir. 1995); *Fraser v. Lintas*, 56 F.3d 722 (6th Cir. 1995).

³² 552 U.S. 248 (2008).

was decided, however, the pension landscape had changed such that “[d]efined contribution plans dominate the retirement plan scene....” Under a defined contribution plan, each participant is assigned his own account with profits and losses being applied solely to the participant’s individual account rather than to the plan as a whole. Thus, LaRue was seeking relief for the alleged decline in value of his own individual account. The question was whether he was also seeking relief on behalf of the plan.

The Supreme Court observed that where defined benefit plans are concerned, fiduciary misconduct affects the entire plan. This contrasts with defined contribution plans where “fiduciary misconduct need not threaten the solvency of the entire plan to reduce benefits below the amount that participants would otherwise receive.” For purposes of determining whether relief was available under §§409 and 502(a)(2), the Supreme Court saw no distinction between these two situations:

Whether a fiduciary breach diminishes plan assets payable to all participants and beneficiaries, or only to person tied to particular individual accounts, it creates the kind of harms that concerned the draftsmen of §409. Consequently, our references to the ‘entire plan’ in *Russell*, which accurately reflect the operation of §409 in the defined benefit context, are beside the point in the defined contribution context.

The Court therefore held that “although §502(a)(2) does not provide a remedy for individual injuries distinct from plan injuries, that provision does authorize recovery for fiduciary breaches that impair the value of plan assets in a participant’s individual account.” According to footnote 4 of the decision, whether LaRue’s alleged losses were based on the diminution in value of assets that should have been sold or the increase in value of assets that should have been purchased, in either case relief was available as “lost profits” under traditional trust law principles. Because LaRue had a potential remedy under §§409 and 502(a)(2), the Court declined to address whether he could also assert a claim for monetary “make whole” relief under ERISA’s general equitable relief provision, §502(a)(3).³³

V. Federal Common Law Claims

In enacting ERISA, Congress mandated that the courts develop federal common law to fill in the gaps left by the statute. Some courts have utilized this mandate to interpret the statute by, for example, creating standards of review of plan benefit decisions, which standards are based largely on the common law of trusts. (These standards and their roots in the common law of trusts are discussed in Chapter 4.³⁴) Other courts have used federal common law to permit parties to bring actions provided by the statute even though the statute does not name those parties as entities entitled to bring such actions. Still other courts have used federal common law to create new types of actions, even though the state law counterparts of such actions are clearly preempted by ERISA. An example of this latter development involves claims of estoppel.

Several federal circuit courts have held that *state* common law claims of estoppel are preempted by ERISA.³⁵ Moreover, several courts have held, either explicitly or implicitly, that an estoppel-type cause of action

³³ For further discussion of the potential availability of “make whole” relief under §502(a)(3), see analysis of *CIGNA Corporation v. Amara*, 131 S. Ct. 1866 (2011), *infra*.

³⁴ *Supra*.

³⁵ *Schonholz v. Long Island Jewish Hospital*, 87 F.3d 72 (2d Cir. 1996); *Salomon v. Transamerica Occidental Life Ins. Co.*, 801 F.2d 659 (4th Cir. 1986); *Degan v. Ford Motor Company*, 869 F.2d 889 (5th Cir. 1989); *Davis v. Kentucky Finance Cos. Retirement Plan*, 887 F.2d 689 (6th Cir. 1989); *Anderson v. John Morrell & Co.*, 830 F.2d 872 (8th Cir. 1987); *Nachwalter v. Christie*, 805 F.2d 956 (11th Cir. 1986).

does not arise under the ERISA statute or under the *federal* common law of ERISA.³⁶ However, not all courts have been so quick to dismiss such a cause of action, particularly under *federal* common law. For example, in *Black v. TIC Investment Co.*,³⁷ the Seventh Circuit held that estoppel principles apply to claims for benefits under unfunded single-employer welfare benefit plans. Noting that estoppel is generally applicable in all types of legal actions, the Court recognized a general reluctance to apply these principles in ERISA actions, especially where there is a concern for the financial stability of a funded benefit plan. The Court held that such a concern did not bar application of estoppel in actions involving an unfunded welfare benefit plan because there was no particular fund to be depleted by the payment of benefits and no danger that others associated with the plan might be harmed.³⁸ Later decisions by the Seventh Circuit appear to limit an estoppel claim to representations made in writing as opposed to oral representations.³⁹ More recently, the Seventh Circuit has suggested that an estoppel-like remedy may be available for breach of fiduciary duty under §502(a)(3), at least where the coverage terms of the benefit plan are not clear and where statements of coverage are made by representatives of the plan.⁴⁰

The Eleventh Circuit has also recognized the applicability of an estoppel claim under federal common law where the alleged representation constitutes an interpretation rather than a modification of the terms of an employee benefit plan. Thus, where the terms of the plan are ambiguous and the representations of the plan fiduciary constitute an interpretation of those terms and the participant or beneficiary has relied to his/her detriment on the fiduciary's representations, estoppel may be appropriate under federal common law.⁴¹ However, equitable estoppel is not available where the plan terms are clear and unambiguous because the alleged misrepresentations would constitute an unenforceable oral modification rather than an interpretation of the plan terms.⁴²

Finally, the Fourth Circuit has held in a split *en banc* decision that although a state law estoppel claim is preempted by ERISA, where the estoppel claim is based on pre-plan representations, it may be brought under federal common law. *Elmore v. Cone Mills Corporation*.⁴³ The Fourth Circuit has also continued to hold that an estoppel claim is not viable—under either state or federal law—where it is based on representations that occurred after the benefit plan was created because such a cause of action would create an impermissible modification of written plan terms.⁴⁴ Like other recent decisions, however, the Fourth Circuit has suggested

³⁶ See, e.g., *McCall v. Burlington Northern/Santa Fe Co.*, 237 F.3d 506 (5th Cir. 2000); *Degan v. Ford Motor Company*, *supra*; *Straub v. Western Union Tel. Co.*, 851 F.2d 1262 (10th Cir. 1988); *Nachwalter v. Christie*, *supra*.

³⁷ 900 F.2d 112 (7th Cir. 1990).

³⁸ See also *Rosen v. Hotel and Restaurant Employees, etc.*, 637 F.2d 592 (3d Cir. 1981).

³⁹ See, e.g., *Bowerman v. Wal Mart Stores, Inc.*, 226 F.3d 574 (7th Cir. 2000); *Downs v. World Color Press*, 214 F.3d 802 (7th Cir. 2000).

⁴⁰ See, e.g., *Killian v. Concert Health Plan*, 742 F.3d 651 (7th Cir. 2013); *Kenseth v. Dean Health Plan, Inc.*, 722 F.3d 869 (7th Cir. 2013).

⁴¹ *Kane v. Aetna Life Ins. Co.*, 893 F.2d 1283 (11th Cir. 1990); *National Cos. Health Benefit Plan v. St. Joseph's Hospital of Atlanta, Inc.*, 929 F.2d 1558 (11th Cir. 1991). See also *Wilson v. Prudential Insurance Co.*, 97 F.3d 1010 (8th Cir. 1996); *Bolton v. Construction Laborers' Pension Fund*, 56 F.3d 1055 (9th Cir. 1995).

⁴² *Katz v. Comprehensive Plan of Group Ins.*, 197 F.3d 1084 (11th Cir. 1999); *Novak v. Irwin Yacht and Marine Corporation*, 986 F.2d 468 (11th Cir. 1993).

⁴³ 23 F.3d 855 (4th Cir. 1994).

⁴⁴ *Coleman v. Nationwide Life Ins. Co.*, 969 F.2d 54 (4th Cir. 1992).

that an estoppel-like remedy may be available where representations of coverage are made and the participant has relied on those representations to his or her detriment.⁴⁵

Creation of federal common law causes of action not expressly provided for in ERISA may be tempered somewhat by the Supreme Court's decision in *Peacock v. Thomas*.⁴⁶ The plaintiff in that case attempted to use a "pierce the corporate veil" theory to enforce a judgment against an individual owner of a corporation. The Fourth Circuit held that a federal common law claim for piercing the corporate veil existed under ERISA's provision for general equitable relief, §502(a)(3). The Supreme Court reversed. The Supreme Court held that the plaintiff could not pursue such a cause of action under ERISA's general equitable relief section where the alleged wrongdoing occurred after the ERISA plan was terminated, the defendant was not a plan fiduciary, and piercing the corporate veil was not itself an independent ERISA cause of action. The Court stated: "[s]ection 502(a)(3) 'does not, after all, authorize appropriate equitable relief at large, but only appropriate equitable relief for the purpose of redress[ing any] violations or enforc[ing] any provisions of ERISA or an ERISA plan.'"⁴⁷

VI. Restitution of Overpaid Plan Benefits

A. Early Development of the Law Under ERISA

Under ERISA, benefits are only payable in accordance with the terms of the benefit plan.⁴⁸ Where benefits are mistakenly paid, as a result of negligence, fraud or otherwise, a question has arisen as to whether the plan, through some representative (such as a fiduciary), may seek restitution of the benefits. Because ERISA preempts state common law causes of action, the action must be based on ERISA's civil enforcement section. Some courts have permitted such actions and have charted two alternative routes for such an action: (1) a party specifically designated by §502(a)(3) may bring an action for equitable relief to redress violations of the plan (*i.e.*, the unauthorized payment of benefits); and (2) where the plaintiff is not a specifically designated party under §502(a)(3), an action for restitution may be brought under the federal common law of ERISA.

Section 502(a)(3) authorizes certain parties to seek redress for violations of the terms of the plan and/or to enforce the terms of the plan. The payment of plan benefits under circumstances where they should not have been paid constitutes a violation of the terms of the plan, thereby permitting a fiduciary to seek enforcement of the terms of the plan.⁴⁹ Restitution of the mistakenly paid benefits is a form of "appropriate equitable relief" under ERISA.⁵⁰

⁴⁵ See, e.g., *McCravy v. Metropolitan Life Ins. Co.*, 690 F.3d 176 (4th Cir. 2012).

⁴⁶ 516 U.S. 349 (1996).

⁴⁷ 516 U.S. at 353.

⁴⁸ See ERISA, §402(a)(1) [29 U.S.C. §1102(a)(1)] ("[e]very employee benefit plan shall be established and maintained pursuant to a written instrument") and §504(a)(1)(D) [29 U.S.C. §1104(a)(1)(D)] ("a fiduciary shall discharge his duties with respect to a plan... in accordance with the documents and instruments governing the plan").

⁴⁹ See *Blue Cross and Blue Shield of Alabama v. Weitz*, 913 F.2d 1544 (11th Cir. 1990); *Provident Life & Accident Insurance Company v. Waller*, 906 F.2d 985 (4th Cir.), *cert. denied*, 112 L. Ed. 2d 524 (1990); *Northern California Food Employers & Retail Clerks Unions Benefit Fund v. Dianda's Italian-American Pastry Co., Inc.*, 645 F. Supp. 160 (N.D. Cal. 1986).

⁵⁰ See *Mertens v. Hewitt Associates*, 508 U.S. 248 (1993); *Blue Cross and Blue Shield of Alabama v. Weitz*, *supra*; *Provident Life & Accident Insurance Company v. Waller*, *supra*; *Northern California Food Benefit Fund v. Dianda's*, *supra*.

The case of *Blue Cross v. Weitz* provides an illustration of how the procedure in §502(a)(3) was intended to work in a case of this type. In *Weitz*, the Eleventh Circuit affirmed a district court holding that an ERISA plan fiduciary may bring an action for restitution of wrongfully paid benefits under §502(a)(3). As the claims administrator for a self-funded health benefits plan, Blue Cross made benefit payments to a psychologist with the understanding that the psychologist was providing medical services to participants. Blue Cross later discovered that the psychologist had not seen any of the participants, but that the participants had been treated by a social worker instead. The plan prohibited the payment of benefits to anyone other than a “physician,” which by definition included licensed psychologists but did not include social workers.

The court held that Blue Cross was a fiduciary authorized to bring an action under §502(a)(3) with respect to its activities in determining claims for benefits and making payments of benefits:

[Blue Cross] serves as the claims administrator under the [Plan] and, with respect to its activities in determining claim eligibility, making payments, and hearing administrative appeals from claim denials, acts as a fiduciary within the meaning of ERISA.⁵¹

The Court also held that the payment of benefits to the psychologist, who was not providing services, and the payment of benefits to the social worker, who was providing services, was a violation of the terms of the plan within the meaning of §502(a)(3) because it was forbidden by the plan:

[The psychologist] stated... that he retained 20 percent of all amounts received from Blue Cross and remitted the remaining amounts to [the social worker]. [The social worker]... did not satisfy the definition of ‘physician’ under the [plan]. The payments to [the psychologist] for compensation of services provided by [the social worker] were therefore in violation of the terms of the [plan].⁵²

The Court then held that restitution of the benefits paid by Blue Cross was “appropriate equitable relief” under §502(a)(3):

As we read the plain language of the statute, [§502(a)(3)] is applicable to the instant case, which has been brought by a ‘fiduciary... to obtain... equitable relief... to redress [plan] violations or... to enforce... the terms of the plan.’ It is undisputed that Blue Cross is a fiduciary *seeking the equitable remedy of restitution*. It likewise seems clear that reimbursement to a psychologist who was not providing outpatient mental health services, or to a licensed clinical social worker who was, would violate the terms of the plan, which allows for payments only to physician providers of outpatient mental health services.⁵³

Accordingly, the Eleventh Circuit upheld the district court ruling that Blue Cross was entitled to obtain restitution of the mistakenly paid health benefits:

[T]he district court applied the plain legislative language of a specific ERISA provision governing the bringing of civil suits. We therefore affirm the district court’s holding that ‘[a]n equitable action to recover benefits erroneously paid... falls within the clear grant of jurisdiction contained in 29 U.S.C. §1132(a)(3).’⁵⁴

In reaching its conclusion that Blue Cross was entitled to seek restitution of the wrongfully paid benefits under §502(a)(3), the Eleventh Circuit approved and followed the district court decision in *Dianda’s*. In *Dianda’s*, the plan administrator was permitted to bring an action against an employer for restitution of benefits wrongfully paid to an ineligible employee as a result of the employer’s inaccurate reporting of the employee’s

⁵¹ 913 F.2d at 1545.

⁵² *Id.* at 1546.

⁵³ *Id.* at 1547 [emphasis added].

⁵⁴ *Id.* at 1549.

hours. The employer argued that §502(a)(3) did not apply to the administrator's action because the administrator was seeking reimbursement and §502(a)(3) only offers equitable relief. The district court held that restitution was a form of "appropriate equitable relief" because "redress" for plan violations "includes compensating the plan for money lost due to such violations."⁵⁵ The Eleventh Circuit in *Weitz* refused to follow the district court decision in *NYSA-ILA GAI Fund v. Poggi*,⁵⁶ which held that a plan could not bring an action for "damages" based on the defendant's wrongful acceptance of plan benefits based on its reading of §502(a)(3) as being limited to actions "to ensure continuing compliance" with the plan or ERISA. The Eleventh Circuit noted that the court in *NYSA-ILA* provided no reasoning for its restrictive interpretation of §502(a)(3) and stated that such a reading was inconsistent with the "plain meaning" of that section.⁵⁷

Even where the plaintiff is not a specifically designated party under §502(a)(3), some courts have allowed the plaintiff to bring an action for restitution under the federal common law of ERISA.⁵⁸ For the most part, federal common law is applied where the plaintiff is not a specifically enumerated party authorized to bring an action for "appropriate equitable relief" under §502(a)(3),⁵⁹ although at least one court has applied federal common law principles where the plaintiff was also able to pursue the matter under the statute.⁶⁰

B. The Supreme Court Speaks: Knudson, Sereboff, and Montanile

In a surprise move, on November 29, 2005, the Supreme Court agreed to review the Fourth Circuit holding in *Mid-Atlantic Medical Services, LLC v. Sereboff*, 407 F.3d 212 (2005). This was a surprise because *Sereboff* presented virtually the same issues that were already decided by the Court in *Great-West Life & Ann. Ins. Co. v. Knudson*, 534 U.S. 204 (2002), *i.e.*, the scope of ERISA's equitable remedies under section 502(a)(3) in the context of a benefit plan's claim for reimbursement of overpaid benefits. Given the many other ERISA-related issues on which the circuits are split (*e.g.*, the Court has declined to address the standard of review/conflict of interest issue in at least four cases over the past two terms), and given the fact that there are relatively few ERISA reimbursement suits in comparison with, say, benefit claims, one had to wonder why the Court decided to revisit this issue so soon after *Knudson*. Was it because the Court was dissatisfied with the narrow holding in *Knudson*? Was it because the Court wanted to reinforce the narrow realm of equitable remedies available under section 502(a)(3)? Speculation abounded.

⁵⁵ 645 F. Supp. at 162.

⁵⁶ 617 F. Supp. 847 (S.D.N.Y. 1985).

⁵⁷ *Blue Cross v. Weitz*, 913 F.2d at 1548.

⁵⁸ *See, e.g.*, *Luby v. Teamsters Health, Welfare, and Pension Trust Funds*, 944 F.2d 1176 (3d Cir. 1991) (permitting benefit fund to bring action for restitution of mistakenly paid death benefits under federal common law); *Provident Life & Accident Ins. Co. v. Waller*, 906 F.2d 985 (4th Cir.), *cert. denied*, 112 L. Ed. 2d 524 (1990) (under federal common law, a fiduciary may pursue the equitable remedy of restitution for mistakenly paid benefits against a plan beneficiary); *Kentucky Laborers District Council Health and Welfare Fund v. Hope*, 861 F.2d 1003 (6th Cir. 1988) (trustees' claim for mistakenly paid benefits arose under federal common law); *see also* *Naugle v. O'Connell*, 833 F.2d 1391 (10th Cir. 1987) (permits plan trustees to pursue action for restitution of mistakenly paid benefits without specifically stating whether action is based on federal common law or §502(a)(3)).

⁵⁹ *See* *Kentucky Laborers*.

⁶⁰ *See* *Provident Life*, *supra*. In *Provident Life*, the Fourth Circuit noted that the plaintiff, which was the plan administrator (*i.e.*, a "fiduciary"), could have also brought its restitution action under §502(a)(3) because it was a specifically enumerated party authorized by the statute to bring such an action.

As things turned out, while the fact that the Court granted certiorari in *Sereboff* may have been a surprise, the decision was not. The issue was whether an ERISA-governed health plan could bring an action for constructive trust or equitable lien as applied to funds obtained by a participant in a personal injury action, pursuant to the plan's reimbursement provision. The Supreme Court held in *Sereboff v. Mid-Atlantic Medical Services, Inc.*, 126 S. Ct. 1869 (2006) that such an action constitutes equitable relief under ERISA, §502(a)(3) and is permissible under the statute. The result is largely supported by case law that has existed since the Nineteenth Century, as evidenced by the fact that the Court relied on numerous cases from that era. Nevertheless, some interesting issues are resolved in *Sereboff* that may provide guidance to ERISA plans seeking to enforce subrogation and reimbursement provisions in order to recoup overpaid plan benefits.

1. What Is an Overpaid Benefit?

Ironically, *Knudson*, *Sereboff*, and similar cases do not involve situations where a plan benefit has been paid by mistake or as a result of fraud or similar conduct by the participant. Rather, these cases involve participants and beneficiaries who are entitled to and who have recovered benefits (usually health or disability benefits) in accordance with the terms of the employee benefit plan. This is an important distinction, because some circuits hold that where benefits are recovered by fraud or similar conduct, a plan fiduciary is entitled to pursue reimbursement remedies under state law, including suits for fraud and unjust enrichment, where applicable. See, e.g., *AFTRA Health Fund v. Biondi*, 303 F.3d 765 (7th Cir. 2002). In contrast, where the participant has recovered benefits legitimately, most of the circuits hold that any reimbursement or restitutionary remedies must arise under ERISA's civil enforcement provisions, or not at all. But see *Providence Health Plan v. McDowell*, 361 F.3d 1243 (9th Cir. 2004) (discussing possible reimbursement claim under state law).

Where a participant lawfully recovers ERISA plan benefits, subrogation and reimbursement issues arise when the participant also recovers other benefits that “offset” the plan benefits and therefore result in an overpayment of previously paid plan benefits. In the context of a health plan, this typically occurs when medical bills are paid by the plan, but the participant also recovers a tort settlement arising from the same illness or injury. Many health plans today include a provision stating that benefits are not payable where there is an available tort claim or a guilty third party tortfeasor. Alternatively, plans provide that if benefits are payable under the plan, such benefits must be reimbursed to the plan where there is a tort recovery arising out of the same incident. In the context of a disability plan, reimbursement issues arise where the participant is paid full benefits and later obtains some other type of benefit that operates as an offset to plan benefits. The most common example is the recovery of a retroactive award of Social Security disability income benefits. This generally occurs long after disability benefits have been paid to the participant and, in many cases, after benefits under the plan have been terminated and results in an overpayment of benefits. In both the health plan and disability plan context, the plan fiduciary is then left with the duty under the plan terms to pursue a recovery action to reimburse the plan for the overpaid benefits.

2. Equitable Relief Options Under ERISA

The specific remedial provision available for reimbursement claims under ERISA is section 502(a)(3). That section authorizes plan fiduciaries, among others, to bring a civil action in federal court for injunctive relief and/or “other appropriate equitable relief” to enforce the terms of ERISA or an ERISA plan or to remedy violations of ERISA or an ERISA plan. On several occasions, the Supreme Court has held that section 502(a)(3) is part of a “comprehensive and reticulated” remedial scheme and the Court has therefore been “especially ‘reluctant to tamper with [the] enforcement scheme’ embodied in the statute by extending remedies not spe-

cifically authorized by its text.” *Knudson*, 534 U.S. at 209. See also *Mertens v. Hewitt Associates*, 508 U.S. 248, 251 (1993); *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 147 (1985).

