

PRACTICE SERIES

ERISA Litigation Handbook

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INTRODUCTION

This is the sixth edition of Jenner & Block's ERISA Litigation Handbook. Like previous versions, this edition provides a basic primer on the issues presented and procedures followed in litigation under the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 - 1461 ("ERISA"), and it has been updated to reflect the latest developments in ERISA case law. We recognize that many professionals find ERISA to be a confusing and complex statute. We hope that by offering a guide covering the wide variety of issues presented in ERISA lawsuits, this Handbook provides a quick reference that will allow the reader to begin the analysis of those issues.

This sixth edition discusses the wide range of issues that arise in litigation under ERISA. Section I addresses the Supreme Court's decisions defining ERISA's preemption of state laws. Section II addresses the question of standing to bring a claim against an ERISA fiduciary. Section III describes the creation and termination of fiduciary status under ERISA, and Section IV details the remedies available for breach of ERISA fiduciary duties. Sections V through VIII focus on specific fiduciary duties under ERISA, including the duties of loyalty, prudence, diversification, and adherence to plan documents. Sections IX and X address transactions ERISA prohibits. Sections XI and XII discuss issues related to ERISA's civil enforcement provisions, and Section XIII provides an updated discussion of procedural considerations like jury trials in ERISA cases and class actions. Section XIV considers the federal courts' power to create a federal common law of ERISA. Section XV highlights specific types of ERISA litigation, including developing issues such as employer stock litigation and 401(k) fee litigation, among others. Section XVI considers the validity of releases of ERISA claims and benefits. Section XVII addresses the special considerations for plan fiduciaries relating to securities litigation. Section XVIII considers important professional responsibility issues attorneys commonly face when representing clients in the ERISA arena. Section XIX discusses ERISA ESOP litigation. Finally, Section XX covers multiemployer plan litigation.

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I. SUPREME COURT PRECEDENT DEFINING ERISA'S PREEMPTION OF STATE LAWS

One of ERISA's most distinguishing yet confounding features is its substantial preemption provisions. ERISA preempts a broad range of state statutes, regulations, and administrative schemes. There are two types of ERISA preemption – complete preemption and conflict preemption. For complete preemption, ERISA completely preempts state law claims that would provide the same remedies as ERISA Section 502(a), 29 U.S.C. § 1132(a), in effect replacing state claims with federal claims and giving rise to federal jurisdiction over them. For conflict preemption, because ERISA was enacted with the goal of establishing uniform national standards for the administration of employee benefits plans, ERISA also preempts state laws that seek to regulate those plans. Through its saving clause, however, ERISA excepts from this broad preemption state laws regulating insurance, as well as securities regulations, banking law and generally applicable criminal law. However, it also stipulates in its “deemer” clause that ERISA plans are not to be regulated as insurance companies.

ERISA's broad preemption language has produced a complicated and often confusing body of case law. The Supreme Court itself has lamented repeatedly that ERISA's preemption provisions are “not a model of legislative drafting” and that the text of the statute is itself “unhelpful.” N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Co., 514 U.S. 645, 656 (1995); Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 47 (1987). Accordingly, this section addresses *only* Supreme Court case law on the topic of preemption, and does not provide an overview of the holdings of lower federal courts on the subject. Other sections of this Handbook address the lower courts' analyses of specific preemption issues, including Sections XII.C.4.d, XV.A.2 and XV.B.4.

See:

Boggs v. Boggs, 520 U.S. 833, 839 (1997). “In large part the number of ERISA preemption cases reflects the comprehensive nature of the statute, the centrality of pension and welfare plans in the national economy, and their importance to the financial security of the Nation's workforce. ERISA is designed to ensure the proper administration of pension and welfare plans, both during the years of the employee's active service and in his or her retirement years.”

A. ERISA COMPLETELY PREEMPTS STATE LAWS THAT COINCIDE WITH ITS CIVIL ENFORCEMENT PROVISIONS

By operation of the Constitution's supremacy clause, ERISA's civil enforcement provisions completely preempt “any state law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy.” Aetna Health Ins. v. Davila, 542 U.S. 200, 208 (2004). State law causes of action are completely preempted and are replaced by a limited number of ERISA causes of action giving rise to federal question jurisdiction.

The Supreme Court in Pilot Life v. Dedeaux described the function and effect of ERISA's civil enforcement provisions:

Under the civil enforcement provisions of § 502(a), a plan participant or beneficiary may sue to recover benefits due under the plan, to enforce the participant's rights under the plan, or to clarify rights to future benefits. Relief may take the form of accrued benefits due, a declaratory judgment on entitlement to benefits, or an injunction against a plan administrator's improper refusal to pay benefits. A participant or beneficiary may also bring a cause of action for breach of fiduciary duty, and under this cause of action may seek removal of a fiduciary. §§ 502(a)(2), 409. In an action under these civil enforcement provisions, the court in its discretion may allow an award of attorney's fees to either party. § 502(g) Our examination of these provisions [makes] us "reluctant to tamper with an enforcement scheme crafted with such evident care as the one in ERISA.

Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 53-54 (1987) (holding that ERISA does not apply and quoting Mass. Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 147 (1985)), overruled in part on other grounds by Ky. Ass'n of Health Plans, Inc. v. Miller, 538 U.S. 329 (2003).

Based on its review of ERISA's legislative history, the Supreme Court has concluded that, in enacting ERISA's virtually unique preemption provisions, Congress intended that a body of substantive federal law would be developed by the courts to apportion rights and obligations among private welfare and pension plans and participants. See Franchise Tax Bd. v. Constr. Laborers Vacation Trust, 463 U.S. 1, 24 n.26 (1983), superseded by statute on other grounds, 28 U.S.C. § 1441(e). The Court has similarly explained that in creating ERISA it was Congress's intent to devise an exclusively federal system under which employee benefits plans would be evaluated. Pilot Life, 481 U.S. at 52. Thus, unless state laws varying the obligations of ERISA plans are preempted in favor of ERISA's civil enforcement provisions, Congress's intent would be thwarted. See id.; Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 144 (1990).

See:

Aetna Health Inc. v. Davila, 542 U.S. 200, 208 (2004). "The purpose of ERISA is to provide a uniform regulatory regime over employee benefit plans. To this end, ERISA includes expansive pre-emption provisions. . . . which are intended to ensure that employee benefit plan regulation would be exclusively a federal concern." (quoting Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504, 523 (1981)).

Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 144 (1990). “It is clear to us that the exclusive remedy provided by § 502(a) is precisely the kind of special feature that warrants preemption in this case.”

Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 52 (1987) (holding that ERISA does not apply), overruled in part on other grounds by *Ky. Ass’n of Health Plans, Inc. v. Miller*, 538 U.S. 329 (2003). “Congress clearly expressed an intent that the civil enforcement provisions of ERISA § 502(a) be the exclusive vehicle for action by ERISA-plan participants and beneficiaries asserting improper processing of a claim for benefits, and . . . varying state causes of action for claims within the scope of § 502(a) would pose an obstacle to the purposes and objectives of Congress.”

Franchise Tax Bd. v. Constr. Laborers Vacation Trust, 463 U.S. 1, 24 (1983), superseded by statute on other grounds, 28 U.S.C. § 1441(e). “ERISA contains provisions creating a series of express causes of action in favor of participants, beneficiaries, and fiduciaries of ERISA-covered plans, as well as the Secretary of Labor. § 502(a), 29 U.S.C. § 1132(a). It may be that . . . any state action coming within the scope of § 502(a) of ERISA would be removable to federal district court, even if an otherwise adequate state cause of action were pleaded without reference to federal law.”

B. CONFLICT PREEMPTION AFFECTS STATE LAWS THAT RELATE TO EMPLOYEE BENEFITS PLANS

Section 514(a) of ERISA, 29 U.S.C. § 1144(a), preempts state laws that relate to ERISA plans. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 91-92 (1983). “[T]he provisions of [ERISA] shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan” 29 U.S.C. § 1144(a). “A law ‘relates to’ an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such plan.” *Shaw*, 463 U.S. at 96-97.

There are some express statutory exceptions to the preemption provision, however. State laws regulating insurance, banking, or securities, as well as generally applicable state criminal laws, are exempt from § 514(a) preemption. *Id.* Section 514(d) provides that “[n]othing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States . . . or any rule or regulation issued under any such law.” 29 U.S.C. § 1144(d). In addition, ERISA Section 4(b)(3), 29 U.S.C. § 1003(b)(3), exempts employee benefit plans “maintained solely for the purpose of complying with applicable workmen’s compensation laws or unemployment compensation or disability insurance laws” from ERISA coverage. 29 U.S.C. § 1003(b)(3).

1. The “relates to” language is broadly interpreted

The Supreme Court has read the reach of ERISA’s preemption provisions broadly. See, e.g., Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724, 739 (1985) (holding that ERISA does not apply), overruled in part on other grounds by Ky. Ass’n of Health Plans, Inc. v. Miller, 538 U.S. 329 (2003); Shaw, 463 U.S. at 97. The Court has held that Congress’s intent in enacting § 514 was to establish the regulation of employee welfare benefit plans as exclusively a federal concern. N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 656 (1995); Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504, 523 (1981). “The basic thrust of [§ 514(a)], then, was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans.” Travelers Ins., 514 U.S. at 657. To that end, the Court has concluded, ERISA broadly defines state law to encompass state statutes, state common law, and state administrative agencies. Ingersoll-Rand, 498 U.S. at 141. “[E]ven indirect state action bearing on private pensions may encroach upon the area of exclusive federal concern.” Alessi, 451 U.S. at 525.

The Supreme Court holds that a state law may relate to an ERISA plan and be preempted under § 514(a) if the state law makes *reference to* an ERISA plan or has a *connection with* an ERISA plan. Travelers Ins., 514 U.S. at 656.

See:

N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 656 (1995). “In Shaw, we explained that ‘[a] law ‘relates to’ an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan.’ The latter alternative, at least, can be ruled out But this still leaves us to question whether the surcharge laws have a ‘connection with’ the ERISA plans, and here an uncritical literalism is no more help than in trying to construe ‘relate to.’ For the same reasons that infinite relations cannot be the measure of preemption, neither can infinite connections. We simply must go beyond the unhelpful text and the frustrating difficulty of defining this key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive.”

District of Columbia v. Greater Wash. Bd. of Trade, 506 U.S. 125, 130 (1992). Statute that regulated both ERISA and ERISA-exempt benefit plans was preempted.

a) ERISA § 514(a), 29 U.S.C. § 1144(a), preempts state laws that refer to ERISA benefit plans

ERISA preempts state laws that refer directly to ERISA benefit plans or that rely on the existence of ERISA plans for their operation. “Where a State’s law acts immediately and exclusively upon ERISA plans, as in Mackey, or where the existence of ERISA plans is essential to the law’s operation, as in Greater Washington Board of

Trade and Ingersoll-Rand, that ‘reference’ will result in pre-emption.” Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., 519 U.S. 316, 324 (1997). Thus, ERISA preempts state laws mandating employee benefit structures or their administration, as well as state laws providing alternative enforcement mechanisms. Travelers Ins., 514 U.S. at 658.

See:

UNUM Life Ins. Co. v. Ward, 526 U.S. 358, 363 (1999) (holding that ERISA does not apply), overruled in part on other grounds by Ky. Ass’n of Health Plans, Inc. v. Miller, 538 U.S. 329 (2003). California’s agency law was preempted by ERISA to the extent that it referred to ERISA plans.

District of Columbia v. Greater Wash. Bd. of Trade, 506 U.S. 125, 129-30 (1992). Statute that regulated both ERISA and ERISA-exempt benefit plans was preempted. The employer-sponsored health insurance programs referred to in the statute were subject to ERISA regulation, and any state law imposing requirements by reference to ERISA plans is preempted.

Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 136 (1990). Texas common law cause of action for wrongful discharge based on employer’s desire to avoid paying into an employee’s pension fund was preempted. “[I]n order to prevail, a plaintiff must plead, and the court must find, that an ERISA plan exists and the employer had a pension-defeating motive in terminating the employment. Because the court’s inquiry must be directed to the plan, this judicially created cause of action ‘relat[es] to’ an ERISA plan [T]here simply is no cause of action if there is no plan.”

Mackey v. Lanier Collection Agency & Serv., Inc., 486 U.S. 825, 831 (1988). Georgia law specifically exempting ERISA plans from generally applicable garnishment procedure was preempted by § 514(a).

b) ERISA § 514(a), 29 U.S.C. § 1144(a), preempts state laws that have a connection with ERISA benefit plans

Section 514(a) also preempts state laws even if they do not refer to ERISA plans, if they nonetheless have a connection with the plans. “[T]o determine whether a state law has the forbidden connection, [the Court] looks both to the ‘objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive,’ as well as to the nature of the effect of state law on ERISA plans.” Dillingham Constr., 519 U.S. at 325. Although generally applicable laws that regulate areas in which ERISA “has nothing to say” are not preempted by § 514(a), statutes that govern central matters of plan administration are preempted because they interfere with nationally uniform plan administration. Egelhoff v. Egelhoff ex rel. Breiner, 532 U.S. 141, 148 (2001).

See:

Gobeille v. Liberty Mut. Ins. Co., 136 S. Ct. 936 (2016). ERISA preempted a state law that required health insurers to report data relating to health insurance claims and enrollment to a state agency. Reporting and disclosure “are central to, and an essential part of, the uniform system of plan administration contemplated by ERISA.” Preemption was necessary to avoid the danger of states imposing varying and burdensome reporting requirements.

Egelhoff v. Egelhoff ex rel. Breiner, 532 U.S. 141, 142 (2001). Statute that bound ERISA plan administrators to pay benefits “to the beneficiaries chosen by state law, rather than to those identified in the plan documents” was preempted because it implicated an area of core ERISA concern, and was contrary to ERISA’s requirements that a plan must specify the basis on which payments are made to and from the plan (§ 1102(b)(4)), and that the fiduciary shall administer the plan in accordance with the documents and instruments governing the plan (§ 1104(a)(1)(D)) and make payments to a beneficiary designated by a participant, or by the terms of the plan (§ 1102(8)).

Boggs v. Boggs, 520 U.S. 833, 836 (1997). ERISA preempts a state law allowing a non-participant spouse to transfer an interest in undistributed pension plan benefits through a testamentary trust.

But see:

Mackey v. Lanier Collection Agency & Serv. Inc., 486 U.S. 825, 831 (1988). ERISA preemption falls short of barring application of a general state garnishment statute to participants’ benefits in the hands of an ERISA welfare benefit plan, even if statute did impose some administrative costs on plans.

