
# ERISA Report

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## Committee Leadership





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### Recent Cases of Interest

# Constructive Knowledge of Breach by ERISA Fiduciary Is Insufficient to Trigger Three-Year Limitations Period

**By H. Sanders Carter, Jr.**

What amounts to "actual knowledge" of a breach that starts the running of ERISA's statute of limitations for a legal action alleging breach of fiduciary duty? In *Intel Corporation Investment Policy Committee v. Sulyma*, 140 S.Ct. 768 (2020), the Supreme Court resolved a circuit split, holding that constructive or imputed knowledge of a breach or an ERISA violation is not sufficient. Instead, "one must in fact be aware of it." *Id.* at 776.

ERISA provides three time periods within which a breach of fiduciary action must be brought, depending on the underlying circumstances.

- Under 29 U.S.C. §1113(1) an action must be filed within six years of "the date of the last action which constituted a part of the breach or violation" or, in the case of a breach by omission, within six years of "the latest date on which the fiduciary could have cured the breach or violation."
- But under §1113(2) suit must be filed within three years of "the earliest date on which the plaintiff had *actual knowledge* of the breach or violation." (Emphasis added.)
- Finally, "in the case of fraud or concealment," §1113 provides that the time to sue begins to run when the plaintiff discovers the breach, and it expires six years from "the date of discovery."

*Sulyma* involved the three-year deadline to file suit after a plaintiff acquires "actual knowledge" of a breach or violation by a plan fiduciary. Specifically, the Court considered whether information that had been provided to the plaintiff disclosing the alleged breach, but which the plaintiff said he had not read or understood, was sufficient to constitute "actual knowledge," triggering the running of the three-year statute. The Court said it was not.

## The Underlying Facts

As an employee of Intel Corporation, Sulyma participated in two retirement plans that were invested in funds managed by the Intel Investment Policy Committee. Initially, the funds consisted mostly of stocks and bonds. After the 2008 stock market decline, the Committee increased investments in alternative assets, such as hedge funds, private equity, and commodities, which required relatively high fees. When the stock market recovered, the funds in which Sulyma's retirement funds were invested lagged behind other funds.

Sulyma filed a putative class action in 2015, alleging that the Committee and plan administrators breached fiduciary duties by overinvesting in alternative assets. The defendants contended the suit was time-barred by §1113(2), because it was filed more than three years after the investment decisions had been disclosed to Sulyma. As a result, the defendants said, Sulyma had actual knowledge of the alleged breach more than three years before the complaint was filed.

The defendants showed:

- that Sulyma had received multiple disclosures, some of which explained the extent to which his retirement plans were invested in alternative assets;
- that Sulyma had received a summary plan description, which showed the funds were invested in both stocks and alternative assets;
- that Sulyma had received emails directing him to annual disclosures, which showed the rates of return for the funds in which his plans were invested; and
- that Sulyma had repeatedly visited a website, which provided additional information about the investments.

But in response to the defendants' motion for summary judgment, Sulyma said he did not read, or did not understand, the information that had been provided to him.

## The Lower Court Rulings

The district court granted summary judgment to the defendants, despite Sulyma's deposition testimony that he did not "remember reviewing" the disclosures, and his declaration that he was "unaware" that his retirement funds "had been invested in hedge funds or private equity." 2017 WL 1217185 (N.D. Cal. Mar. 31, 2017).

The Ninth Circuit reversed, construing the "actual knowledge" requirement of §1113(2) to mean "what it says: knowledge that is actual, not merely a possible inference from ambiguous circumstances." 909 F.3d 1069, 1076 (2018). The court held that summary judgment for the defendants was improper. Despite the fact that Sulyma had been given information sufficient to inform him about the allegedly imprudent investments, his testimony created a factual dispute as to when he actually acquired knowledge that would trigger the running of his time to file suit.

Other circuit courts of appeals had come to the same conclusion. *See, e.g., Caputo v. Pfizer, Inc.*, 267 F.3d 181, 194 (2d Cir. 2001) ("when the Legislature intends to incorporate a constructive knowledge requirement into an ERISA statute of limitations, it ordinarily does so explicitly"); *Gluck v. Unisys Corp.,* 960 F.2d 1168, 1177 (3d Cir. 1992) ("actual knowledge of all material facts constituting a breach of fiduciary duty or violation of ERISA is the *sine qua non* for application of section 1113's three-year limitation"); *Brock v. Nellis*, 809 F.2d 753, 755 (11th Cir. 1987) ("To charge the Secretary [of Labor] with actual knowledge of an ERISA violation, it is not enough that he had notice that something was awry; he must have had specific knowledge of the actual breach of duty upon which he sues."); *Reich v. Lancaster,* 55 F.3d 1034, 1056–57 (5th Cir. 1995); *Radiology Center, S.C., v. Stifel, Nicolaus & Co.*, 919 F.2d 1216, 1222 (7th Cir. 1990).

But the Sixth Circuit had decided otherwise. In *Brown v. Owens Corning Investment Review Committee*, 622 F.3d 564 (6th Cir. 2010), the court held that constructive knowledge of a breach was sufficient to start the running of the three-year statute. "Actual knowledge does not 'require proof that the individual Plaintiffs actually saw or read the documents that disclosed' the allegedly harmful investments," the court said. *Id.* at 571. "An ERISA plaintiff has actual knowledge when he or she has 'knowledge of all the relevant facts, not that the facts establish a cognizable legal claim under ERISA.'" *Id.* at 570.

## The Supreme Court Decision

In a unanimous decision, Justice Alito focused on the word "actual," writing that the time to file suit under §1113(2) "begins only when a plaintiff actually is aware of the relevant facts, not when he should be." 140 S.Ct. at 778. "Thus, to have 'actual knowledge' of a piece of information, one must be aware of it." *Id.* at 776.

The Court held that Sulyma's imputed or constructive knowledge of facts showing the alleged fiduciary breach, based on information provided to him, was not sufficient, regardless of whether he read or understood it. "The addition of 'actual' in §1113(2) signals that the plaintiff's knowledge must be more than 'potential, possible, virtual, conceivable, theoretical, hypothetical, or nominal," the Court said, quoting Black's Law Dictionary 53 (4th ed. 1951). *Id.* at 777. "[I]f a plaintiff is not aware of a fact, he does not have 'actual knowledge' of that fact however close at hand the fact might be." *Id.*

Whether Sulyma's claim was time-barred could not be decided on motion for summary judgment, because his denial that he read or understood the information provided to him created a factual dispute concerning what knowledge he actually had. While the decision clarified what amounts to "actual knowledge," the Court also said: "Nothing in this opinion forecloses any of the 'usual ways' to prove actual knowledge at any stage of the litigation." *Id.* at 779, citing *Farmer v. Brennan,* 511 U.S. 825, 842 (1994).

> Evidence of disclosure would no doubt be relevant, as would electronic records showing that a plaintiff viewed the relevant disclosures and evidence suggesting that the plaintiff took action in response to the information contained in them. And though "[a]t the summary judgment stage, facts must be viewed in the light most favorable to the nonmoving party," that is true "only if there is a genuine dispute as to those facts." If a plaintiff's denial of knowledge is "blatantly contradicted by the record," "a court should not adopt that version of the facts for purposes of ruling on a motion for summary judgment."