In *Mertens*, the Supreme Court held that the term “equitable” in section 502(a)(3) “must mean *something* less than *all* relief.” 508 U.S. at 258 n. 8 (emphasis in original). In that case, the Court refused to extend the term “equitable” to all forms of relief previously available in a court of equity and instead held that equitable relief under section 502(a)(3) must be limited to “those categories of relief that were *typically* available in equity,” including, among other things, restitutionary remedies. *Id.* at 256.

3. Reimbursement Claims and *Knudson*

Knudson presented a fairly typical reimbursement scenario for ERISA plans. The participant was injured in an automobile accident. Her medical bills were paid by her health plan and totaled over \$400,000. Most of the bills were ultimately paid by the health plan’s stop-loss carrier, Great-West. The plan included a reimbursement provision that stated that where there was any recovery from a third-party tortfeasor, the participant was obligated to reimburse the plan up to the amount of benefits paid by the plan. After the participant’s medical bills were paid, she obtained a tort settlement. Most of the tort recovery was assigned to attorney’s fees and a trust established for the participant’s ongoing medical care. Less than \$14,000 was earmarked for reimbursement of the health plan.

The stop-loss carrier, as assignee of the health plan, sued the participant to enforce the plan’s reimbursement provision under section 502(a)(3), seeking injunctive relief and restitution. Unfortunately, the plan did not sue the trust fund or the participant’s tort attorney. Instead, the plan sued the participant directly, seeking “restitution” of the health benefits previously paid for the participant’s medical care. The participant argued that the relief sought by the plan was not “equitable” and that the plan had no cause of action under section 502(a)(3).

The Supreme Court agreed with the participant and held that the plan was seeking legal relief, not equitable relief. The Court held that the plan was not seeking injunctive relief because it was merely pursuing the payment of money past due under a contract. With regard to the plan’s restitution claim, the Court noted that in the days of the divided bench, there was a distinction between “legal restitution” and “equitable restitution.” The Court characterized “equitable restitution” as “a claim to specific property (or its proceeds) held by the defendant.” 534 U.S. at 215. The participant in *Knudson* was not in possession of any specific property or fund over which the plan was attempting to assert a claim because the tort settlement proceeds were placed in a special needs trust and/or paid to the participant’s tort lawyer. Because the plan was not seeking relief with respect to any specific fund, the Supreme Court held that the plan was merely seeking “the imposition of personal liability on respondents for a contractual obligation to pay money.” The Court held that this constituted a claim for legal relief (or “legal restitution”) and therefore was not an available remedy under section 502(a)(3).

4. Post-*Knudson* Developments and *Sereboff*

After *Knudson*, most reimbursement suits under ERISA plans have revolved around whether or not the plan is asserting a claim over an existing fund. In general, if a plan asserts a claim for reimbursement against a fund that has already been dissipated, the claim is considered legal and therefore not permissible under section 502(a)(3). On the other hand, if the plan asserts a claim against an existing fund, most circuits held that such a claim was equitable (e.g., restitution or a suit for a constructive trust) and that such a claim was within the scope of the remedies allowed under section 502(a)(3). Two circuits have disagreed—the Sixth and the

Ninth—leading to the split that the Supreme Court resolved in *Sereboff*. See, e.g., *Qualchoice, Inc. v. Rowland*, 367 F.3d 638 (6th Cir. 2004); *Westaff (USA) Inc. v. Arce*, 298 F.3d 1164 (9th Cir. 2002).

In *Sereboff*, the health plan paid accident-related medical bills totaling \$75,000. The Sereboffs eventually recovered \$750,000 from the tortfeasor, but refused to reimburse their health plan. Instead, they put their share of the settlement funds into investment accounts. When the plan fiduciary sued for reimbursement, the Sereboffs agreed to set aside the reimbursement amount, pending a ruling on the plan's reimbursement claim. The district court granted summary judgment to the fiduciary, ruling that because the reimbursement claim was asserted against an existing fund, it constituted equitable relief under section 502(a)(3). The Sereboffs appealed.

The Fourth Circuit affirmed, holding that the fiduciary's claim was in the nature of equitable restitution and therefore proper under section 502(a)(3). Specifically, the court held that the remedy sought by the fiduciary was equitable because the fiduciary was pursuing an identifiable fund that in good conscience belonged to the fiduciary under the terms of the ERISA plan. In so holding, the Fourth Circuit joined the Fifth, Seventh, and Tenth Circuits, all of whom held that where an ERISA plan fiduciary seeks to obtain reimbursement where there is an identifiable fund over which the defendant has control, the remedy is considered equitable under *Knudson*.

5. Speculation About Why Cert Was Granted in *Sereboff*

Exactly what the Supreme Court would do in *Sereboff* was anybody's guess. In the short term, the Court would presumably resolve the circuit split as to whether pursuit of an existing identifiable fund constituted equitable relief in the context of an ERISA plan's reimbursement claim. The petitioner's position was that while the existence of an identifiable fund may be equitable in some contexts, because the "identifiable fund" in *Sereboff* was made up of tort settlement proceeds and not the health plan benefits paid by the ERISA plan, the plan fiduciary was not seeking a return of the money paid out by the plan. Rather, the fiduciary was merely attempting to assert a contractual claim for money damages against a party who happened to have control over a fund of money that did not constitute the overpaid plan benefits. According to the petitioner, this was no different than in *Knudson*, where the plan was seeking contractual damages from the participant where the damages represented the benefits previously paid out by the health plan. The petitioner's argument reflected the reasoning of the Sixth Circuit in *Qualchoice* and the Ninth Circuit in *Westaff*, and was the reason that those courts concluded that relief against the fund was not equitable and was not available under section 502(a)(3).

If the Supreme Court decided to focus on the narrow issue at hand, *Sereboff* would accomplish nothing more than some fine-tuning of *Knudson*. If that was the Court's intent, one had to ask why this issue was deemed important enough to deserve the Court's attention twice in four years. This is not to belittle reimbursement claims. However, in the grand scheme of the ERISA world, there are other, more pervasive, issues that merit the Court's attention.

Some thought that maybe the Court was looking at broader issues affecting ERISA's remedies generally. *Knudson* was a 5–4 decision that included vigorous dissents and separate opinions by Justices Ginsburg and Stevens. Justice Ginsburg's dissent was joined by Justices Stevens, Souter, and Breyer. Justice Ginsburg criticized the majority for focusing on "ancient classifications" between "legal restitution" and "equitable restitution" that Congress did not intend when enacting ERISA. According to Justice Ginsburg, the restitutionary relief sought in *Knudson* (i.e., the transfer of funds from the participant to the plan over which the plan claimed to be the rightful owner) was equitable and available under section 502(a)(3) because it was exactly

the type of relief that was “typically available in equity.” Justice Ginsburg wrote that the “equitable relief” available under section 502(a)(3) should include the categories of relief that were typically available in equity, including injunction, mandamus, and restitution, without regard to distinctions between legal and equitable restitution that go back to the days of the divided bench.

Certainly, when pursuing reimbursement claims, most insurers would like to see the broader relief described in Justice Ginsburg’s opinion. However, insurers should tread softly on this issue. The limited remedies under ERISA can be a sword or a shield, depending on one’s perspective. In most cases, including suits involving claims for unpaid benefits, insurers have vigorously argued that ERISA’s remedies are narrow and limited. Indeed, this position has saved insurers and plan sponsors billions of dollars and more than likely is one of the principal reasons why many health and disability plans still exist at affordable rates. To the extent that plans and their insurers push for a broader reading of section 502(a)(3), they must recognize that such a position can backfire in the long run. To quote the old adage, insurers and ERISA plans must be “careful what they ask for, because they might get it.”

6. The Supreme Court’s Ruling in *Sereboff*

The issue phrased by the Court was “whether the relief [the health plan] requested... was ‘equitable’ under §502(a)(3).” Discussing its previous decision in *Knudson*, the Court noted that “[w]e explained that one feature of equitable restitution was that it sought to impose a constructive trust or equitable lien on ‘particular funds or property in the defendant’s possession.’” In contrast to *Knudson*, the health plan in *Sereboff* “sought ‘specifically identifiable’ funds that were ‘within the possession and control of the Sereboffs.’” The fact that the health plan was asserting its action against a defendant who controlled an identifiable fund was a sufficient basis to show that the health plan was seeking an equitable remedy:

[The health plan] alleged breach of contract and sought money, to be sure, but it sought its recovery through a constructive trust or equitable lien on a specifically identifiable fund, not from the Sereboffs’ assets generally, as would be the case with a contract action at law. ERISA provides for equitable remedies *to enforce plan terms*, so the fact that the action involves a breach of contract can hardly be enough to prove relief is not equitable; that would make §502(a)(3)(B)(ii) an empty promise. This Court in *Knudson* did not reject Great-West’s suit out of hand because it alleged a breach of contract and sought money, but because Great-West did not seek to recover a particular fund from the defendant. Mid-Atlantic does.

The Supreme Court emphasized that, in addition to seeking an equitable remedy, a plaintiff under §502(a)(3) must also “establish that the basis for its claim was equitable.” The Court distinguished between equitable liens as a matter of restitution and equitable liens by agreement or assignment. An equitable lien as a matter of restitution requires that the plaintiff trace the funds at issue to the fund against which the lien is asserted. An equitable lien by agreement or assignment does not require tracing of the funds. The Supreme Court held that the health plan in *Sereboff* was asserting an equitable lien by agreement or assignment, and that it was not required to trace the specific funds at issue. The only requirement of such a claim is that the lien be asserted against the fund identified by the contract. The agreement (*i.e.*, the health plan) in *Sereboff* identified the fund that was the target of the lien (*i.e.*, “[a]ll recoveries from a third party”). As a result, the Court rejected the Sereboffs’ argument that in order for the health plan’s action to be equitable, it was required to show that the fund against which the lien was asserted contained the actual health plan benefits originally paid by the health plan. In pursuing an equitable lien by agreement or assignment, “the fund over which a lien is asserted need not be in existence when the contract containing the lien provision is executed.”

7. Issues Left Open in *Sereboff*

For those looking to *Sereboff* for broader guidance on issues other than the narrow question of whether asserting a lien against an identifiable fund is permissible under §502(a)(3), there must be some disappointment. For example, as in *Knudson*, there was no discussion about whether reimbursement claims by ERISA plan fiduciaries are or are not governed exclusively by ERISA. *Sereboff* was limited to the question of whether such an action was cognizable under ERISA, and there was no discussion, one way or the other, about whether such a claim is also cognizable under state law. *See, e.g., Providence Health Plan v. McDowell*, 385 F.3d 1168 (9th Cir. 2004) (discussing possible reimbursement claim under state law).

There also was no discussion, as some plaintiffs had hoped, that would broaden the types of relief generally available under §502(a)(3). Some viewed *Sereboff* as an opportunity for the dissenters in *Knudson*, who appeared to support a broader “make whole” relief under §502(a)(3), to establish their view. The *Knudson* dissenters did join the majority in *Sereboff*, but that case is clearly intended to follow the remedial boundaries established in *Knudson* and earlier in *Mertens*. For now at least, ERISA’s equitable remedies remain limited to something short of “make-whole” relief.

Finally, the Court declined to address whether and under what circumstances the equitable lien asserted by the health plan was “appropriate” equitable relief in that case. The Sereboffs argued that the plan’s assertion of a lien over the entire amount of the benefits previously paid violated principles such as the make-whole doctrine. Under the make-whole doctrine, the plan would have been required to compromise its reimbursement claim to the extent the Sereboffs were required to compromise their personal injury action. The Supreme Court pointed out that the Sereboffs did not raise this issue in either the district court or the court of appeals, and the Supreme Court declined to address it in the first instance.

8. Practical Advice Following *Sereboff*

In general, the decision in *Sereboff* serves to reinforce the kinds of advice that most ERISA plans found appropriate after *Knudson*:

- ERISA plan fiduciaries should assert reimbursement claims sooner rather than later. Once personal injury and other settlements are dissipated by the participant, equitable relief under ERISA §502(a)(3) is very difficult.
- ERISA plan fiduciaries, must identify a specific fund in order to assert equitable reimbursement claims.
- When asserting reimbursement claims, ERISA plan fiduciaries must pursue the proper defendant, *i.e.*, the person or entity who has control over the identified fund.

Followers of the Supreme Court in this area of the law, have been at a loss as to why the Court granted certiorari in *Sereboff*. The issue was certainly the subject of a circuit split and important in its own right. However, there are much more divisive and important issues under ERISA that deserve the Court’s attention. There were some who theorized that by agreeing to review *Sereboff*, the Supreme Court was heading in a new direction from *Knudson*. Such speculation turned out to be wrong. The result in *Sereboff* was not surprising and flowed naturally from previous decisions such as *Knudson* and *Mertens*.

9. *Montanile*: Dissipation of Overpayment

In *Montanile v. Board of Trustees of National Elevator Industry Health Benefit Plan*, 136 S. Ct. 2861 (2016), the Supreme Court answered at least one of the questions left open in *Sereboff*, *i.e.*, whether an equitable lien

by agreement can be applied to a fund that has been dissipated by the participant. Like the plan fiduciaries in *Knudson* and *Sereboff*, the health plan fiduciaries in *Montanile* sought to assert a lien against a participant's tort recovery. The participant's personal injury attorney notified the plan of the recovery and that the money would be transferred to the client's trust account unless the plan objected. The plan did not respond, the money was transferred, and the plan waited six months to sue the participant for the overpayment. By that point, the participant claimed that the money had been dissipated. There was a split in the circuits over whether an equitable lien by agreement could be asserted against other assets of the participant where the designated fund was dissipated. The Supreme Court held that where a participant wholly dissipates a designated fund on non-traceable items, the plan no longer has a valid claim for equitable relief under ERISA, §502(a)(3).

VII. Remedies for Disclosure Violations and Make Whole Equitable Relief

The Supreme Court accepted review in *CIGNA Corporation v. Amara*, 131 S. Ct. 1866 (2011) to decide the level of proof required where a plan participant seeks to remedy violations of ERISA's notice and disclosure provisions. Specifically, the question was whether the lower courts correctly applied a class-wide "likely harm" standard to such claims. Before it reached this issue, the Court unanimously held that a summary plan description ("SPD") and a summary of material modifications ("SMM") are not of equal standing with a master plan document in determining applicable plan benefits and that the terms of an SPD and an SMM cannot be enforced pursuant to ERISA, §502(a)(1)(B). According to Justice Scalia's concurring opinion, that is where the decision should have ended. However, the majority felt differently and proceeded to address several other issues, including the potential remedies that may arise under §502(a)(3) as a result of a plan administrator's violation of ERISA's reporting and disclosure requirements.

A. Factual Background

In 1998, CIGNA Corporation converted its traditional defined benefit pension plan into a cash balance plan. A traditional defined benefit pension plan provides benefits on an annuity basis, with the amount of the benefit calculated on the basis of length of service and salary. In contrast, a cash balance plan provides benefits based on an account that includes defined employer contributions compounded by interest. Because many of the participants had already earned benefits under the old plan, the value of their existing benefits was converted into an opening account balance under the cash balance plan.

The plaintiffs included a class of 25,000 participants. The plaintiffs alleged that CIGNA affirmatively misrepresented certain matters related to the new plan and also omitted certain information in its communications, all of which potentially made the new plan less generous than the old plan. Specifically, the participants alleged that CIGNA violated ERISA's notice and disclosure requirements in several misleading ways, including representations that the participants would not be worse off under the new plan and that the new plan would not save money to CIGNA. The participants sought relief under two provisions of ERISA. The participants sought relief under ERISA, §502(a)(1)(B), which allows participants to sue for benefits due under the terms of an ERISA plan and to seek a declaration of a participant's rights to future benefits under an ERISA plan. The participants also sought relief under ERISA, §502(a)(3), which permits participants to obtain injunctive or other appropriate equitable relief to remedy violations of ERISA and to enforce the terms of ERISA.

The district court determined that CIGNA intentionally misled the participants and that it violated ERISA's notice and disclosure requirements. Among other things, the district court found that CIGNA failed to

disclose aspects of the new plan that could result in less generous benefits than the participants had under the old plan.

The district court then determined the appropriate relief. It agreed with CIGNA that the participants must show some form of harm from the disclosure violations. However, the court ruled that each individual participant did not need to show an injury. Rather, the court applied a burden shifting mechanism whereby the court found that the evidence supported that the participants as a whole suffered “likely harm” from the violations. In order to avoid relief, CIGNA was then required to demonstrate that some or all of the individual participants did not suffer actual harm. The district court also reformed the new plan to accord with CIGNA’s representations that the participants would be as well off under the new plan as under the old plan. The district court then awarded benefits to the participants under the plan as reformed, pursuant to §502(a)(1)(B). The district court specifically declined to determine whether relief was appropriate as equitable relief under §502(a)(3), finding such an analysis unnecessary because, in the district court’s view, relief was already available under §502(a)(1)(B). The Second Circuit affirmed, adopting *in toto* the district court’s lengthy memorandum decision.

B. Supreme Court Accepts Review

CIGNA and the participants filed cross-petitions for a writ of certiorari in the United States Supreme Court. The Supreme Court granted CIGNA’s petition specifically to address “whether a showing of ‘likely harm’ is sufficient to entitle plan participants to recover benefits based on faulty disclosures.” The Court held in abeyance the participants’ petition. On review, CIGNA reiterated its argument that each participant was required to show detrimental reliance before any relief could be available based on the misrepresentations and omissions.

C. Supreme Court Decision in Amara

1. Section 502(a)(1)(B) Not Applicable

The Supreme Court held that the district court erred in granting relief under §502(a)(1)(B), primarily because the participants were already receiving or were eligible to receive benefits in accordance with the plan as written, the participants were seeking benefits beyond the plan as written, and therefore the participants could not show entitlement to benefits under the terms of the plan, as required under §502(a)(1)(B). The Court observed, “[t]he statutory language [of §502(a)(1)(B)] speaks of ‘*enforc[ing]*’ the ‘terms of the plan,’ not of *changing* them.”

To award plan benefits under §502(a)(1)(B), the district court was required to view the SPD, SMM, and other CIGNA communications as “plan terms.” The Supreme Court held that these communications do not have the same status as the plan itself: “we cannot agree that the terms of statutorily required plan summaries (or summaries of plan modifications) necessarily may be enforced (under §502(a)(1)(B)) as the terms of the plan itself.” The Court cited two reasons for this conclusion. First, the terms of the statutory provision mandating the creation and distribution of SPDs and SMMs “suggests that information *about* the plan provided by those disclosures are not itself *part* of the plan.” Second, the Court noted that while a plan is created by the plan sponsor, SPDs and SMMs are the responsibility of the plan administrator, which may or may not be the same entity, but even if the same, the entity is acting in different capacities. A plan sponsor is generally viewed as a settlor in trust terminology, and is not subject to ERISA’s fiduciary provisions because a settlor

does not act as a fiduciary in that capacity. In contrast, a plan administrator is a fiduciary and is subject to ERISA's fiduciary requirements. The Court concluded:

For these reasons taken together we conclude that the summary documents, important as they are, provide communication with beneficiaries *about* the plan, but that their statements do not themselves constitute the *terms* of the plan for purposes of §502(a)(1)(B). We also conclude that the District Court could not find authority in that section to reform CIGNA's plan as written.

2. Potential Equitable Relief under §502(a)(3)

Having eliminated §502(a)(1)(B) as an avenue for relief, the Court moved on to consider whether §502(a)(3) provided any potential relief to the participants. This is an issue that the district court expressly did not decide because it viewed it as unnecessary. The Supreme Court said otherwise, noting that “[t]he case before us concerns a suit by a beneficiary against a plan fiduciary (whom ERISA typically treats as a trustee) about the terms of a plan (which ERISA typically treats as a trust),” and went on to say that the suit “is the kind of lawsuit that, before the merger of law and equity, respondents could have brought only in a court of equity, not a court of law.” Reciting the maxim that “[e]quity suffers not a right to be without a remedy,” the Court discussed whether the relief awarded by the district court constituted “appropriate equitable relief” under §502(a)(3).

The Court determined that the district court's reformation remedy was within the scope of equitable relief: “The power to reform contracts (as contrasted with the power to enforce contracts as written) is a traditional power of an equity court, not a court of law, and was used to prevent fraud.” The Court also observed that the remedy imposed by the district court “essentially held CIGNA to what it had promised, namely, that the new plan would not take from its employees benefits they had already accrued.” The Court determined that this “remedy resembles estoppel, a traditional equitable remedy.”

This discussion then took the Court to the question of what to do about the monetary relief awarded by the district court. According to the Court, this too was appropriate as equitable relief. “Equity courts possessed the power to provide relief in the form of monetary ‘compensation’ for a loss resulting from a trustee's breach of duty, or to prevent the trustee's unjust enrichment.” This type of equitable monetary remedy was known as “surcharge.” In courts of equity, the surcharge remedy “extended to a breach of trust committed by a fiduciary encompassing any violation of a duty imposed upon that fiduciary.” The Court distinguished its decision in *Mertens v. Hewitt Associates*, 508 U.S. 248 (1993), in which the Court held that monetary remedies were not available under §502(a)(3) against a non-fiduciary service provider, saying “insofar as an award of make-whole relief is concerned, the fact that the defendant in this case, unlike the defendant in *Mertens*, is analogous to a trustee makes a critical difference.”