2. The “relates to” language does not apply to an arrangement that is not a “plan” under ERISA

Despite the mandate that the scope of ERISA’s preemption be broadly construed, the Supreme Court has limited its extent by declining to extend preemption to any state laws that may have some effect on ERISA plans or plan benefits. For example, a major limitation on preemption’s reach is that it applies only to state laws that relate to what a court considers a “plan” under ERISA. See Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 6-7 (1987).

Congress intended preemption to afford employers the advantages of a uniform set of administrative procedures governed by a single set of regulations. This concern only arises, however, with respect to benefits whose provision by nature requires an ongoing administrative program to meet the employer’s obligation. It is for this reason that Congress

preempted state laws relating to *plans*, rather than simply to *benefits*. Only a plan embodies a set of administrative practices vulnerable to the burden that would be imposed by a patchwork scheme of regulation.

Fort Halifax, 482 U.S. at 11-12. The Court has distinguished between state laws that regulate plans and are therefore preempted, see id., and those that have merely an “indirect economic influence,” which are not, see Travelers Ins., 514 U.S. at 662 (noting cost uniformity not ERISA goal). Thus, the Court has held that a generally applicable insurance surcharge is not preempted even though it may increase the ultimate costs of an employee benefits plan and require plan administrators to “shop for the best deal [they] can get.” Id. at 659-60. “If a State law creates no prospect of conflict with a federal statute, there is no warrant for disabling it from attempting to address uniquely local social and economic problems.” Fort Halifax, 482 U.S. at 19.

See also:

De Buono v. NYSA-ILA Med. & Clinical Servs. Fund, 520 U.S. 806, 815-16 (1997). *New York statute that imposed a tax on medical centers’ gross receipts for patient services was not preempted because the tax statute did not ‘relate to’ employee benefit plans and was not the type of state law Congress intended ERISA to preempt.*

Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc., 519 U.S. 316, 319 (1997). *California statute excepting contractors on public works projects from prevailing wage law for workers participating in approved apprenticeship programs was not preempted because the law did not ‘relate to’ employee benefits plans.*

Voelske v. Mid-South Ins. Co., 572 S.E.2d 841, 844 (N.C. Ct. App. 2002). *Plaintiff’s state law insurance claims were preempted because they related to an ERISA plan, even though the only employee eligible for the plan was the company’s owner. Citing Madonia v. Blue Cross & Blue Shield of Va., 11 F.3d 444 (4th Cir. 1993), the court held that a business owner is considered an employee for the purpose of determining who is a participant under the plan. Under North Carolina law, the specific state insurance law claims were not exempt from the preemption clause because they did not regulate the business of insurance.*

C. LAWS REGULATING INSURANCE

ERISA does not generally preempt state laws regulating insurance, and this is the chief exception to the ERISA preemption’s broad sweep. State laws regulating insurance fall under ERISA’s savings clause, § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A) and are not preempted. However, ERISA’s deemer clause, § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B), makes it clear that state laws “cannot deem an ERISA plan to be an insurance company” and therefore subject to state insurance

law regulation. Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 46 (1987). The Court has also noted that ERISA's insurance provisions are not models of legislative drafting: "While Congress occasionally decides to return to the States what it has previously taken away, it does not normally do both at the same time." Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724, 740 (1985). The Court has also determined that "even a state law that can arguably be characterized as 'regulating insurance' will be preempted if it provides a separate vehicle to assert a claim for benefits outside of, or in addition to, ERISA's remedial scheme." Aetna Health Inc. v. Davila, 542 U.S. 200, 218 (2004) .

1. The saving clause excepts from preemption state laws that regulate insurance

Under the saving clause, "except as provided in [the deemer clause], nothing in [ERISA] shall be construed to exempt or relieve any person from any law of any State which regulates insurance . . ." 29 U.S.C. § 1144(b)(2)(A). The operative question in determining whether a state law is excepted from preemption under the saving clause is whether it regulates insurance. UNUM Life Ins. Co. v. Ward, 526 U.S.358, 367-68 (1999)

The Court has recognized the presumption that Congress did not intend to preempt areas of traditional state regulation. Metro. Life, 471 U.S. at 740. Furthermore, it has stated that "[u]nless Congress intended to include laws regulating insurance contracts within the scope of the insurance saving clause, it would have been unnecessary for the deemer clause explicitly to exempt such laws from the saving clause when they are all applied directly to benefit plans." Id. at 741. The Court has also concluded that Congress clearly intended § 502(a) to be the exclusive remedy for asserting benefit claims. Pilot Life, 481 U.S. at 52-53.

See:

Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 50 (1987). "Certainly a common-sense understanding of the phrase 'regulates insurance' does not support the argument that the Mississippi law of bad faith falls under the saving clause. A common-sense view of the word 'regulates' would lead to the conclusion that in order to regulate insurance, a law must not just have an impact on the insurance industry, but must be specifically directed toward that industry. Even though the Mississippi Supreme Court has identified its law of bad faith with the insurance industry, the roots of this law are firmly planted in the general principles of Mississippi tort and contract law. Any breach of contract, and not merely breach of an insurance contract, may lead to liability for punitive damages under Mississippi law."

In 2004, the Supreme Court held that ERISA preempted Texas state law claims regarding HMOs' regulation of benefit denials by HMOs, because the state law liability was derived wholly from an ERISA plan's rights and obligations. Aetna, 542 U.S. at 217.

In Aetna, the Court, in a unanimous decision Justice Thomas authored, ruled that patients cannot use state health care liability laws to sue the administrators of ERISA-regulated employee benefit plans for claims relating to the denial of coverage of treatment or service. The Court first reiterated ERISA's broad preemption provisions as well as Congress's intent to limit ERISA remedies to those listed in § 502(a). Id. at 209. Therefore, the Court determined that "any state law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted." Id.

The Court rejected the Plaintiffs' argument that the legal violations complained of were independent state duties. It held that because plaintiffs' causes of action were brought to remedy only the benefit denials under ERISA-regulated benefit plans, their state law claims fall within the scope of ERISA's civil enforcement mechanism and were completely preempted by ERISA. Id. at 213.

Finally, despite the Plaintiffs' claim that the Texas law regulated insurance, the Court held that ERISA preempted it. Moreover, the action should be removed to federal court because "[u]nder ordinary principles of conflict preemption . . . even a state law that can arguably be characterized as 'regulating insurance' will be preempted if it provides a separate vehicle to assert a claim for benefits outside of, or in addition to, ERISA's remedial scheme." Id. at 217.

Aetna did not involve any action against the physicians or their employers. It only addressed pure eligibility decisions by HMOs acting in their fiduciary capacity, even though those decisions might involve medical judgments.

In previous actions involving the HMO regulation, the Court held that ERISA did not preempt two state laws each regulating HMOs because the laws fell under ERISA's saving clause for laws regulating insurance. See Ky. Ass'n of Health Plans, Inc. v. Miller, 538 U.S. 329, 334 (2003); Rush Prudential HMO, Inc., v. Moran, 536 U.S. 355, 359 (2002).

In Rush Prudential, the Court, in a 5-4 decision Justice Souter authored, concluded ERISA did not preempt an Illinois state law that required an independent review by a physician when an HMO and a patient disagreed over whether a procedure was medically necessary. 536 U.S. at 375. The Court determined that the law regulated insurance. Id. The Court first found that because HMOs are risk-bearing organizations, perform much of the business formerly performed by traditional indemnity insurers and are regulated by state laws as insurers, they are insurers even though they provide medical care as well. Id. at 366-68. Second, the Illinois law was "specifically directed at the insurance industry" because it was unlikely that the Illinois law would apply beyond orthodox HMOs, which the Court had already concluded were insurers. Id. at 372. Factors under the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq.*, confirmed the Court's conclusion that the Illinois law regulated insurance. Id. at 373-74.

Shortly after Rush Prudential, the Court again considered a state law purporting to regulate insurance and articulated a new two-part test that a law must satisfy to be a law that regulates insurance under the saving clause. See Ky. Ass'n of Health Plans, 538 U.S. at 341-342. Kentucky passed an "Any Willing Provider" ("AWP") statute that prevented HMOs from limiting the number of health care providers in their networks by requiring that the HMOs not discriminate against any provider that is willing to meet the terms set by the HMO for participation. Id. at 333. The HMOs claimed that ERISA preempted the law, but the Sixth Circuit found that the law regulated insurance and was saved under § 1144(b)(2)(A). Id. at 334. The Court unanimously affirmed the Sixth Circuit in an opinion by Justice Scalia.

The Court stated that the law was specifically directed at insurers because it only applied to the HMOs and not health care providers. Id. at 334-335. While the laws would impact healthcare providers indirectly, the Court found that such indirect effects on non-insurers were insignificant to whether the law was specifically directed at insurers. Id. at 335-36. The HMOs also argued that the act did not regulate insurance because it only affected the relationship between the insurers and the providers and not the actual terms of an insurance policy. Id. The Court rejected this argument as well, finding that because the statute imposes conditions on the right to engage in the insurance business, it regulates insurance as contemplated in the saving clause. Id. at 337-38. The law also was specifically directed at regulating insurance because it affected the "risk pooling arrangement between the insurer and the insured [by] expanding the number of providers from whom an insured may receive health services [in a way that] alter[s] the scope of permissible bargains between insurers and insureds." Id. at 338-39.

In Rush Prudential and earlier cases interpreting § 1144(b)(2)(A), the Court looked to factors under the McCarran-Ferguson Act as part of its analysis of whether a law regulated insurance. Id. at 341. The Court concluded in Kentucky Ass'n of Health Plans, however, that its reliance on McCarran-Ferguson was misdirected because it failed to provide clear guidance to lower courts and ultimately added little to the analysis. Id. Instead, the Court made a "clean break" from those factors and now holds that for a state law to "regulate insurance" under § 1144(b)(2)(A), it must (1) "be specifically directed towards entities engaged in insurance;" and (2) "must substantially affect the risk pooling arrangement between the insurer and the insured." Id. at 341-42.

2. The deemer clause exempts employee benefit plans from regulation as insurance companies

ERISA's deemer clause exempts plans from regulation as insurance companies. It provides that 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. 29 U.S.C. § 1144(b)(2)(B).

Under the Supreme Court's holding in Shaw v. Delta Air Lines, Inc., “[o]nly separately administered disability plans maintained solely to comply with the Disability Benefits Law are exempt from ERISA coverage under § 4(b)(3).” 463 U.S. 85, 108 (1983). States may, however, require employers to maintain separate plans to comply with state laws. Id. “In other words, while the State may not require an employer to alter its ERISA plan, it may force the employer to choose between providing disability benefits in a separately administered plan and including the same state-mandated benefits in its ERISA plan. Id. If the State is not satisfied that the ERISA plan comports with the requirements of its disability insurance law, it may compel the employer to maintain a separate plan that does comply.” Id.

The deemer clause is also given a fairly expansive interpretation. Citing ERISA's legislative history, the Court declined to read the word “purporting” as limiting the scope of the clause. FMC Corp. v. Holliday, 498 U.S. 52, 63-64 (1990). The Court has recognized that in describing the deemer clause, the Conference Report omitted the word “purporting,” stating instead that “an employee benefit plan is not to be considered as an insurance company, bank, trust company, or investment company (and is not to be considered as engaged in the business of insurance or banking) for purposes of any State law that regulates insurance companies, insurance contracts, banks, trust companies, or investment companies.” Id.

The Court has also rejected the view that the deemer clause is directed solely at laws governing the business of insurance. Id. at 64. The Court in FMC Corp. noted that “the savings and deemer clauses employ differing language to achieve their ends—the former saving, except as provided in the deemer clause, ‘any law of any State which regulates insurance,’ and the latter referring to ‘any law of any State purporting to regulate insurance companies [or] insurance contracts.’” Id. It concluded, however, that the language of the deemer clause is “either coextensive with or broader, not narrower, than that of the saving clause.” Id. The Court's “rejection of a restrictive reading of the deemer clause does not lead to the deemer clause's engulfing the saving clause” because the savings clause has the independent effect of protecting state insurance regulation of insurance contracts purchased by employee benefit plans from preemption. Id. at 64.

II. STANDING TO BRING A CLAIM AGAINST A FIDUCIARY UNDER ERISA

ERISA § 502(a), 29 U.S.C. § 1132(a), identifies the four classes of persons or entities who possess express statutory standing to sue an ERISA fiduciary. In addition to the parties expressly granted standing to sue an ERISA fiduciary, courts have also granted standing to participants, beneficiaries, and fiduciaries to sue fiduciaries for individual, rather than plan, relief under the more open-ended language of § 502(a)(3). Some courts have either concluded parties fall within the expressly-listed classes of parties who may sue ERISA fiduciaries, or they have granted standing to other parties that are not expressly empowered to sue under § 502 (a) on the theory that the list of parties may sue ERISA fiduciaries under § 502(a) is not exclusive. See generally David P. Kallus, *ERISA: Do Health Care Providers Have Standing to Bring a Civil Enforcement Action Under Section 1132(a)?*, 30 SANTA CLARA L. REV. 173 (1990); Jeffrey A. Brauch, *The Danger of Ignoring Plain Meaning: Individual Relief For Breach of Fiduciary Duty Under ERISA*, 41 WAYNE L. REV. 1233 (Spring 1995).

Before analyzing the statutory language in § 502(a) that confers standing to sue an ERISA fiduciary, however, it is necessary to briefly review the constitutional and prudential considerations involved in the concept of standing.

A. CONSTITUTIONAL AND PRUDENTIAL REQUIREMENTS FOR STANDING

Constitutional standing, at its root, involves justiciability. The standing inquiry “focuses on whether the plaintiff is the proper party to bring the suit,” even if the inquiry “often turns on the nature and source of the claim asserted.” Raines v. Byrd, 521 U.S. 811, 818 (1997) (citations omitted). The threshold requirement for standing involves presenting a “case or controversy” within the meaning of Article III, § 2, cl. 1 of the Constitution. See C. WRIGHT, A. MILLER, & E. COOPER, *FEDERAL PRACTICE & PROCEDURE* § 3531 (2d ed. 1984). This case or controversy limitation is “crucial in maintaining the ‘tripartite allocation of power’ set forth in the Constitution.” DamierChrysler Corp. v. Cuno, 547 U.S. 332, 341 (2006). Supreme Court decisions have set an “irreducible minimum” for the Article III requirement for constitutional standing: A plaintiff must “allege personal injury fairly traceable to the defendant’s allegedly unlawful conduct,” and that his or her injury is “likely to be redressed by the requested relief” for the federal courts to have jurisdiction over the dispute. *Id.* at 342 (citations omitted). For a discussion of ERISA’s preemptive effects, which may also have an effect on the availability of federal jurisdiction, see generally Section I of this Handbook.