*Id.* (internal citations omitted). "Today's opinion" the Court said, "also does not preclude defendants from contending that evidence of 'willful blindness' supports a finding of 'actual knowledge.'" *Id.*

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# When COBRA Meets COVID-19: Concerns for Plan Administrators and TPAs

**By Jean E. Tomasco**

What happens when COBRA meets COVID? While it may sound like the premise of a horror movie along the lines of "Snakes on a Plane" or "Sharknado," extensions of COBRA notice deadlines due to the pandemic have the potential to be a fright fest for group health plan administrators and third-party administrators (TPAs).

## COBRA Basics

For group health plans sponsored by employers with 20 or more employees, COBRA (the Consolidated Omnibus Budget Reconciliation Act) allows plan participants and their covered dependents to elect to continue coverage under their plan when they might otherwise lose it due to a "qualifying event."

Qualifying events include termination of employment, such as furloughs and layoffs, as well as reduction of an employee's work hours below the threshold necessary for plan participation. Certain leaves of absence (although not those granted under the Family and Medical Leave Act) may constitute a qualifying event if the plan doesn't otherwise allow participants to continue coverage while on leave. Other qualifying events include a covered dependent "aging out" of the plan, death of the covered employee, and divorce from the covered employee.

The maximum period for COBRA coverage depends on various factors, including the nature of the qualifying event, but ranges between 11 and 36 months. Unless an employer agrees to cover a portion of the COBRA premiums—which is not required—a person electing continuation coverage must pay the full monthly premium for the group coverage, including any portion of the premium previously paid by the employer. In addition, an administrative fee of up to 2 percent of the premium can be charged. While COBRA coverage can be expensive, it may be more affordable than similar coverage in the marketplace, particularly for individuals with chronic health conditions and significant medical expenses.

## COBRA Notices

Plan administrators (or TPAs retained to handle COBRA administration) are required to provide participants with certain notices regarding their right to continuation coverage under COBRA. There is an initial general notice that must be provided to participants and their spouses within 90 days after they begin participating in the plan. The U.S. Department of Labor (DOL) has a model notice for this purpose. This general COBRA information also must be in the plan's summary plan description (SPD), and employers often include it in their employee handbooks as well.

COBRA also mandates that, at the time of a qualifying event, any qualified beneficiaries (the eligible employee and participating spouse and dependents) must be given information about their COBRA rights, including their options for electing continuation coverage, the costs, and the time periods for electing coverage and paying premiums. While the DOL has a model notice for this as well, many administrators devise their own forms. The notice and election process is complicated and more likely to cause potential problems for plan administrators if not done correctly.

Once a group health plan is informed by the employer or participant that a qualifying event has occurred, the plan administrator (or TPA) must provide the information regarding COBRA rights and election notices to the qualified beneficiaries within 14 days. Qualified beneficiaries must be given at least 60 days to elect coverage; the election period begins on the *later* of the qualifying event, the date they would otherwise lose coverage under the plan, or the date they receive the election notice. (Each qualified beneficiary has the right to make their own decision; they need not follow what the employee or another qualified beneficiary may decide.)

A plan must provide at least 45 days following the initial election for the qualified beneficiary to pay the first premium. ERISA §602(3)(B), 29 U.S.C. § 1162(3)(B), I.R.C. §4980B(f)(2)(C). Subsequent COBRA premium payments are due monthly (typically on the first of the month), with a 30-day grace period. ERISA §602(2)(C), 29 U.S.C. §1162(2)(C). COBRA continuation coverage may be terminated for failure to pay premiums on time.

Adding the 60-day election period to the 45-day period for the initial premium payment, a qualified beneficiary has up to 105 days before a premium is due. Rather than elect and pay for COBRA coverage right away, a qualified bene-

ficiary may elect coverage but hold the premium payment until near the end of the 45-day period, to give themselves time either to see whether they incur medical expenses that would exceed the cost of the COBRA premium or to try to obtain other health insurance.

## The Pandemic and Its Effect on COBRA

As we are all too aware, in early 2020 the coronavirus began spreading rapidly in the United States and the rate of COVID-19 cases started to increase exponentially. On March 13, 2020, President Trump declared a National Emergency beginning March 1, 2020, as a result of the COVID-19 outbreak. The Department of Health and Human Services (HHS) also has made a determination that a public health emergency exists.

Facing state shutdown orders and supply-chain disruptions, many businesses were hard hit by the pandemic and began laying off employees or significantly reducing their hours. In most cases, these events would be qualifying events triggering the COBRA notice, election, and premium payment process, requiring qualified beneficiaries to decide within that 105-day window whether to elect, and then pay for, continued health insurance coverage.

## Relief: Tolling Deadlines during the "Outbreak Period"

Recognizing the numerous challenges faced by plan participants and beneficiaries as result of the pandemic as well as the difficulty group health plans might have in complying with certain notice obligations, on May 4, 2020, the DOL (Employee Benefits Security Administration), the Department of the Treasury, and the Internal Revenue Service (the "Agencies") jointly issued relief by extending certain deadlines under the Employee Retirement Income Security Act (ERISA) and the Internal Revenue Code for health plans, certain other group welfare plans, pension plans, and participants and beneficiaries of those plans (the "Relief Notice"). 85 Fed. Reg. 26351 (May 4, 2020).

Of significant note, the Relief Notice provides that all group health plans subject to ERISA or the Code must *disregard* the period from March 1, 2020, until 60 days after the announced end of the National Emergency, or such other date announced by the Agencies in a future notification. This tolling period is known as the "Outbreak Period." 85 Fed. Reg. 26353.

In addition to the Relief Notice, the DOL issued EBSA Disaster Relief Notice 2020-01, separately announcing an extension of deadlines for furnishing other required notices or disclosures to plan participants, beneficiaries, and other persons so that plan fiduciaries and plan sponsors have additional time to meet their obligations during the COVID-19 outbreak.

This extension applies to the furnishing of notices, disclosures, and other documents required by provisions of Title I of ERISA over which the DOL has interpretive and regulatory authority, other than those notices and disclosures already addressed in the Relief Notice. An employee benefit plan and the responsible plan fiduciary will not be in violation of ERISA for a failure to timely furnish a notice, disclosure, or document that must be furnished during the Outbreak Period, provided the plan and responsible fiduciary act in good faith and furnish the notice, disclosure, or document as soon as administratively practicable under the circumstances.

The Outbreak Period is tied to the President's National Emergency declaration, which does not have a set end date and remains in effect as of this writing. Given the increasing number of COVID-19 cases as we head into winter, as well as the fact that HHS has extended into January 2021 its own determination that a public health emergency exists, it seems unlikely that an end to the National Emergency will be announced soon. Unfortunately, it may extend well into 2021.

However, although there is no set end date for the National Emergency, the Relief Notice and EBSA Notice indicate that the tolling period for deadlines during the Outbreak Period is subject to the statutory duration limitation in ERISA §518, 29 U.S.C. §1148, and Internal Revenue Code §7508A. These sections generally limit to a maximum of one year the length of any tolling period attributable to a Presidentially declared disaster or HHS public health emergency. (Furthermore, no plan shall be treated as failing to operate in accordance with the terms of the plan solely as a result of complying with the postponement of a deadline under those sections.)

Assuming there is no executive or legislative action that would change the statutory duration limitation, the Outbreak Period therefore would end, at the latest, on March 1, 2021, even if the National Emergency and/or HHS public health emergency declarations extend beyond that. At present, however, as it is possible—albeit unlikely—that either declaration could end earlier, the last date of the Outbreak Period cannot be determined with certainty.