3. Required Level of Proof

Having resolved various “preliminaries,” the Court finally reached the issue on which it had granted review, *i.e.*, the level of proof necessary for the participants to obtain relief for CIGNA's disclosure violations. Limiting its discussion to equitable relief under §502(a)(3), the Court held that under the law of equity, there was no general requirement for detrimental reliance, although the Court acknowledged that some remedies, such as estoppel, do require such a showing: “when a court exercises its authority under §502(a)(3) to impose a remedy equivalent to estoppel, a showing of detrimental reliance must be made.” This portion of the Court's decision appears to apply to the reformation remedy imposed by the district court which the Court said “resembles estoppel.”

The Court said that other forms of equitable relief do not require detrimental reliance. The requisite showing depends on the theory of relief sought. For example, because a court of equity would not surcharge a trustee for a nonexistent harm, “a fiduciary can be surcharged under §502(a)(3) only upon a showing of actual harm—proved (under the default rule for civil cases) by a preponderance of the evidence.” Thus, finally reaching the issue on which it granted CIGNA’s petition, the Supreme Court held that “likely harm” was not sufficient to obtain the remedy awarded by the district court, but that to obtain a remedy for CIGNA’s disclosure violations, “a plan participant or beneficiary must show that the violation injured him or her.” To do so, each participant must show harm and causation, but not detrimental reliance.

Justice Scalia, joined by Justice Thomas, wrote a concurring opinion in which he agreed that §502(a)(1)(B) does not provide relief for misrepresentations in an SPD, but criticized the majority for addressing the question of the appropriate relief under §502(a)(3) because the district court never decided the issue. Justice Scalia took issue with the application of a reformation remedy because “here, the Court would be employing that doctrine to alter the terms of a contract in response to a third party’s misrepresentations—not those of a party to the contract.” This is because an SPD is the responsibility of the plan administrator, not the plan sponsor that created the plan. Justice Scalia also observed that the remedy of surcharge raised the same question as a showing of detrimental reliance, *i.e.*, actual harm and detrimental reliance both require individualized proof, unlike class-wide “likely harm.”

VIII. Post-*Amara* Developments

Barely a year after *Amara* was decided, the Supreme Court again agreed to address the scope of what constitutes “appropriate” equitable relief under section 502(a)(3) in *U.S. Airways, Inc. v. McCutchen*, 133 S. Ct. 1537 (2013).

McCutchen involved the scope of a plan’s right to enforce its reimbursement and subrogation provisions. It implicated not only *Amara*, but also earlier reimbursement decisions under section 502(a)(3) such as *Knudson, supra* and *Sereboff, supra*. The question in *McCutchen* was whether a plan’s action to enforce reimbursement rights under section 502(a)(3) was subject to equitable defenses such as unjust enrichment, even where such defenses override express plan terms. In that sense, the case also potentially implicated the plan document rule that was central to the Court’s decision in *Kennedy v. Plan Adm’r. for DuPont Sav. & Inv. Plan*, 555 U.S. 285 (2009). Finally, in addressing the question of what Congress intended by the word “appropriate” as a modifier of the phrase “equitable relief” in section 502(a)(3), *McCutchen* potentially required the Court to explain what it meant when it decided *Varity Corporation v. Howe*, 516 U.S. 489 (1996) and held that section 502(a)(3) is a catch-all provision, authorizing relief only where other subsections of 502(a) did not provide adequate relief. Thus, the decision in *McCutchen* potentially involved clarification of no less than five previous Supreme Court ERISA decisions construing section 502(a)(3).

A. Background Facts

U.S. Airways maintained a self-funded health plan for its eligible employees. The plan contained a provision stating that if medical expenses were incurred through the fault of a third party, “the Plan will be subrogated to all your rights of recovery [and] You will be required to reimburse the Plan for amounts paid for claims out of any monies recovered from a third party.” The parties agreed that the language requiring reimbursement from “any monies recovered from a third party” required reimbursement free from any obligation to

pay attorney's fees and litigation expenses and without regard to whether the participant was made whole by the tort recovery.

McCutchen was a participant in the health plan. After he was involved in an auto accident, the plan paid \$66,866 for McCutchen's medical expenses arising from the accident. McCutchen hired a personal injury attorney and pursued the tortfeasor for damages. He eventually recovered \$110,000 from the tortfeasor's insurer and from his own underinsured motorist coverage. After paying attorney's fees and expenses, McCutchen's net recovery was approximately \$66,000. Assuming this figure would be subject to a reduction for the plan's portion of the litigation fees and costs, McCutchen's tort attorney placed \$41,500 in a trust account for possible payment to the plan and/or disbursement to McCutchen. It is unclear how much of the tort recovery was distributed to McCutchen.

The plan sued McCutchen for full recovery of the \$66,866 it paid in benefits pursuant to section 502(a)(3), asserting an equitable lien by agreement. The district court granted summary judgment to the plan and awarded the plan the \$41,500 fund held in trust as well as an additional \$25,366 from McCutchen's own funds.

B. Third Circuit Decision

The Third Circuit reversed and vacated the district court judgment. The court held that in order for equitable relief to be "appropriate" under section 502(a)(3), relief must be subject to traditional equitable principles that would deny or limit such relief: "it would be strange indeed for Congress to have intended that relief under [section 502(a)(3)] be limited to traditional equitable categories, but not limited by other equitable doctrines and defenses that were traditionally applicable to those categories... we find that Congress intended to limit the equitable relief available under [section 502(a)(3)] through the application of equitable defenses and principles that were typically available in equity." 663 F.3d at 676.

The Third Circuit also held that such "equitable defenses and principles" would apply even in the face of contrary ERISA plan language. Citing *Amara*, the court stated: "the importance of the written benefit plan is not inviolable, but is subject—based upon equitable doctrines and principles—to modification and, indeed, even equitable reformation under [section 502(a)(3)]... While the basis for the reformation in [*Amara*] was intentional misrepresentations by the employer and fiduciary, the broader and more relevant point is that when courts were sitting in equity in the days of the divided bench... contractual language was not as sacrosanct as it is normally considered to be when applying breach of contract principles at common law." 663 F.3d at 678–79.

The Third Circuit concluded that full reimbursement would unjustly enrich the plan and "amounts to a windfall for [the plan], which did not exercise its subrogation rights or contribute to the cost of obtaining the third-party recovery." *Id.* The court also observed that full reimbursement to the plan would leave McCutchen with less than full recovery for his medical bills, thus undermining the purpose of the health plan. The matter was remanded to the district court to decide appropriate equitable relief, taking into account McCutchen's potential equitable defenses.

The Supreme Court granted the plan's petition for certiorari.

C. The Department of Labor's Position

Participating as *amicus curiae* in the Supreme Court, the United States Department of Labor weighed in on the nature of appropriate equitable relief, taking the position that while general equitable defenses do not

override the terms of an ERISA plan to reduce a plan's reimbursement, the common fund doctrine requires a plan to incur its share of attorney's fees and costs when it obtains reimbursement of plan benefits through the efforts of a participant.

The DOL took the position that the Third Circuit confused enforcement of an equitable lien by agreement with equitable restitution, two distinct forms of equitable relief, as held by the Supreme Court in *Sereboff*. An equitable lien by agreement requires enforcement of the terms of the agreement, independent of equitable defenses. Equitable restitution, on the other hand, is enforced independent of any agreement and does incorporate equitable defenses. Citing *Sereboff*, the DOL argued that the health plan in *McCutchen* was seeking to enforce an equitable lien by agreement, meaning that McCutchen's "obligation to [the plan] is determined by the plan, not by general unjust enrichment or other principles of equitable restitution."

The DOL contended that use of the word "appropriate" to modify "equitable relief" in section 502(a)(3) is not intended to import equitable defenses into every application of the statutory provision, but is instead intended to recognize two principles: (a) the principle that equitable relief under section (a)(3) is a catch-all remedy that applies only where there is no adequate remedy under other subsections of 502(a); and (b) the principle that a court is permitted to apply a suitable remedy from the general range of "equitable relief" in a given case and that the applicable claims and defenses will turn on the type of relief at issue. However, according to the DOL, the term "appropriate" does not give courts "broad discretion to decline to enforce an equitable lien by agreement based on the court's case-specific judgment about what fairness and equity require."

The DOL also argued that, even if the case had involved the application of equitable restitution and the defense of unjust enrichment had been applicable, enforcement of the plan's reimbursement right would not be inequitable and McCutchen would not be able to rely on unjust enrichment to reduce the plan's recovery: "Enforcement of the plan term is equitable to participants and beneficiaries as a class because it reduces plan expenses, and is equitable to [McCutchen] in particular because the reimbursement obligation was part of a quid pro quo for his immediate receipt of plan benefits even though a third party was responsible for his injuries."

Having argued that equitable defenses do not override plan terms when a plan is enforcing an equitable lien by agreement, the DOL went on to contend that a different analysis applies to the recovery of attorney's fees and litigation costs, which do apply and do override plan terms to the contrary. The DOL said that "in that limited area," the historic powers of equitable courts to charge costs and attorney's fees to a party that recovered funds based on the efforts of another party would govern. Here, the plan did not pursue its subrogation right but instead recovered based on the efforts of McCutchen and his tort attorney. In these circumstances, according to the DOL, a court sitting in equity has the power to apportion attorney's fees and costs to the plan, even when the plan is enforcing an equitable lien by agreement.

D. Supreme Court Decision

The Supreme Court heard argument on November 27, 2012 and issued its decision on April 16, 2013. It held that, when an ERISA plan enforces an equitable lien by agreement, the terms of the plan are controlling and override general equitable defenses that might otherwise apply. However, in the absence of plan terms disclaiming such defenses, certain principles may apply to reduce the plan's recovery, such as the common fund doctrine.

The Court found guidance in its previous decision in *Sereboff*. In that case, the Sereboffs argued, among other things, that because the health plan's reimbursement claim was equitable, it should be limited by equitable defenses, such as the make whole rule. The Court rejected the Sereboffs' argument, saying they were

“improperly mixing and matching rules from different equitable boxes.” While the defenses might be applicable if the plan was seeking general equitable relief apart from the plan itself, they did not apply when the plan was seeking to enforce an equitable lien by agreement which is based on contract terms that define the parties’ relationship.

In *McCutchen*, the Court found *Sereboff* to be controlling and held that it was fatal to McCutchen’s attempt to limit the plan’s reimbursement claim on the basis that it resulted in unjust enrichment where the clear plan terms gave the plan priority in recovering medical expenses. The Court reiterated that an equitable lien by agreement—because it is based on the terms of a contract—“both arises from and serves to carry out a contract’s provisions.” Enforcement of the lien “means holding the parties to their mutual promises.” It also means “declining to apply rules—even if they would be ‘equitable’ in a contract’s absence—at odds with the parties’ expressed commitments.” In the context of McCutchen’s arguments, the Court held that “McCutchen therefore cannot rely on theories of unjust enrichment to defeat US Airways’ appeal to the plan’s clear terms.” In the context of relief under §502(a)(3) generally, the Court held that “hewing to the parties’ exchange yields ‘appropriate’ as well as ‘equitable’ relief.” In other words, there is no unjust enrichment when a court applies plan terms and enforces the parties’ written agreement.

The Supreme Court also held that the same principles resulted in rejection of the DOL’s position that the common fund doctrine should not be subject to plan terms that disclaim responsibility for sharing in the attorney’s fees and costs incurred in obtaining a tort recovery. In the Court’s words, “if the agreement governs, the agreement governs: The reasons we have given (and the Government mostly accepts) for looking to the contract’s terms do not permit an attorney’s-fees exception.” Because principles of unjust enrichment give way to a plan’s terms, so does the common fund doctrine because if a plan disclaims the common fund doctrine, reimbursement absent a reduction for attorney’s fees and costs is not “unjust enrichment” by definition. In reaching this result, the Court noted that ERISA requires that benefit plans be in writing, that §502(a)(3) is expressly designed to “enforce the terms of the plan,” and that ERISA otherwise is intended to “protect contractually defined benefits.” All of this adds up to congressional intent that plan terms be paramount: “The plan, in short, is at the center of ERISA. And precluding McCutchen’s equitable defenses from overriding plain contract terms helps it to remain there.”

Ultimately, the Court found that the plan at issue in *McCutchen* was silent as to the plan’s obligation to pay a portion of McCutchen’s attorney’s fees and costs. The Court found that general language regarding the amount of the plan’s recovery did not speak to the costs of obtaining that recovery. The Court held that, in view of this “contractual gap,” “the common-fund doctrine provides the best indication of the parties’ intent” and that the plan’s reimbursement recovery could be reduced such that the plan would share in a portion of the costs incurred to obtain the tort settlement.

E. Lessons Learned from McCutchen

Many of the lessons from the Court’s decision in *McCutchen* relate to plan drafting. Clearly, the Court gave the green light to ERISA plan drafters to write reimbursement provisions broadly to exclude any equitable defenses and/or obligations to share in fees and costs incurred in establishing the fund from which the plan seeks reimbursement. Of course, there is a downside to such broad drafting because in cases where the tort recovery is small, refusal to share in the costs of recovery may discourage participants (and their tort attorneys) from seeking such recoveries in the first place: if the entire recovery goes to the plan, why would anyone even bother to pursue such a recovery?

The Court also commented in a footnote about the distinction between subrogation and reimbursement rights. The plan in *McCutchen* was seeking to enforce a reimbursement right. It conceded that if it were seeking to enforce a subrogation claim, its rights might be narrower because the plan would be standing in McCutchen's shoes and would be subject to any restrictions that would apply to his tort claim. The lesson here is that, when writing ERISA plans, drafters should include both subrogation and reimbursement clauses and should be careful to distinguish between these two separate types of claims so as to give themselves broader options.

A question may arise as to how broadly one can read *McCutchen*. The Court was careful to note that its decision was in the context of a reimbursement claim that was based on an equitable lien by agreement. How far does the decision apply outside of the equitable lien by agreement context? If plan drafters can limit equitable defenses, can they also limit remedies against the plan? Answers to these questions will need to be hashed out in the lower courts.

Finally, the Court interpreted the health plan and determined that it was silent on the application of the common fund doctrine. The Court acknowledged that there was broad language sufficient to preclude the application of unjust enrichment defenses, but that this "leaves space for the common-fund rule to operate" because "the contract, for its part, says nothing specific about that issue." It is curious that the Court interpreted the health plan without any reference whatsoever to whether the health plan administrator was granted discretion to interpret the plan, per *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989). If such discretion was granted, the Court presumably would be required to defer to the administrator's interpretation of the plan language. It would seem that if an ERISA plan contains discretionary authority, there must be some room for argument that where the plan is arguably ambiguous as to whether it disclaims application of the common-fund doctrine, the administrator's interpretation that it does disclaim the doctrine must be granted deference. None of this is discussed in *McCutchen*. Of course, from a plan drafting perspective, the best way to avoid this issue is to state explicitly that the plan will not share in the fees and costs of obtaining the third party recovery.

F. Other Developments Under §502(a)(3)

The question of what constitutes "make whole" relief has also seen some development post-*Amara* as seen in a recent *en banc* decision by the Sixth Circuit in *Rochow v. Life Ins. Co. of N. America*.⁶¹ In that case, the plaintiff sought judicial review of the defendant's decision to deny his claim for long term disability benefits under ERISA. After obtaining a judgment that the denial was arbitrary and capricious, which was affirmed on appeal, the trial court awarded nearly \$1 million in past due benefits pursuant to §502(a)(1)(B) and then allowed the plaintiff to pursue additional equitable remedies of equitable accounting and disgorgement of profits under §502(a)(3). After extensive discovery and a bench trial, the trial court awarded over \$3 million in disgorged profits to the plaintiff.

On appeal, a split panel of the Sixth Circuit affirmed the trial court, but the panel decision was vacated and on March 5, 2015, the Sixth Circuit sitting *en banc* voted to overturn the disgorgement decision. The court held that, under the Supreme Court decision in *Varity Corp. v. Howe*, *supra*, a plaintiff is not permitted to bring parallel actions for benefits under §502(a)(1)(B) and equitable relief under §502(a)(3) unless the plaintiff demonstrates that under the circumstances of the case (a) relief under §502(a)(1)(B) is inadequate,

⁶¹ 2015 WL 925794 (6th Cir. March 5, 2015).

or (b) the plaintiff has sustained a separate injury remediable under §502(a)(3). The court also held that plaintiff's allegations of defendant's delay in deciding his claim for benefits, which formed the basis for his disgorgement claim, were part of his claim for denied benefits under §502(a)(B) and did not constitute a separate injury justifying additional relief under §502(a)(3) nor did it demonstrate that the relief afforded by §502(a)(1)(B) was inadequate. Ultimately, the question is one of make whole relief, so the court remanded the matter to the district court for consideration of an award of prejudgment interest, which the court held is part of the remedy for denied benefits under §502(a)(1)(B).

IX. Attorney Fees and Costs

Since its enactment in 1974, ERISA has contained a fee-shifting provision. For the most part, this provision has been applied with very little fanfare or litigation, particularly where ERISA welfare benefits were concerned. However, in recent years, plaintiffs' attorneys have begun to use this provision to attempt to claim fantastic fee awards as a substitute for the extracontractual damages that are not otherwise available under ERISA. This has sparked a flurry of litigation nationwide over an issue that, until now, was a rather routine post-judgment proceeding. These attempts to make attorney fees the latest ERISA battleground require defense counsel and their clients to be well aware of the issues and factors governing attorney fee awards under ERISA.

A. ERISA's Fee-Shifting Provision

ERISA's civil remedies section provides for the recovery of attorney fees and costs by either party to the action:

In any action under this subchapter... by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney's fee and costs of action to either party.⁶²

The purpose of an attorney fee award under ERISA is compensatory, not punitive. It has been held that "the provision for attorneys' fees under ERISA is not in the nature of a punitive damage award, but rather is analogous to an assessment of costs." *Rivera v. Benefit Trust Life Ins. Co.*⁶³ Thus, one federal appellate court rejected "stacking" of an attorney fee award in a case involving multiple plaintiffs because "stacking would frustrate ERISA's remedial scheme by converting the award of attorney fees from purely compensatory damages to punitive damages." *Ford v. Uniroyal Pension Plan*.⁶⁴

B. Factors Governing Fee Awards Under ERISA

A court may award fees and costs to either a plaintiff or a defendant. However, fees and costs are only recoverable in a court proceeding and are not recoverable for work performed in connection with an administrative appeal.⁶⁵ Even when fees are sought in connection with a lawsuit under ERISA's civil enforcement

⁶² 29 U.S.C. §1132(g)(1).

⁶³ 921 F.2d 692, 697 (7th Cir. 1991).

⁶⁴ 154 F.3d 613, 621 (6th Cir. 1998).

⁶⁵ See, e.g., *McElwaine v. U.S. West, Inc.*, 176 F.3d 1167, 1172 n. 8 (9th Cir. 1999); *D'Emanuele v. Montgomery Ward & Co., Inc.*, 904 F.2d 1379, 1382 (9th Cir. 1990).

section, it is generally held that only the *prevailing* party may receive such an award although a party need not prevail on all issues in order to recover fees.⁶⁶

A party seeking plan benefits under ERISA cannot recover fees and costs where a decision to deny the benefit claim is upheld because the decision was reasonable.⁶⁷ Even so, one court has observed that there is no specific requirement in ERISA that a party must prevail in order to recover fees, even though application of various factors will in most instances result in an award in favor of the party that most substantially prevails. The court held that it was an abuse of discretion to award fees to an insurer that filed a successful interpleader action under ERISA.⁶⁸

It is generally true that a decision whether to award fees and costs rests in the discretion of the trial court and will be reversed only upon abuse of that discretion.⁶⁹ However, there are several limitations on this discretionary authority. Appellate courts require the district court to specifically state the reasoning relied on to support its decision.⁷⁰ Failure to fully explain the reasoning for an attorney fee award will result in a remand for further explanation.⁷¹ Another limitation on the trial court's discretion is that where a substantive judgment is modified on appeal, the case will be remanded to the trial court for reconsideration of an attorney fee award.⁷² Finally, a federal district court must have subject matter jurisdiction under ERISA before it has authority to award fees and costs under ERISA. Where a district court grants a motion to dismiss based on the absence of jurisdiction under ERISA, that court has no jurisdiction to award fees and costs to the plaintiff under ERISA's fee-shifting provision.⁷³

Federal appellate courts have been fairly uniform in requiring trial courts to apply five factors as guidelines in deciding whether to award fees and costs to a prevailing plaintiff under ERISA. The factors generally applied are as follows:

- 1) the degree of the defendant's culpability or bad faith;
- 2) the ability of the defendant to satisfy an award of fees and costs;
- 3) whether an award of fees and costs against the defendant would deter others from acting under similar circumstances;
- 4) whether the party requesting fees sought to benefit all participants and beneficiaries of an ERISA plan or to resolve a significant legal question regarding ERISA;

⁶⁶ See, e.g., *Trustmark Life Ins. Co. v. University of Chicago Hospitals*, 207 F.3d 876 (7th Cir. 2000); *Shelby County Health v. Southern Council*, 203 F.3d 926 (6th Cir. 2000); *Griffin v. Jim Jamison, Inc.*, 188 F.3d 996 (8th Cir. 1999).

⁶⁷ *Perlman v. Swiss Bank Corp. Comprehensive Disability Protection Plan*, 195 F.3d 975 (7th Cir. 1999).