More recently, the Supreme Court decided Thole v. U.S. Bank N.A., which addressed the issue of standing for participants in defined benefit pension plans to sue under ERISA. 140 S. Ct. 1615 (2020). The Thole plaintiffs alleged that U.S. Bank’s fiduciaries mismanaged plan assets in a defined benefit plan, causing the plan to lose \$750 million. While the case was ongoing, the plan became overfunded, and U.S. Bank moved to dismiss for lack of standing. The Court held that the Thole plaintiffs lacked standing because “they [had] received all of their vested pension benefits” to that point,

and were “legally entitled to receive the same monthly payments for the rest of their lives,” regardless of the outcome of the case. Id. at 1622. The Court observed that “[w]inning or losing” the case would not affect those payments, so the plaintiffs lacked a sufficient injury, and thus standing. Id.

The Thole Court held that trust law did not apply because, unlike in a trust, the plaintiffs lacked an equitable or property interest in the plan. Id. at 1619–20. The Court also rejected the argument that plaintiffs could represent the plan’s interest because the Court affirmed that the plaintiffs must retain their own individual standing to do so. Id. at 1620. The plaintiffs’ argument that ERISA affords them a cause of action to sue also failed because the Court held that it did “not affect the Article III standing analysis.” Finally, the plaintiffs argued that if they could not sue, no one could, putting ERISA defined benefit plans beyond the reach of the courts for redress of fiduciary breaches. Id. at 1621. The Court disagreed, pointing out that “defined-benefit plans are regulated and monitored in multiple ways,” including that “employers and their shareholders . . . [have] strong incentives to root out fiduciary misconduct” because they may end up on the hook for the cost of any misconduct. Id. On the other hand, the Court observed that employers and shareholders would also be entitled to any surplus the plan generates, giving them good reason to ensure sound management. Id. The Court also pointed out that the Department of Labor is empowered to police fiduciaries, that fiduciaries would also be able to sue other fiduciaries, and that state and federal criminal laws may apply to some breaches, further dis-incentivizing breaches. Id.

Only a few lower courts have begun applying Thole’s holding outside of the defined benefit context, and it remains to be seen whether it will also apply to the defined contribution context. Contrast Ortiz v. American Airlines, Inc., No. 4:16-cv-151, 2020 WL 4504385, at *13 (N.D. Tex. Aug. 5, 2020), with Boley v. Universal Health Services, Inc., No. 20-cv-2644, 2020 WL 6381395, at *1 (E.D. Pa. Oct. 30, 2020).

Along with the constitutional requirement for standing, the Supreme Court has developed an additional set of limitations not derived from Article III, referred to as “prudential standing.” While not “exhaustively defined,” the Court has explained that these limitations encompass “the general prohibition on a litigant’s raising another person’s legal rights, the rule barring adjudication of generalized grievances more appropriately addressed in the representative branches, and the requirement that a plaintiff’s complaint fall within the zone of interests protected by the law invoked.” Elk Grove Unified Sch. Dist. v. Newdow, 542 U.S. 1, 12 (2004) (quoting Allen v. Wright, 468 U.S. 737, 751 (1984)). The Supreme Court’s holding in Lexmark Int’l, Inc. v. Static Control Components, Inc., 572 U.S. 118 (2014), however, “call[ed] into question the viability of the prudential standing doctrine.” City of Oakland v. Lynch, 798 F.3d 1159, 1163 n. 1 (9th Cir. 2015). For instance, while the Court in Lexmark still applied the “zone of interests” test to determine whether a cause of action was created by statute, it clarified, however, that it is a “misnomer” to refer to this test as a rule of prudential standing, as it is more a simple “tool for determining who may invoke the cause of action [under a statute].” Lexmark, 572 U.S. at 127, 130. However, the extent to which the Court abrogated traditional prudential standing consideration remains unclear. See,

e.g., HomeAway Inc. v. City & Cty. of San Francisco, No. 14-cv-04859, 2015 WL 367121, at *6–7 (N.D. Cal. Jan. 27, 2015)

In sum, even where ERISA expressly grants a class of individuals standing to sue an ERISA fiduciary, each individual must also meet the constitutional standing “case or controversy” and “injury in fact” requirements, and, to the extent they survived post-Lexmark, any prudential concerns associated with the action.

B. EXPRESS STATUTORY GRANTS OF STANDING

Three ERISA provisions, §§ 502(a)(2), 502(a)(3), and 502(c), expressly grant specific parties standing to sue fiduciaries. Some courts have held that parties not enumerated in these sections also have standing to bring ERISA actions against fiduciaries. The majority of cases concern the standing of these enumerated parties.

1. Parties enumerated in ERISA § 502(a)(2), 29 U.S.C. § 1132(a)(2)

Section 502(a)(2) states that a civil action may be brought by the Secretary of Labor, by a participant, a beneficiary or a fiduciary for appropriate relief under section 409 of ERISA, 29 U.S.C. 1109. 29 U.S.C. § 1132(a)(2). Section 409 outlines liability for breaches of fiduciary duty and provides that a plan fiduciary must make good to the plan any losses resulting from the breach of any of the responsibilities, obligations, or duties ERISA imposes on fiduciaries. 29 U.S.C. § 1109(a).

The four classes of plaintiffs identified in § 502(a) are almost certainly able to bring suit because the statute expressly grants them standing to sue an ERISA fiduciary. In some cases, however, there are questions of interpretation as to whether the plaintiff is a member of one of the four enumerated classes.

ERISA defines the four enumerated classes in ERISA § 3 as the following:

- (7) The term “participant” means any 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 which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit.
- (8) The term “beneficiary” means 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.
- (9) The term “person” means an individual, partnership, joint venture, corporation, mutual company, joint-stock

company, trust, estate, unincorporated organization, association, or employee organization . . .

- (13) The term “Secretary” means the Secretary of Labor . . .
- (21) Except as otherwise provided in subparagraph (B) [which deals with investment companies], 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 responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan . . .

29 U.S.C. § 1002. For more on these expressly named parties to a § 502(a)(2) action, see Section XI.A.1.

Section 502(a)(2) incorporates § 409(a), which states that fiduciaries who are found liable for breach of their fiduciary duties must make good *to the plan* for any losses resulting from that breach. 29 U.S.C. §§ 1109(a), 1132(a)(2) (emphasis added). Therefore, although the Secretary of Labor, participants, beneficiaries, and fiduciaries all have standing to bring a civil action against an ERISA fiduciary, any resulting awards are paid to the plan as a whole, rather than to the party who brings the suit. Mass. Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 148 (1985). In Russell, Russell was a beneficiary of a defined-benefit plan with standing to sue under § 502(a)(2) whose disability payments were temporarily terminated and then later paid retroactively. Id. at 136. She sued under § 502(a)(2) for damages sustained as a result of the refusal to pay her claims. Id. The majority opinion stated that, because § 502(a) incorporated § 409(a), damages could only be paid to the plan, and not to the individual bringing the suit. Id. at 140. Furthermore, because of “ERISA’s interlocking, interrelated, and interdependent remedial scheme, which is in turn part of a ‘comprehensive and reticulated statute[,]’” the Court doubted that Congress had intended to authorize individual remedies which it then forgot to expressly include. Id. at 146 (quoting Nachman Corp. v. Pension Benefit Guar. Corp., 446 U.S. 359, 361 (1980)).

Justice Brennan’s concurrence in Russell has been adopted by many courts which have concluded that individual claims for breach of fiduciary duty are only available under § 502(a)(3).

The Court, however, has since limited Russell’s restriction on individual damages to defined-benefit plans. In LaRue v. DeWolff, Boberg & Assoc., Inc., the

Supreme Court held that the “entire plan” language in Russell spoke to the consequences of § 409 on employee benefit plans that paid defined benefits. 552 U.S. 248, 255–56 (2008). The Court turned to § 404(c) to extrapolate a new rule for defined contribution plans. Section 404(c) bars a participant from recovering against a fiduciary for any breach if the participant exercises discretion and control over his or her own account. Id. Therefore, a rule of law that prohibited participants from seeking individual damages in connection with their defined contribution plans would render § 404(c) nugatory. Id. at 256. Section 502(a)(2) now allows plan beneficiaries to personally recover for all losses incurred by their individual accounts.

In arriving at the holdings in both Russell and LaRue, the Court applied the same rule: successful § 502(a)(2) suits result in a fiduciary paying back any losses to the plan itself. The difference is that in a defined-benefit plan, all the members of the plan will benefit from the payment, while in a defined contribution plan only certain members of the plan will benefit. This is because in a defined contribution plan, the members investment choices are not the same. A fiduciary might be liable for one investment decision, but only 50% of the plan members will have made the choice to invest in that option. Although only 50% of the plan members will benefit from the fiduciary’s payment, the payment nevertheless goes to the plan.

Participants, beneficiaries, and fiduciaries have another limitation: the temporal limitation. The plaintiff must have been a member of one of the four established classes of parties at the time the suit was filed, irrespective of the time of the ERISA violation. See, e.g., Chuck v. Hewlett Packard Co., 455 F.3d 1026, 1039 (9th Cir. 2006); Nahigian v. Leonard, 233 F. Supp. 2d 151, 165 (D. Mass. 2002); T & M Meat Fair, Inc. v. United Food and Commercial Workers, Local 174, AFL-CIO, 210 F. Supp. 2d 443, 448–49 (S.D.N.Y. 2002).

Courts often do not distinguish between standing to sue and ability to bring an action, treating them as largely the same. For example, a participant has standing to sue an ERISA fiduciary under § 502(a)(2), but relief runs to the plan, not to the individual. The individual participant may have standing to sue the fiduciary, but is nonetheless unable to bring the action for his or her own relief.

See:

Smith v. Med. Benefit Adm’rs Grp., Inc., 639 F.3d 277, 283 (7th Cir. 2011). An action to recover for a breach of fiduciary duty under § 502(a)(2) requires an injury to the plan and relief to the plan. An action to obtain relief under § 502(a)(3) can be individual relief, but only injunctive or equitable relief.

Peabody v. Davis, 636 F.3d 368, 373 (7th Cir. 2011). Under § 502(a)(2) the fiduciary pays back the plan for a breach of fiduciary duty. But under § 502(a)(3) an individual may recover only appropriate equitable relief and only to the extent that such relief is not available under another section.

Evans v. Akers, 534 F.3d 65, 72–73 (1st Cir. 2008). The major difference between § 502(a)(1)(B) and § 502(a)(2) is the proper defendant. A suit to recover under § 502(a)(1)(B) is brought against the plan administrator, while § 502(a)(2) seeks to hold fiduciaries liable in their personal capacities for breaching a fiduciary duty. In the later instance, the relief goes to the plan. *Lee v. Burkhart*, 991 F.2d 1004 (2d Cir. 1993). Plaintiffs, seek damages for breach of fiduciary duty on their own behalf, are barred from suing under § 502(a)(2), which gives participants standing to sue a fiduciary with respect to a plan.

2. Parties enumerated in ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3)

Section 502(a)(3) allows actions to enjoin any act that violates ERISA or the plan or to obtain other “appropriate equitable relief” to redress such violations or enforce ERISA or the plan. Like § 502(a)(2), that section expressly grants standing to participants, beneficiaries, or fiduciaries. 29 U.S.C. § 1132(a)(3).

Justice Brennan’s concurrence in *Russell* agreed with the majority that extra-contractual relief in § 502(a)(2) went to the plan. He also approved that the majority did not address whether extracontractual damages running to an individual rather than the plan might be a form of “other appropriate relief” under § 502(a)(3) because it was not part of the controversy in *Russell*. 473 U.S. at 150. Justice Brennan opined that such relief should be available under § 502(a)(3), noting that the legislative history showed that Congress intended to incorporate the fiduciary standards of trust law into ERISA, and under principles of trust law, “fiduciaries owed strict duties running directly to beneficiaries in the administration and payment of trust benefits.” *Id.* at 152–53. He thus concluded that § 502(a)(3)’s authorization of “appropriate equitable relief” “to redress . . . any act or practice which violates any provision of this title” meant that the section entitled participants, beneficiaries, or fiduciaries to equitable relief running to themselves rather than to the plan. *Id.* at 153–54 (emphasis in original).

After *Russell*, the Supreme Court in *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 260 (1993), held that § 502(a)(3)’s wording permitting “appropriate equitable relief” did not authorize suits for money damages against nonfiduciaries who knowingly participate in a fiduciary’s breach of fiduciary duty.

One of the Supreme Court’s most important cases addressing relief under § 502(a)(3), *Varity Corp. v. Howe*, 516 U.S. 489, 491 (1996), solidified the view of most circuits that § 502(a)(3) authorizes ERISA plan beneficiaries to bring a suit that seeks individualized equitable relief for beneficiaries for violations of fiduciary duties. Equitable relief under § 502(a)(3), however, is only “appropriate” where other ERISA provisions did not provide redress. *Id.* at 515. The Supreme Court heard the case to resolve a split among the circuits. Prior to *Varity*, the Ninth Circuit in particular had held that no individual redress was permissible under § 502(a)(3), while the Third Circuit had permitted actions against fiduciaries for individual legal relief.

Based on Varity, many courts have interpreted § 502(a)(3) to mean that participants, beneficiaries, and fiduciaries may sue ERISA fiduciaries for relief running to themselves and not to the plan so long as the relief is equitable and not legal (e.g. compensatory damages or monetary relief).

See:

Montanile v. Bd. of Trustees of Nat. Elevator Indus. Health Benefit Plan, 577 U.S. 136, 144 (2016). ERISA fiduciary seeking reimbursement for medical payments paid on behalf of participant who later obtained settlement proceeds from third party cannot bring suit to attach lien against that participant's general assets under § 502(a)(3) because the suit is not one for "appropriate equitable relief," where participant dissipated the entire settlement fund on nontraceable items.

Great-West Life & Annuity Ins. Co. v. Knudson, 534 U.S. 204, 220–21 (2002). Even if the plaintiff is a fiduciary, the plaintiff cannot seek legal relief under § 502(a)(3). Nor can the plaintiff seek a remedy that is quintessentially a legal one. Section 502(a)(3) is different in that regard from § 502(a)(1)(B).

Wilkins v. Mason Tenders Dist. Council Pension Fund, 445 F.3d 572, 578–59 (2d Cir. 2008). Section 502(a)(3) only authorizes equitable relief, which means that only in very limited circumstances will money awards be available.