## Effect of the Tolling Period on COBRA Deadlines

The tolling of deadlines during the Outbreak Period expressly applies to the 60-day COBRA election period as well as any deadlines for making COBRA payments,

including not only the 45-day period following the initial election, but also the subsequent monthly deadlines for making premium payments to maintain COBRA coverage. 85 Fed. Reg. 26354.

To illustrate the effect of the Relief Notice extensions on COBRA deadlines, assume the Outbreak Period ends on March 1, 2021. John Employee, a participant in his employer's health plan, was laid off fairly early in the pandemic, on May 15, 2020. The plan administrator provided him with a COBRA election notice on June 1, 2020. Under the standard COBRA deadlines, he would normally have had until July 31, 2020, to decide whether to elect COBRA coverage. However, given the Relief Notice, John now has until April 30, 2021 (60 days after the end of the Outbreak Period), to elect COBRA coverage, and another 45 days following the election to pay the initial premium.

Plans also can disregard the Outbreak Period when determining the date for providing a COBRA election notice. 85 Fed. Reg. 26454. Nevertheless, plans should consider providing election notices as they usually would under the standard timeframes, for several reasons. It can minimize the amount of time following the Outbreak Period for elections to be made as the notices will have already been sent out. Further, qualified beneficiaries with health issues may want to elect COBRA coverage sooner rather than later to avoid problems with payment of medical claims. In addition to the standard COBRA election notice, however, plan administrators should include information explaining the extended deadlines under the Relief Notice so qualified beneficiaries can make an informed decision.

## Questions for Plan Administrators to Consider

Given the tolling of COBRA deadlines by the Relief Notice, there is a far longer period when plans will be "in limbo"—that is, when plan administrators and TPAs do not know whether qualified beneficiaries will elect and pay for continued health coverage. In addition, because of lags between when the National Emergency was declared, the Relief Notice published, and the date the National Emergency actually began, there are a number of questions for plan administrators and TPAs to consider, as follows.

### *What should plans do about qualified beneficiaries who have not yet elected COBRA or paid premiums, and now have an extended time to do so?*

During "normal" (non-pandemic) times, while waiting for qualified beneficiaries to elect and pay premiums for coverage, plans usually take one of the following approaches: (1) they terminate coverage when the qualified beneficiary would otherwise lose it and, if payment is received, retroactively reinstate coverage; or (2) they continue coverage until the end of the 105-day initial window (or 30-day payment grace period for subsequent payments) and, if payment isn't received, retroactively cancel coverage back to the date when it otherwise would have been lost.

In either case, if a medical provider asks about coverage for someone seeking treatment, the plan administrator (and insurer if the plan is insured) should accurately advise the provider of the qualified beneficiary's status and that coverage is not guaranteed but, rather, is contingent on the payment of premiums.

Without guidance from the IRS or the DOL on this issue, plans will likely continue their usual approach even though the period of uncertainty will be longer given the tolling of the normal COBRA deadlines. Claims processors and benefits specialists who field calls from providers (and participants) asking about coverage status should be aware of the extended deadlines, the potential for delays, and the individual's status in the interim, and respond accordingly.

### *What about qualified beneficiaries who experienced a qualifying event shortly before the National Emergency began on March 1, 2020, but who had not elected and/or paid for COBRA coverage as of March 1, 2020? What about those who experienced a qualifying event after March 1, 2020, but before the Relief Notice was published?*

The Outbreak Period, which began on March 1, 2020, is disregarded for purposes of determining the qualified beneficiaries' election period and premium due dates, and essentially acts like a "pause" button. Once the Outbreak Period ends, qualified beneficiaries would essentially pick up where they left off, and still have time to make an election or, if they have already made an election, pay the premiums due for their COBRA coverage.

For example, if a qualified beneficiary's election period had started to run before March 1, 2020, the plan can count that time toward the 60-day period, so that the individual will have fewer than 60 days remaining to make an election once the Outbreak Period ends. If the individual had already elected coverage but, as of March 1, 2020, still had time left to make a premium payment, they will have that remaining time to pay once the Outbreak Period ends. Plan administrators need to consider how this will be tracked and managed.

Furthermore, because the National Emergency declaration was made two weeks after the stated beginning of the National Emergency, and the Relief Notice was not issued until two months later, individuals who were provided with COBRA election notices shortly before or following March 1, 2020, would not have received information about the tolling period. As accurate communications are important, plans would be well advised to provide the extension information to such individuals if they haven't already done so.

### *What if a qualified beneficiary waits until after the Outbreak Period to elect COBRA or pay premiums that otherwise would have come due during the Outbreak Period, but cannot afford the large premium payment due to ensure retroactive coverage for the entire period? What if they pay only part of it?*

Generally, a qualified beneficiary who elects COBRA must pay the full premium retroactive to the date they otherwise would have lost coverage in order to continue coverage. However, an individual who waits until the Outbreak Period has run before making their election or before paying premiums that accrued during the Outbreak Period will have a large amount due in order to reinstate coverage and have it be continuous. (Depending on the date of the qualifying event and the end date of the Outbreak Period, the person could owe more than a year's worth of premium payments.) Absent further guidance or relief from the government, qualified beneficiaries may not be able to pay the full amount.

However, an example in the Relief Notice indicates that, if a qualified beneficiary makes a partial payment of the premium due in a timely manner, the beneficiary can obtain COBRA coverage equal to the number of months covered by the partial payment. The example (using an overly optimistic date of June 29, 2020, as the end of the Outbreak Period) indicates that a qualified beneficiary who makes a partial payment equal to two months' premiums on the premium due date (which date is determined by disregarding the Outbreak Period)—even though additional months of premiums are owed—would have coverage for the two months for which timely premium payments were made. Benefits and services provided by the group health plan during that two-month period would be covered under the terms of the plan. However, the individual would not be entitled to COBRA coverage for any month after that. *See* 85 Fed. Reg. 26354, Ex. 4. While the example involves monthly premium payments rather than an initial payment, it suggests limited coverage might be available for partial initial payments as well.

### *When the Outbreak Period ends, should plans send out COBRA notices to everyone who had a qualifying event shortly before or following March 1, 2020, and who has not already elected COBRA?*

There is no legal requirement to do so. If a plan has sent out the notice and election forms to the qualified beneficiaries already, and has advised them of the Relief Notice extending their timeframe for electing coverage and paying premiums, an additional notice may not be necessary. However, sending an additional notice or reminder at the end of the Outbreak Period may be helpful, particularly if it sets out the final dates for individuals to make elections, the premium due date, and amount of the premiums due at that time. Plan administrators and TPAs therefore may want to consider doing so, especially if there is a risk that individuals may claim earlier notices were confusing or incomplete.

### *What if the President decides in the future that only certain parts of the country are experiencing an emergency due to the pandemic?*

Given that COVID-19 cases continue to rise nationwide, it seems unlikely that this will occur before the March 1, 2021 latest end date for the Outbreak Period. However, the Relief Notice provides that, to the extent there are different Outbreak Period end dates for different parts of the country, the Agencies will issue additional guidance regarding the application of the relief.

## Conclusion

The pandemic, and the National Emergency declaration, have gone on far longer than the Agencies (and most people) initially expected. As we head into 2021, which we hope will be much better than 2020, it is possible that the Agencies will provide further guidance as to what will happen when the long Outbreak Period finally draws to a close. Until then, plan administrators and COBRA TPAs should remain informed about the effects of the Relief Notice extensions, and ensure that qualified beneficiaries and providers are kept informed as well.