⁶⁸ *Gibbs v. Gibbs*, 210 F.3d 491 (5th Cir. 2000).

⁶⁹ *Van Gerwen v. Guarantee Mut. Life Ins. Co.*, 214 F.3d 1041, 1045 (9th Cir. 2000).

⁷⁰ See, e.g., *Pratt v. Petroleum Production Management Inc. Employee Savings Plan & Trust*, 920 F.2d 651 (10th Cir. 1990).

⁷¹ *Van Gerwen*, 214 F.3d at 1047 (remand to explain how poor representation of plaintiff's counsel resulted in reduction of fee award to plaintiff).

⁷² *Pitman v. Blue Cross Blue Shield of Oklahoma*, 217 F.3d 1291, 1299 (10th Cir. 2000); *Deboard v. Sunshine Mining and Mfg. Co.*, 208 F.3d 1228 (10th Cir. 2000).

⁷³ *In re Knight*, 207 F.3d 1115 (9th Cir. 2000).

5) the relative merits of the parties' positions.⁷⁴

Trial courts are instructed to consider and explain how each of the five factors are implicated in a given case, without giving predominance to any one factor.⁷⁵ No single factor is conclusive. For example, the absence of bad faith on the part on either side should not be the sole reason to deny an award of fees and costs.⁷⁶ Furthermore, proof of traditional "bad faith" in the insurance contract sense may not be necessary to support an award of attorney fees where there is proof of some other form of culpable conduct on the part of the losing party.⁷⁷

In light of the uniform application of the five-factor test in determining whether to award fees in an ERISA case, many courts have held that there is no presumption under ERISA that a prevailing party will recover such an award.⁷⁸ Other courts have held that a prevailing plaintiff-employee (as opposed to a prevailing defendant) should ordinarily be awarded attorney fees.⁷⁹ Still other courts have taken a middle-of-the-road approach, holding that where a plaintiff prevails in a suit for plan benefits, there is a "modest" presumption in favor of awarding fees to the plaintiff unless the defendant can show the existence of special circumstances making the award of fees unjust.⁸⁰

In deciding whether to award fees and costs to a prevailing *defendant*, some courts have applied the same factors considered in reviewing a plaintiff's request for fees.⁸¹ Other courts have adopted a separate test for prevailing defendants. For example, the Seventh Circuit has observed that the failure to award fees to a prevailing defendant would rarely constitute an abuse of discretion.⁸² That Court has approved an alternative test for application to prevailing defendants: fees are awarded to the prevailing party unless the loser's position, while rejected by the Court, had a solid basis—more than merely not frivolous but less than meritorious.⁸³ This standard is also flexible enough to allow the court to take into account special circumstances that might otherwise make the award unjust (such as the plaintiff's inability to pay the award). As the Seventh Circuit has summarized it, this standard essentially asks the question of whether the losing party's position

⁷⁴ See, e.g., *Riley v. Administrator of Supersaver 401K Plan*, 209 F.3d 780 (5th Cir. 2000); *Deboard v. Sunshine Mining and Mfg. Co.*, 208 F.3d 1228 (10th Cir. 2000); *Maune v. International Brotherhood of Elec. Workers*, 83 F.3d 959 (8th Cir. 1996); *Denzler v. Questech, Inc.*, 80 F.3d 97 (4th Cir. 1996); *Wells v. U.S. Steel and Carnegie Pension Fund*, 76 F.3d 731 (6th Cir. 1996); *Miller v. United Welfare Fund*, 72 F.3d 1066 (2d Cir. 1995); *Barnes v. Independent Auto. Dealers Ass'n of Cal.*, 64 F.3d 1389 (9th Cir. 1995); *Florence Nightingale Nursing Service, Inc. v. Blue Cross/Blue Shield of Alabama*, 41 F.3d 1476, 1485 (11th Cir.), *cert. denied*, 514 U.S. 1128 (1995); *McPherson v. Employees Pension Plan*, 33 F.3d 253 (3d Cir. 1994); *Gray v. New England Telephone and Telegraph Co.*, 792 F.2d 251 (1st Cir. 1986).

⁷⁵ *Riley v. Administrator of Supersaver 401K Plan*, 209 F.3d 780 (5th Cir. 2000).

⁷⁶ See, e.g., *Riley v. Administrator of Supersaver 401K Plan*, 209 F.3d at 782; *Smith v. CMTA-IAM Pension Trust*, 746 F.2d 587 (9th Cir. 1984).

⁷⁷ *McPherson v. Employees Pension Plan*, 33 F.3d at 256–57.

⁷⁸ *Maurer v. Joy Technologies, Inc.*, 212 F.3d 907 (6th Cir. 2000); *Todd v. AIG Life Ins. Co.*, 47 F.3d 1448 (5th Cir. 1995); *Freeman v. Continental Ins. Co.*, 996 F.2d 1116 (11th Cir. 1993).

⁷⁹ *Barnes v. Independent Auto. Dealers Ass'n of Cal.*, 64 F.3d at 1397.

⁸⁰ *Stanton v. Larry Fowler Trucking, Inc.*, 52 F.3d 723 (8th Cir. 1995); *Little v. Cox's Supermarkets*, 71 F.3d 637 (7th Cir. 1995); *Reinking v. Phila. American Life Ins. Co.*, 910 F.2d 1210 (4th Cir. 1990).

⁸¹ *Peckham v. Board of Trustees, etc.*, 719 F.2d 1063 (10th Cir. 1983).

⁸² *Nichol v. Pullman Standard*, 889 F.2d 115 (7th Cir. 1989).

⁸³ *Id.*

was substantially justified and taken in good faith or whether the losing party was simply out to harass its opponent.⁸⁴ The Seventh Circuit has also applied this “substantially justified” test in lieu of the five-factor test to determine whether an award of fees to a *plaintiff* is appropriate.⁸⁵

The five-factor test is applied to determine the *appropriateness* of a fee award.⁸⁶ Once the court determines that a fee award is appropriate, the same five factors are not relevant to determining the reasonable amount of fees to be awarded.⁸⁷ Thus, where a losing party conceded that a fee award was appropriate, the trial court was not permitted to consider the factor of “bad faith” in calculating the amount of the fee award.⁸⁸

C. Some Success on the Merits Required for Fee Awards

In *Hardt v. Reliance Standard Life Ins. Co.*,⁸⁹ the Supreme Court was faced with two issues: (1) whether ERISA’s fee-shifting provision includes a “prevailing party” requirement; and (2) whether a district court remand to a claim administrator for further review of a denied claim for benefits satisfies a “prevailing party” standard. Hardt sued for long term disability benefits under an ERISA-governed plan. During the claim review, Hardt balked at various requests for information, including a request for a functional capacity evaluation. Her claim was denied. On review in the district court, the court ruled that the claim administrator failed to provide an appropriate claim review process and remanded to the claim administrator for further review. On remand, Hardt submitted additional evidence and, based on the new evidence, the claim administrator approved Hardt’s disability benefit claim. Hardt then returned to the district court and sought attorney’s fees and costs under ERISA’s fee-shifting provision. The district court awarded fees based on the five-factor test. On appeal, the Fourth Circuit reversed, holding that Hardt was not a prevailing party and therefore not entitled to fees under ERISA.

On review before the Supreme Court, Hardt and her *amici* argued that there is no prevailing party requirement under ERISA and that the five-factor test provides a thorough guide to the award of fees under ERISA. The respondent and its *amici* argued that ERISA requires substantial success on the merits, that a remand does not constitute success on the merits, and that the five-factor test is inappropriate because it is skewed toward successful plaintiffs and against successful defendants. The Supreme Court held that ERISA requires a showing of “some success on the merits” and that once this is determined, a court can apply the five-factor test or some other test as a gauge in exercising its discretion to award fees under ERISA. The Court also held that under the facts in that case, Hardt had achieved something more than “trivial success on the merits” and that the district court properly exercised its discretion in awarding fees. However, the Supreme Court specifically determined not to address whether a remand order, without more, always satisfies the “some success on the merits” requirement.

⁸⁴ *Meredith v. Navistar*, 935 F.2d 124, 128 (7th Cir. 1991).

⁸⁵ *Trustmark Life Ins. Co. v. University of Chicago Hospitals*, 207 F.3d 876 (7th Cir. 2000); *Harris Trust and Savings Bank v. Provident Life and Accident Ins. Co.*, 57 F.3d 608 (7th Cir. 1995).

⁸⁶ *Curry v. Contract Fabricators Inc. Profit Sharing Plan*, 891 F.2d 842, 849 (11th Cir. 1990).

⁸⁷ *Id.*; *DeEmanuele v. Montgomery Ward & Co., Inc.*, 904 F.2d 1379, 1382 (9th Cir. 1990) (five-factor test does not apply to determination of the amount of attorney fees).

⁸⁸ *D’Emanuele*, *supra*.

⁸⁹ 130 S. Ct. 2149 (2010).

D. Calculating Fee Awards Under ERISA

1. The Lodestar Method

The United States Supreme Court has held that the lodestar method of determining fees is the “guiding light of our fee-shifting jurisprudence” and that there is a “strong presumption” that the lodestar represents the ‘reasonable’ fee” under federal statutes that allow for a recovery of “reasonable attorney’s fees.”⁹⁰ A lodestar award is based on two elements: (1) determination of a reasonable hourly rate; and (2) determination of the number of hours reasonably expended.⁹¹ The burden of proving both of these elements rests on the fee applicant.⁹²

The fee applicant must demonstrate that the claimed hourly rate is based on prevailing market rates in the local community. As the Supreme Court held in the context of another federal fee-shifting statute: “reasonable fees’... are to be calculated according to prevailing market rates in the relevant community”:

In seeking some basis for a standard, courts properly have required prevailing attorneys to justify the reasonableness of the requested rate or rates. To inform and assist the court in the exercise of its discretion, the burden is on the fee applicant to produce satisfactory evidence—in addition to the attorney’s own affidavits—that the requested rates are in line with those prevailing in the community for similar services by lawyers of reasonably comparable skill, experience, and reputation. A rate determined in this way is normally deemed to be reasonable, and is referred to—for convenience—as the prevailing market rate.⁹³

The fee applicant also has the burden to prove that the hours claimed were “reasonably expended” in prosecution of the case:

The party seeking an award of fees should submit evidence of hours worked and rates claimed. Where the documentation of hours is inadequate, the district court may reduce the award accordingly.

...

Where settlement is not possible, the fee applicant bears the burden of establishing entitlement to an award and documenting the appropriate hours expended and hourly rates. The applicant should exercise ‘billing judgment’ with respect to hours worked... and should maintain billing time records in a manner that will enable a reviewing court to identify distinct claims.⁹⁴

The Supreme Court has held that a lodestar figure may be *reduced* by the time spent on work that is redundant, excessive, and/or unsuccessful.⁹⁵ A plaintiff also cannot recover fees under ERISA for pursuing claims that she lost:

In some cases a plaintiff may present in one lawsuit distinctly different claims for relief that are based on different facts and legal theories. In such a suit... counsel’s work on one claim will be unrelated to

⁹⁰ City of Burlington v. Dague, 505 U.S. 557, 562 (1992).

⁹¹ Hensley v. Eckerhart, 461 U.S. 424, 433 (1983).

⁹² Id. at 437.

⁹³ Blum v. Stenson, 465 U.S. 886, 895 n. 11 (1984); see also Johnson v. Georgia Highway Express, Inc., 488 F.2d 714, 718 (5th Cir. 1974) (“The customary fee for similar work in the community should be considered”).

⁹⁴ Hensley, 461 U.S. at 433, 437.

⁹⁵ Hensley, 461 U.S. at 434–37.

his work on another claim. Accordingly, work on an unsuccessful claim cannot be deemed to have been ‘expended in pursuit of the ultimate result achieved.’⁹⁶

The court may reduce the amount of a fee award either by identifying “specific hours that should be eliminated, or it may simply reduce the award to account for the limited success.”⁹⁷ Where the petitioning party fails to demonstrate that it exercised “billing judgment” in submitting its claimed hours of work, the hours claimed will also be reduced.⁹⁸

Consistent with the Supreme Court holding in *Hensley*, a plaintiff should not be permitted to recover fees under ERISA for attempts to pursue preempted state law claims. ERISA preempts all state laws that “relate to” an employee benefit plan.⁹⁹ Where a plaintiff attempts to preserve state law claims, he/she should not be permitted to recover fees under ERISA for those attempts:

We agree... that the district court’s award of attorney’s fees should not include [plaintiff’s] costs of litigating in state court. The state court actions were not brought under ERISA. Consequently, *section 1132(g)(1) provides no authority for an award of costs incurred by [plaintiff] in those actions.*¹⁰⁰

Time pursuing state law claims is *not* expended in order to further an ERISA claim and should not form the basis for an attorney fee award under ERISA.¹⁰¹ The plaintiff in *Life Partners* sued for death benefits under an ERISA plan. Originally the plaintiff filed the matter under state law. After the state law complaint was dismissed, the plaintiff amended the complaint to bring a claim for benefits under ERISA. Plaintiff prevailed on his ERISA claim. The district court awarded attorney fees to the plaintiff under ERISA based in part on its conclusion that the defendant’s defense to the ERISA benefit claim “bordered on being frivolous.”¹⁰² Nevertheless, the court of appeals reversed that portion of the fee award that included time spent by the plaintiff pursuing state law claims:

As the district court itself ruled, the initial complaint filed by [plaintiffs] failed to state a claim on which relief could be granted because it alleged only state causes of action that were preempted by ERISA. Until [plaintiffs] amended their complaint... to state a cause of action under ERISA, LINA’s defense to the claims was valid and meritorious. We therefore conclude that [plaintiffs] should not have been awarded attorney’s fees incurred prior to the amending of the complaint... Accordingly, we affirm the district court’s order awarding attorneys’ fees but vacate the amount of that award and remand for a redetermination of the proper amount of such fees, consistent with this opinion.¹⁰³

The principle that fees should only be recovered for work that furthers the party’s ERISA claim is further supported by the recent decision in *McElwaine*.¹⁰⁴ The plaintiff in that case sued her former employer for pension benefits allegedly due her and other early retirees. Thereafter, the defendant received certain informa-

⁹⁶ *Id.* at 434–35. *See also* Deboard v. Sunshine Mining and Mfg. Co., 208 F.3d at 1245 (no abuse of discretion where trial court reduced fee award for time spent on issues the trial court determined were meritless).

⁹⁷ *Hensley*, 461 U.S. at 436–37.

⁹⁸ *Walker v. HUD*, 99 F.3d 761, 769–70 (5th Cir. 1996).

⁹⁹ 29 U.S.C. §1144(a).

¹⁰⁰ *Downey Community Hospital v. Wilson*, 977 F.2d 470, 474 (9th Cir. 1992) [emphasis added].

¹⁰¹ *Life Partners, Inc. v. Life Ins. Co. of North America*, 203 F.3d 324 (5th Cir. 1999).

¹⁰² *Id.* at 326.

¹⁰³ *Id.*

¹⁰⁴ *Supra.*

tion from the Internal Revenue Service that caused it to approve plaintiff's claim. The plan informed plaintiff and other early retirees of the decision.¹⁰⁵ Even so, the plaintiff continued to litigate the matter and to incur further fees and costs. The district court awarded fees to the plaintiff for all of her work based on the fact that the plaintiff was able to recover the disputed benefits. The Ninth Circuit reversed in part, holding that it was an abuse of discretion to award fees for work performed after the plaintiff was informed that her benefits would be paid because at that point the plaintiff's work no longer furthered her ERISA claim and thereafter "nothing remained to be achieved by further litigation."¹⁰⁶

The decisions in *Downey*, *Life Partners*, and *McElwaine* are consistent with the idea that a party should not be rewarded for pursuing meritless claims and mindlessly multiplying the cost of legal proceedings.¹⁰⁷ Federal courts should require fee applicants to itemize their time based on work performed that furthered their successful ERISA claim versus work that is performed in an effort to take the case outside of ERISA in pursuit of state law claims, which should be excluded from the award.

2. Fee Multipliers

Once the lodestar figure is determined, the trial court has limited discretion to adjust the lodestar figure upward or downward based on certain factors. The Supreme Court has held that "[w]e have established a 'strong presumption' that the lodestar represents the 'reasonable' fee... and have placed upon the fee applicant who seeks more than that the burden of showing that 'such an adjustment is *necessary to the determination of a reasonable fee*.'"¹⁰⁸ Likewise, the federal appellate courts have cautioned that "[s]uch upward or downward adjustments are the exception rather than the rule since *the lodestar amount is presumed to constitute a reasonable fee*."¹⁰⁹ Thus, a multiplier may be applied only in "rare, exceptional circumstances."¹¹⁰ Where a multiplier is applied, "the court should explain with particularity its reasons for finding that there are factors, not already subsumed within the initial lodestar calculation" that justify the multiplier.¹¹¹ The multiplier must be supported by "specific evidence on the record and detailed findings by the district court."¹¹²

Originally there were twelve factors eligible for consideration in multiplying a fee award: (1) the time and labor required for the litigation; (2) the novelty and complication of the issues; (3) the skill required to properly litigate the issues; (4) whether the attorney had to refuse other work to litigate the case; (5) the attorney's customary fee; (6) whether the fee is fixed or contingent; (7) whether the client or case circumstances imposed any time constraints; (8) the amount involved and the results obtained; (9) the experience, reputation, and ability of the attorneys; (10) whether the case was 'undesirable'; (11) the type of attorney-client rela-

¹⁰⁵ 176 F.3d at 1174.

¹⁰⁶ *Id.*

¹⁰⁷ *See, e.g., Gibbs v. Gibbs*, 210 F.3d at 506 (affirming an order denying attorney fees where an award of fees would only encourage premature lawsuits).

¹⁰⁸ *Dague*, 505 U.S. at 562 [emphasis added].

¹⁰⁹ *D'Emanuele*, 904 F.2d at 1383 [emphasis added]. *See also Brytus v. Spang & Co.*, 203 F.3d 238 (3d Cir. 2000).

¹¹⁰ *Id.* at 1383; *Kerr v. Screen Extras Guild, Inc.*, 526 F.2d 67, 70 (9th Cir. 1975).

¹¹¹ *Hall v. Bolger*, 768 F.2d 1148, 1151 (9th Cir. 1985).

¹¹² *Jordan v. Multnomah County*, 815 F.2d 1258, 1262 (9th Cir. 1987).

tionship and whether that relationship was long-standing; and (12) awards made in similar cases.¹¹³ However, the United States Supreme Court has since held that consideration of several of those factors is not appropriate because they are already subsumed in the initial lodestar calculation. The subsumed factors include: the novelty and complexity of the issues; the special skill and experience of counsel; the quality of the representation; the results obtained; and the superior performance of counsel.¹¹⁴

The Supreme Court has also held that, as a matter of law, a fee award cannot be based on a contingency fee arrangement nor can the lodestar figure be enhanced based on “the risk of loss.”¹¹⁵ Consideration of such a factor would duplicate factors already considered in determining the lodestar amount:

We note at the outset that an enhancement for contingency would likely duplicate in substantial part factors already subsumed in the lodestar. The risk of loss in a particular case (and, therefore, the attorney’s contingent risk) is the product of two factors: (1) the legal and factual merits of the claim, and (2) the difficulty of establishing those merits. The second factor, however, is ordinarily reflected in the lodestar—either in the higher number of hours expended to overcome the difficulty, or in the higher hourly rate of the attorney skilled and experienced enough to do so... Taking account of it again through lodestar enhancement amounts to double counting.¹¹⁶

Consideration of a “risk of loss” factor or perceived difficulty in finding counsel also cannot be intelligibly applied:

Instead of enhancement based upon the contingency risk posed by each case, *Dague* urges that we adopt the approach set forth in the Delaware Valley II concurrence. We decline to do so, first and foremost because we do not see how it can intelligibly be applied. On the one hand, it would require the party seeking contingency enhancement to ‘establish that without the adjustment for risk [he] ‘would have faced substantial difficulties in finding counsel in the local or other relevant market’... On the other hand, it would forbid enhancement based ‘on an assessment of the ‘riskiness’ of any particular case.’ But since the predominant reason that a contingent-fee claimant has difficulty finding counsel in any legal market where the winner’s attorney’s fees will be paid by the loser is that attorneys view his case as too risky (*i.e.*, too unlikely to succeed), these two propositions, as a practical matter, collide.¹¹⁷

Although the fee-shifting statute at issue in *Dague* was a statute other than ERISA, federal circuit courts have uniformly held that *Dague* prohibits consideration of any “risk of loss” factor in awarding attorney fees under ERISA.¹¹⁸

Another enhancement factor that has seen recent litigation is the “undesirability” factor. Some plaintiffs have argued that ERISA cases are undesirable because of ERISA’s prohibition of damage awards and the application in some cases of a deferential review standard. Plaintiffs argue that ERISA law makes it finan-

¹¹³ *Johnson v. Georgia Express*, 488 F.2d at 717–19.

¹¹⁴ *Blum v. Stenson*, 465 U.S. 886, 891, 898–90 (1984); *see also D’Emanuele*, 904 F.2d at 1383.

¹¹⁵ *Dague*, 505 U.S. at 567.

¹¹⁶ *Dague*, 505 U.S. at 562–63.

¹¹⁷ *Id.* at 563–64.