Peralta v. Hispanic Bus., Inc., 419 F.3d 1064, 1076 (9th Cir. 2005). Money damages for past harms are not an available equitable remedy under § 502(a)(3).

LaRocca v. Borden, Inc., 276 F.3d 22, 28–29 (1st Cir. 2002). If the plaintiff can pursue benefits under the plan pursuant to another ERISA section, there is an adequate remedy which bars further remedy under § 502(a)(3).

Tolson v. Avondale Indus., Inc., 141 F.3d 604 (5th Cir. 1998). Because plaintiff has adequate redress for disavowed claims through his right to bring suit pursuant to § 502(a)(1)(B), he has no claim for breach of fiduciary duty under § 502(a)(3).

Hall v. LHACO, Inc., 140 F.3d 1190 (8th Cir. 1998). Plaintiff was not entitled to injunctive relief under § 502(a)(3) because defendant was no longer the administrator of his plan, and injunctive relief is prospective in nature.

Wald v. Sw. Bell Corp. Customcare Med. Plan, 83 F.3d 1002 (8th Cir. 1996). Where adequate relief may be obtained through another section of ERISA, § 502(a)(1)(B), plaintiff does not have a cause of action for injunctive relief under § 502(a)(3).

Switzer v. Wal-Mart Stores, Inc., 52 F.3d 1294, 1302 (5th Cir. 1995). *Equitable remedies under ERISA are narrowly drawn; the statute does not constitute a “roving commission to do equity.”*

Roig v. Ltd. Long Term Disability Program, No. 99-cv-2460, 2000 WL 1146522, at *10 (E.D. La. Aug. 4, 2000), *aff'd in part*, 275 F.3d 45 (5th Cir. 2001) (table). *Where a claim for equitable relief under § 502(a)(3) is merely duplicative of a claim for relief under another ERISA provision, the claim under § 502(a)(3) must be dismissed.*

Anderson v. Ill. Bell Tel. Co., 961 F. Supp. 1208 (N.D. Ill. 1997). *Because the plaintiff sought unpaid benefits allegedly owed to her, which was a monetary form of relief, her action did not meet the requirements of § 502(a)(3).*

Kessen v. Plumbers' Pension Fund, Local 130, 877 F. Supp. 1198 (N.D. Ill. 1995). *Plaintiff could not maintain an action under § 502(a)(3) because the relief he sought was monetary and not equitable.*

3. Parties enumerated in ERISA § 502(c), 29 U.S.C. § 1132(c)

Section 502(c) provides another cause of action against a plan administrator who fails to provide required notices under 29 U.S.C. § 1166 or § 1021(e) or who fails to comply with valid requests for plan information. 29 U.S.C. § 1132(c)(1). Section 502(a)(1)(A) authorizes either participants or beneficiaries to bring claims under § 502(c). 29 U.S.C. § 1132(a)(1)(A).

Because ERISA defines a fiduciary in § 1002 as one who “has any discretionary authority or discretionary responsibility in the administration of such plan,” 29 U.S.C. § 1002(21)(A)(iii), a plan administrator is usually a fiduciary. Accordingly, a suit under § 502(c) for the administrator’s refusal to supply requested information is essentially a breach of fiduciary duty suit. However, the statutory penalties under § 502(c) are limited to \$110 per day and are available at the court’s discretion. As a result, a suit by a participant or beneficiary solely under § 502(c) is unlikely, unless it exists as a count of a larger lawsuit.

See:

Mondry v. Am. Family Mut. Ins. Co., 557 F.3d 781, 794 (7th Cir. 2009). *The expressly designated plan administrator is the only administrator with a duty to produce plan documents. A claims administrator designation does not bring that party into the reach of § 502(c).*

Hunt v. Hawthorne Assocs. Inc., 119 F.3d 888 (11th Cir. 1997). *Plaintiff did not prove that the plan fiduciary actually served as the plan administrator, so plaintiff was not entitled to relief under § 502(c).*

C. RIGHTS OF PARTIES NOT ENUMERATED IN ERISA § 502(a), 29 U.S.C. § 1132(a), TO BRING SUITS AGAINST FIDUCIARIES

In the early 1980s, the circuits were split on whether a party not enumerated in § 502(a) had standing to sue. Compare, Fentron Indus. Inc. v. Nat'l Shopmen Pension Fund, 674 F.2d 1300 (9th Cir. 1982) (holding that legislative intent behind ERISA evidenced that list of parties granted standing to sue was not exclusive) with Pressroom Unions-Printers League Income Sec. Fund v. Cont'l Assurance Co., 700 F.2d 889 (2d Cir. 1983) (holding that under the general statutory construction rule *expression unieus est exclusion alterius*, only enumerated parties had standing).

However, more recently, courts have decided that ERISA's list of parties with standing to sue in § 502(a) is exclusive. See, e.g., Coleman v. Champion Int'l Corp./Champion Forest Prods., 992 F.2d 530 (5th Cir. 1993) (explaining 2d, 3d, 6th, 7th, 11th, and D.C. Circuits have rejected Fentron's zone of interest test). Indeed, the Ninth Circuit has also backed off its holding in Fentron. See, e.g., Paige v. State of Cal., 102 F.3d 1035, 1039 (9th Cir. 1996) (stating Fentron "is no longer controlling authority"); Pilkington PLC v. Perelman, 72 F.3d 1396, 1401 (9th Cir. 1995) (declining to rely on Fentron and noting it had been "largely undermined" by Supreme Court authority); Cripps v. Life Ins. Co. of N. Am., 980 F.2d 1261, 1265 (9th Cir. 1992) (stating that it was not necessary to determine whether Fentron remains good law, as its reasoning "has twice been repudiated by the Supreme Court").

The Supreme Court has also weighed in on the issue and favored exclusivity. In Harris Trust & Sav. Bank v. Salomon Smith Barney Inc., 530 U.S. 238 (2000), the Supreme Court was asked to decide whether plaintiff could bring a suit under § 502(a)(3) against a "nonfiduciary 'party in interest.'" Id. at 241. In deciding that issue, the Court stated that while language in § 502 did not limit the universe of possible defendants, "§ 502(a) itself demonstrates Congress' care in delineating the universe of *plaintiffs* who may bring certain civil actions." Id. at 247 (emphasis in original). Therefore, it would seem conclusive that parties who are not listed in § 502(a) do not have standing to bring a suits against fiduciaries.

See:

Raymond B. Yates, M.D., P.C. Profit Sharing Plan v. Hendon, 541 U.S. 1, 16 (2004). *Holding that under Title I of ERISA, a working owner qualifies as a plan participant.*

Longaberger Co. v. Kolt, 586 F.3d 459, 468 (6th Cir. 2009), *abrogated on other grounds by* Montanile v. Bd. of Trustees of Nat. Elevator Indus. Health Benefit Plan, 577 U.S. 136, 144 (2016). *Noting that the Supreme Court's finding in* Harris *limits the universe of potential plaintiffs who may bring a civil action for equitable relief under § 502(a)(3), but that section does not limit the universe of possible defendants.*

Sonoco Prods. Co. v. Physicians Health Plan, Inc., 338 F.3d 366, 372 (4th Cir. 2003). Holding that employer has no standing to bring a § 502(a) claim because employer can neither be a participant nor a beneficiary and, in this case, employer was not suing as a fiduciary.

City of Hope Nat'l Med. Ctr. v. Seguros de Sevicios de Salud, 156 F.3d 223, 227–28 (1st Cir. 1998). Recognizing that only those enumerated parties listed under § 502 have standing to sue. But granting standing to the assignee of a beneficiary or participant because they stand in the shoes of the assignor.

Local 153 Health Fund v. Express Scripts, Inc., No. 4:05-MD-01672, 2007 WL 4333380, at *4–5 (E.D. Mo. Dec. 7, 2007). Noting that the Eighth Circuit has not addressed whether § 502(a) gives standing exclusively to those named, but choosing to follow the majority view and holding that a non-enumerated party does not have standing under § 502(a).

Yates v. Blended Health, L.L.C., No. 1:07-cv-234, 2007 WL 4986317, at *5 (E.D. Tex. Aug. 9, 2007). Explaining that the Fifth Circuit has twice expressly rejected Fentron's holding. Non-enumerated parties do not have standing to bring ERISA claims under § 502(a).

Uon Suk Park v. Trs. of the 1199 SEIU Health Care Emps. Pension Fund, 418 F. Supp. 2d 343, 351–52 (S.D.N.Y. 2005). Finding that non-enumerated party standing under § 502(a) has been rejected by the Second Circuit.

III. FIDUCIARY STATUS UNDER ERISA

A fiduciary to an ERISA plan may be personally liable for any breach of his or her duty. ERISA provides that “[n]o fiduciary shall be liable with respect to a breach of fiduciary duty under this title if such breach was committed . . . after he ceased to be a fiduciary.” 29 U.S.C. § 1109(b). Accordingly, whether a person is a fiduciary and when a person took on that status is a crucial question in litigation for alleged breaches of fiduciary duty.

Similarly, a person who has taken on fiduciary status can avoid fiduciary liability for subsequent actions by ceasing to be a fiduciary under the Act. Terminating such fiduciary status, however, is not always easily accomplished. As one writer has said, “it is easier under ERISA to assume fiduciary status than to shed it.” Jane Kheel Stanley, *The Definition of a Fiduciary Under ERISA: Basic Principles*, 27 REAL PROP. PROB. & TR. J. 237, 257 (1992). As a result, it is extremely important to understand both how a person may become a fiduciary and how fiduciaries may divest themselves of that status once they no longer wish to serve in a fiduciary capacity.

A. CREATION OF FIDUCIARY STATUS

It is axiomatic that plaintiffs may only bring an ERISA breach of fiduciary duty claim against a “fiduciary.” E.g., Wright v Or. Metallurgical Corp., 360 F.3d 1090, 1101 (9th Cir. 2004); Daniels v. Thomas & Betts, 263 F.3d 66, 73 (3d Cir. 2001); Plumb v. Fluid Pump Serv., Inc., 124 F.3d 849, 854 (7th Cir. 1997). Under ERISA, a person or entity can become a fiduciary if (i) he or she is a named or designated fiduciary in the plan documents or (ii) he or she functions as a fiduciary by exercising discretionary authority or control over the management or operation of the plan. 29 U.S.C. § 1102(a)(2); 29 U.S.C. § 1002(21)(A); CSA 401(k) Plan v. Pension Prof'ls Inc., 195 F.3d 1135, 1140 (9th Cir. 1999); Plumb, 124 F.3d at 854; Woods v. Southern Co., 396 F. Supp. 2d 1351, 1364 (N.D. Ga. 2005).

1. Fiduciary status as a named fiduciary

Under 29 U.S.C. § 1102(a)(2), the term “named fiduciary” means “a fiduciary who is named in the plan instrument, or who, pursuant to a procedure specified in the plan, is identified as a fiduciary (A) by a person who is an employer or employee organization with respect to the plan or (B) by such an employer and such an employee organization acting jointly.” Persons who are expressly named as fiduciaries will nearly always be proper defendants in claims for breach of fiduciary duty to the extent the claim challenges actions within the scope of the named fiduciaries’ duties.

See:

United States v. Jackson, 524 F.3d 532, 545 (4th Cir. 2008), vacated and remanded on other grounds by Jackson v. United States, 555 U.S. 1163 (2009). *Under ERISA, an administrator is an example of a fiduciary.*

Therefore, an individual expressly named an administrator most likely is a fiduciary as well.

In re Luna, 406 F.3d 1192, 1201-02 (10th Cir. 2005). The court noted that once an individual is named a fiduciary by express designation, the fiduciary is subject to ERISA's statutory duties. Determining whether an individual is a named fiduciary is a "straightforward inquiry."

But see:

Womack v. Orchids Paper Prods. Co. 401(k) Sav. Plan, 769 F. Supp. 2d 1322, 1329 (N.D. Okla. 2011). The court held that it was not controlling that defendant was named fiduciary of the plan and that the court must look to the function performed by the alleged fiduciary when that alleged fiduciary performed the omission giving rise to the alleged breach.

2. Fiduciary status by performing fiduciary functions

ERISA also functionally defines a "fiduciary" as one who exercises discretionary authority or control over the management of an employee benefit plan or has discretionary authority in the administration of a plan. 29 U.S.C. § 1002(21)(A)(i), (iii). "Fiduciary duties under ERISA attach not just to particular persons, but to particular persons performing particular functions." *Edmonson v. Lincoln Nat. Life Ins. Co.*, 725 F.3d 406, 413 (3d Cir. 2013) (citing *Hozier v. Midwest Fasteners, Inc.*, 908 F.2d 1155, 1161 (3d Cir. 1990)).

Under ERISA, a person is a fiduciary only "to the extent" he or she performs enumerated tasks, and "a person may be an ERISA fiduciary for some purposes," but not for others. *Plumb*, 124 F.3d at 854 (citing *Klosterman v. W. Gen. Mgmt., Inc.*, 32 F.3d 1119, 1122 (7th Cir. 1994)); *Baker v. Kingsley*, 387 F.3d 649, 660 (7th Cir. 2004); *Kerns v. Benefit Trust Life Ins. Co.*, 992 F.2d 214, 216 (8th Cir. 1993); *Adamczyk v. Lever Bros. Co.*, 991 F. Supp. 931, 935-36 (N.D. Ill. 1997). In assessing whether a person can be held liable for a breach of fiduciary duty, courts must ask whether the person is a fiduciary with respect to the particular activity the plaintiff seeks to challenge. *Plumb*, 124 F.3d at 854. "In every case charging breach of ERISA fiduciary duty, then, the threshold question is not whether the actions of some person employed to provide services under a plan adversely affected a plan's beneficiary interest, but whether that person was acting as a fiduciary (that is, was performing a fiduciary function) when taking the actions subject to complaint." *Pegram v. Herdrich*, 530 U.S. 211, 226 (2000). Therefore, to determine whether a person can be held liable for a breach of fiduciary duty, "a court must ask whether [that] person is a fiduciary with respect to *the particular activity at issue*." *Plumb*, 124 F.3d at 854 (quoting *Coleman v. Nationwide Life Ins. Co.*, 969 F.2d 54, 61 (4th Cir. 1992), *as amended* (July 17, 1992) (emphasis added)); accord *Briscoe v. Fine*, 444 F.3d 478, 486 (6th Cir. 2006); *Johnston v. Paul Revere Life Ins. Co.*, 241 F.3d 623, 632 (8th Cir. 2001); *see also* James

Lockhart, Annotation, *When is Employer, Labor Union, Affiliated Entity or Person, or Pension or Welfare Plan “Fiduciary” Within the Meaning of §3(21)(A)(i) or (iii) of Employee Retirement Security Act of 1974 (29 U.S.C.A. §1002(21)(A)(i) or (iii))*, 178 A.L.R. Fed. 129 (2004).