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# Are Courts Exhausted of Exhaustion?

**By Richard F. Hawkins III**

The exhaustion of remedies requirement for ERISA claimants prior to filing suit under 29 U.S.C. §1132(a)(1)(B) is almost as well-settled as the notion that the Earth is round.

As the Supreme Court noted in *Heimeshoff v. Hartford Life & Accident Insurance. Company*, 571 U.S. 99, 105 (2013), the courts of appeals have uniformly adopted the exhaustion of remedies doctrine for §1132(a)(1)(B) claims, and, indeed, exhaustion-of-remedies defenses are ubiquitous in ERISA denial-of-benefits cases.

Imagine the surprise, then, that seasoned ERISA practitioners must have felt when they read – and *re*-read – Circuit Judge Thapar's concurrence in the Sixth Circuit case of *Wallace v. Oakwood Healthcare, Inc.*, 954 F.3d 879 (6th Cir. 2020), which questioned the very foundation on which the doctrine is based.

## The Underlying Facts

Before we get to the concurrence, let us start with the case itself. In *Wallace*, Cheryl Wallace, a registered nurse, began to suffer from numerous conditions following a trip to Belize in September 2012. 954 F.3d at 884. She went out on medical leave in the fall of 2012 and did not return until mid-2013. *Id.* at 884–85. Even then, her work stint was very brief, and almost immediately she went back out on leave. *Id.* at 885.

Wallace then filed a claim for disability benefits with Reliance Standard Life Insurance Company, which, as of January 1, 2013, had become the new insurer, funder, and claims fiduciary for the disability benefit plan sponsored by Wallace's employer. *Id.* Reliance denied the claim but told Wallace she could seek further review if she so desired. *Id.* In fact, in its denial letter, Reliance expressly told Wallace that her "failure to request a review within 180 days of [her] receipt of this letter may constitute a failure to exhaust the administrative remedies available under [ERISA] and may affect [her] ability to bring a civil action under [ERISA]." *Id.*

Wallace did not seek further review from Reliance. *Id.* Instead, she believed she needed to go backwards—to the date of the onset of her disabling medical conditions. As such, she filed a claim with the plan's *former* insurer, funder, and fiduciary, Hartford Life & Accident Insurance Company. *Id.* Hartford denied the claim and Wallace appealed, fully participating in the administrative process. *Id.* Ultimately, Hartford upheld its denial decision. *Id.*

Wallace then filed her ERISA denial-of-benefits suit. *Id.* Her main benefit claim, though, was *not* against Hartford (who was sued, but later dismissed). Instead, it was against Reliance. *Id.* In other words, Wallace focused on the entity with which she had simply made a one-time claim, *not* the entity with which she had fully participated in the internal administrative process.

Cue a motion to dismiss by Reliance. It said that dismissal was required because Wallace failed to exhaust her administrative remedies with it. And under ordinary circumstances, this argument should have carried the day. But, here, there was a wrinkle: the "underlying plan document did not describe either the claim review process or an exhaustion requirement." *Id.* at 885.

The district court therefore denied the motion and found that Wallace "was not required to exhaust her administrative remedies because [the] plan did not affirmatively require exhaustion." *Id.* at 886. The court later awarded Wallace benefits. Reliance appealed, arguing as its main point that "exhaustion is required *whether or not* it is explicitly stated in a plan document." *Id.* at 887 (emphasis added).

## Sixth Circuit Decision

The Sixth Circuit disagreed. It said that "because [Reliance] did not describe any internal claims review process or remedies in its plan document, the plan did not establish a reasonable claims procedure pursuant to ERISA regulations," and thus, Wallace's "administrative remedies must be deemed exhausted." *Id.* It also expressly rejected Reliance's circumstantial argument that it "was not required to include [its claims procedures] in its plan document because it detailed those procedures in its benefits denial letter." *Id.*

The court of appeals focused on the fact that ERISA requires benefit plans to be established and maintained pursuant to a "*written instrument*" and held that "for a plan fiduciary to avail itself of [the] exhaustion requirement, its underlying plan document must—at a minimum—detail its required internal appeal procedures." *Id.*

Simply put, the Sixth Circuit held that, if a company's underlying plan document does not set forth internal claims appeal procedures, then a claimant is not required to internally appeal a denial decision and, instead, can go straight to federal court. This holding, in and of itself, is significant, because it potentially creates an end-around for plaintiffs to avoid having to go through a full and complete administrative appeal. In fact, the court of appeals even went so far as to say that its rule of law would govern *even if* the plan's summary plan description *does* contain a summary of the claims and appeals procedures. *Id.* In other words, the SPD cannot carry the water, so to speak, for a deficient plan document.

## Judge Thapar Questions Exhaustion Doctrine

Then came Judge Thapar and his concurrence. Although he agreed that, under existing law and on the facts of the case, Wallace was not required to exhaust her administrative remedies with Reliance, he questioned the entire legality of the exhaustion-of-remedies doctrine. Ominously, he began by saying "[i]t is troubling to have not better reason for a rule of law than that the courts made it up for policy reasons." *Id.* at 900. He then said "that seems to be the case with ERISA's exhaustion requirement," and that "[f]ederal courts should consider when—or even whether—it's legitimate to apply this judge-made doctrine." *Id.*

According to Judge Thapar, the exhaustion requirement is fundamentally flawed. He noted, for example, that since ERISA is silent on the issue of exhaustion, courts are likely going out of bounds – and beyond their constitutional authority – by creating a doctrine that is not even required by the statute. *Id.* Just as important, he also questioned the very "origin story" of the doctrine in the ERISA context.

He explained that the doctrine was created in an "era of unabashed purposivism" and lamented that its creation was the result of "policy judgments, legislative tea-reading, and an unexplained analogy to the Taft-Hartley Labor Management Relations Act." *Id.* Indeed, he said "[i]t should bother us that such a ubiquitous doctrine, one that has thwarted many an employee's efforts to enforce his benefit rights, rest on such shaky foundations." *Id.* He said, "we should think twice about whether requiring exhaustion is legitimate." *Id.*

Criticism of the exhaustion requirement in the ERISA denial-of-benefits context is nothing new. Scholarship as far back 1992 has claimed that exhaustion is "unsupported by the text of the statute, the legislative history or any policy that is consistent with ERISA." Jay Conison, *Suits for Benefits Under ERISA*, 54 U. Pitt. L. Rev. 1, 22 (1992).

And as recently as 2014, one professor, following a symposium on ERISA matters, reasoned that "[t]here is nothing … to suggest that the authority to sue [for benefits under ERISA] is conditioned on jumping through a hoop, and there is no language elsewhere in ERISA that sets forth a prerequisite that must be satisfied before a participant or beneficiary may file suit under section 502(a)(1)(B)." James A. Wooten, *A Reflection on ERISA Claims Administration and the Exhaustion Requirement*, 6 Drexel L. Rev. 573, 581 (2014). Indeed, he claimed that the historical evidence "suggests that ERISA's drafters *would have rejected* the idea that participants or beneficiaries should have to satisfy a prerequisite, such as the exhaustion requirement, before filing suit to enforce benefit rights." *Id.* at 580–81.

Judge Thapar's shot-across-the-bow may therefore renew such assertions and/or spur judicial or Congressional action on exhaustion.