¹¹⁸ *Murphy v. Reliance Standard Life Ins. Co.*, 247 F.3d 1313 (11th Cir. 2001); *McElwaine*, 176 F.3d at 1173–74 (enhancement of fees under ERISA due to contingent representation is prohibited by *Dague*); *Cook v. Niedert*, 142 F.3d 1004, 1014 (7th Cir. 1998) (per *Dague*, fees awarded under ERISA cannot be enhanced with a risk multiplier based on contingency); *Drennan v. General Motors Corp.*, 977 F.3d 246, 253 (6th Cir. 1992) (trial court’s enhancement of attorney fee award under ERISA due to contingent arrangement was invalid under *Dague*).

cially unattractive for plaintiff's attorneys to handle such cases. This is an improper application of the "undesirability" factor.

Some courts have held that, after *Dague*, the "undesirability" factor is no longer viable, particularly where it is equated with considerations involving financial risk of loss.¹¹⁹ To hold otherwise would allow a court to consider financial riskiness in the context of "undesirability" even though *Dague* held that financial riskiness is not an appropriate factor to consider in determining whether to enhance a lodestar fee award.

The "undesirability" factor has been applied primarily in cases where there are non-monetary barriers discouraging representation in a particular case. For example, in *Guam Society of Obstetricians and Gynecologists v. Ada*,¹²⁰ the Court upheld a multiplier of 2.0 in a case challenging the constitutionality of Guam's anti-abortion statute. The Court cited specific evidence submitted by the fee applicants that several local law firms had declined the case because of fear of ostracism and threats to their personal safety as a result of their involvement in a highly emotional and controversial issue.¹²¹ Similarly, in *Jordan*,¹²² the fee applicant argued that his prisoner lawsuit was "unpopular" and therefore "undesirable" for purposes of computing an attorney fee award. The Ninth Circuit disagreed, holding that "[p]ublic anger that the opening of a much-needed freeway section might be delayed by the prisoners' opposition does not constitute the sort of unpopularity that entitles a civil rights plaintiff to fee enhancement in the absence of evidence that the plaintiffs or their counsel were adversely affected by that unpopularity."¹²³ In short, the "undesirability" factor refers to social "undesirability" and is applicable only when the case involves socially controversial or unpopular issues or other unique circumstances.

At least two federal courts have expressly held that ERISA disputes are not "undesirable" for purposes of determining an attorney fee award.¹²⁴ There is little, if any, case authority to the contrary.

The author is not aware of any published case law upholding an enhancement of a lodestar attorney fee award under ERISA. In fact, the Ninth Circuit recently overturned a fee award in which the trial court applied a "negative" multiplier.¹²⁵ The district court determined a lodestar award in favor of the plaintiff but then applied a .75 multiplier due to poor representation by plaintiff's counsel. The Ninth Circuit upheld reductions of hours by the district court in determining the lodestar figure.¹²⁶ However, the Ninth Circuit was highly critical of the trial court's use of a multiplier. The appellate court held that the quality of counsel's representation was already taken into account in determining a reasonable hourly fee and the number of compensable hours under the lodestar method. The Ninth Circuit also held that fee awards under ERISA are intended to compensate, not to punish. The circuit court acknowledged that in some rare cases, a multiplier

¹¹⁹ *Davis v. City and County of San Francisco*, 976 F.2d 1536, 1546 n. 4 (9th Cir. 1992) ("the *Dague* opinion can also be read as casting doubt on the relevance of a case's 'desirability' to the fee calculation").

¹²⁰ 100 F.3d 691 (9th Cir. 1996), *cert. denied*, 522 U.S. 949 (1997).

¹²¹ *Id.* at 697.

¹²² *Supra*.

¹²³ *Id.*

¹²⁴ *Bowen v. Southtrust Bank of Alabama*, 769 F. Supp. 889, 898 (M.D. Ala. 1991) ("[t]here is no evidence that ERISA cases are undesirable"); *Malone v. Exclusive Healthcare, Inc.*, 2000 U.S. Dist. Lexis 2955 (D. Neb. 2000) (ERISA benefit dispute "was not the type of case that one would say is undesirable").

¹²⁵ *Van Gerwen*, 214 F.3d at 1045–47.

¹²⁶ *Id.* at 1047–48.

might be appropriate and therefore remanded the case to the trial court for detailed explanation of its reasons for the multiplier and why the quality of counsel's representation was not already taken into account in determining the lodestar.¹²⁷ This opinion amply illustrates how rare enhancement of a lodestar fee award ought to be in ERISA cases.

3. Class Actions (Common Fund Cases)

Although a contingency fee award is not appropriate generally in ERISA cases, some courts have held that a contingency award may be considered in an ERISA case involving a common fund. Cases involving a common fund give the trial court a choice to award fees based on the lodestar method or to instead award fees based on a percentage of the recovery.¹²⁸ The reason why a percentage fee is appropriate in common fund cases is because the fee is paid by the claimants to the fund rather than by the defendant.¹²⁹ Where the percentage fee is paid by all parties who recover a share of the common fund, there is no danger that the nonlitigating parties will be unjustly enriched at the expense of the named parties.¹³⁰

¹²⁷ *Id.*

¹²⁸ *Brytus v. Spang & Co.*, 203 F.3d at 243; *Cook v. Niedert*, 142 F.3d at 1010–11.

¹²⁹ *Id.*

¹³⁰ *Brytus v. Spang & Co.*, 203 F.3d at 245–46.

Interference with Protected Rights Under Section 510

I. Introduction

Congress' attempt to protect participants and their beneficiaries would be futile without the enactment of Section 510 [29 U.S.C. §1140]. This section prohibits discrimination and other types of interference with a participant or beneficiary's rights under a benefit plan:

It shall be unlawful for any person to discharge, fine, suspend, expel, discipline, or discriminate against a participant or beneficiary for exercising any right to which he is entitled under the provisions of an employee benefit plan... or for the purpose of interfering with the attainment of any right to which such participant may become entitled under the plan....

Section 510 assures that all of the regulatory provisions accomplish their purpose and that participants and their beneficiaries are not denied their rights under employee benefit plans as a result of actions affecting the employment relationship that underlies participation in an employee benefit plan.

This chapter will discuss the issues related to the substantive elements of §510 and the procedures for remedying violations of that section. Section B discusses ERISA's broad preemption clause and its impact on wrongful discharge actions where the motivating factor for the discharge is to interfere with a participant's or beneficiary's rights under an employee benefit plan. Section C discusses the substantive elements and burden of proof to establish a violation of §510. Section D discusses standing to sue under §510 and the proper defendants in such an action.

II. Preemption of State Law

In *Ingersoll-Rand v. McClendon*,¹ the Supreme Court addressed the issue of whether ERISA's preemption clause and §510 interact to "pre-empt[]" a state common law claim that an employee was unlawfully discharged to prevent his attainment of benefits under a plan covered by ERISA."² Perry McClendon worked for Ingersoll-Rand as a salesman. After he had worked there almost ten years, Ingersoll-Rand discharged him. McClendon alleged that a principal reason for his termination was Ingersoll-Rand's desire to avoid making contributions to his pension fund. (McClendon was not aware of the fact that he already had enough credited service to vest in the pension fund.) McClendon sued under state law, seeking compensatory and punitive damages under various theories.

The state trial court granted summary judgment to Ingersoll-Rand, finding that McClendon's employment was at-will. On appeal, the Texas Supreme Court reversed. The appellate court held that §510 of ERISA

¹ 498 U.S. 133 (1990).

² *Id.* at 135.

created a public policy exception to the employment-at-will doctrine and found that McClendon had stated a cause of action for wrongful discharge.

The United States Supreme Court reversed the state supreme court and held that McClendon's state law claim was preempted by ERISA. The Court held that McClendon's state law cause of action was expressly preempted by ERISA's preemption clause and that it was also preempted by implication because it was in conflict with §510 and ERISA's exclusive civil remedy provisions.

McClendon's state law claim was expressly preempted by ERISA's preemption clause because it "relate[d] to" an employee benefit plan. This was based in large part on the fact that the state law cause of action recognized by the Texas Supreme Court hinged on the existence of an employee benefit plan:

Here, the existence of a pension plan is a critical factor in establishing liability under the State's wrongful discharge law. As a result, this cause of action relates not merely to pension benefits, but to the essence of the pension *plan* itself.

We have no difficulty in concluding that the cause of action which the Texas Supreme Court recognized here—a claim that the employer wrongfully terminated plaintiff primarily because of the employer's desire to avoid contributing to or paying benefits under the employee's pension fund—"relate[s] to" an ERISA-covered plan within the meaning of [ERISA's preemption clause] and is preempted.³

The Court rejected McClendon's suggestion that application of the preemption clause was limited to laws affecting plan terms, conditions or administration. The Court noted that its prior precedents and its broad reading of ERISA's preemption provision would not allow for such a restrictive interpretation. The Court further noted that its holding was consistent with the intent of Congress in enacting ERISA's preemption clause, that is, to create national uniformity in the regulation of employee benefit plans:

Allowing state based actions like the one at issue here would subject plans and plan sponsors to burdens not unlike those that Congress sought to foreclose through [the preemption clause]. Particularly disruptive is the potential for conflict in substantive law. It is foreseeable that state courts, exercising their common law powers, might develop different substantive standards applicable to the same employer conduct, requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction. Such an outcome is fundamentally at odds with the goal of uniformity that Congress sought to implement.⁴

The Supreme Court also held that McClendon's state law claim was preempted by implication because it conflicted with §510 and ERISA's exclusive civil enforcement provisions. The Court noted that §510 regulated the specific type of conduct that McClendon was attempting to regulate under state law:

By its terms §510 protects plan participants from termination motivated by an employer's desire to prevent a pension from vesting. Congress viewed this section as a crucial part of ERISA because, without it, employers would be able to circumvent the provision of promised benefits... We have no doubt that this claim is prototypical of the kind Congress intended to cover under §510.⁵

However, the mere fact that the state law claim conflicted with §510 did not automatically preclude McClendon from bringing his action under state law. Rather, the Court stated that it must look for "special features" that would warrant preemption. The Court found these "special features" in the exclusive remedy provisions

³ *Id.* at 135, 139–40.

⁴ *Id.* at 142.

⁵ *Id.* at 143.

of ERISA, §502(a). The interaction of §510, which is enforced through the exclusive remedy provisions of §502(a), dictated that McClendon's state law cause of action was preempted:

We... [conclude] that the requirements of conflict pre-emption are satisfied in this case. Unquestionably, the Texas cause of action purports to provide a remedy for the violation of a right expressly guaranteed by §510 and exclusively enforced by §502(a). Accordingly we hold that '[w]hen it is clear or may fairly be assumed that the activities which a State purports to regulate are protected' by §510 of ERISA, 'due regard for the federal enactment requires that state jurisdiction must yield'....⁶

Thus, to the extent that a claimant alleges that his/her discharge was motivated by a desire to prevent him/her from collecting benefits or otherwise participating in an employee benefit plan, his/her sole remedy is under ERISA.

III. Substantive Elements and Burden of Proof

The purpose of §510 has been stated as follows:

The legislative history [of §510] reveals that the prohibitions were aimed primarily at preventing unscrupulous employers from discharging or harassing their employees in order to keep them from obtaining vested pension rights.⁷

To prevail under such a claim, a plaintiff must prove that the defendant "discharged [the plaintiff] with the specific intent of interfering with [the plaintiff's] ERISA benefits."⁸ Speculative allegations that the defendant had something to gain by the employment action are not sufficient.⁹ The plaintiff must prove that "the employer made a conscious decision to interfere with the employee's attainment of [benefits]" and that "the desire to [interfere with the attainment of] benefits was a 'determinative factor' in [the employer's] decision to terminate."¹⁰ The mere fact that a particular action may not be "fair" does not establish a violation of §510,

⁶ *Id.* at 145.

⁷ *West v. Butler*, 621 F.2d 240, 245 (6th Cir. 1980).

⁸ *Simmons v. Willcox*, 911 F.2d 1077, 1082 (5th Cir. 1990). *See also* *Roush v. Weastec, Inc.*, 96 F.3d 840 (6th Cir. 1996) (plaintiff must show that employer had purpose of interfering with attainment of rights under a benefit plan); *Lehman v. Prudential Insurance Company of America*, 74 F.3d 323 (1st Cir. 1996) (defendant must be motivated by discriminatory purpose); *Kapetanovich v. Rockwell Int'l*, 1993 U.S. App. Lexis 36785 (3d Cir. 1993) (the critical element of recovery under section 510 is proof of the employer's specific intent to violate the statute); *Unida v. Levi Strauss & Company*, 986 F.2d 970 (5th Cir. 1993) (evidence that the employer closed a specific plant to cut costs and evidence that the pension and benefit costs were rising on a company-wide basis is not sufficient to support a 510 claim); *Conkwright v. Westinghouse Electric Corp.*, 933 F.2d 231 (4th Cir. 1991) (plaintiff must prove the specific intent of the employer to interfere with plaintiff's benefit rights); *Rush v. United Technologies*, 930 F.2d 453 (6th Cir. 1991) (plaintiff must show specific intent to violate ERISA); *McClendon v. Continental Can Co.*, 908 F.2d 1171, 1177 n.9 (3d Cir. 1990) (the employer's "specific intent" to interfere with benefit rights is a "key factor" in establishing an section 510 violation); *Clark v. Resistoflex Company*, 854 F.2d 762, 770 (5th Cir. 1988) (plaintiff must show that the employer had "specific intent to violate ERISA"); *Dister v. Continental Group, Inc.*, 859 F.2d 1108, 1111 (2d Cir. 1988) (an essential element of the plaintiff's case is to show that the employer was at least in part motivated by the specific intent to engage in activity proscribed by section 510).

⁹ *Simmons v. Willcox*, 911 F.2d at 1082; *Clark v. Resistoflex*, 854 F.2d at 771; *Nixon v. Celotex Corp.*, 693 F. Supp. 547, 555 (W.D. Mich. 1988).

¹⁰ *Turner v. Schering-Plough Corp.*, 901 F.2d 335, 347 (3d Cir. 1990).

nor does it satisfy the plaintiff's burden to show that the employer "deliberately discriminated against [the plaintiff] for the purpose of interfering with [the plaintiff's] rights" under the plan.¹¹

In addressing the matter of proof under §510, the courts have adopted the shifting burden analysis utilized in Title VII cases, while assigning the ultimate burden of proof to the plaintiff. Generally, this analysis utilizes the following steps:

First: The plaintiff must tender evidence of a *prima facie* case (*i.e.*, that plaintiff belongs to the protected class; that plaintiff was qualified for the position from which he was terminated; and that the plaintiff was terminated under circumstances that provide some basis for believing that the prohibited intent was present).

Second: If the plaintiff succeeds in proving a *prima facie* case, then the employer must articulate some legitimate reason for the termination.

Third: If the employer articulates a legitimate reason for the termination, then the plaintiff has the burden of persuasion as to whether the intent to interfere with rights secured by ERISA played a determinative role in the termination decision.¹²

In a "mixed motive" case, a plaintiff must prove that "but for" the impermissible consideration, the plaintiff would not have been terminated. In other words, if the plaintiff would have been terminated even in the absence of an illegal intent, there is no violation under §510.¹³

The elements and burden of proof in a §510 action are illustrated by the decision in *Humphreys v. Bellaire Corp.*¹⁴ The plaintiff was discharged by his employer two months before his pension vested. The termination took place shortly after the mine over which plaintiff was a manager was sold by his employer to another company. After his termination, the plaintiff took a job with the purchaser of the mine at a lower salary. Plaintiff then sued his former employer.

On appeal from the district court's summary judgment in favor of plaintiff's former employer, the Sixth Circuit affirmed. Applying the shifting burden of proof analysis discussed above, the Sixth Circuit held the plaintiff met his *prima facie* case by showing that his pension would have vested two months after his discharge. The Court held that the proximity between plaintiff's discharge and the vesting of his pension provided at least some inference of intentional, prohibited activity under §510. The Court also held that the employer presented a legitimate reason for the termination through evidence that the plaintiff was perceived as being out for himself rather than being a company man. The plaintiff then made two arguments that this "reason" was mere pretext: (a) that his discharge resulted in monetary savings for his former employer; and (b) the proximity between his discharge and vesting. The Sixth Circuit held that monetary savings could not form a basis for a §510 violation without "something more." The "something more" was some showing that there was a causal link between plaintiff's pension benefits and the adverse employment decision. The

¹¹ Varhola v. Doe, 820 F.2d 809, 816–17 (6th Cir. 1987). See also Lehman v. Prudential Insurance, *supra* (no claim under §510 where loss of benefits was incidental to but not the reason for the adverse employment action).

¹² See, e.g., Shahid v. Ford Motor Company, 76 F.3d 1404 (6th Cir. 1996); Little v. Cox's Supermarkets, 71 F.3d 637 (7th Cir. 1995); Kinkead v. Southwestern Bell Telephone Company, 49 F.3d 454 (8th Cir. 1995); Ritter v. Hughes Aircraft Company, 58 F.3d 454 (9th Cir. 1995); Barbour v. Dynamics Research Corp., 63 F.3d 32 (1st Cir. 1995); Turner v. Schering-Plough Corp., *supra*; Dister v. Continental Group, Inc., *supra*.

¹³ See Gavalik v. Continental Can Co., 812 F.2d 834, 859 (3d Cir. 1987).

¹⁴ 966 F.2d 1037 (6th Cir. 1992).

plaintiff was required to submit evidence from which a reasonable jury could find that the employer's desire to avoid pension benefits was a determining factor in plaintiff's discharge. Plaintiff's evidence of proximity between his discharge and vesting also was not sufficient proof of pretext. The Court noted that "any possible inference of pretext that might be drawn from the proximity to vesting is eliminated because [plaintiff] was discharged on or about the date of the sale of the mine." Under the circumstances, "[plaintiff's] meager evidence is not sufficient to create a genuine issue of material fact."

Another illustration of the required proof under §510 is the case of *Rush v. McDonald's Corporation*.¹⁵ In that case, after the plaintiff was promoted from a part-time to a full-time position, she was fired for absenteeism. She sued her former employer under several discrimination theories, including a claim under §510. Her §510 claim was apparently based on the fact that while she was still classified as a part-time employee, her employer denied her benefits that were available to full-time employees, which benefits were more generous than benefits applicable to part-time employees. The plaintiff argued that ERISA required her employer to provide identical benefits to its part-time and full-time employees. The plaintiff also argued that ERISA required her to be eligible for full-time employee benefits because she did the work of a full-time employee.

After summary judgment was granted by the district court, the Seventh Circuit affirmed. The Court held that ERISA does not contain any requirement that all employees be eligible for the same benefits, but only that "once the decision is made to afford benefits, like situated employees must be treated in similar fashion." There is no discrimination under §510 "in having full-time and part-time employees, and having different benefit plans for these two groups." The Seventh Circuit also held that §510 did not require that the plaintiff be treated as a full-time employee for purposes of the benefit plans simply because she did the work of a full-time employee. Section 510 is only applicable "when there is discrimination against a participant in a plan with respect to benefits to which a participant is entitled." The Court noted that the plaintiff did receive all of the benefits available to part-time employees but that she did not become eligible for benefits under the full-time benefit plans because she did not fall within the particular group covered by the plans. Accordingly, plaintiff failed to demonstrate that the employer-employee relationship, rather than merely the benefit plan itself, was changed in some discriminatory or wrongful way.

IV. Proper Parties Plaintiff and Defendant

A. Plaintiffs in §510 Actions

In *Ingersoll v. McClendon*, the Supreme Court held that the exclusive mode of enforcement for violations of §510 lies under ERISA's civil remedy provision.¹⁶ More specifically, §502(a)(3) permits an action to enjoin any act or practice that violates ERISA or the terms of a benefit plan and permits the award of "appropriate equitable relief" to redress the violations or to enforce the provisions of ERISA or the terms of a benefit plan.¹⁷

An action for equitable relief may be brought by a plan participant or a plan beneficiary. Likewise, §510 prohibits discriminatory action "against a participant or beneficiary." A plan *participant* is defined by ERISA as:

¹⁵ 966 F.2d 1104 (7th Cir. 1992).

¹⁶ §502(a).

¹⁷ *Ponsetti v. G.E. Pension Plan*, 614 F.3d 684 (7th Cir. 2010) (Section 510 suits are actionable through section 502(a)(3)).

[A]ny employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan... or whose beneficiaries may be eligible to receive any such benefit.¹⁸

The Supreme Court has held that a former employee does not fall within the “may become eligible” language of this definition unless he has a reasonable expectation of returning to covered employment or a colorable claim to vested benefits.¹⁹ A plan *beneficiary* is defined by ERISA as:

[A] person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder.²⁰

Most courts have held that the parties specifically enumerated in ERISA’s civil enforcement section are the *only* parties authorized to bring the actions delineated therein.²¹ However, this is not a unanimous view.²²

A case illustrating the position that only a “participant” or “beneficiary” may bring an action under §510 is *McKinnon v. Blue Cross and Blue Shield of Alabama*.²³ In *McKinnon*, the plaintiff’s father had filed an action for plan benefits. When plaintiff’s father died, plaintiff, who worked for the same employer as her father, was substituted in the suit as executrix of her father’s estate. Shortly thereafter, the plaintiff was fired. She then sued under §510. The district court held that she had no standing to pursue an action under §510, and the Eleventh Circuit affirmed. The appellate court held that the plaintiff, as an individual, was not a “participant” or “beneficiary” of *her father’s* benefit plan. Because §510 only protects a “participant or beneficiary,” plaintiff had no standing to bring an action under §510 where the alleged retaliatory discharge related to her father’s benefit plan. A case illustrating the types of individuals included within the definition of “participant” for purposes of an action under §510 is *Fleming v. Ayers & Associates*.²⁴ The plaintiff in *Fleming* worked as a nurse in defendant’s nursing home facility. After plaintiff gave birth to a child who required substantial medical care, plaintiff resigned. Shortly thereafter, plaintiff contacted her former employer about a job at a facility closer to her home. Plaintiff was immediately hired for a part-time position with the intent that the job would eventually become full-time. The next day, however, the plaintiff was told that she would not be hired. The defendant admitted that the reason for this change was the defendant’s concern with the high medical costs associated with the birth of plaintiff’s child. The Sixth Circuit affirmed the district court’s holding that plaintiff was a participant under ERISA and had standing to bring an action under §510. The defendant argued that plaintiff could not be a “participant” because she was hired for a part-time position and health insurance benefits were not available for part-time employees. The Court rejected this argument noting that the defendant intended plaintiff to move into a full-time position in the future, at which time she

¹⁸ ERISA, §3(7) [29 U.S.C. §1002(7)].