See:

Pegram v. Herdrich, 530 U.S. 211, 225-26 (2000). The Court held that an ERISA fiduciary can “wear different hats” as an employer and plan fiduciary, but ERISA requires “that the fiduciary with two hats wear only one at a time.” It further stated that an individual is a fiduciary “only ‘to the extent’ that he acts in such a capacity in relation to a plan.” Therefore, the threshold question is “whether the person was acting as a fiduciary . . . when taking the action subject to complaint.”

Livick v. The Gillette Co., 524 F.3d 24, 29-30 (1st Cir. 2008). The court held that an unnamed fiduciary is liable as a fiduciary only to the extent of the fiduciary tasks that he assumes. The court also stated that it will ask “whether that person was acting as a fiduciary . . . when taking the action subject to complaint.”

Parker v. Bain, 68 F.3d 1131, 1139-40 (9th Cir. 1995). A person becomes a fiduciary when he exercises discretion over plan assets, such as directing employee to “cash in” assets of the plan and to transfer assets of the plan to the company’s general account.

Chao v. Unique Mfg. Co., Inc., 649 F. Supp. 2d 827, 832-34 (N.D. Ill. 2009). One with control or authority over plan assets may be liable as a fiduciary even if he or she does not have discretion to oversee the assets. But the court noted that it must be “practical control” and not just possession or custody and it does not apply to someone who has authority but does not exercise it.

Adamczyk v. Lever Bros Co., 991 F. Supp. 931, 937-38 (N.D. Ill. 1997). The court determined that “it is the nature of the act and not the persona of the actor that determines fiduciary capacity.” Therefore, a defendant employer can be a fiduciary and have a duty not to mislead when it comes to communicating its intentions about implementing a new benefits plan, provided the plan has been given serious consideration.

But see:

Gard v. Blankenburg, 33 F. App’x 722, 727 (6th Cir. 2002). The court held that trustees do not function as fiduciaries when they amend, modify, or terminate a plan. There is no distinction between a single-employer or multi-employer plan for this purpose.

IT Corp. v. Gen. Am. Life Ins. Co., 107 F.3d 1415, 1418-19 (9th Cir. 1997).
A person who functions as a fiduciary may face liability under ERISA even if the terms of a contract state that the person is not a fiduciary.
Regardless of the terms of the contract, the court will look to the actual control and authority an individual exercises over the plan.

Patten v. Northern Trust Co., 703 F. Supp. 2d 799, 808-09 (N.D. Ill. 2010).
When a plaintiff alleges in the complaint that defendant is a functional fiduciary by tracking the language of the statute, the court will not grant the defendant's motion to dismiss because a determination of fiduciary status is fact-intensive.

3. Performing ministerial tasks does not create fiduciary status

Under 29 U.S.C. § 1002(21)(A), a person is not a fiduciary if he or she performs only ministerial functions. 29 C.F.R. § 2509.75-8 D-2; see also, e.g., Humana Health Plan, Inc. v. Nguyen, 785 F.3d 1023, 1027 (5th Cir. 2015); Kenseth v. Dean Health Plan, Inc., 610 F.3d 452, 465 (7th Cir. 2010); CSA 401(k) Plan, 195 F.3d at 1138-39; Van Doren v. Capital Research & Mgmt. Co., Civ. Action No. 10-1425 KSH, 2010 WL 5466839, at *3-5 (D.N.J. Dec. 30, 2010). An individual is not a fiduciary if he has no discretion under the plan and he performs his duties as specified in the plan. Kenseth, 610 F.3d at 465 (finding that "role as customer service representative was ministerial in nature" because individual had no authority or discretion in administering plan). The Department of Labor has promulgated regulations explaining what is meant by the term "ministerial." See 29 C.F.R. § 2509.75-8. Persons who perform certain types of tasks "within a framework of policies, interpretations, rules, practices and procedures made by other persons" are not fiduciaries. 29 C.F.R. § 2509.75-8 D-2. Examples of ministerial duties under the regulation include applying plan rules to determine eligibility; calculating expected benefits; preparing employee communications; orienting new participants and advising them of their rights under the plan; and processing claims. 29 C.F.R. § 2509.75-8 D-2.

The mere ability to make a decision in carrying out a ministerial task does not rise to the level of discretion required to be an ERISA fiduciary. CSA 401(k) Plan, 195 F.3d at 1139-40; see also Santomenno v. Transamerica Life Ins. Co., 883 F.3d 833, 840 (9th Cir. 2018) (finding that actions that involved only ministerial tasks did not create fiduciary liability); In re Luna, 406 F.3d at 1203 (finding failure to perform an act is not exercise of discretion). Courts have held that a party does not become a fiduciary simply because it may have a limited ability to decide how to carry out a task. See, e.g., Klosterman v. Western Gen. Mgmt. Inc., 32 F.3d 1119, 1124 (7th Cir. 1994) (holding service provider was not a fiduciary despite deciding how to develop computer system to process claims based plan parameters and utilizing "manuals and other printed information, not provided by [p lan sponsor], in making the determinations"); Bd. of Trs. of the Western Lake Superior Piping Indus. Pension Fund v. Am. Benefit Plan Adm'rs, Inc., 925 F. Supp. 1424, 1432-33 (D. Minn. 1996).

However, fiduciaries can be liable to plan participants and beneficiaries for failing to train those individuals who perform ministerial duties, such as customer service representatives. Kenseth, 610 F.3d at 479-80. If the fiduciary owes a duty to participants and beneficiaries, it must ensure that the duty is met through non-fiduciaries either by training or supervising those who perform ministerial functions. Id. at 480 (finding that fiduciary has duty to provide complete and accurate information and when plan itself is not clear and complete, failing to train and supervise a customer service representative who gave incorrect information is breach of fiduciary duty).

See:

Johnston v. Paul Revere Life Ins. Co., 241 F.3d 623, 632-33 (8th Cir. 2001). An insurance broker that filled out forms for a plan participant but did not inform the participant that his “own occupation” coverage was denied did not breach its fiduciary duty because the insurance broker was not a fiduciary. The court stated that performing ministerial tasks applies to an insurance broker who fills out forms.

Schmidt v. Sheet Metal Workers’ Nat’l Pension Fund, 128 F.3d 541, 545-48 (7th Cir. 1997). A person is not a fiduciary if she performs ministerial tasks related to the plan’s administration, like answering participants’ questions or mailing out forms. A fiduciary will not be liable for the mistake of one who performs ministerial tasks, such as a misstatement, if the fiduciary did not authorize, participate in, or have knowledge of the misstatement and the fiduciary provided adequate disclosures in plan materials.

*Mills v. Sw. Serv. Adm’rs, Inc., No. 10-cv-00262, 2011 WL 1936587, at *4 (D. Ariz. May 20, 2011). A service provider was entitled to summary judgment because the court determined it was not a fiduciary. The court found that the defendant provided only ministerial tasks by housing the records reflecting plan participants, summarizing records, and carrying out the plan’s “day-to-day functions.”*

Bd. of Trs. of the Western Lake Superior Piping Indus. Pension Fund v. Am. Benefit Plan Adm’rs, Inc., 925 F. Supp. 1424, 1430-31 (D. Minn. 1996). A pension fund sued a company it hired to perform administrative services related to the plan. The court granted the service provider’s motion for summary judgment because the service provider performed only ministerial tasks such as answering participant calls, preparing the plan’s annual report, preparing communications to participants, maintaining plan records, and determining participant eligibility based on plan documents. There was no showing that the service provider had assumed a fiduciary status, and the terms of the operative contract repudiated that there was any such status.

But see:

Livick v. Gillette Co., 524 F.3d 24, 29-30 (1st Cir. 2008). The First Circuit stated that a fiduciary is only liable for the acts of other fiduciaries, and when the fiduciaries have provided clear and complete information to begin with, they are not liable for the mistakes of those who perform ministerial tasks.

IT Corp. v. Gen. Am. Life Ins. Co., 107 F.3d 1415, 1419-21 (9th Cir. 1997). The court held that although the contract between the employer and benefits administrator stated that IT Corp would only perform “ministerial functions,” the court must look beyond the “magic words” to the duties actually performed. Because it was alleged that IT Corp had to interpret the plan to determine whether to refer a claim back to the employer and had control of plan assets because it could write checks, that court denied defendant’s motion to dismiss.

B. TERMINATING FIDUCIARY STATUS ARISING FROM FORMAL TITLE OR POSITION

There is a small body of case law addressing the topic of how and when termination of fiduciary status arising from a formal title or position can be effected under ERISA. Although there are no hard, clear rules as to how such fiduciary status may be resigned or terminated, federal case law provides some guiding principles.

1. Fiduciary status cannot be terminated informally

Fiduciary status that arises as the result of holding a formal title or position cannot be terminated informally. Rather, to relinquish fiduciary status, the fiduciary must unequivocally cease all fiduciary functions and terminate, in writing, all contracts or arrangements with the plan concerning the fiduciary position. See Lowen v. Tower Asset Mgmt., Inc., 829 F.2d 1209, 1219 (2d Cir. 1987). “[A]bsent such a clear resignation or removal under permissible circumstances,” a court may hold that fiduciary status continued despite an attempt to terminate that status informally. Freund v. Marshall & Ilsley Bank, 485 F. Supp. 629, 635 (W.D. Wis. 1979); see also Ulico Cas. Co. v. Clover Capital Mgmt., Inc., 217 F. Supp. 2d 311, 316 (N.D.N.Y. 2002); Pension Benefit Guar. Corp. v. Greene, 570 F. Supp. 1483, 1497-98 (W.D. Pa. 1983), aff’d, 727 F.2d 1100 (3d Cir. 1984). The reason for requiring such a formal resignation is that “[t]he protection which ERISA is intended to afford private pension and benefit plans would be vitiated” if an ERISA fiduciary were able to simply walk away from a plan. Glaziers & Glassworkers Union Local No. 252 Annuity Fund v. Newbridge Sec. Inc., 93 F.3d 1171, 1184 (3d Cir. 1996).

See:

Chitkin v. Lincoln Nat’l Life Ins. Co., 15 F.3d 1083, No. 92-55406, 1993 WL 484720, at *1 (9th Cir. Nov. 24, 1993) (table). An insurance company that had issued a group life insurance policy to an ERISA plan did not

relinquish its fiduciary status merely by ceasing to serve as an insurer of the plan.

Lowen v. Tower Asset Mgmt., Inc., 829 F.2d 1209, 1218-19 (2d Cir. 1987). *An investment manager who had a formal contract with a plan could not claim that he ceased to be a fiduciary when the plan's trustees orally modified the plan's agreement with him.*

Freund v. Marshall & Ilsley Bank, 485 F. Supp. 629, 635-36 (W.D. Wis. 1979). *The fiduciary status of certain plan trustees did not automatically terminate when their employees dropped out of the plan and they ceased their business relationship with the company that originally formed the plan.*

But see:

Coleman Clinic, Ltd. v. Mass. Mut. Life Ins. Co., 698 F. Supp. 740, 746-47 (C.D. Ill. 1988). *A defendant's fiduciary duty to an ERISA plan ended when he ceased his employment with the plan's insurer.*

2. Termination must be unequivocal

For a person to effectively resign or terminate ERISA fiduciary status, the resignation or termination must be unequivocal. The rule is that a person cannot claim to have been divested of fiduciary status and also continue to perform fiduciary functions. See Lowen, 829 F.2d at 1219 (stating "fiduciary obligations may not be turned on and off like running water"). Instead, courts have consistently held that fiduciary status continues to the extent that the fiduciary continues to exercise discretionary functions in relation to a plan. See, e.g., Smith v. Provident Bank, 170 F.3d 609, 613 (6th Cir. 1999); Ulico Cas. Co., 217 F. Supp. 2d at 316; Wilson Land Corp. v. Smith Barney Inc., No. 5:97-CV-51 9-BR(2), 1999 WL 1939270, at *3 (E.D.N.C. May 17, 1999); Conway v. Marshall & Ilsley Trust Co., No. 87 C 20379, 1988 WL 124924, at *2 (N.D. Ill. Nov. 1, 1988). Thus, it is not enough for an ERISA fiduciary merely to formalize the intent to terminate or resign from fiduciary status. Instead, a fiduciary who wishes to shed all fiduciary obligations must also unequivocally cease to perform any of the functions described in § 3(21) of ERISA, 29 U.S.C. § 1002(21). See Lowen, 829 F.2d at 1219.

See also:

Smith v. Provident Bank, 170 F.3d 609, 613 (6th Cir. 1999). *Bank that had no discretionary authority over a plan that was charged only with the "ministerial" task of transferring plan assets to another bank was nevertheless held liable as an ERISA fiduciary because it controlled plan assets.*

PBGC v. Greene, 570 F. Supp. 1483, 1497-98 (W.D. Pa. 1983), *aff'd*, 727 F.2d 1100 (3d Cir. 1984). *The plaintiffs' attempt to resign as trustees was*

ineffective to terminate their fiduciary status because they continued to perform trustee functions and retained possession of the plan's checkbooks, passbooks, and other documents.

3. Fiduciary status can only be resigned or terminated in the manner specified in the plan

Typically, fiduciary status is not terminated under ERISA unless it is resigned or terminated in compliance with the plan's documents. See Reich v. Mercantile Bank, No. 591-11 C, 1994 U.S. Dist. LEXIS 21308, at *16-*17 (E.D. Mo. Apr. 16, 1994) (Reich v. Mercantile Bank I); Russo v. Unger, No. 86 Civ. 9741, 1991 WL 254570, at *6 n.4 (S.D.N.Y. Nov. 20, 1991). Absent such compliance, a court may hold that fiduciary obligations continued regardless of whether the fiduciary intended to terminate the fiduciary obligations. See Chambers v. Kaleidoscope, Inc. Profit-Sharing Plan & Trust, 650 F. Supp. 359, 369-70 (N.D. Ga. 1986) (holding that defendant remained obligated as plan administrator and trustee because there was no evidence that he complied with plan's prerequisites for resignation).

The same rule applies to the removal of plan trustees. For example, in Burud v. Acme Electric Co., 591 F. Supp. 238, 243-44 (D. Alaska 1984), the court concluded that a trustee's resolution removing a fellow trustee from his fiduciary position was ineffective as a matter of law because the plan documents did not vest the trustees with the power of removal.