## Purposes of the Requirement

Until then, however, exhaustion of remedies for ERISA (a)(1)(B) benefit claims is the state of the law. And regardless of whether or not the requirement is extra-statutory, we should remember that the doctrine serves several salutary purposes.

Among other things, it "giv[es] claims administrators an opportunity to correct errors, promot[es] consistent treatment of claims, provid[es] a non-adversarial dispute resolution process, decreas[es] the cost and time of claims resolution, assembl[es] a fact record that will assist the court if judicial review is necessary, and minimize[es] the likelihood of frivolous lawsuits." *Angevine v. Anheuser-Busch Cos. Pension Plan*, 646 F.3d 1034, 1037 (8th Cir. 2011). *See also Makar v. Health Care Corp. of Mid-Atlantic (CareFirst)*, 872 F.2d 80, 83 (4th Cir. 1989) ("the exhaustion requirement enables plan fiduciaries to efficiently manage their funds; correct their errors; interpret plan provisions; and assemble a factual record which will assist a court in reviewing the fiduciaries' actions").

As well, it is excused "only when pursuing an administrative remedy would be futile or there is no administrative remedy to pursue." *Angevine*, 646 F.3d at 1037. We therefore should continue to invoke the doctrine as we always have done and should emphasize that "Congress intended plan fiduciaries, not the federal courts, to have primary responsibility for claims processing." *Makar*, 872 F.2d at 83.

## Conclusion

In the end, *Wallace* and Judge Thapar's concurrence are timely reminders of two key things.

First, plan sponsors need to ensure that their underlying plan documents—*not just the SPDs*—contain claim and appeal procedures. Without them, courts, especially those in the Sixth Circuit, will likely excuse claimants from having to go through the administrative process prior to filing suit. While such a "fast-track" may not make a difference in the outcome of the claim, it may be troublesome to defend, especially if it deprives the administrator of an opportunity to fully develop the record related to the claim.

Second, we should remember how important the doctrine is in the first place. Practitioners have likely taken the doctrine for granted. As such, now is as good a time as any to become re-familiar with the doctrine so as to ensure that, unless and until it is abolished by Congress or the courts, it is steadfastly enforced.

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# Does High Risk of Contracting COVID-19 Qualify an Insured for Disability Benefits?

**By Kristina Pett and Danielle Shure**


For the past ten months countries throughout the globe have tried various approaches to combat COVID-19. In an effort to curb the spread, many employers have permitted, and in some cases required, employees to work remotely.

As companies begin to reopen and require employees to return to the work-place, we anticipate an influx of disability claims from individuals who are at an increased risk for becoming severely ill from COVID-19. In order to prevail, these individuals will need to show that their "high risk" status constitutes an injury or sickness which precludes them from performing the material duties of their own occupations, and after a period of time, any gainful occupation.

Courts throughout the nation agree that a diagnosis, or in this case "high risk status," by itself, is not the equivalent of a disability. *See, e.g., Lopez v. Standard Ins. Co.*, 2017 WL 532119, *24 (M.D. Fla. Jan. 24, 2017), *adopted*, 2017 WL 519258 (M.D. Fla. Feb. 8, 2017), *aff'd*, 743 F. App'x 359 (11th Cir. 2018); *Hollifield v. Unum Life Ins. Co. of Am.*, 640 F. Supp. 2d 1224, 1237 (C.D. Cal. 2009); *Ned v. Hartford*, 2007 WL 594902, *9 (W.D. La. Feb. 16, 2007). Rather, "[i]t is an individual's ability to function, not simply their diagnosis, that entitles him or her to disability benefits." *Hollifield*, 640 F. Supp. 2d at 1237.

Therefore, in order to receive benefits, claimants will need to establish that: (a) they are at high risk of becoming severely ill from COVID-19; (b) the risks of returning to the work-place create a reasonable likelihood that they will contract the virus; and (c) reasonable accommodations could not mitigate the risk of contracting the virus. Interestingly, there is no way for a claimant to prove with certainty where he falls on the risk spectrum. Therefore, to avoid an arbitrary and capricious claim decision, plan administrators should weigh each factor, and not allow any one factor to be dispositive.

## Who Is Most at Risk?

With respect to the first prong, there is a lack of certainty in the medical community as to who is most at risk of becoming severely ill from COVID-19. The Centers for Disease Control and Prevention ("CDC") recognizes that "there are limited data and information about the impact of underlying medical conditions and whether they increase the risk for severe illness from COVID-19." *See People with Certain Medical Conditions*, CDC.gov (last accessed Oct. 24, 2020). However, certain underlying conditions create

a greater risk, and therefore should be afforded greater weight in the analysis.

The CDC states that adults of any age with the following conditions are at increased risk of severe illness from COVID-19:

- Cancer;
- Chronic kidney disease;
- COPD (chronic obstructive pulmonary disease);
- Heart conditions, such as heart failure, coronary artery disease, or cardiomyopathies;
- Immunocompromised state (weakened immune system) from solid organ transplant;
- Obesity and severe obesity;
- Sickle cell disease;
- Smoking; and
- Type 2 diabetes mellitus.

*Id.*

The CDC also states that adults of any age with the following conditions "might" be at an increased risk:

- Asthma (moderate to severe);
- Cerebrovascular disease;
- Cystic fibrosis;
- Hypertension or high blood pressure;
- Immunocompromised state from blood or bone marrow transplant, immune deficiencies, HIV, use of corticosteroids, or other immune weakening medicines;
- Neurologic conditions such as dementia;
- Liver disease;
- Overweight;
- Pregnancy;
- Pulmonary fibrosis;
- Thalassemia; and
- Type 1 diabetes mellitus.
- Type 2 diabetes mellitus.

*Id.*

Notably, these conditions, by themselves, are not sufficient to establish a disability, as the administrator will also need to consider the nature of the workplace and potential accommodations. However, individuals with conditions on the second list might need to show a greater risk inherent in the workplace than those on the former list to be deemed disabled.

## Work Environment Risk Factors

With respect to the second factor, experts seem to agree that "the more people you interact with, the more closely you interact with them, and the longer that interaction, the higher your risk of getting and spreading COVID-19." *Id.* Therefore, a claimant who works in an environment which requires close interaction with others for extended periods of time is more likely to qualify for disability benefits than a claimant who works in a private office isolated from others.

However, plan administrators must balance the risks associated with performing one's duties at the workplace, with the third factor—the availability of reasonable accommodations. The CDC states that to avoid contracting the virus, individuals should wash their hands often, put 6 feet of distance between themselves and others, cover their mouths and noses with a mask, and regularly clean and disinfect surfaces. *See How to Protect Yourself & Others*, CDC.gov (last accessed Oct. 24, 2020). The degree to which a claimant's own occupation, or other gainful occupations, allows for these accommodations will affect whether an underlying condition precludes her from safely returning to the workplace.

For example, in *Hake v. Guardian Life Ins. Co.*, 2009 WL 10693480 (D. Nev. 2009), the court upheld an administrator's determination that a radiologist was capable of obtaining gainful employment, despite a chronic sinus condition and methicillin-resistant Staphylococcus aureus ("MRSA"), which meant that a sinus infection was "potentially life threatening" and limited his ability to interact with patients. *Id.* at *3.

Interestingly, a vocational specialist determined that "radiology groups would not likely hire a radiologist with a restriction of no patient contact and no employment in medical settings." *Id.* at *4. However, the administrator relied on information from the CDC stating that "standard precautions (including hand washing and gloving) should control the spread" of potentially harmful infections. *Id.* The administrator determined that the radiologist could "perform his occupation either in a hospital environment with standard precautions, or outside a hospital environment even without standard precautions." *Id.* at *12.