¹⁹ *Firestone v. Bruch*, 489 U.S. at 117.

²⁰ *Id.* at §3(8) [29 U.S.C. §1002(8)].

²¹ *See, e.g., Allstate Ins. Co. v. The 65 Security Plan*, 879 F.2d 90 (3d Cir. 1989); *Hermann Hospital v. MEBA Medical & Benefits Plan*, 845 F.2d 1286 (5th Cir. 1988); *Teagardener v. Republic-Franklin, Inc. Pension Plan*, 909 F.2d 947 (6th Cir. 1990).

²² *See Amalgamated Clothing & Textile Workers’ Union v. Murdock*, 861 F.2d 1406 (9th Cir. 1988) (allowing a non-enumerated party to bring an action under ERISA where the party can demonstrate that he has suffered an injury in fact, that he arguably falls within the zone of interests protected by the statute, and where the statute does not preclude the party from bringing suit).

²³ 935 F.2d 1187 (11th Cir. 1991).

²⁴ 948 F.2d 993 (6th Cir. 1991).

would receive health benefits, and that a “participant” includes persons who “*may become eligible*” to receive benefits in the future.

B. Defendants in §510 Actions

Section 510 states that it is unlawful for “*any person*” to interfere with the rights of a participant or beneficiary under an employee benefit plan. ERISA contains an all-encompassing definition of the term “person”:

The term “person” means an individual, partnership, joint venture, corporation, mutual company, joint-stock company, trust, estate, unincorporated organization, association, or employee organization.²⁵

A commonsense reading of these two sections indicates that the statute means precisely what it says: “*any person*” can be held liable for a violation of §510. The commonsense reading of the statute has not always held true, however. Some confusion has arisen as to the identity of intended defendants under §510, at least partially as a result of the fact that §510 was intended to prevent *employers* from using their position with respect to plan participants and beneficiaries to deny those individuals their rights under benefit plans.²⁶ Given this purpose of §510, some courts have observed that only an employer may be sued under §510.²⁷

Other courts have relied on the broad statutory language and have held that “*any person*” may be held liable for a violation of §510.²⁸ District court decisions in *Thomas v. Telemecanique, Inc.*²⁹ and *Swanson v. UA Local 13 Pension Plan*³⁰ provide a couple of interesting examples of how some courts have addressed this issue.

In *Thomas*, the plaintiff claimed that several defendants had interfered with her right to recover disability and health insurance benefits under her employer’s benefit plan. One of the defendants was plaintiff’s co-worker, who had reported incidents of plaintiff’s alleged malingering to plaintiff’s employer. Plaintiff was ultimately terminated from her position and her benefits ceased. After plaintiff sued her co-worker under §510, the co-worker sought dismissal from the action, arguing that she was unable to provide the relief requested by the plaintiff (*i.e.*, lost benefits). The district court refused to dismiss the co-worker because the plaintiff had specifically alleged that her co-worker interfered with plaintiff’s rights under ERISA, as is required for an action under §510. With respect to the co-worker’s argument that she could not recoup plaintiff’s lost benefits, the court noted that plaintiff was seeking not only equitable relief, but also attorney fees and other “just and proper” relief for which the co-worker might be held liable.

In *Swanson*, the district court put a slightly different twist on §510, holding that “persons” other than employers may be proper defendants in a §510 action and that in some circumstances, individuals may be liable for such violations “if their alleged activity has directly and fundamentally altered the plan participant’s employment relationship so as to interfere with his pension rights.”³¹ However, the court refused to

²⁵ ERISA, §3(9) [29 U.S.C. §1002(9)].

²⁶ See *West v. Butler*, *supra*, 621 F.2d at 245.

²⁷ See, e.g., *Byrd v. MacPapers, Inc.*, 961 F.2d 157 (11th Cir. 1992) (only an employer can be sued under §510; an insurer would not be a proper defendant).

²⁸ See, e.g., *Inter-Modal Rail Employees Ass’n v. Atchison, Topeka and Santa Fe Railway*, 80 F.3d 348 (9th Cir. 1996); *Tingey v. Pixley-Richards West, Inc.*, 953 F.2d 1124 (9th Cir. 1992).

²⁹ 768 F. Supp. 503 (D. Md. 1991).

³⁰ 779 F. Supp. 690 (W.D.N.Y.) *aff’d*, 953 F.2d 636 (2d Cir. 1991).

³¹ 779 F. Supp. at 702.

find a pension plan to be a proper defendant under §510 because pension plans are “conspicuously absent” from the list contained in ERISA’s definition of a “person.”³²

V. Retaliation Claims

Section 510 also prohibits retaliation for certain types of conduct by employee in relation to their employee benefit plans. There is some disagreement in the courts as to exactly what types of conduct are protected from retaliation under §510, an issue addressed by the Seventh Circuit in *George v. Junior Achievement of Central Indiana, Inc.*, 694 F.3d 812 (7th Cir. 2012). In that case, an employee complained that certain contributions were not deposited into his retirement account. Following these complaints, the employer deposited the money. Several months later, the employee was terminated. He sued, alleging that his termination was in retaliation for his complaints about the pension contributions, and that this was a violation of §510. Among other things, the employer argued that the plaintiff’s complaints were informal and that only testimony in a formal proceeding is protected by §510. The Seventh Circuit disagreed. It held that informal complaints are sufficient to form a basis for a §510 retaliation claim. However, it also set forth criteria for such a claim as follows: (a) in order to constitute a violation of §510, the adverse employment action must be caused by the complaint or the response to the complaint, and (b) the grievance must be plausible though not necessarily one on which the employee is correct.

³² *Id.*

Applicable Limitations Periods

I. Claims for Benefits and for Interference with Protected Rights

A. State Statutory Periods of Limitation

ERISA contains no specific limitations period for actions seeking plan benefits under §502(a)(1)(B) [29 U.S.C. §1132(a)(1)(B)]. Courts have filled this gap by looking to the most analogous state statute of limitations period.¹ For example, the Eighth Circuit has held that “a suit for ERISA benefits under [§502(a)(1)(B)] should be characterized as a contract action for statute of limitations purposes....”² Other courts have agreed and have applied the limitations period applicable to breach of contract actions to suits for benefits under ERISA.³ However, not all courts have found a state contract limitations period to be “most analogous” to ERISA benefit actions. For example, in actions originating in Pennsylvania, the Third Circuit has chosen to apply that state’s wage payment and collection three-year limitations period to such actions.⁴

Where the action is one for interference with protected rights under §510 [29 U.S.C. §1140], the courts have been even more diverse in determining the applicable limitations period. For example, the Eleventh Circuit has applied a state limitations period applicable to contracts in writing to such actions.⁵ More recently, the Court applied a state limitations period governing actions for retaliatory discharge under Florida workers’ compensation law.⁶ Even more recently, the Eleventh Circuit applied a two-year limitations period to a §510 action, which limitations period was borrowed from state statutes governing actions for wages and retaliatory discharge. The Court rejected a longer period applicable to general contract actions.⁷ The Third Circuit, on the other hand, has found such actions to be more analogous to employment discrimination actions, thereby applying Pennsylvania’s six-year residuary limitations period.⁸

¹ *Johnson v. State Mutual Life Assurance Co. of America*, 942 F.2d 1260 (8th Cir. 1991).

² *Id.* See also *Winnett v. Caterpillar, Inc.*, 609 F.3d 404 (6th Cir. 2010) (Tennessee six-year limitations period for contracts applied to ERISA benefit claim); *Cavegn v. Twin City Pipe Trades Pension Plan*, 223 F.3d 827 (8th Cir. 2000) (Minnesota two-year limitations period for benefit claims under contract applied to ERISA claim).

³ *Wetzel v. Lou Ehlers Cadillac Group LTD Program*, 222 F.3d 643 (9th Cir. 2000) (*en banc*); *Harrison v. Digital Health Plan*, 183 F.3d 1235 (11th Cir. 1999); *Shofer v. Stuart Huck Co.*, 970 F.2d 1316 (4th Cir. 1992); *Mead v. Pension Appeals and Review Committee*, 966 F.2d 190 (6th Cir. 1992); *Jenkins v. Local 705*, 713 F.2d 247 (7th Cir. 1983).

⁴ *Vernau v. Vic’s Market, Inc.*, 896 F.2d 43 (3d Cir. 1990). See also *Lang v. Aetna Life Ins. Co.*, 196 F.3d 1102 (10th Cir. 1999) (Utah’s three-year period for actions on policy of first-party insurance governed ERISA claim for benefits); *Kennedy v. Electricians Pension Plan*, 954 F.2d 1116 (5th Cir. 1992) (actions for plan benefits are “personal” actions, subject to a ten-year prescriptive limitations period).

⁵ See, e.g., *Cavegn v. Twin City Pipe Trades Pension Plan*, 223 F.3d 827 (8th Cir. 2000); *Clark v. Coats & Clark*, 865 F.2d 1237 (11th Cir. 1989).

⁶ *Byrd v. MacPapers, Inc.*, 961 F.2d 157 (11th Cir. 1992).

⁷ *Musick v. Goodyear Tire & Rubber Co., Inc.*, 81 F.3d 136 (11th Cir. 1996).

⁸ *Gavalik v. Continental Can Co.*, 812 F.2d 834 (3d Cir. 1987). See also *McClure v. Zoecon*, 936 F.2d 777 (5th Cir. 1991) (applying state limitations period for wrongful discharge and employment discrimination actions).

B. Contractual Periods of Limitation

Some courts have held that where an ERISA plan includes a contractual limitations period, that period is controlling even if it is shorter than the otherwise applicable state statutory period. For example, the Seventh Circuit has held that where an ERISA plan contains a limitations period which is reasonable, that limitations period is enforceable:

The dominant view in contract law is that contractual limitations periods shorter than the statute of limitations are permitted, provided they are reasonable... We think that the dominant view is right because it is consistent with the principle of party autonomy that underlies the law of contracts, and that it should be applicable to ERISA plans.⁹

This is consistent with United States Supreme Court authority, which states that:

[I]t is well established that, in the absence of a controlling statute to the contrary, a provision in a contract may validly limit, between the parties, the time for bringing an action on such contract to a period less than that prescribed in the general statute of limitations, provided that the shorter period itself shall be a reasonable period.¹⁰

In *Doe v. Blue Cross*, the Seventh Circuit held that a 39-month contractual limitations period was reasonable under ERISA even though the claimant had only seventeen months to file suit after the plan finally denied his claim.¹¹ Another federal court has also applied a three-year limitations period virtually identical to the period at issue in *Doe*.¹² Another federal appellate court has held that a contractual limitations period as short as ninety days was reasonable under ERISA.¹³ The Ninth Circuit has held that only a *statutory* period of limitations governs ERISA actions, although if a participant satisfies the statutory period, a question then arises as to whether the participant can meet the contractual requirements for benefits, including the contractual limitations period.¹⁴ This latter decision appears to go a long way to reach the same result as the courts that enforce a contractual limitations period in ERISA benefit actions.

C. Accrual of Limitations Periods

Accrual of the applicable statutory limitations period is governed by federal law.¹⁵ Most courts have agreed that an action for benefits accrues at the time the benefits are denied by the fiduciary.¹⁶ At least one circuit court has indicated that even where the claim has not been formally denied, the cause of action accrues at the

⁹ *Doe v. Blue Cross & Blue Shield United of Wisconsin*, 112 F.3d 869, 874 (7th Cir. 1997).

¹⁰ *Order of United Commercial Travelers v. Wolfe*, 331 U.S. 586, 608 (1947).

¹¹ 112 F.3d at 873.

¹² *Lang v. Aetna Life Ins. Co.*, 196 F.3d 1102 (10th Cir. 1999).

¹³ *Northlake Regional Medical Center v. Waffle House System Employee Benefit Plan*, 160 F.3d 1301, 1303 (11th Cir. 1998) (following the Seventh Circuit decision in *Doe*).

¹⁴ *Wetzel v. Lou Ehlers Cadillac Group LTD Program*, 222 F.3d 643 (9th Cir. 2000) (*en banc*).

¹⁵ *Young v. Verizon's Bell Atlantic Cash Balance Plan*, 615 F.3d 808 (7th Cir. 2010); *Winnett v. Caterpillar, Inc.*, 609 F.3d 404 (6th Cir. 2010).

¹⁶ *Young v. Verizon's Bell Atlantic Cash Balance Plan*, 615 F.3d 808 (7th Cir. 2010); *Lang v. Aetna Life Ins. Co.*, 196 F.3d 1102 (10th Cir. 1999); *Stevens v. Employer-Teamsters Joint Counsel No. 84 Pension Fund*, 979 F.2d 444 (6th Cir. 1992); *Mason v. Aetna Life Ins. Co.*, 901 F.2d 662 (8th Cir. 1990); *Menhorn v. Firestone Tire & Rubber Co.*, 738 F.2d 1496 (9th Cir. 1984); *Paris v. Profitsharing Plan*, 637 F.2d 357 (5th Cir. 1981); *Reiherzer v. Shannon*, 581 F.2d 1266 (7th Cir. 1978).

time of such event as should have alerted the claimant to an entitlement to benefits that he did not receive.¹⁷ Another court has phrased the accrual period somewhat differently by stating that a cause of action for plan benefits accrues for statute of limitations purposes at such time as there has been a repudiation by the fiduciary that is clear and made known to the claimant.¹⁸ Still another court has held that the statute of limitations period does not accrue for a formal claim for benefits has not been filed or has been denied.¹⁹ Moreover, a fiduciary's informal reexamination of plaintiff's claim several years after plaintiff was notified of the cessation of benefits "will not renew a claimant's cause of action for statute of limitations purposes."²⁰

Where an ERISA plan includes an accrual provision that requires a limitations period to begin running other than when the benefit claim is denied, the circuits were split as to whether such an accrual provision is enforceable, even where the provision is mandated for inclusion in an ERISA-governed insurance policy. Published and unpublished decisions in several circuits enforced accrual dates that run from events other than the denial of benefits.²¹ By way of example, in the Seventh Circuit decision in *Doe v. Blue Cross & Blue Shield United of Wisconsin*, *supra*, the plan required that any legal action be commenced within thirty-nine months after the date of the services for which benefits were sought (a health plan was at issue in *Doe*). The plaintiff and the plan in *Doe* were involved in a protracted claim process, which spanned nearly a year and a half of the limitations period. Even so, when the final decision was announced, the plaintiff still had another 17 months to bring suit, but he waited another year and a half. The Seventh Circuit had no difficulty concluding that the limitations period and accrual date in the employee benefit plan were reasonable "in general and in [that] case." The court noted that the employee had been represented by counsel throughout the administrative appeal process and that the plan provided the plaintiff substantially more than the 30 to 60 days a litigant would ordinarily have to appeal an administrative decision. Noting that the plan participant was required to exhaust administrative remedies before filing suit under ERISA, the Seventh Circuit expressed concern that if the internal appeals process took longer than the contractual limitations period, the plaintiff could be barred from suing even though the plan forbade him to sue earlier. However, the court held that the applicable deadline was enforceable in that case because the plaintiff had more than a year after the claim was denied in which to commence suit, a period the court deemed reasonable.

¹⁷ *Cotter v. Eastern Conference of Teamsters, etc.*, 898 F.2d 424 (4th Cir. 1990).

¹⁸ *Larsen v. NMU Pension Trust, etc.*, 902 F.2d 1069 (2d Cir. 1990).

¹⁹ *Davenport v. Harry N. Abrams, Inc.*, 249 F.3d 130 (2d Cir. 2001).

²⁰ *Mason v. Aetna Life Ins. Co.*, 901 F.2d at 664.

²¹ See *Burke v. PriceWaterhouseCoopers LLP Long Term Dis. Plan*, 572 F.3d 76, 81 (2d Cir. 2009) (proof of claim accrual provision mandated by New York insurance law is enforceable); *Rice v. Jefferson Pilot Financial Ins. Co.*, 578 F.3d 450 (6th Cir. 2009) (rejecting the "clear repudiation rule" and enforcing contractual proof of claim provision); *Salisbury v. Hartford Life and Acc. Ins. Co.*, 583 F.3d 1245 (10th Cir. 2009) (rejecting minority view); *Harris Methodist Fort Worth v. Sales Support Services Inc. Employee Health Care Plan*, 426 F.3d 330, 337–38 (5th Cir. 2005) (enforcing three-year limitations period that began to run from date proof of loss was due); *Doe v. Blue Cross & Blue Shield United of Wisconsin*, 112 F.3d 869, 875 (7th Cir. 1997) (enforcing 39-month limitations period that began to run from the date of the services for which benefits were sought); *Blaske v. Unum Life Insurance Company of America*, 131 F.3d 763, 764 (8th Cir. 1997) (enforcing policy limitations provision that began the period at the time that proof of claim was required); *Clark v. NBD Bank, N.A.*, 3 Fed. Appx. 500 (6th Cir. 2001) (enforcing plan limitations period providing that "no action... shall be brought after the expiration of three years after the time written proof of loss is required to be furnished"); *Moore v. Berg Enters.*, 1999 U.S. App. LEXIS 30481 (10th Cir. 1999) (enforcing three-year statute of limitations running from the date proof of loss was required).

The Seventh Circuit reaffirmed its holding in *Abena v. Metropolitan Life Ins. Co.*, 544 F.3d 880 (7th Cir. 2008), enforcing an insurance policy proof of claim accrual provision even where benefits were paid for a time and later terminated. The Seventh Circuit noted that such a provision “is better suited to the initial claim decision than it is to claims that are initially granted and subsequently terminated” but held that “that fact is not controlling.” Applying the provision to the facts of that case, the court held that the lawsuit was untimely:

We can certainly imagine circumstances in which application of this provision would not be reasonable. For example, if the employer paid the claim for three or more years and then terminated payments, it would be unreasonable to enforce a limitations period that ended before the claim could have even accrued. Or if the appeals process was so protracted that the claimant was unable to file suit within the contractual period, the application of this provision would not be reasonable. But that is not what happened here. Even though the claim initially was granted and then terminated two years later, Abena still had seven months following the conclusion of the internal appeals process in which to file his suit in the district court. By his own admission at oral argument, there was no reason he could not file his suit during that time. Indeed, he was represented by counsel during that time. In these circumstances, application of the contractual limitations period is not unreasonable.

In contrast, a handful of circuits refused to enforce contractual accrual provisions, even in the face of nationally uniform insurance laws, largely on the ground that such provisions “conflict” with federal common law.²² For example, in *White v. Sun Life*, *supra*, the court held that unambiguous ERISA plan language requiring the contractual limitations period to begin on the date a claimant’s proof of claim was due was *per se* unenforceable even though it was mandated by insurance laws in almost every state. The court concluded that parties to an ERISA plan may not alter the federal default rule that a limitations period begins when the claim is denied. It stated that the plan’s limitations period provided an unacceptable level of uncertainty because starting a limitations period before a claim is denied would allow unscrupulous ERISA claim administrators to delay claim decisions in order to compress the limitations period and because courts would be required to determine in each case whether the remaining period was reasonable.

A lengthy dissent in *White* concluded that the limitations period was “eminently reasonable” because it provided Respondent more than sufficient time to file her lawsuit, that the insurance policy language was “the very one that North Carolina and the vast majority of other states require be included in insurance policies like the one at issue here,” and that no controlling law prohibits adoption of the limitations period specified in the Policy. The dissent observed that tying the limitations period to the date that proof of claim was due has the perfectly rational purpose of ensuring that no suit is too remote in time from the events giving rise to the claim. The dissent also rejected the majority’s conclusion that federal common law can override the unambiguous terms of an ERISA plan. He explained that the three-year period was well designed to leave a claimant with ample time to decide whether to file suit. ERISA claim regulations allow a claim administrator no more than 195 days to decide a claim, including any administrative appeal, thereby eliminating “any significant possibility that a devious plan administrator could believe he could run out the three-year clock on a claimant before the claimant could sue.” The dissent also stated that, regardless of whether the majority might identify policy reasons why the default period would be preferable, it is for the plan drafter to determine plan terms, not the courts. The dissent concluded that it was the majority’s refusal to enforce the clear plan language that created uncertainty in the administration of ERISA plans and expressed concern that the majority’s reliance

²² *White v. Sun Life Assurance Company of Canada*, 488 F.3d 240 (2007); *Miller v. Fortis Benefits Ins. Co.*, 475 F.3d 516, 520–21 (3d Cir. 2007); *Price v. Provident Life & Accident Ins. Co.*, 2 F.3d 986 (9th Cir. 1993).

on federal common law to nullify unambiguous ERISA plan terms “will also leave future claimants and plan administrators under a variety of plans wondering which plan provisions this court will refuse to apply next.”