Finally, it should be noted that compliance with plan documents must be precise for a termination, resignation, or removal to be effective. Thus, in Greene, the court held that two trustees who had provided notice of their resignation to the remaining trustees had not tendered a valid resignation, because they failed to also provide notice to the company as specifically required in the plan documents. PBGC, 570 F. Supp. at 1497-98. As a result, the court held that the trustees' fiduciary obligations to the plan remained intact. Id. at 1498.

4. The resigning fiduciary must make adequate arrangements for the continued prudent management of the plan

Courts have consistently held that ERISA's requirement that a fiduciary discharge his duties "with care, skill, prudence, and diligence," extends to his resignation under ERISA. See 29 U.S.C. § 1104(a)(1)(B); Glaziers & Glassworkers, 93 F.3d at 1183; Freund v. Marshall & Ilsley Bank, 485 F. Supp. 629, 636 (W.D. Wis. 1979). Thus, "once a fiduciary relationship exists, the fiduciary duties arising from it do not necessarily terminate when a decision is made to dissolve that relationship." Glaziers & Glassworkers, 93 F.3d at 1183. Rather, "an ERISA fiduciary's obligations to a plan are extinguished only when adequate provision has been made for the continued prudent management of plan assets." Id.; see also Allison v. Bank One-Denver, 289 F.3d 1223, 1239 (10th Cir. 2002); Ream v. Frey, 107 F.3d 147, 154 (3d Cir. 1997).

There are no clearly defined rules as to what constitutes adequate provision for the continued prudent management of plan assets. However, at the very least, it appears that a resigning fiduciary has a “turnover duty” to determine who the successor fiduciary will be, and to investigate the successor’s qualifications. See Reich v. Mercantile Bank, No. 91-cv-00011, 1996 U.S. Dist. LEXIS 21963, at *71 (E.D. Mo. Feb. 2, 1996) (Reich v. Mercantile Bank II); Glaziers and Glassworkers, 93 F.3d at 1183-84; Chambers v. Kaleidoscope, Inc. Profit-Sharing Plan & Trust, 650 F. Supp. 359, 369 (N.D. Ga. 1986).

See also:

Freund v. Marshall & Ilsley Bank, 485 F. Supp. 629, 635-36 (W.D. Wis. 1979). A fiduciary who had merely obtained representations that an ERISA plan would be continued, and that successor trustees would be appointed, had not made adequate provision for the continued prudent management of the plan. A fiduciary’s responsibilities to a plan do not end until a qualified successor fiduciary is appointed.

Some courts have also held that a resigning fiduciary has a duty to disclose to the plan’s trustees or beneficiaries all material information which is necessary for the protection and continuation of the plan.

See:

Ream v. Frey, 107 F.3d 147, 154 (3d Cir. 1997). It would be contrary to ERISA’s explicit statutory directives to allow a fiduciary to resign without notice to the plan beneficiaries under circumstances where the fiduciary has information indicating that the beneficiaries’ interests might need protection.

Glaziers & Glassworkers Union Local No. 252 Annuity Fund v. Newbridge Sec., Inc., 93 F.3d 1171, 1183-84 (3d Cir. 1996). A securities broker-dealer had a fiduciary duty to advise several group benefit plans of information that they needed for their own protection, despite the fact that the plans had terminated their relationship with the broker-dealer.

However, although courts may require resigning fiduciaries to appoint a qualified successor and to disclose all material information necessary for the protection and continuation of the plan, courts have rejected the argument that a resigning fiduciary must investigate his successor’s intentions prior to terminating his fiduciary status. Reich v. Mercantile Bank II, 1996 U.S. Dist. LEXIS 21963, at *71-*72.

See:

*Reich v. Mercantile Bank, No. 91-cv-00011, 1996 U.S. Dist. LEXIS 21963, at *71 (E.D. Mo. Feb. 2, 1996). A resigning trustee did not have a fiduciary duty before it resigned to determine what its successor’s plans were for an Employee Stock Ownership Program.*

Coleman Clinic, Ltd. v. Mass. Mut. Life Ins. Co., 698 F. Supp. 740, 747 (C.D. Ill. 1988). *A resigning fiduciary had no fiduciary duty with respect to his successor's decision to terminate an ERISA plan, because a resigning fiduciary's duty to provide for the continued prudent management of a plan does not extend to events which were not foreseeable at the time he resigned.*

5. A fiduciary may relinquish some obligations to a plan by delegating some fiduciary responsibilities

Although fiduciary responsibilities may not be waived, they can be delegated by express provision in the plan instrument. Ariz. State Carpenters Pension Tr. Fund v. Citibank, 125 F.3d 715, 719 (9th Cir. 1997); Presley v. Blue Cross-Blue Shield of Ala., 744 F. Supp. 1051, 1058 (N.D. Ala. 1990). ERISA § 405(c)(1) specifically provides that a plan's documents may allow "named fiduciaries to designate persons . . . to carry out fiduciary responsibilities," other than the management and control of plan assets. 29 U.S.C. § 1105(c)(1). Upon delegation of fiduciary responsibilities in this manner, "the fiduciary is not thereafter liable for the acts or omissions of the person carrying out the fiduciary responsibility, except to the extent it participates knowingly in the breach, or fails to act reasonably in discharging its own responsibilities and thereby enables the other fiduciary to commit the breach, or it has knowledge of a breach by such other fiduciary and makes no reasonable efforts under the circumstances to remedy the breach." Presley, 744 F. Supp. at 1058; see 29 U.S.C. § 1105(c)(2); 29 C.F.R. § 2509.75-8 FR-14; see also Ariz. State Carpenters Pension Tr. Fund, 125 F.3d at 719; Int'l Bhd. of Elec. Workers, Local 90 v. Nat'l Elec. Contractors Ass'n, No. 3:06cv2, 2008 WL 918481, at *6 (D. Conn. Mar. 31, 2008); In re GCO Servs., LLC, 324 B.R. 459, 464 (S.D.N.Y. 2005). As such, a plan fiduciary may terminate fiduciary obligations to the extent that fiduciary responsibilities can be delegated in accordance with the plan's documents.

See:

Presley v. Blue Cross-Blue Shield of Ala., 744 F. Supp. 1051, 1058 (N.D. Ala. 1990). *The defendant had not breached its fiduciary duty to notify the plaintiff of her employer's failure to make premium payments on an employee medical plan, because the defendant had effectively delegated that responsibility to the plaintiff's employer.*

However, if the plan documents do not provide "a procedure for the designation of persons who are not named fiduciaries to carry out fiduciary responsibilities, then any such designation which the named fiduciaries make will not relieve the named fiduciaries from responsibility or liability for the acts and omissions of the persons so designated." 29 C.F.R. § 2509.75-8 FR-14; see also In re Sears, Roebuck & Co. ERISA Litig., No. 02 C 8324, 2004 WL 407007, at *7 (N.D. Ill. Mar. 3, 2004).

Finally, a named fiduciary may reduce his fiduciary duty to prudently manage and control plan assets by appointing an investment manager under ERISA § 402(d)(1), 29 U.S.C. § 1102(c)(3). See Lowen v. Tower Asset Mgmt., Inc., 829 F.2d 1209, 1219 (2d Cir. 1987). Under § 405(d)(1), “once such an appointment has been made, the trustees cannot be held liable for any act or omission of that investment manager so far as the assets entrusted to the manager are concerned.” Id. As a result, the investment advisor “becomes a fiduciary with a duty of care and duty of loyalty to the plan while the trustees’ legal responsibilities regarding the wisdom of the investments are correspondingly reduced.” Id.

C. TERMINATING FIDUCIARY STATUS ARISING FROM THE EXERCISE OF FIDUCIARY FUNCTIONS

Courts have not yet addressed the question of how and when a person who has obtained fiduciary status informally, through the exercise of fiduciary functions, may terminate or resign fiduciary duties to a plan. As a result, there is no clear answer to whether such a person can terminate fiduciary obligations informally, by ceasing to serve in a fiduciary capacity, or whether some formal action is required to terminate the fiduciary status. Until a court specifically addresses that question, informal fiduciaries may be able to protect themselves by resigning or terminating their fiduciary duties in the same manner required of formal fiduciaries.

1. Resign formally

To resign effectively, courts have held that a formal fiduciary must “terminate in writing all contracts or arrangements with the plan” concerning the fiduciary position. Lowen v. Tower Asset Mgmt., Inc., 829 F.2d 1209, 1219 (2d Cir. 1987). Absent such a clear resignation, courts have held formal fiduciaries to have continued in fiduciary status. See PBGC, 570 F. Supp. at 1497.

There is no reason to expect that future courts will apply a different standard to informal fiduciaries. Thus, an informal fiduciary who wishes to relinquish fiduciary status should resign or terminate fiduciary obligations formally, in writing, to the appropriate parties responsible for the plan.

2. Resign unequivocally

Courts have consistently held that a person retains fiduciary status to the extent that he continues to exercise any of the discretionary functions set forth in ERISA § 3(21), 29 U.S.C. § 1002(21). See Smith v. Provident Bank, 170 F.3d 609, 613 (6th Cir. 1999); Wilson Land Corp. v. Smith Barney Inc., No. 97-cv-519, 1999 WL 1939270, at *3 (E.D.N.C. May 17, 1999); see also Conway v. Marshall & Ilsley Tr. Co., No. 87-cv-20379, 1988 WL 124924, at *1-*2 (N.D. Ill. Nov. 1, 1988). Therefore, a fiduciary who gained that status informally and wishes to relinquish fiduciary duties must unequivocally cease to perform any of the functions set forth in ERISA § 3(21). See Lowen v. Tower Asset Mgmt., Inc., 829 F.2d 1209, 1219 (2d Cir. 1987). This not only means that fiduciaries must explicitly cease to serve in fiduciary positions, but it also

means that they must relinquish possession of the plan's checkbooks, passbooks, and other documents. See Pension Benefit Guar. Corp., 570 F. Supp. at 1497-98.

3. Resign in the manner specified in the plan documents

Courts have held that formal fiduciary status is not terminated under ERISA unless it is resigned or terminated in the manner specified in the plan documents. See Reich v. Mercantile Bank I, 1994 U.S. Dist. LEXIS 21308, at *16-*17; see also Chambers v. Kaleidoscope, Inc. Profit Sharing Plan & Trust, 650 F. Supp. 359, 369 (N.D. Ga. 1986). Although no court has held that an informal fiduciary must also resign in this way, such resignation, if possible, would make the fiduciary's intent to terminate fiduciary obligations undeniably clear. As a result, an informal fiduciary who follows the plan's requirements for resignation may be able to protect himself against later challenges that the resignation was void for lack of adequate notice to the plan. Accordingly, any resigning fiduciary should resign in accordance with the plan documents if possible.

4. Make adequate arrangements for the continued prudent management of the plan

Courts have held that an ERISA fiduciary's obligations to a plan are extinguished only when the fiduciary has made adequate arrangements for the continued prudent management of the plan. See Freund, 485 F. Supp. at 635; Ream, 107 F.3d at 154. Such arrangements include a "turnover duty" to determine who the successor fiduciary will be, and investigation of the successor's qualifications, although they do not include a duty to investigate the successor's intentions. See Reich v. Mercantile Bank II, 1996 U.S. Dist. LEXIS 21963, at *71; Chambers, 650 F. Supp. at 369. In addition, some courts have held that a resigning fiduciary also has a duty to disclose all material information necessary for the protection and continuation of the plan. See Ream, 107 F.3d at 154; see also Glaziers & Glassworkers, 93 F.3d at 1182-83.

Although no court has held that a resigning informal fiduciary has a duty to make arrangements for the continuation of the plan, courts may apply the same rule to them as well. For example, in Chambers, the court noted that "the very purpose of imposing a fiduciary duty upon plan trustees and administrators is defeated if a fiduciary may abandon his or her duties in derogation of plan requirements, and without ensuring that the fiduciary obligations will be met." 650 F. Supp. at 369. Likewise, it would seem contrary to ERISA to allow an informal fiduciary, who has exercised fiduciary functions, to abandon his fiduciary status without making adequate arrangements for the plan's continued prudent management. Accordingly, an informal fiduciary who wishes to effectively terminate his fiduciary status would do well to make sure that the plan's trustees appoint a qualified successor fiduciary to take his or her place.

IV. ERISA REMEDIES FOR BREACH OF FIDUCIARY DUTIES

A. PERMISSIBLE ACTIONS FOR BREACH OF FIDUCIARY DUTIES

Two ERISA provisions, §§ 502(a)(2) and 502(a)(3), codified at 29 U.S.C. §§ 1132(a)(2) and 1132(a)(3), authorize actions for breaches of fiduciary duties. Although compensatory and punitive damages are not available under ERISA, equitable relief, including restitution, imposition of constructive trusts, injunctions, and specific performance, may be available to ERISA claimants under these sections.

Section 1132(a)(2) states: “A civil action may be brought by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title.” 29 U.S.C. § 1109 states:

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.

29 U.S.C. § 1109. In Massachusetts Mutual Life Insurance Co. v. Russell, 473 U.S. 134, 140-42 (1985), the Supreme Court declared that the only relief authorized under this section is to the plan itself. Thus an individual plaintiff can bring an action under § 1132(a)(2), but any recovery goes to the plan itself and not to the individual.

But see:

LaRue v. DeWolff, Boberg & Assocs., Inc., 552 U.S. 248, 254-55 (2008). *Although beneficiaries in a defined-contribution plan will not benefit equally from payments to the plan (due to varied investments), the recovery does go to the plan itself before it is distributed and therefore is allowed under § 1132(a)(2).*

The second section under which an action for a fiduciary duty breach may be brought is 29 U.S.C. § 1132(a)(3). Section 1132(a)(3) states:

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

29 U.S.C. § 1132(a)(3). In contrast to § 1132(a)(2), § 1132(a)(3) has been interpreted to provide relief to individuals rather than the plan as a whole. See Mertens v. Hewitt Assocs., 508 U.S. 248, 260 (1993). In contrast to § 502(a)(2), however, relief under § 1132(a)(3) is limited to “appropriate equitable relief.” See id. at 253. For a discussion of the extent to which these provisions preempt state claims, see Section I of this Handbook.