In *Humble v. Liberty Life Assur. Co. of Boston*, 2008 WL 2370154 (M.D. Pa. June 9, 2008), the court reached a simi-

lar outcome and upheld an administrator's decision that an immune-compromised nurse was not disabled because she was capable of performing sedentary work in "a number of nursing-related capacities that did not expose her to direct patient contact." *Id.* at **8, 11.

A physician board certified in internal and occupational and environmental medicine opined that the claimant's immunocompromised status precluded her from "working in direct patient care or in environments with high likelihoods of infectious disease exposure." *Id.* at *3. However, this would not preclude work in an "ordinary office environment." *Id.* Therefore, the court upheld the administrator's decision to deny benefits because the claimant was capable of performing sedentary work in an environment where she would not be exposed to patients.

However, in *Smith v. Champion Int'l Corp.*, 573 F. Supp. 2d 599 (D. Conn. 2008), the court held that there were issues of fact as to whether an administrator unreasonably denied the claim of an executive secretary who stopped working due to "bronchieactasis with recurrent, drug resistant infections." *Id.* at 641. The claimant's physician and a pulmonary specialist agreed that she was at an "increased risk for developing infections on exposure to various populations," which "could be potentially significant in her case, and it is likely that she would require more antibiotic care and increased hospitalization if she had them." *Id.* However, there was also evidence supporting that sedentary work did not present a greater health risk than the performance of her regular daily activities, which included "some shopping, and limited visiting with friends and family." *Id.* at 642–43.

## Conclusion

Based on these cases, we anticipate that disability claims based on "high risk" status will vary depending on the unique facts and circumstances each case. Only time will tell whether courts will view COVID-19 differently than other immune-compromising conditions. On the one hand, we are in the midst of a global pandemic and each have a duty to curb the spread of this virus and keep the most vulnerable populations safe. On the other hand, insurance policies, like all contracts, must be interpreted by their plain terms regardless of the social context. Ultimately, a claimant's likelihood of succeeding on a disability claim based on high risk status will hinge on: (a) the nature of their underlying condition; (b) the risks inherent in their workplace; and (c) the availability of reasonable accommodations.

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# ERISA Update

**Edited by Joseph M. Hamilton**

## First Circuit

*Denial of Health Insurance Benefits and Attorney's Fee Upheld on Appeal*

In *Doe v. Harvard Pilgrim Health Care, Inc.*, 2020 WL 5405367 (1st Cir. 2020), the First Circuit upheld the district court decision that Harvard Pilgrim appropriately denied benefits for residential mental health treatment. The court also upheld the denial of an award of attorney's fees for an earlier remand of the case.

Doe was a dependent beneficiary in a group health benefit plan provided by Doe's father's employer. The plan was funded by a policy issued by Harvard Pilgrim. The plan provided coverage for in-patient care, intermediate care, and outpatient mental health care only to the extent medically necessary. The plan utilized strict guidelines to determine whether residential mental health treatment was necessary. Doe sued after her claim for residential mental health treatment was partially denied.

The case has a somewhat convoluted procedural history. The district court initially upheld Harvard Pilgrim's decision in 2017. Doe appealed and the First Circuit remanded the case on the grounds that the administrative record should have been expanded. The district court then did so and, after allowing additional briefing and argument, again found that Doe had not met her burden to show that she was entitled to coverage for residential treatment during the disputed period. Doe appealed again.

Noting that in its prior decision it had held that that under the *de novo* standard of review, the district court's factual findings would be reviewed only for clear error, the First Circuit found none. While Doe attacked Harvard Pilgrim's expert reports, the First Circuit found that it was not clear error for the district court to rely on those reports or read them in the manner suggested by Doe.

Doe also argued that the district court should have had a bench trial and required the various experts to testify and be subject to cross-examination. The First Circuit stated that such a proposal had long ago been rejected in *Orndorf v. Paul Revere Life Ins. Co.*, 404 F.3d 510 (1st Cir. 2005). The court reiterated that it has consistently held that the record before the district court should match the record reviewed by the administrative decision maker absent special circumstances.

Lastly, the First Circuit upheld the denial of Doe's request for attorney's fees for the period leading up to the First Circuit's initial decision remanding the case back to the district court. The First Circuit reviewed the five-factor test it has repeatedly utilized to consider an award of attorney's fees and found the district court made no legal or clear factual error in the exercise of its discretion that attorney's fees were not warranted.

The First Circuit affirmed the decision of the district court.

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## Second Circuit

*No Requirement to Exhaust Administrative Remedies if Plan Does Not Have Administrative Appeals Process*

*Weyant v. Phia Grp. LLC*, 823 F. App'x 51 (2d Cir. 2020), provides a reminder that, although there is a firmly established obligation to exhaust administrative remedies before filing suit, this obligation depends on the plan setting forth those remedies in the first place.

The plaintiff brought a putative class action against her health plan's claims administrator, challenging the plan's right to assert a lien against her accident tort settlement that sought reimbursement for benefits the plaintiff received as a result of the accident. The district court granted summary judgment for the defendants, finding the plaintiff failed to exhaust her administrative remedies.

The Second Circuit found there was no evidence that the health plan had established an administrative process for challenging the plan's reimbursement rights. Therefore, the plaintiff could not be faulted for not exhausting administrative remedies that did not exist.

The court distinguished the situation where it was unclear whether the plan provided an administrative process (in which case the question would be whether the

plaintiff reasonably interpreted the plan as not requiring exhaustion).

The court also found fault with the district court's reliance on the fact that the plaintiff's tort attorney sent a check to the plan to satisfy its lien "under protest," but without attempting to determine whether there was an appeals process, and without explaining the grounds for the protest, explaining, "[b]ecause there was no administrative remedy available, Weyant's counsel was not required to inquire about the proper procedures to follow."

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## Third Circuit

*Breach of Fiduciary Duty Claims Against a Church Are Not Governed by ERISA*

Many claimants try to avoid ERISA. But, in *Dixon v. Washington*, 819 F. App'x 95 (3d Cir. 2020), the plaintiffs went to great lengths to try to find coverage under ERISA.

The plaintiffs were congregants of the First Baptist Church. They sued the former pastor, a trustee, and a deacon for either taking church money or allowing church funds to be taken. The complaint included claims for breach of fiduciary duty under ERISA.

Affirming the decision of the district court to dismiss the lawsuit, the Third Circuit noted that none of the plaintiffs was a participant or a beneficiary of any plan sponsored by the church. Therefore, while a scholarship fund like the one involved may qualify as an ERISA plan, since the plaintiffs were not employees of the church, they lacked ERISA standing.

Not giving up, the plaintiffs argued that because they hired the pastor, they were his employer. But since the alleged plan – the scholarship program – was for congregants and not employees, there was no employee benefit plan.

It seems like the court could have saved a lot of time simply by holding that even if there was a plan, the church plan exemption under 29 U.S.C. §1002(33)(A) of ERISA barred the claim.

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## Fourth Circuit

*Defined Contribution Plan Participant Alleges Breach of Fiduciary Duties and Revives Proposed Class Action*

In *Stegemann v. Gannett Co., Inc.*, 2020 WL 4664798 (4th Cir. 2020), a split Fourth Circuit revived a proposed ERISA class action against Gannett Company, breathing new life into accusations that too much of workers' retirement savings were improperly kept in the stock of a related company, TEGNA, Inc.