The Supreme Court resolved the circuit split regarding the accrual of limitations periods under ERISA in *Heimeshoff v. Hartford Life Ins. Co.*²³ That case involved a claim for long term disability benefits. The plan, which was insured, provided that any suit for benefits must be brought within three years after proof of claim was due under the policy. Heimeshoff filed a timely claim for benefits which was denied. Heimeshoff appealed, which is his right under ERISA, and the appeal was also denied. Heimeshoff did not file suit until almost three years after the final denial and more than three years after proof of loss was due.

The Supreme Court noted that a limitations period would typically accrue for an ERISA benefit claim at the time the claim is administratively denied. However, the Court also held that this default rule does not prevent plan sponsors from providing a different rule in the plan. The Court reiterated its long time rule that contractual limitations periods should be enforced as written so long as the contractual period is reasonable, noting that this rule is particularly apt in the context of ERISA plans which are required to be in writing. In the context of Heimeshoff’s claim, there was still more than a year to file suit after his claim was finally denied. The Court held that this period was more than sufficient to file suit in an ERISA benefits dispute and upheld the contractual proof of loss accrual provision, abrogating *White* and other similar circuit court decisions.

With respect to long term disability policies, where monthly payments of benefits are in dispute, a question has arisen as to whether a separate accrual, and therefore a separate period of limitations, applies to each monthly benefit. Although the Ninth Circuit held for a time that separate accrual periods applied to long term disability benefit disputes under ERISA, the law now appears to be that the limitations period accrues from the time of the final denial (or termination) of benefits and that a new period does not accrue for each month of outstanding benefits.²⁴

With respect to an interference claim under §510, it has been held that such a cause of action accrues when the plaintiff is terminated from his employment (or at the time of other adverse employment action) where the plaintiff is aware of all facts that would put reasonable persons on notice that the plaintiff has an actionable claim.²⁵

II. Breach of Fiduciary Duty Claims

ERISA provides a specific statute of limitations for claims involving alleged fiduciary breaches:

No action may be commenced under this subchapter with respect to a fiduciary’s breach of any responsibility, duty, or obligation under this part, or with respect to a violation of this part, after the earlier of—

²³ 134 S. Ct. 604 (2013).

²⁴ *Wetzel v. Lou Ehlers Cadillac Group LTD Program*, 222 F.3d 643 (9th Cir. 2000) (*en banc*); *Lang v. Aetna Life Ins. Co.*, 196 F.3d 1102 (10th Cir. 1999).

²⁵ *Heidman v. PFL, Inc.*, 904 F.2d 1262 (8th Cir. 1990). *See also* *Tolle v. Carroll Touch, Inc.*, 977 F.2d 1129 (7th Cir. 1992) (because §510 actions, like intentional employment discrimination cases, are intended to prevent actions taken for an unlawful purpose, it is the decision and the participant’s discovery of this decision that dictates accrual); *Godfrey v. BellSouth Telecommunications, Inc.*, 89 F.3d 755 (11th Cir. 1996) (statute of limitations accrued at time plaintiff exhausted administrative remedies).

- (1) six years after (A) the date of the last action that constituted a part of the breach or violation, or
(B) in the case of an omission, the latest date on which the fiduciary could have cured the breach or violation, or
- (2) three years after the earliest date on which the plaintiff had actual knowledge of the breach or violation;

except that in the case of fraud or concealment, such action may be commenced not later than six years after the date of discovery or such breach or violation.²⁶

The basic time period for actions based on fiduciary breaches is the six-year period designated by §413.²⁷ This period is reduced to three years in cases where the plaintiff had knowledge of the breach. This shorter period is effectuated by the plaintiff's knowledge of the transaction that constituted the alleged breach, not by the plaintiff's knowledge of the law.²⁸ There is a split of authority as to whether constructive knowledge is sufficient to trigger application of the shorter time period or whether "actual" knowledge is required.²⁹

The statute also requires application of the six-year period in the "case of fraud or concealment," in which case the statute begins to run "after the date of discovery of such breach or violation." A blanket assertion that the alleged breaches were "fraudulent" and/or constituted "concealment" does not make a plaintiff's claims timely. The phrase "in case of fraud or concealment" refers to the methods used by the fiduciary to conceal the breach and should not be construed to refer to the nature of the alleged breach itself.³⁰ It has also been held that in order for the six-year period to be applicable, plaintiffs must allege and prove actual fraud.³¹ Plaintiffs must show that the defendant made a false representation of fact, with knowledge of its falsity, that was intended to and did induce reliance on the part of the plaintiff, in addition to other traditional elements of a fraud claim.³²

The commencement of an action in a clearly inappropriate forum does not toll the statute of limitations for breach of fiduciary duty actions under §502(a)(2) [29 U.S.C. §1132(a)(2)].³³

²⁶ ERISA, §413 [29 U.S.C. §1113]. See *The Radiology Center, S.C. v. Stifel, Nicolaus & Co.*, 919 F.2d 1216 (7th Cir. 1990); *Pension Benefit Guaranty Corporation v. Scherling*, 905 F.2d 173 (8th Cir. 1990); *Diduck v. Kaszycki & Sons Contractors, Inc.*, 874 F.2d 912 (2d Cir. 1989).

²⁷ *Fink v. National Savings and Trust Co.*, 772 F.2d 951 (D.C. Cir. 1985).

²⁸ *Blanton v. Anzalone*, 760 F.2d 989 (9th Cir. 1985).

²⁹ Compare *Fink v. National Savings & Trust Co.*, *supra* (constructive knowledge is sufficient) with *Brown v. Owens Corning Investment Review Committee*, 622 F.3d 564 (6th Cir. 2010) (actual knowledge means knowledge of the facts or transaction that constituted the alleged violation); *Wolin v. Smith Barney Incorporated*, 83 F.3d 847 (7th Cir. 1996) (the statute speaks only in terms of actual, not constructive knowledge of the breach); *The Radiology Center, S.C. v. Stifel, Nicolaus & Co.*, *supra* (same); and *Gluck v. Unisys Corporation*, 1992 U.S. App. Lexis 5647 (3d Cir. 1992) (actual knowledge of a breach or violation requires that a plaintiff have actual knowledge of all material facts necessary to understand that some claim exists, which facts could include necessary opinions of experts, knowledge of a transaction's harmful consequences, or even actual harm).

³⁰ *The Radiology Center, S.C. v. Stifel, Nicolaus & Co.*, *supra*.

³¹ *Schaefer v. Arkansas Medical Society*, 853 F.2d 1487, 1491 (8th Cir. 1988).

³² *Id.* See also *Diduck v. Kaszycki & Sons Contractors, Inc.*, 974 F.2d 270 (2d Cir. 1992) (where the breach involves fraud or concealment, an action is timely if brought within six years after the breach is discovered).

³³ *Shofer v. Stuart Huck Co.*, 970 F.2d 1316 (4th Cir. 1992).

Jurisdiction and Removal to Federal Court

I. Subject Matter Jurisdiction

ERISA provides the federal courts with exclusive subject matter jurisdiction of most types of actions, such as actions for breach of fiduciary duties or actions for general equitable relief.¹ Actions for benefits, on the other hand, are delegated to the state *and* federal courts, which together have concurrent jurisdiction over such actions.² Federal court jurisdiction can also be based on the general federal question statute,³ where the complaint seeks relief expressly allowed by federal law, or where it requires construction of federal law, or where a distinctive policy of a federal statute requires application of federal legal principles.⁴ When filed in federal court, venue lies in the district “where the plan is administered, where the breach took place, or where a defendant resides or may be found.”⁵ It is axiomatic that the existence of an ERISA plan is a prerequisite to federal court jurisdiction.⁶ Moreover, ERISA jurisdiction only applies to claims arising after January 1, 1975.⁷

II. Removal to Federal Court

Prior to the amendment of the federal removal statute, 28 U.S.C. §1441(b), those actions that rested within the exclusive jurisdiction of the federal courts were not removable to federal court because of the absence of derivative jurisdiction. With the amendment of the removal statute and the elimination of the derivative jurisdiction requirement, removal of such claims to federal court should no longer present a problem.

Removal is also proper with respect to claims for benefits under §502(a)(1)(B), over which the federal and state courts have concurrent jurisdiction. This is true even though the plaintiff’s complaint is grounded entirely on state law and despite the fact that federal preemption is usually a defense. In *Metropolitan Life Ins. Co. v. Taylor*,⁸ the Supreme Court held that where a suit raises only state law claims but “relates to” an employee benefit plan, it is necessarily federal in character because of the fact that Congress intended to occupy the field of employee benefits law. Accordingly, the suit “arises under federal law” for purposes of the general federal question statute,⁹ and is removable to federal court.

¹ 29 U.S.C. §1132(e)(1).

² *Id.*

³ 28 U.S.C. §1331.

⁴ *Airco Industrial Gases, Inc. v. The Teamsters Health and Welfare Pension Fund*, 850 F.2d 1028 (3d Cir. 1988).

⁵ ERISA, §502(e)(2).

⁶ See discussion in Chapter 2, *supra*.

⁷ See ERISA, §514(b)(1) [29 U.S.C. §1144(b)(1)].

⁸ 481 U.S. 58 (1987).

⁹ 28 U.S.C. §1331.

The doctrine applied in *Metropolitan Life v. Taylor* is known as the “complete preemption” doctrine. For ERISA purposes, a state law claim is “completely preempted” by ERISA and therefore removable to federal court where it lies within the scope of ERISA’s civil enforcement scheme, §502(a). If a state law claim lies within the scope of ERISA’s civil enforcement scheme, it has been displaced by ERISA (*i.e.*, it has been “completely preempted”) and is “recharacterized” as a claim arising under federal law.¹⁰

Application of the complete preemption doctrine is illustrated by the decision in *Rice v. Panchal*.¹¹ The plaintiff was a participant in an employer-sponsored preferred provider organization. The plaintiff claimed that a non-network doctor to whom he was referred by his network doctor committed malpractice. The plaintiff alleged that his network doctor was responsible for the negligence of the treating doctor and that the plan insurer was vicariously liable for the network doctor’s negligence. After the plaintiff filed the action in state court, it was removed to federal court. The district court dismissed the complaint against the plan insurer on the ground that it was preempted by ERISA. The Seventh Circuit reversed, holding that the claim was not completely preempted and that the federal court lacked removal jurisdiction.

The Seventh Circuit agreed that it was not necessary that ERISA *replace* the state law remedy in order for the complete preemption principle to apply; it was only necessary that the state law claim be within the scope of ERISA’s civil enforcement scheme and that the state law remedy was *displaced* by ERISA.¹² In determining whether the state law vicarious liability claim was displaced by ERISA, the Court found the key question to be whether resolution of the claim required interpretation of the employee benefit plan.¹³ The Seventh Circuit held that the claim did not involve interpretation of the employee benefit plan where the only issue was whether the doctor’s status as a preferred provider made the insurer liable under the state law of *respondeat superior*.¹⁴

While the right to removal can be waived, it has been held that language in a plan booklet to the effect that suits to recover benefits may be filed in state or federal court is not sufficient for a finding of waiver.¹⁵ To the contrary, at least one circuit court has held that ERISA’s provision granting concurrent jurisdiction over claims for benefits is intended to permit either party to choose a federal forum.¹⁶

One final issue that has vexed the courts is the ability of a third-party defendant to remove an action to federal court where the original defendant has not done so. This issue often arises where a medical care provider files a collection action against a patient for recovery of medical expenses and the patient then files a third-party action for indemnity against his/her group health insurer. The original complaint is based on state common law, while the third-party complaint is clearly a claim for benefits under an ERISA plan and is therefore subject to federal preemption. Whether the third-party defendant may remove the action to federal court depends on whether the third-party action is a “separate and independent cause of action” from the original action. To date, the courts have split on this issue.¹⁷

¹⁰ *Metropolitan Life*, 481 U.S. at 64.

¹¹ 65 F.3d 637 (7th Cir. 1995).

¹² 65 F.3d at 640–41.

¹³ *Id.* at 644–46.

¹⁴ *Id.* at 645.

¹⁵ *Clorox Co. v. United States District Court for the Northern District of California*, 779 F.2d 517 (9th Cir. 1985).

¹⁶ *Chilton v. Savannah Foods & Industries*, 814 F.2d 620 (11th Cir. 1987).

¹⁷ *Compare* *The Menninger Clinic, Inc. v. Equicor, Inc.*, 1992 U.S. Dist. Lexis 18880 (D. Kan. 1992) (the better rule is against allowing removal by a third-party defendant); *University of Chicago Hospital & Medical Center v. Rivers*,

III. When Is ‘Preemption’ Considered ‘Complete Preemption’ Under ERISA?

The simple answer to this question is: “It depends on the circuit.” This fact was reinforced in *Felix v. Lucent Technologies, Inc.*¹⁸ The Tenth Circuit held that the plaintiffs’ state law fraud claims were not completely preempted by ERISA and therefore failed to provide a basis for federal court removal jurisdiction even though the plaintiffs were seeking ERISA-governed early retirement benefits that they allegedly would have been entitled to “but for” misrepresentations by their employer. *Felix* widens a split in the circuits as to whether removal jurisdiction exists in claims where plaintiffs seek damages in the form of ERISA-governed benefits where the plaintiffs allege that they have been excluded from participation in the ERISA plan because of the defendant’s conduct. One would think that these types of cases should always be governed by ERISA. Unfortunately, *Felix* demonstrates that this is not always the case.

A. Background of Complete Preemption

Complete preemption is a concept that only applies in the context of determining federal court removal jurisdiction. If there is another basis for removal (e.g., diversity jurisdiction), the question of complete preemption is irrelevant. Likewise, if a case is originally filed in federal court and there is no need to remove the case from state court, the concept of complete preemption also does not apply.

Complete preemption arises as an exception to the well-pleaded complaint rule. Under the latter rule, a state law case is not removable to federal court on federal question grounds if the complaint is phrased completely in state law terms. As an exception to the well-pleaded complaint rule, complete preemption exists where the state law claim is supplanted by one or more federal causes of action because Congress has so “completely preempted” the state law claim that it is considered a federal claim, regardless of how the plaintiff phrases his complaint. In other words, the complete preemption doctrine prevents a plaintiff from artfully pleading his cause of action so as to avoid governing federal law and thereby furthers the intent of Congress that federal law should control the substantive area at issue.

A landmark complete preemption case in ERISA law is *Metropolitan Life Ins. Co. v. Taylor*.¹⁹ Taylor sued his disability insurer following a denial of benefits, alleging various state law breach of contract and tort claims. Taylor’s state court complaint contained no reference to federal law. Nevertheless, the insurer removed the case to federal court. Under the well-pleaded complaint rule, where a plaintiff is considered the master of his complaint, the state court action would not be removable. However, the Supreme Court held that the insurer properly removed Taylor’s complaint because Taylor’s state law causes of action were completely preempted by ERISA. Specifically, the Court held that Taylor had an express cause of action for disability benefits under ERISA’s civil enforcement provision, section 502(a). Because Congress intended ERISA’s civil enforcement scheme to be the exclusive means for obtaining benefits under the terms of an ERISA-governed plan, Taylor could not avoid federal law by artfully pleading his action under state law. The

701 F. Supp. 647 (N.D. Ill. 1988) (same); *Reality Therapy Counseling & Recovery Center, Inc. v. Davis*, 831 F. Supp. 567 (E.D. La. 1993) (no removal where third-party claim was not separate and independent) *with* *Jefferson Parish Hospital District No. 2 v. Harvey*, 788 F. Supp. 282 (E.D. La. 1992) (noting that the Fifth Circuit has spearheaded a minority rule that a third-party defendant may remove an action to federal court); *Charter Medical Corp. v. Friese*, Cause No. 1:89-CV-2013-RHH (N.D. Ga. 1989) (third-party indemnity action is removable as separate and independent cause of action).

¹⁸ 387 F.3d 1146 (10th Cir. 2004).

¹⁹ 481 U.S. 58 (1987).

Supreme Court held that Taylor's state law claims were "necessarily federal in character" and that removal to federal court was appropriate under the complete preemption doctrine.

There is occasionally some confusion between "complete preemption" for removal purposes and statutory preemption under ERISA, section 514. Section 514 states that all state laws are superseded by ERISA to the extent the state laws "relate to" an ERISA-governed plan. However, the fact that state law causes of action may "relate to" an ERISA plan is not a sufficient basis for federal court removal under the complete preemption doctrine. Rather, the state law causes of action must be within the scope of ERISA's civil enforcement provision so as to be in conflict with the exclusivity of that provision before they can be "completely" preempted for removal purposes.

B. The Felix Decision

These general principles now bring us to the holding in *Felix*. The plaintiffs in *Felix* were former employees of Lucent. The plaintiffs alleged that they accepted an early retirement package and left their employment at Lucent based on representations by Lucent management that the company would not offer any better early retirement packages in the future. As it turned out, after the plaintiffs retired, Lucent did offer a better package that would have netted the plaintiffs several thousand dollars in additional early retirement incentive benefits.

The plaintiffs sued Lucent in state court based on allegations of state law fraud. Lucent removed the case to federal court and filed a motion to dismiss, alleging that the fraud claims were preempted by ERISA because the disputed benefits were only available under an ERISA-governed plan. The district court granted the motion to dismiss and denied the plaintiffs' motion to remand. Both rulings were based on the conclusion that the plaintiffs' state law fraud claims were preempted because they "relate[d] to" an ERISA plan under section 514. The plaintiffs appealed.

The Tenth Circuit reversed and ordered the district court to remand the matter to state court based on the absence of any removal jurisdiction. The Tenth Circuit correctly held that preemption under section 514 was not a sufficient basis for removal jurisdiction where the plaintiffs' complaint was based entirely on state law. The Tenth Circuit also correctly held that Lucent was required to establish that the plaintiffs' fraud claims were completely preempted as being within the scope of ERISA's civil enforcement provision, section 502(a), before removal jurisdiction would exist.

The Tenth Circuit observed that a fundamental criterion of complete preemption is that the plaintiff must have standing to pursue a federal law claim before that federal claim will completely preempt a state law cause of action. Thus, the focus for the Tenth Circuit's inquiry in *Felix* was whether the plaintiffs would have standing under ERISA to pursue benefits under the early retirement program that went into effect after they left Lucent. Limiting its analysis to section 502(a)(1)(B), which provides a federal cause of action to plan participants to recover benefits due under the terms of their plan, the Tenth Circuit held that the plaintiffs did not have standing to pursue a federal claim under 502(a)(1)(B) because they were never participants in the later-enacted retirement incentive plan. Because the plaintiffs had no standing under section 502(a)(1)(B), the Court held that their state law fraud claim was not completely preempted and that there was no basis for federal court removal jurisdiction. The Court also concluded that because the plaintiffs did not have standing to sue for benefits under the plan, the remedy that the plaintiffs were seeking constituted state law "damages" reflecting the lost retirement incentive benefits rather than the benefits themselves.

Lucent argued that complete preemption did exist because, under the allegations in the complaint, the plaintiffs were claiming that "but for" Lucent's alleged misrepresentations, they would have continued their

employment and would have been eligible to participate in the later retirement plan. Indeed, Lucent pointed out that the damages sought by the plaintiffs were measured by the benefits that would have been available under the later incentive plan. Noting a split in the circuits, the Tenth Circuit rejected the “but for” test proposed by Lucent as a basis for complete preemption. The Tenth Circuit expressly rejected contrary holdings in the First, Second, Fifth, Sixth, and Eighth Circuits. The Tenth Circuit sided with the Fourth and Eleventh Circuits that require a plaintiff to be eligible for benefits under an existing ERISA plan *before* a state law claim will be completely preempted for removal purposes. Specifically, the Tenth Circuit held in *Felix* that the plaintiffs did not have a colorable claim to benefits under the later retirement plan even though the very basis for their lawsuit was that the actions of Lucent had prevented them from being eligible for those benefits.

C. Potential Fallout from Felix

The *Felix* decision raises several concerns. First, in the context of life, health, and disability insurance law, does *Felix* impact the removal of benefit claims where a denial of benefits is based on the plaintiff’s lack of status as an eligible employee (*i.e.*, a participant) in the benefit plan? For example, if a plaintiff can concoct a claim that the reason for his failure to meet basic eligibility requirements is that he received misrepresentations by his employer and/or the insurer that coverage would be in force, is removal of this claim prevented by *Felix*? Certainly, if the plaintiff is seeking the requisite benefits under the ERISA plan, the basis for the plaintiff’s claim is that he should be a participant and such an action should be completely preempted by ERISA.

Second, *Felix* and similar holdings appear to encourage creative pleading by plaintiffs. Removal was prevented in *Felix* because the plaintiffs claimed that they were not seeking plan benefits or reinstatement in the later retirement plan, but instead they were seeking “damages” that just happened to represent lost benefits under that plan. Can plaintiffs simply re-cast their remedies as claims for “damages” in order to avoid removal to federal court? This is not likely in most cases, but *Felix* certainly leaves this possibility open in the right factual scenarios. This seems to be contrary to the very purpose of the complete preemption doctrine, which is to avoid “artful pleading” designed to avoid federal court jurisdiction.

A third question left unanswered in *Felix* is the impact of that holding on the plaintiffs’ claims on remand. The Tenth Circuit all but acknowledged that once the case returned to state court, the plaintiffs’ claims were probably subject to statutory preemption under section 514. The Tenth Circuit also made it clear that the plaintiffs had no valid claim under ERISA, section 502(a)(1)(B). What’s left?