The Supreme Court initially interpreted the phrase “appropriate equitable relief” in Mertens. Justice Scalia, writing for the Court’s majority, stated that “equitable relief” as used in the statute refers to “categories of relief that were *typically* available in equity (such as injunction, mandamus, and restitution, but not compensatory damages).” Id. at 256. The Court stated that “[a]lthough they often dance around the word, what petitioners in fact seek is nothing other than compensatory *damages* – monetary relief for all losses their plan sustained as a result of the alleged breach of fiduciary duties. Money damages are, of course, the classic form of *legal* relief.” Id. at 255.

Lower court opinions following Mertens then varied in what they considered “equitable relief.” Plaintiffs bringing § 502(a)(3) claims often attempted to frame their prayer for relief as a claim for restitution to meet the standard for “equitable relief” articulated in Mertens. Thus, many circuit courts had to determine when a plaintiff sought the equitable remedy of “restitution,” versus an attempt to contort compensatory damages into equitable relief.

For example, the Eighth Circuit determined that restitution was sought in Varity Corp. v. Howe, 36 F.3d 746, 756-57 (8th Cir. 1994). In Varity, beneficiaries of a firm’s welfare benefit plan sued their plan’s administrator alleging that the administrator, who was also their former employer, led them to withdraw from the plan and forfeit their benefits. Id. at 749-50. The Eighth Circuit ordered the plaintiffs reinstated to the plan and ordered monetary damages equivalent to the benefits that the plaintiffs would have received had they remained in the original plan. Id. at 756-57. The Eighth Circuit’s majority reasoned that this remedy was equitable relief “in the nature of restitution” because it put the plaintiffs back in the position in which they would have been had there been no fiduciary duty breach. Id. Varity was later appealed to the Supreme Court. While the Supreme Court agreed that an individual may sue for relief under § 502(a)(3), it did not address whether the monetary damage award qualified as restitution and therefore “appropriate equitable relief.” Varity Corp. v. Howe, 516 U.S. 489, 492 (1996). Because the Supreme Court did not address the nature of the remedy, significant doubt remained as to the exact relief available under § 502(a)(3).

In 2002, the Supreme Court addressed this open issue and concluded that a judicial order to pay money is not “equitable relief” and therefore not authorized in a § 502(a)(3) claim merely because party claims it is seeking “restitution.” Great-W. Life & Annuity Ins. Co. v. Knudson, 534 U.S. 204, 210 (2002). In Knudson, the respondent was injured in an automobile accident and the benefit plan paid her medical expenses. Id. at 207. The plan provided that if the respondent recovered any amount from a third party for her injuries, she was obligated to reimburse Great West and the other

petitioners for the medical expenses they had paid. Id. When the respondent settled a tort claim stemming from the accident with a third party, the petitioners sued under ERISA § 502(a)(3) to enforce the plan's terms, claiming that they were entitled to an order that the respondent reimburse them for their payments. Id. at 207-08. The Ninth Circuit affirmed summary judgment for the respondent, concluding that the petitioners did not seek an appropriate equitable remedy as § 502(a)(3) requires. Id. at 209.

The Supreme Court affirmed the Ninth Circuit in a 5-4 decision. Id. at 221. The Court first reiterated that, under Mertens, "equitable relief" refers only to relief that was "*typically available in equity*" and that "[m]oney damages are, of course, the classic form of legal relief." Id. at 210 (quoting Mertens, 508 U.S. at 256). The Court concluded that the petitioners sought a remedy that would "impose personal liability on respondents for a contractual obligation to pay money – relief that was not typically available in equity." Id. While the petitioners argued that they sought an equitable remedy of restitution, the Court distinguished between restitution at law and restitution in equity. Id. 212-14. Great West and the other petitioners sought restitution at law because:

The basis for petitioners' claim is not that respondents hold particular funds that, in good conscience, belong to petitioners, but that petitioners are contractually entitled to *some* funds for benefits that they conferred. The kind of restitution that petitioners seek, therefore, is not equitable – the imposition of a constructive trust or equitable lien on particular property – but legal – the imposition of personal liability for the benefits that they conferred upon respondents.

Id. at 214. Because the petitioners sought legal relief which sought to impose personal liability on a contractual obligation to pay money, § 502(a)(3) did not authorize the action. Id. at 221.

In 2011, the Supreme Court again considered the scope of the remedies under § 502(a)(3) in CIGNA Corp. v. Amara, 563 U.S. 421 (2011). In this case, CIGNA Corp. made the decision to change its ERISA benefits plan, and in doing so, sent out summary plan descriptions (SPDs) advising of the change. Id. at 432. However, the district court found those SPDs to be misleading and a violation of CIGNA's fiduciary duty to plan participants. Id. at 432-33. As a remedy for the breach, the district court changed the language of the new plan to mirror the erroneous language of the SPDs and ordered CIGNA to implement the new language. Id. at 433-34. The Supreme Court held that such a remedy was not allowed under § 502(a)(1)(B) of the plan. Id. at 435-36. However, the court then went on to speculate that such a remedy could be authorized under § 502(a)(3) as "other appropriate equitable relief." Id. at 438. The Supreme Court suggested that the lower court's re-write of the plan could fall within the remedies of reformation, estoppel or surcharge, each of which the majority of the Court considered to be a traditional equitable remedy. Id. at 440-42. The Court did not rule

that any of these remedies did apply, however. Instead, it remanded the case to the district court to make that determination. Id. at 442-43.

B. REMEDIES

1. Compensatory and punitive damages are not available

The Supreme Court has clearly ruled that compensatory and punitive damages are not recoverable in an ERISA action for breach of fiduciary duty. In Massachusetts Mutual Life Insurance Co. v. Russell, 473 U.S. 134, 144 (1985), the Supreme Court held that neither compensatory nor punitive relief was available under ERISA. See also 29 U.S.C. § 1109. The Court declared that “[t]he 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.” Russell, 473 U.S. at 146. Thus remedies for breach of fiduciary duty under ERISA are limited to remedies of an equitable rather than a legal nature.

See:

Great-W. Life Annuity Ins. Co. v. Knudson, 534 U.S. 204, 210 (2002). *Petitioners seeking to impose personal liability on respondents for a contractual obligation to pay money is relief that was not typically available in equity and is therefore not available under § 502(a)(3).*

Mertens v. Hewitt Assocs., 508 U.S. 248, 256-58 (1993). *Participants in benefits plan sued actuary claiming that the actuary had caused losses by allowing the plan sponsor to select improper actuarial assumptions, failing to disclose that the plan sponsor was one of Hewitt’s clients, and not identifying the plan’s funding shortfall. The Supreme Court held that petitioners were seeking compensatory damages and that ERISA does not authorize awards of compensatory damages for breach of fiduciary duty. Equitable relief refers to categories of relief that were typically available in equity, such as injunction, mandamus, and restitution, but not to compensatory damages.*

Mass. Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 148 (1985). *Beneficiary of employee benefit plan brought an action to recover damages for improper processing of her claims for disability benefits. The Supreme Court held that the relevant text of ERISA, the structure of the entire statute, and the legislative history all supported the conclusion that Congress did not provide and did not intend the judiciary to provide a cause of action for extracontractual damages caused by improper or untimely processing of benefit claims.*

Smith v. Med. Benefit Adm’rs Grp., Inc., 639 F.3d 277, 283-84 (7th Cir. 2011). *Plan participant’s suit to recover for surgery that was preauthorized but not covered under the insurance plan cannot stand under § 502(a)(3)*

because monetary compensation for an injury is a classic form of legal relief.

See also:

Kenseth v. Dean Health Plan, Inc., 610 F.3d 452, 482-83 (7th Cir. 2010). Plan beneficiary sued to recover costs of surgery, saying the Plan wrongly denied coverage. The court found that such relief was legal rather than equitable, especially because plaintiff alleged she suffered a pecuniary loss and other consequential damages. The court remanded to the district court to determine whether the plaintiff had any claims for equitable relief.

Amschwand v. Spherion Corp., 505 F.3d 342, 348 (5th Cir. 2007), overruled on other grounds by Gearlds v. Entergy Servs., Inc., 709 F.3d 448, 452 (5th Cir. 2013). Plaintiff sued under § 502(a)(3) to recover the combined life insurance benefits she would have been entitled to if her husband had complied with a certain rule under the policy. The court held that the plaintiff's attempt to recover the lost proceeds was a form of "make-whole" damages that she was not entitled to in equity.

Allinder v. Inter-City Prods. Corp. (USA), 152 F.3d 544, 552 (6th Cir. 1998). Former employee sued employer for alleged violations of ERISA, alleging that employer refused to complete a form necessary for her to file a long-term disability insurance claim. Employee was eventually paid the benefits due under the policy but sought compensatory and punitive damages for the initial misrepresentation and resultant delay in payment. The Sixth Circuit affirmed the district court's decision to dismiss the case because ERISA §1132(a)(3) does not authorize suits for either compensatory or punitive damages.

Cent. States, Se. & Sw. Areas Health & Welfare Fund ex rel. Bunte v. Health Special Risk, Inc., 756 F.3d 356, 361-63 (5th Cir. 2014). The Fifth Circuit affirmed dismissal of ERISA provider's request for injunctive relief to compel the payment of money past due under a contract, or specific performance of a past due monetary obligation because the nature of the remedy sought was money damages, which does not fall within "those categories of relief that were typically available in equity." Buckley Dement, Inc. v. Travelers Plan Adm'rs of Ill., Inc., 39 F.3d 784, 787-88 (7th Cir. 1994). Sponsor, administrator and fiduciary of health care plan sued third-party claims administrator for violation of alleged fiduciary duty under ERISA and for breach of contract, negligence, and breach of common law fiduciary duty. The complaint generally alleged that Travelers failed to submit the appropriate claims before the expiration of its policy. Buckley requested monetary relief and punitive damages. The Seventh Circuit held that the relief sought by the plaintiffs was not equitable in nature and therefore could not be recovered under §502(a)(3). The substance of the remedy sought was monetary relief for all losses sustained as a result of

the breach of fiduciary duty, and such recovery was not sanctioned under ERISA §502(a)(3).

2. Restitution

Following Mertens v. Hewitt Associates, 508 U.S. 248, 256-58 (1993), most circuit courts treated Justice Scalia's list of equitable remedies (injunction, mandamus, and restitution) as exhaustive. See LaRue v. DeWolff, Boberg & Assocs., 450 F.3d 570, 575 (4th Cir. 2006). However, as discussed above, a controversy continued to exist regarding the definition of restitution and when courts could order monetary damages or order a constructive trust. Even though Justice Scalia identified monetary damages as the classic form of legal relief, some circuit courts maintained that restitution may take the form of a monetary payment and therefore qualified as an equitable remedy.

Great-West Life & Annuity Insurance Co. v. Knudson, 534 U.S. 204, 213-14 (2002) clarified, however, that an order that imposes a personal liability for a contractual obligation to pay money is not relief typically available in equity, even if the plaintiffs call it "restitution." By distinguishing between "restitution at law" and "restitution in equity," the Court found that for restitution to be equitable relief under § 502(a)(3) it must impose a constructive trust or equitable lien on particular property that in good conscience belongs to the plaintiff and not merely the obligation to pay money to the plaintiff. See id. at 214.

To further address confusion among the circuit courts as to when restitution was an equitable remedy, the Supreme Court decided Sereboff v. Mid Atlantic Medical Services, Inc., 547 U.S. 356, 362-63 (2006). This case basically presented the same set of facts as Knudson. Mid Atlantic sued the Sereboffs, a husband and wife who had been in a car accident, for money received in a third party settlement of certain tort claims stemming from the car accident. Id. at 360. The policy between Mid Atlantic and the Sereboffs included a third party provision stating that Mid Atlantic could recover reimbursement of health benefits paid from the Sereboffs in this instance. Id. at 359. The court held that because the Sereboffs still possessed the money from the settlement (and at the beginning of the suit, the portion claimed by Mid Atlantic had been set aside by order of the district court), Mid Atlantic was pursuing an equitable remedy in recovering that money, provided the basis for Mid Atlantic's claim was equitable. Id. at 362-63. The Court distinguished Knudson by explaining that in that case, the Knudsons were no longer in possession of the funds, as the funds had been placed in a "Special Needs Trust" under California law. Id. at 362; accord US Airways, Inc. v. McCutchen, 569 U.S. 88, 94-95 (2013); accord Montanile v. Bd. Trs. of Nat. Elevator Indus. Health Benefit Plan, 577 U.S. 136 (2016).

Even with the Supreme Court's clarification, there is some uncertainty among the appellate courts about when to characterize restitution as equitable or legal.

See:

Mondry v. Am. Family Mut. Ins. Co., 557 F.3d 781, 805-07 (7th Cir. 2009). The court held that the plaintiff had a viable claim against the defendant for the lost time value of money the plaintiff was forced to spend until she obtained copies of her insurance forms. The Seventh Circuit found that a breach of fiduciary duty for failing to give a plan participant plan documents could give rise to unjust enrichment in the form of “interest-free” use of money. Because the plaintiff was seeking restitution of funds in the defendant’s possession obtained by breach of trust, the remedy was equitable.

Coan v. Kaufman, 457 F.3d 250, 263-64 (2d Cir. 2006). The plaintiff sought relief from plan fiduciaries under § 502(a)(3), asking for both monetary damages and an injunction to restore funds to terminated 401(k) plans to be distributed to former participants. The Second Circuit held that the injunctive relief sought was not equitable in nature because the plaintiffs did not seek to recover a particular fund from the defendant. The Second Circuit explained that the injunctive relief sought by plaintiff was effectively a money damages request, which is unavailable under § 502(a)(3). Accordingly, the court concluded that the remedies sought by plaintiff are unavailable under ERISA. The court also held that a suit against a fiduciary (as opposed to a non-fiduciary) did not expand the world of equitable relief available under § 502(a)(3).

Knieriem v. Grp. Health Plan, Inc., 434 F.3d 1058, 1061 (8th Cir. 2006). Beneficiary sued insurer after insurer denied coverage of a stem-cell transplant. Plaintiff claimed that he was entitled to the procedure under the policy and sought restitution of the foregone benefit. The court denied relief, holding that plaintiff essentially sought monetary relief rather than any recoupment of expenses already paid.

Depot, Inc. v. Caring for Montanans, Inc., 915 F.3d 643, 665 (9th Cir. 2019). Small employers sued health insurance companies asserting breach of fiduciary duty and prohibited transaction claims under § 502(a)(3) and seeking “restitution” and “disgorgement.” The Ninth Circuit affirmed dismissal of the small employers’ claims for restitution because the small employers sought recovery from the insurance companies’ general funds, which was restitution at law, not equity. For the restitutionary remedy to be equitable, the small employers would need to seek recovery from a specific fund.