Appellants Stegemann and Quatrone were participants in the Gannett 401(k) Savings Plan. They brought an action on behalf of themselves and other plan participants against appellees Gannett, which was the plan sponsor, and Gannett Benefit Plans Committee, the plan's management committee. Appellants alleged appellees breached their fiduciary duties of prudence and diversification under ERISA, *see* 29 U.S.C. §§1104(a)(1)(B) and (C) and 29 C.F.R. §2550.404a-1(b)(1)(i), and ignored an imprudent single-stock fund in the plan for several years, resulting in millions of dollars of losses.

The district court dismissed the complaint for failure to state a claim, and concluded that Gannett and the Committee could not have known the single-stock fund was imprudent, nor were they obligated to diversify it, absent any notice it was imprudent. The district court held that while fiduciaries did have a duty to maintain a diversified plan, they did not have the duty to force participants to diversity their holdings by liquidating the TEGNA fund.

The Fourth Circuit, however, vacated the judgment and remanded the case for further proceedings. Citing *Schweitzer v. Investment Comm. of the Phillips 66 Sav. Plan*, 90 F.3d 190 (5th Cir. 2020), it held that to state a claim a plaintiff need only plausibly allege that a fiduciary breached a duty causing a loss to the employee benefit plan. The court found that appellants sufficiently set forth facts describing how appellees failed to monitor a fund, which led to a failure to recognize and remedy a defect, which then led to a loss to the plan.

The court rejected the appellees' argument that a plaintiff is required to plead "special circumstances" in order to state a claim that an investment was imprudent for want of diversification, and further rejected their argument that, because the plan was of the defined contribution type, individual participants could choose how to allocate their own funds, thereby absolving fiduciaries of any responsibility for not divesting imprudent funds that are frozen to new investments.

The Fourth Circuit analyzed the duty of prudence under ERISA, including the duties of investigation, monitoring, and diversification. It further relied on *DiFelice v. U.S. Airways, Inc.*, 497 F.3d 410 (4th Cir. 2007), which held that each available fund on a menu must be prudently diversified, regardless of whether the plan's menu contains other funds which individuals may or may not elect to combine with a single-stock fund to create a prudent portfolio. The court found, if it were otherwise, any participant-driven 401(k) plan would be prudent so long as a fiduciary could argue that a participant could, and should, have further diversified his risk, and found such a result to be "perverse."

The court next turned to whether a fiduciary is obligated to divest a non-diversified fund, rejecting appellees' argument that since the TEGNA stock fund was frozen to new investments and participants were able to leave the fund on their own initiative, no further action was required. The court relied on the *Tatum* series of cases, *Tatum v. R.J. Reynolds Tobacco Co.*, 392 F.3d 636 (4th Cir. 2004); *Tatum v. RJR Pension Inv. Comm.*, 761 F.3d 346 (4th Cir. 2014); and *Tatum v. RJR Pension Inv. Comm.*, 855 F.3d 553 (4th Cir. 2017), which demonstrated that fiduciaries of defined contribution plans have the power to force divestment and that, in some circumstances, forcing divestment is the objectively prudent thing to do even if the fund is frozen.

The court further held the fiduciary of a defined contribution plan should not have the benefit of a safe harbor on account of participant choice without first proving each of the intricate requirements of 29 C.F.R. §2550.404c-1. In other words, as-yet-unproven participant choice does not abrogate a fiduciary's duties such that a plaintiff fails to state a claim where the plaintiff attacks the prudence of an option on a plan's menu.

Finally, the court distinguished this case from *Fifth Third Bancorp v. Dudenhoeffer*, 573 U.S. 409 (2014). Unlike the allegations in *Dudenhoeffer*, the appellants did not contend that fiduciaries should have outsmarted an efficient market. Instead, they alleged that their fiduciaries should have recognized the imprudence of a fund based on the fund's composition, which did not shift an imprudent non-diversification claim under the ambit of *Dudenhoeffer*.

Judge Paul Niemeyer dissented, writing at length that the majority's opinion ignored the "irresistible reasoning" behind the district court's decision and "sidestep[ping it] with a myopic analysis." Judge Niemeyer found the majority erroneously focused on a single investment option on the plan's diversified menu in concluding that the complaint adequately alleged a breach of those duties. He found the majority's approach to be a "mechanically derived holding . . . divorced from common sense and that will unnecessarily restrict the options offered in defined contribution plans."

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## Sixth Circuit

*Plan Reasonably Demanded Return of Pension Overpayment, Which Was Appropriate Equitable Relief*

The decision in *Zirbel v. Ford Motor Co.*, 2020 WL 6704157 (6th Cir. 2020), begins with an admirably pithy and complete summary of the case:

"Donna Zirbel received a $351,000 retirement-benefits payment from Ford Motor Company. But the payment was two sizes too big. When Ford learned of the mistake, it asked for the extra money back. Zirbel refused. She sued Ford, seeking a declaration that she could keep the money. Ford stood by its decision. The district court granted summary judgment to Ford, requiring Zirbel to return the $243,000 in overpayments. We affirm."

What followed was a straightforward trip through the typically opaque world of ERISA equitable remedies.

The court first concluded that the plan committee's decision to require Zirbel to return the excess payments "was neither wrong nor arbitrary and capricious," in part because the plan document specifically required participants to return such overpayments. The court noted that the request for payment was required "by the plan's fiduciary duty to the other beneficiaries of the plan. The court also noted that, while the plan had a process for Zirbel to ask for a waiver of repayment, Zirbel never applied for a waiver (though Ford apparently expressly gave her the option to do so), and "nothing requires Ford to provide a waiver on its own initiative."

The court rejected the argument that *de novo* review was required because a third-party administrator, not the plan fiduciary, made the initial decision, holding that the correct fiduciary "made the final decision, and that suffices."

The court then turned to the question whether enforcement of that demand involved "appropriate equitable relief" under 29 U.S.C. §1132(a)(3). Zirbel's argument on this point apparently was that, because she deposited the overpayment into an account with other funds, any

equitable lien that the plan had on the overpayment did not translate to the commingled funds.

The court rejected it: "Nothing from the receipt of those funds to the start of the lawsuit changed that calculation [that an equitable lien attached to the overpayment]. Once she received the overpayment, she placed it into her accounts. This commingling gave Ford an equitable lien against those accounts up to the overpayment. Because Zirbel does not argue that she dissipated the funds in those accounts into nontraceable items, that's all we need to know. Ford could recover through this equitable lien."

The court also rejected Zirbel's argument that, by investing, spending, and gifting some of the money in the commingled account, she dissipated the overpayment, preventing recovery under *Montanile v. Board of Trustees of the National Elevator Industry Health Benefit Plan*, 577 U.S. 136 (2016). The court held: "simply commingling funds into accounts and spending the money does not by itself extinguish a lien. She has no answer to Ford's analysis on this front. She has not, for example, asked us to distinguish between her accounts when it comes to where the lien should attach or for that matter claimed complete dissipation."

Finally, the court upheld the rejection of Zirbel's claim that the plan should be equitably estopped from recovering the overpayment, because she was unable to establish fraudulent misrepresentations. The court observed that there was evidence that Zirbel knew she received too much money when she received it. Of note, the overpayment was due to Ford's use of an incorrect date regarding her employment, "and Zirbel knew that her commencement date was 2009, not 1998."