The answer to that question might lie in the issue that the Court did not address in *Felix*, *i.e.*, whether the plaintiffs had standing to pursue other causes of action under ERISA, section 502(a). For example, the Court expressly declined to address whether the plaintiffs’ claims were completely preempted to the extent their fraud claims might be characterized as breach of fiduciary duty claims under section 502(a)(3) because “the Plaintiffs do not request equitable relief as required by” that section. Is the Court saying that because the plaintiffs chose to characterize their claims as “damages” claims rather than requests for “equitable relief,” their state law claims cannot be subject to complete preemption? If so, this is most disturbing. In *Varity Corp. v. Howe*,²⁰ the plaintiffs alleged that they were induced by their employer to leave a viable pension plan and instead become participants in a plan that became defunct. The lower court concluded that representations by the employer were fraudulent and constituted a breach of fiduciary duty under ERISA. The equitable remedy was reinstatement in the viable pension plan pursuant to section 502(a)(3). The facts in *Varity Corp.*

²⁰ 516 U.S. 489 (1996).

do not seem all that remote from the facts in *Felix*. If the plaintiffs in *Varity Corp.* had a breach of fiduciary claim under section 502(a)(3), one wonders why there was no such claim in *Felix* other than the fact that the plaintiffs chose not to bring such a claim. For the *Felix* court not to consider section 502(a)(3) as a possible basis for complete preemption seems directly contrary to the very reason for the complete preemption doctrine: the refusal of federal courts to deny removal jurisdiction based solely on artful pleading.

In the end, the plaintiffs in *Felix* may end up with nothing: no federal law claim under ERISA and no state law claims because they are preempted by ERISA section 514. While at first blush, this may seem like a defense victory, it really makes no sense. Ultimately, the plaintiffs were seeking to be participants in a plan from which they allegedly were excluded by Lucent's misrepresentations. Their claims certainly sound like a colorable claim for participant status and the benefits that would apply to that status. The claims should be adjudicated in federal court.

Jury Trials

I. Majority Rule

A major bone of contention between plaintiffs and defendants in ERISA actions is whether there is a right to a jury trial under ERISA itself or under the Seventh Amendment. ERISA is silent on the issue. The Seventh Amendment guarantees a right to a jury trial in actions at common law, as opposed to actions in equity, “where the value in controversy shall exceed twenty dollars.” The majority rule in the federal appellate courts is that there is no right to a jury trial in ERISA cases.

The seminal case on the subject of the right to a jury trial is *Wardle v. Central States, Southeast and Southwest Areas Pension Fund*,¹ in which the Court held that there is no statutory right to a jury trial in an action for benefits under §502(a)(1)(B). The primary basis for the Court’s holding was the Court’s belief that “Congress’ silence on the jury right issue,” which the Court concluded “reflects an intention that suits for pension benefits by disappointed applicants are equitable.”² This conclusion was based on the fact that “[s]uch suits under the law of trusts have existed for quite a while” and that such suits have always been “considered equitable in character.”³ The Court stated that this historical position:

[H]as been based primarily on the law of trusts, which provides a beneficiary with a legal remedy only with respect to money the trustee is under a duty to pay unconditionally and immediately to the beneficiary... Thus the most reasonable interpretation is that Congress intended to provide general federal jurisdiction over these equitable suits that had traditionally been brought in state courts.⁴

Virtually every circuit court deciding the issue since *Wardle* has held similarly, whether the action is for benefits under §502(a)(1)(B) or one for general equitable relief under §502(a)(3). Like the decision in *Wardle*, these holdings are largely based on the conclusion that such actions are equitable in nature, thus negating any requirement for a jury trial under ERISA or under the Seventh Amendment. The First Circuit has held that there is no right to a jury trial in an action for ERISA plan benefits under §502(a)(1)(B).⁵ In *Katsaros v. Cody*,⁶ the Second Circuit held that an action for restitution against pension fund trustees was equitable in nature and that there is no right to a jury trial. The same court has held that there is no right to a jury trial in an action for benefits under ERISA, §502(a)(1)(B).⁷ In *Cox v. Keystone Carbon Co.*,⁸ the Third Circuit held that an employee seeking severance benefits under ERISA has no right to a jury trial. The Third Circuit has also

¹ 627 F.2d 820 (7th Cir. 1980).

² *Id.* at 829.

³ *Id.*

⁴ *Id.*

⁵ *Hampers v. W.R. Grace & Co., Inc.*, 202 F.3d 44 (1st Cir. 2000).

⁶ 744 F.2d 270 (2d Cir. 1984).

⁷ *DeFelice v. American Int’l Assur. Co. of N.Y.*, 112 F.3d 61 (2d Cir. 1997); *Sullivan v. LTV Aerospace and Defense Co.*, 82 F.3d 1251 (2d Cir. 1996).

⁸ 894 F.2d 647 (3d Cir. 1990).

held that there is no right to a jury trial under ERISA's general equitable relief section, §502(a)(3), or under the breach of fiduciary duty section, §502(a)(2).⁹ The Fourth and Fifth Circuits have held generally that there is no right to a jury trial under ERISA.¹⁰ The Sixth Circuit has broadly held that there is no right to a jury trial for actions under ERISA's civil enforcement section, §502, particularly where the plaintiff seeks solely injunctive relief or back pay or where the plaintiff seeks reinstatement in an ERISA plan and benefits due him/her under the plan.¹¹ The Seventh Circuit confirmed its holding in *Wardle* in the case of *Brown v. Retirement Committee of the Briggs & Stratton Retirement Plan*,¹² although it has also held that where a claim for general equitable relief under ERISA, §502(a)(3) is combined with a claim for legal relief under the Labor Management Relations Act, 29 U.S.C. §185(a), the plaintiff is entitled to a trial by jury for the legal remedy.¹³ The Eighth Circuit has repeatedly held generally that there is no right to a jury trial under ERISA, §502, particularly where the plaintiff is seeking benefits under a plan and/or remedies for breach of fiduciary duty.¹⁴ The Ninth Circuit has held that where ERISA is the only law governing a particular case, there is no independent constitutional or statutory right to a jury trial.¹⁵ The Tenth Circuit has held that there is no right to a jury in a §510 action, nor is there a right to a jury trial in an action for plan benefits under §502(a)(1)(B).¹⁶ Finally, the Eleventh Circuit has noted that the authority is "overwhelming" to the effect that there is no right to a jury trial in an action under §502(a).¹⁷

II. Aberrant Decisions

Despite the virtual unanimity of the circuit courts, several district courts have parted ways with this authority to hold that there is a right to a jury trial in certain types of actions under ERISA.¹⁸

⁹ *Pane v. RCA Corp.*, 868 F.2d 631 (3d Cir. 1989).

¹⁰ *Berry v. CIBA-GEIGY*, 761 F.2d 1003 (4th Cir. 1985) (action for plan benefits); *Calamia v. Spivey*, 632 F.2d 1235 (5th Cir. 1980) (same).

¹¹ *Wilkins v. Baptist Healthcare System, Inc.*, 150 F.3d 609 (6th Cir. 1998); *Bair v. General Motors Corp.*, 895 F.2d 1094 (6th Cir. 1990); *Daniel v. Eaton Corp.*, 839 F.2d 263 (6th Cir. 1988).

¹² 797 F.2d 521 (7th Cir. 1986).

¹³ *Burgher v. Feightner*, 722 F.2d 1356 (7th Cir. 1983).

¹⁴ *Houghton v. Sipco, Inc.*, 38 F.3d 953 (8th Cir. 1994); *Kirk v. Provident Life and Accident Insurance Company*, 942 F.2d 504 (8th Cir. 1991); *Vorpahl v. Retirement Plan for Employees of Union Oil Company, etc.*, 749 F.2d 1266 (8th Cir. 1984); *In re Vorpahl*, 695 F.2d 318 (8th Cir. 1982).

¹⁵ *Ingram v. Martin Marietta Long Term Disability Income Plan*, 244 F.3d 1109 (9th Cir. 2001); *Nevill v. Shell Oil Co.*, 835 F.2d 209 (9th Cir. 1987); *Blau v. Del Monte Corp.*, 748 F.2d 1348 (9th Cir. 1984).

¹⁶ *Adams v. Cyprus Amax Minerals Co.*, 149 F.3d 1156 (10th Cir. 1998); *Zimmerman v. Sloss Equipment, Inc.*, 72 F.3d 822 (10th Cir. 1995).

¹⁷ *Blake v. Union Mutual Stock Life Ins. Co.*, 906 F.2d 1525 (11th Cir. 1990). *See also* *Chilton v. Savannah Foods & Industries*, 814 F.2d 620 (11th Cir. 1987); *Howard v. Parisian*, 807 F.2d 1560 (11th Cir. 1987).

¹⁸ *See, e.g.,* *Hulcher v. United Behavioral Systems, Inc.*, 919 F. Supp. 879 (E.D. Va. 1995) (right to trial by jury in action for medical benefits); *Brasher v. Prudential Ins. Co. of America*, 771 F. Supp. 280 (W.D. Ark. 1991) (it is fairly well established that jury trials are not inappropriate in all actions under ERISA; an action to recover money due under a contract is plainly a legal action); *Gangitano v. NN Investors Life Ins. Co., Inc.*, 733 F. Supp. 342 (S.D. Fla. 1990) (the Seventh Amendment guarantees a claimant the right to a jury trial in an action for benefits); *Utilicorp United, Inc. v. Kemper Financial Services, Inc.*, 741 F. Supp. 1363 (W.D. Mo. 1989) (in absence of binding precedent, a plaintiff is entitled to a jury trial in an action for breach of fiduciary duties under ERISA).

Exhaustion of Remedies

I. The General Rule: Claims for ERISA Benefits

The vast majority of courts have enforced an exhaustion of remedies standard in ERISA cases, despite the fact that such a requirement appears nowhere in the statute itself. An early case on this subject is the Ninth Circuit decision in *Amato v. Bernard*.¹ In that case, a union member brought an action against the union pension plan seeking, among other things, a declaration that he was entitled to a full pension under the plan. During the course of the suit, the plan raised an issue as to whether the plaintiff had adequately exhausted the plan's claim procedures. Since there is no express language in the statute requiring exhaustion, the Court was faced with the issue of whether Congress intended to grant the courts the authority to enforce such a requirement. The Ninth Circuit held that it did.

The Ninth Circuit cited four reasons for this holding. First, the Court noted that Congress authorized the courts to develop federal common law to deal with issues arising under ERISA. Second, Congress forged a strong link between the Labor Management Relations Act and ERISA. The federal courts have established federal common law under the LMRA, and part of that law states that where administrative remedies are available, they must be exhausted before a suit is initiated. Third, ERISA mandates specific claims procedures. The Court concluded that it would “be anomalous if the same good reasons that presumably led Congress to require covered plans to provide administrative remedies for aggrieved claimants did not lead the courts to see that those remedies are regularly used.”² Finally, the Court stated that the “primary” reason for the exhaustion requirement is to allow for fully considered decisions by the plan fiduciary, further refining and defining the problem in the given cases, so as to assist the courts in resolving the controversies. Most circuits have agreed with this reasoning, particularly in cases involving claims for benefits.³

II. Statutory Claims

Although the circuits have been fairly uniform in requiring exhaustion in actions for plan benefits, there is a split of authority as to whether exhaustion is required in actions alleging statutory breaches, such as actions for breach of fiduciary duties and actions for interference with plan rights under §510. For example, in *Kross v.*

¹ 618 F.2d 559 (9th Cir. 1980).

² *Id.* at 567.

³ See *Drinkwater v. Metropolitan Life Ins. Co.*, 846 F.2d 821 (1st Cir. 1988); *Kennedy v. Empire Blue Cross & Blue Shield*, 989 F.2d 566 (2d Cir. 1993); *Berger v. Edgewater Steel Co.*, 911 F.2d 911 (3d Cir. 1990); *Makar v. Health Care Corp. of Mid-Atlantic*, 872 F.2d 80 (4th Cir. 1989); *Simmons v. Willcox*, 911 F.2d 1077 (5th Cir. 1990); *Smith v. Blue Cross and Blue Shield United of Wisconsin*, 959 F.2d 655 (7th Cir. 1992); *Anderson v. Alpha Portland Industries, Inc.*, 727 F.2d 177 (8th Cir. 1984); *Mark Kuckenmeister, CPA v. Randall S. Kuckenmeister, CPA*, 619 F.3d 1010 (9th Cir. 2010); *Chorosevic v. Met Life Choices*, 600 F.3d 934 (10th Cir. 2010); *Held v. Manufacturers Hanover Leasing Corporation*, 912 F.2d 1197 (10th Cir. 1990); *Byrd v. MacPapers, Inc.*, 961 F.2d 157 (11th Cir. 1992).

Western Electric Company, Inc.,⁴ the Court held that the fact that a plaintiff's claim is based on ERISA statutory violations rather than a claim for benefits is "insufficient to override the well-established federal policy, and supporting case law, favoring exhaustion of administrative remedies prior to bringing an ERISA-based lawsuit in federal court."⁵ The Court stated that a plaintiff may be required, in the discretion of the trial court, to exhaust administrative procedures before bringing an action for interference with the vesting of his pension benefits under §510, regardless of whether those procedures could reinstate him in his job, and that such procedures would support the "strong federal policy... encouraging private resolution of ERISA-related disputes...."⁶

Other courts have disagreed with this line of authority, holding that exhaustion is not required where a statutory violation is alleged. For example, in *Zipf v. American Telephone and Telegraph Company*,⁷ the Third Circuit declined to impose an exhaustion requirement to actions based on substantive rights created by ERISA. The Court noted that ERISA's requirement of internal claims and appeal procedures applied to claims, and there was no suggestion that Congress meant for those procedures to apply to "Section 510 claims based on violations of ERISA's substantive guarantees."⁸ In fact, the Court held that ERISA's legislative history "suggests that the remedy for Section 510 discrimination was intended to be provided by the courts."⁹ Moreover, the Court stated that the considerations supporting an exhaustion requirement in benefit claims cases, such as deference to administrative expertise, were absent in cases involving substantive statutory rights. The Court found a "strong interest in judicial resolution of 'statutory claims' for the purpose of providing a consistent source of law" and based on the fact that "statutory interpretation is not only the obligation of the courts, it is a matter within their peculiar expertise."¹⁰

III. Exceptions to the Exhaustion Requirement

Even though most courts have applied the exhaustion requirement rather strictly, it is clear that enforcement of the requirement rests in the discretion of the district court, reversible only upon abuse of that discretion.¹¹ Moreover, the courts generally recognize two exceptions to exhaustion: where exhaustion is futile or where the remedy is inadequate.

⁴ 701 F.2d 1238 (7th Cir. 1983).

⁵ *Id.* at 1245.

⁶ *Id.* at 1244. *See also* *Lindemann v. Mobil Oil Corporation*, 79 F.3d 647 (7th Cir. 1996); *Simmons v. Willcox*, *supra* (exhaustion required in claims for benefits as well as claims for breach of fiduciary duties, or else plaintiffs would simply recharacterize their benefit claims as actions for breach of fiduciary duties); *Springer v. Wal-Mart Associates' Group Health Plan*, 908 F.2d 897 (11th Cir. 1990) (exhaustion applies to actions for benefits and to actions based on statutory violations).

⁷ 799 F.2d 889 (3d Cir. 1986).

⁸ *Id.* at 892.

⁹ *Id.*

¹⁰ *Id.* at 893. *See also* *Chailland v. Brown & Root, Inc.*, 45 F.3d 947 (5th Cir. 1995) (exhaustion not applicable in action under §510); *Richards v. General Motors Corporation*, 991 F.2d 1227 (6th Cir. 1993) (same); *Graphic Communications Union, etc. v. GCIU-Employer Retirement Benefit Plan*, 917 F.2d 1184 (9th Cir. 1990) (same); *Held v. Manufacturers Hanover Leasing Corporation*, 912 F.2d 1197 (10th Cir. 1990) (same).

¹¹ *Curry v. Contract Fabricators Inc. Profit Sharing Plan*, 891 F.2d 842 (11th Cir. 1990).

Where a plan does not provide for any administrative remedies, resort to the administrative process would be futile.¹² However, bare allegations of futility are not sufficient; a plaintiff must make a “clear and positive” showing of futility in order to avoid the exhaustion requirement.¹³ In addition, the mere fact that there is no “neutral arbitrator” to resolve the initial claim does not, by itself, constitute futility.¹⁴ Likewise, the fact that an appeal is heard by the same entity as the initial decision and that the entity has an interest in saving costs is not enough to support a finding of futility or the administrative procedures inadequate.¹⁵ However, where the administrator in control of the administrative procedures denies a claimant meaningful access to those procedures by failing and/or refusing to provide the claimant with documentation describing the procedures, the court has discretion not to require exhaustion.¹⁶ Furthermore, where the fiduciary has a “fixed policy of denial” of benefits and has violated the plan’s administrative procedures by failing to provide the claimant with a written notice of denial or specific reasons for the denial, exhaustion is futile and is excused.¹⁷

Two other potential exceptions to the exhaustion requirement have been rejected, at least in the Seventh Circuit. For example, in *Edwards v. Briggs & Stratton Retirement Plan*, 639 F.3d 355 (7th Cir. 2011), the plaintiff argued that the untimely filing of her administrative appeal should be excused on the ground of “substantial compliance.” The Seventh Circuit noted that it had applied the substantial compliance doctrine to excuse a claim administrator’s technical failures under the ERISA claim procedure regulations, but that it had never applied the doctrine to excuse a claimant’s untimely attempt to exhaust the plan’s administrative remedies. The court also noted that a plan has an interest in the finality of its decisions and that the administrator is required by ERISA to enforce plan terms, including applicable administrative appeal deadlines. The court rejected the plaintiff’s attempt to impose a “substantial compliance” exception to the exhaustion requirement.

The court also rejected a “notice-prejudice” exception to the exhaustion requirement. The Seventh Circuit noted that Wisconsin law applied a notice-prejudice rule to a claimant’s failure to give timely notice of a claim under an insurance policy. However, the plan under which the plaintiff was seeking benefits in *Edwards* was not an insured plan. Moreover, the court held that the notice-prejudice rule is only applied to the initial filing of a claim for benefits and the court was reluctant to expand the rule beyond its previous uses to excuse the late filing of an administrative appeal.

IV. Issue Exhaustion vs. Claim Exhaustion

Despite the fact that virtually every circuit requires claim exhaustion under ERISA, some courts have distinguished claim exhaustion from issue exhaustion and have held that a claimant is not required to exhaust all potential issues. Specifically, these courts hold that if a claimant exhausts the administrative appeal process with respect to his/her claim, there is no requirement that the claimant raise every potential issue related to

¹² *Berger v. Edgewater Steel Co.*, *supra*.

¹³ *Lindemann v. Mobil Oil Corporation*, *supra*; *Kennedy v. Empire Blue Cross*, *supra*; *Smith v. Blue Cross*, *supra*; *Springer v. Wal-Mart*, *supra*; *Carper v. Dominion Bankshares Mortgage Corporation*, 892 F.2d 1041 (4th Cir. 1990).

¹⁴ *Dale v. Chicago Tribune Company*, 797 F.2d 458 (7th Cir. 1986).

¹⁵ *Springer v. Wal-Mart*, *supra*; *Denton v. First National Bank of Waco*, 765 F.2d 1295 (5th Cir. 1985).

¹⁶ *Epright v. Environmental Resources Mgmt., Inc.*, 81 F.3d 335 (3d Cir. 1996); *Conley v. Pitney Bowes*, 39 F.3d 714 (8th Cir. 1994); *Curry v. Contract Fabricators*, *supra*.

¹⁷ *Berger v. Edgewater Steel Company*, *supra*.

that claim. This means that the claimant can raise in court—for the first time—additional reasons for overturning a benefit denial that were not raised during the claim review process. These holdings are ironic in the sense that claim administrators are required to raise every potential basis for a denial during the claim review process on penalty of later waiving a basis. In other words, while claim administrators are held to the requirement that they raise every potential basis for a denial before suit is filed so that a claimant can respond to each basis during the administrative review process, claimants are not held to the same requirement, leaving claim administrator decisions open to challenge on bases that were never presented to the claim administrator and to which the claim administrator never had an opportunity to respond.

An example of a case discussing the distinction between claim exhaustion and issue exhaustion is *Vaught v. Scottsdale Healthcare Corp. Health Plan*, 546 F.3d 620 (9th Cir. 2008). The claimant filed an administrative appeal of the denial of a medical benefit claim. He raised a laundry list of procedural issues challenging the process used by the claim administrator to decide the issue but the claimant raised no substantive issues. After filing suit, the claimant raised for the first time several substantive challenges to the denial. The district court held that the claimant waived the substantive arguments by failing to exhaust the arguments during the administrative process. The Ninth Circuit reversed in a split decision over a strong dissent. The majority held that neither ERISA, nor any DOL regulations, nor the plan itself, required exhaustion of every issue. The majority held that the claimant's assertion of procedural errors was sufficient to satisfy the exhaustion requirement and that his lawsuit could go forward also on substantive grounds. The court remanded to the district court to determine the standard of review and whether additional evidence outside of the administrative record would be appropriate.

The *Vaught* court cited only one other circuit court decision and that was *Wolf v. National Shopmen Pension Fund*, 728 F.2d 182 (3d Cir. 1984). As in *Vaught*, the plaintiff in *Wolf* raised new bases for overturning a pension benefit denial that she did not raise during the administrative review process. The Third Circuit held that while claim exhaustion is required in ERISA benefit cases, issue or “theory” exhaustion is not required. Ultimately, the Third Circuit affirmed a district court judgment in favor of the claimant based in part on the new theory that was never raised during the administrative review process.