The court finally held that requiring repayment was not unfair or inequitable: "Zirbel knew that the retroactive payment was too high when she got it, the text of the plan put her on notice that Ford could demand repayment, and she admits she has the capacity to return the money—all preventing her from wrongly keeping money from a finite retirement fund meant to benefit many other Ford retirees and their spouses."

The court was particularly not swayed by "the indignity of paying taxes on money she must now return[.] … While we are not tax advisors, she may have recourse: say re-opening the past tax returns or seeking a tax credit for future tax returns. She has not claimed at any rate that these options are unavailable."

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## Seventh Circuit

*$5 Per Day Penalty for Delay in Responding to ERISA Document Request Was Not an Abuse of Discretion*

In *Griffin v. TeamCare*, 813 F. App'x 235 (7th Cir. 2020), the Seventh Circuit reviewed and upheld a district court decision imposing a $5 per day penalty for a plan's delay in providing requested documents pursuant to 29 U.S.C. §§1024(b)(4), 1132(c).

The plaintiff was a *pro se* medical doctor who treated three patients insured by TeamCare's health plan. He requested documents pursuant to 29 U.S.C. §§1024(b)(4). TeamCare failed to send the plan description until 187 days after the request, information concerning the methodology for determining reasonable and customary allowances until 716 days after the request, and the claims processor agreements until 743 days after the request.

The doctor sought, among other things, penalties for failure to timely provide the requested documents. The parties settled the underpayment claims, and the district court granted summary judgment to the doctor on the penalty claims, holding that TeamCare was obligated to provide the requested information. The district court assessed a penalty of $5 per day running from the 31st day after the doctor's request until the day TeamCare provided the last requested document, a total of $3,555 for 711 days.

The district court explained that the most important consideration was to incentivize TeamCare to comply with ERISA's document production rules. Other important considerations included the length and reasons for the delay, evidence of bad faith, and prejudice. The doctor did not have any evidence of bad faith or prejudice. The district court noted that the parties did not make any arguments concerning the issue of whether separate penalties should be imposed for each of the requests, so it imposed one penalty.

The Seventh Circuit upheld the $5 per day penalty, noting that penalties are not mandatory for §1024 violations and courts may impose any penalty that will deter noncompliance with ERISA's disclosure requirements. Further, the Seventh Circuit held that the district court considered the relevant factors in assessing the penalties, and its decision was not an abuse of discretion.

The Seventh Circuit further determined the doctor waived her argument that the district court should have assessed a separate penalty for each document request, because she never raised it in the district court. The Seventh Circuit noted that while the doctor was correct that each delayed response can establish a separate violation under 29 U.S.C. §1132(c)(1), the district court was not obligated to assess a separate penalty for each violation.

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## Ninth Circuit

*No Fee Recovery During Administrative Phase for Breach of Fiduciary Duty Claim*

In *Castillo v. Metropolitan Life Ins. Co.*, 970 F.3d 1224 (9th Cir. 2020), the Ninth Circuit held that a plan participant cannot recover attorney's fees incurred during administrative proceedings as equitable relief of surcharge for a claim under 29 U.S.C. §1132(a)(3).

Castillo began receiving long-term disability benefits under a Verizon employee benefit plan. He then retired, and rolled over his pension plan into an individual retirement account. MetLife informed him that his disability benefits would be reduced to account for the pension rollover, sought to recover benefits overpaid, and withheld future benefits.

Castillo appealed administratively, and MetLife reversed its determination. Castillo sought to recover the attorney's fees he incurred during the appeal of his claim. He brought a claim for breach of fiduciary duty under §1132(a)(3). MetLife moved to dismiss. The court dismissed the claim on the basis that fee awards are not "other appropriate equitable relief" under §1132(a)(3). Castillo appealed.

The Ninth Circuit reviewed *de novo*. The court first noted two basis for fee recovery under ERISA. For claims for benefits under §1132(a)(1)(B), ERISA allows the court to exercise discretion to award fees under §1132(g). Such an award is for fees incurred during the judicial proceeding only, not during the administrative phase.

For breach of fiduciary duty claims under §1132(a)(3), such as Castillo's, ERISA allows "other appropriate equitable relief," such as surcharge, as would be typically available in equity and for which there is no other adequate remedy at law. Fees obtained on an (a)(3) claim are also awarded under §1132(g), and again, are for those incurred during the judicial proceeding only.

The court then examined its prior holding in *Cann v. Carpenters' Pension Tr. Fund*, 989 F.2d 313 (9th Cir. 1993), in which it held that fees incurred in an administrative proceeding are not recoverable under §1132(g), which only authorizes recovery in legal "actions" not judicial proceedings. The court in *Cann* reasoned that to allow recovery during judicial proceedings would undermine the "soundness and stability" of plans. ERISA plans may be dissuaded from denying invalid claims to avoid paying fees, to the detriment of the plan as a whole.

The court found that Castillo was trying to accomplish under §1132(a)(3) what *Cann* prohibits under §1132(g). The Ninth Circuit opined that the availability of fees should not turn on "the claimant's characterization of the benefits in dispute or that ERISA should be interpreted in a way to incentivize claimants to characterize denial-of-benefits claims as a breach-of-fiduciary-duty claims."

Next, the court extended its reasoning in *Cann* "to some extent." It found that while on its face, nothing in Section 1132(a)(3) expressly defeats a claim for fees in administrative proceedings, the language, context, and purpose of ERISA as a whole compels the finding that such fees are not recoverable. (Note 5 of the opinion leaves open the possibility that recovery might be different in the case of misconduct or similar circumstances.) The court reasoned as follows. Section 1132(g) applies only to legal "actions." The American Rule's presumption is against fee shifting. ERISA does not contain an explicit provision stating that fees under §1132(g) include those for administrative proceedings. Therefore, under rules of statutory interpretation, the court cannot infer that Congress meant to include fees for administrative proceedings in the recovery provision of §1132(g).

The court concluded that §1132(a)(3) does not authorize an award of attorney's fees incurred during the administrative phase of the ERISA claims process, and affirmed dismissal of Castillo's complaint.

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## Tenth Circuit

*De Novo Review Applied when SPD Did Not Adequately Notify Participants of Plan Documents Reserving Discretion*

In *Lyn M. v. Premera Blue Cross*, 966 F.3d 1061 (10th Cir. 2020), the Tenth Circuit held in a 2–1 decision that a summary plan description stating that a plan participant could "ask to examine or receive free copies of all pertinent plan documents, records, and other information relevant to your claim" did not disclose the existence of the plan instrument or any other plan document reserving discretion to the plan administrator and was not adequate to notify participants of "this possible limit on the scope of judicial review."

Finding that participants could not be bound by terms about which they had no notice, the majority held that the district court erred in applying the arbitrary and capricious standard of review and should have engaged in *de novo* review. The court of appeals therefore remanded the case to the district court to conduct a *de novo* review of Premera's decision.

One justice wrote a dissenting opinion. She disagreed with the majority's imposition of a new duty on plan administrators to notify members "that undistributed, inspectable documents could affect the scope of judicial review," stating that this new notification requirement is not supported by ERISA or Tenth Circuit case law.

She noted that ERISA only requires that a plan be made available, which was satisfied by the language in the SPD offering examination or free copies of all pertinent plan documents. Further, she noted that ERISA sets out the requirements for a compliant SPD and does not require a plan administrator to notify participants of the applicable standard of review of their claims.

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