Cent. States, Se. & Sw. Areas Health & Welfare Fund v. Gerber Life Ins. Co., 771 F.3d 150 (2d Cir. 2014); Cent. States, Se. & Sw. Areas Health & Welfare Fund v. Bollinger, Inc., 573 F. App’x 197 (3d Cir. 2014); Cent. States, Se. & Sw. Areas Health & Welfare Fund ex rel. Bunte v. Health Special Risk, Inc., 756 F.3d 356 (5th Cir. 2014); Cent. States, Se. & Sw. Areas Health & Welfare Fund v. First Agency, Inc., 756 F.3d 954 (6th Cir. 2014); Cent. States, Se. & Sw. Areas Health & Welfare Fund v. Student

Assur. Servs., Inc., 797 F.3d 512 (8th Cir. 2015). Health benefit plan commenced several actions under ERISA against various insurance entities seeking restitution to reimburse the health benefit plan for medical expenses paid by the health benefit plan. The courts of appeals that examined the health benefit plans' restitutionary claims found that the health benefits plan sought a legal remedy because there was no specific block of money that had passed from the health benefits plan to the various defendants.

Edmonson v. Lincoln Nat. Life Ins. Co., 725 F.3d 406, 420 (3d Cir. 2013). The Third Circuit found that group life insurance plan beneficiary's claim for disgorgement, based on insurer's alleged conduct in paying benefits using a retained asset account, which allowed the insurer to hold onto the benefits and invest them for its own profit until the beneficiary affirmatively chose to withdraw them from the account, was an equitable remedy available under ERISA; beneficiary's disgorgement claim was akin to an accounting for profits, which was a form of equitable restitution.

Teets v. Great-W. Life & Annuity Ins. Co., 921 F.3d 1200, 1230-31 (10th Cir. 2019). Plan participant failed to establish that his claims for restitution and accounting for profits based on non-fiduciary investment fund manager's purported use of plan assets for its own benefit were equitable in nature because participant failed to identify specific assets that manager allegedly commingled with its other assets to generate profits he sought to disgorge.

Bilyeu v. Morgan Stanley Long Term Disability Plan, 683 F.3d 1083 (9th Cir. 2012). The Ninth Circuit remanded the district court's grant of summary judgment in favor of life insurance company on its counterclaim for restitution of overpaid benefits under § 502(a)(3) because the life insurance company failed to show that it was seeking equitable relief, identify a particular fund it was entitled to, or that the overpaid long-term disability benefits could be traced or remained in defendant's possession.

Or. Teamster Emp'rs Tr. v. Hillsboro Garbage Disposal, Inc., 800 F.3d 1151, 1160 (9th Cir. 2015). Claim by health plan seeking restitution of health benefits paid on behalf of employees was not cognizable under § 502(a)(3). The plan sought enforcement of plan's reimbursement provision, which specifically provided for remedies, indicating that action was an action at law to remedy breach of legal obligation. The Ninth Circuit explained that the remedy sought was legal and not equitable because the plan did not seek recovery from an identifiable res. Treasurer, Trs. of Drury Indus., Inc. Health Care Plan & Tr. v. Goding, 692 F.3d 888, 896-97 (8th Cir. 2012). Plan administrator's action to recover benefits conferred on beneficiary from law firm that represented beneficiary in a civil suit for damages related to injuries for which beneficiary had already

received ERISA benefits sought a legal remedy and therefore would not be allowed under § 502(a)(3).

3. Surcharge

In CIGNA Corp. v. Amara, 563 U.S. 421, 442-44 (2011), the Supreme Court discussed another type of remedy traditionally available in equity: surcharge. According to the Court in Amara, surcharge provides monetary compensation for a loss that occurs as a result of a fiduciary's breach of duty. Id. at 442. This monetary remedy was enforced in equity to prevent a fiduciary's unjust enrichment. Id. at 441. In Amara, the Supreme Court explained that a "surcharge" was an equitable remedy that potentially could be granted as relief for violations under § 502(a)(3). Id. at 444. However, the Court's language in describing the imposition of a surcharge seemed to limit this remedy solely to claims against fiduciaries because it is a remedy for a breach of a *fiduciary* duty. See id. Therefore, a surcharge might not be an appropriate remedy against a non-fiduciary.

Since Amara, federal courts have found that surcharge is an available equitable remedy under § 502(a)(3).

See:

In re DeRogatis, 904 F.3d 174, 199-200 (2d Cir. 2018). *The Second Circuit vacated a district court's judgment that did not determine whether plaintiff would be entitled to surcharge or other equitable relief. The court instructed that the district court should consider whether plaintiff would be entitled to a surcharge or other "appropriate equitable relief" under § 502(a)(3) if she successfully proves that the welfare fund breached a fiduciary duty.*

Pa. Chiropractic Ass'n v. Blue Cross Blue Shield Ass'n, No. 09-cv-5619, 2012 WL 182213, at *7 (N.D. Ill. Jan. 23, 2012). *Plaintiff needed to prove actual harm for the court to surcharge a trustee/fiduciary. The court held that under Amara, the plaintiff must show that the alleged denial of an administrative process caused actual harm.*

Moyle v. Liberty Mut. Ret. Ben. Plan, 823 F.3d 948, 965 (9th Cir. 2016). *Plan participants sought payments of benefits under retirement plan and equitable relief in the form of reformation and surcharge. The Ninth Circuit reversed the district court's grant of summary judgment in favor of the retirement plan on the equitable claims under § 502(a)(3). The Ninth Circuit explained that reformation and surcharge do not always require detrimental reliance on summary plan descriptions. Instead, plaintiffs need only show harm and causation.*

Silva v. Metro. Life Ins. Co., 762 F.3d 711, 722 (8th Cir. 2014). *Beneficiary of deceased employee's life insurance policy sued employer and insurer seeking equitable relief under § 502(a)(3), including surcharge. The*

district court granted summary judgement and found that a § 502(a)(3) claim for surcharge would be futile. The Eighth Circuit reversed the district court's summary judgement order because beneficiary could show harm resulting from the plan administrator's breach of fiduciary duty by failing to provide a summary plan description.

Kenseth v. Dean Health Plan, Inc., 722 F.3d 869, 883 (7th Cir. 2013). The Seventh Circuit reversed the pre-Amara entry of summary judgement for plan administrator. The Seventh Circuit explained that after Amara equitable relief under § 502(a)(3) is broader than the court has previously held and includes surcharge, which is equitable "make-whole relief in the form of money damages." The court noted that the district court even remarked that – based on the previous limitations to § 502(a)(3) claims – "[m]any might be surprised to learn that [the] defendant has no legal duty to make things right" even though the administrator lulled the plaintiff "into believing she had coverage for an expensive operation, only to reverse course after the procedure was performed, leaving her with a stack of medical bills." The Seventh Circuit held that equitable relief available under § 502(a)(3) includes surcharge if plaintiff can show a breach of fiduciary duty and that the breach caused her damages.

Gearlds v. Entergy Servs., Inc., 709 F.3d 448, 452 (5th Cir. 2013). The Fifth Circuit reversed the district court's dismissal of § 502(a)(3) claims under Rule 12(b)(6) and explained that plaintiff sufficiently stated a claim for relief in the form of surcharge that is cognizable under ERISA.

McCrary v. Metro. Life Ins. Co., 690 F.3d 176, 183 (4th Cir. 2012). The Fourth Circuit reversed the district court's determination in its dismissal order that surcharge is unavailable as a matter of law under § 502(a)(3) and explained that Amara makes it clear that surcharge is an available equitable remedy.

4. Rescission

A rescission is an avoidance of a transaction. Dan B. Dobbs, *Handbook on the Law of Remedies* § 4.3(6) at 422 (3d ed. 2018). Like the restitution claim involved in Knudson, a rescission claim can sound in law or in equity. Rescission at law occurs when the plaintiff gives notice to the defendant that the transaction has been voided and tenders to the defendant the benefits received by the plaintiff under the contract. Griggs v. E.I. DuPont de Nemours & Co., 385 F.3d 440, 445-46 (4th Cir. 2004) (Griggs II). An action for rescission in equity, however, is a suit to have the court terminate the contract and order restitution. Id. at 446. Distinguishing between "rescission at law" and "rescission at equity," the Fourth Circuit has held that equitable actions for rescission are appropriate under ERISA. Id. Other circuits have reached the same conclusion.

See:

Adams v. Brink's Co., 261 F. App'x 583, 596-97 (4th Cir. 2008). Employer sought rescission where overpaid benefits would be reduced by a reduction in future payments to the employee. The court denied the employer relief because the employee detrimentally relied on an incorrect calculation of benefits prepared by the employer. Thus, it would be "inequitable" to grant the employer rescission in light of the misrepresentations.

Griggs v. E.I. DuPont de Nemours & Co., 385 F.3d 440, 445-49 (4th Cir. 2004) (*Griggs II*). Employee who took early retirement brought action against employer claiming that employer negligently misrepresented the tax consequences of his election to take early retirement. The Fourth Circuit found that the plaintiff could not unilaterally "unretire" by returning his benefits and returning to work, so his action to amend his benefit election to select a monthly annuity rather than a lump sum payment clearly involved equitable rescission. The court held, as a matter of federal common law, rescission may be granted as "appropriate equitable relief" under ERISA, even if a full restoration of benefits conferred in the transaction cannot be accomplished.

Provident Life & Acc. Ins. Co. v. Sharpless, 364 F.3d 634, 640 (5th Cir. 2004). The Fifth Circuit held that ERISA permits an action seeking rescission of an ERISA-governed insurance policy if a beneficiary makes a material misrepresentation when applying for the policy.

Perez v. Bruister, 823 F.3d 250, 266 (5th Cir. 2016). The Fifth Circuit affirmed the district court's denial of rescission but also recognized there may be some ERISA cases where rescission is the proper recovery or if fair market value cannot be easily determined.

Shipley v. Arkansas Blue Cross & Blue Shield, 333 F.3d 898, 902-03 (8th Cir. 2003). The Eighth Circuit held that "misrepresentation as to a material matter made knowingly in an application for an ERISA-governed insurance policy is sufficient to rescind the policy."

Sec. Life Ins. Co. of Am. v. Meyling, 146 F.3d 1184, 1191 (9th Cir. 1998). Insurer sued to rescind insured employee's policy for misrepresentations in application. The Sixth Circuit held that under federal common law in applying ERISA, rescission is a remedy available when an insured makes material, false representations regarding health.

5. Reformation

The Supreme Court in *Amara* also suggested that the equitable remedy of reformation could be available as appropriate equitable relief under ERISA § 502(a)(3). *Amara*, 563 U.S. 440-41. Reformation is the restructuring of the language of a contract so that the terms reflect the parties' mutual intent or to prevent fraud. *Id.* at 440. In

Amara, the Court stated that reformation could accomplish the equitable result of remedying the false and misleading information that the plan provided to participants. Id. Although stated in dictum, the court acknowledged that reformation is a form of equitable relief available in ERISA actions. See id.

See:

Amara v. CIGNA Corp., 775 F.3d 510, 526-30 (2d Cir. 2014). The Second Circuit held that the district court did not err in determining that plaintiffs established a basis for the court to reform a pension plan due to defendant's fraud and plaintiffs' unilateral mistake. The court explained that reformation is an equitable remedy under § 502(a)(3) to redress fraud committed by plan administrators and plan sponsors.

Young v. Verizon's Bell Atl. Cash Balance Plan, 615 F.3d 808, 818-19 (7th Cir. 2010). Reformation was available as a remedy where there is clear and convincing evidence that the plan does not reflect the parties' intent or there is a scrivener's error. The court explained that most circuits that have decided the issue have concluded that ERISA authorizes, or at least does not foreclose the possibility of, reformation.

Moyle v. Liberty Mut. Ret. Ben. Plan, 823 F.3d 948, 965 (9th Cir. 2016). Plan participants sought payments of benefits under retirement plan and equitable relief in the form of reformation and surcharge. The Ninth Circuit reversed the district court's grant of summary judgment in favor of the retirement plan on the equitable claims under § 502(a)(3). The Ninth Circuit explained that reformation and surcharge do not always require detrimental reliance on summary plan descriptions. Instead, plaintiffs need only show harm and causation.

Silva v. Metro. Life Ins. Co., 762 F.3d 711, 722 (8th Cir. 2014). Beneficiary of deceased employee's life insurance policy sued employer and insurer seeking equitable relief under § 502(a)(3), including reformation. The Eighth Circuit reversed the district court's summary judgement order because beneficiary could show mutual mistake or fraud of one party and the mistake of the other. The Eighth Circuit explained that it was arguably fraudulent for the insurer to collect premiums from an employee who never had an approved policy.

6. Imposition of Constructive Trust

Another remedy that is clearly equitable and within a court's power in an ERISA action for fiduciary duty breach is the imposition of a constructive trust. "If A wrongfully appropriates money or other property belonging to B, the court can order A to hold the property in trust for B." Clair v. Harris Tr. & Sav. Bank, 190 F.3d 495, 498-99 (7th Cir. 1999). In Knudson, the Supreme Court explained that constructive trusts and equitable liens were available remedies in equity. Knudson, 534 U.S. at 213. The

constructive trust remedy operates much like restitution and there is a similar emphasis on ill-gotten gain. This remedy may be more attractive to courts that are reluctant to order any type of monetary payment given Justice Scalia's discussion of monetary damages in Mertens as the classic legal remedy and therefore inappropriate under ERISA. See Mertens, 508 U.S. at 255.

See:

Montanile v. Bd. of Trs. of Nat. Elevator Indus. Health Benefit Plan, 136 S. Ct. 651, 659 (2016). The Supreme Court explained that although constructive trusts and equitable liens are equitable remedies and thus available under § 502(a)(3), those remedies can only be enforced against specifically identified funds properly belonging to plaintiffs that remain in the defendants' possession or against traceable items that the defendant purchased with the funds. Constructive trusts or equitable liens cannot be enforced upon any part of the wrongdoer's property. Accordingly, the Supreme Court reversed the lower courts' decisions permitting plaintiff to recover out of defendant's general assets.

Gen. Produce Distrib., Inc. v. Prof'l Benefit, No. 08-cv-5681, 2009 WL 2449025, at *11 (7th Cir. Aug. 7, 2009). A plaintiff brought an action to recover, through a constructive trust, funds that were not distributed at the termination of the plan and fees paid to fiduciaries. The court determined that a constructive trust in these circumstances was an equitable remedy permitted by the statute.

Admin. Comm. of Wal-Mart Stores, Inc. Assocs.' Health & Welfare Plan v. Varco, 338 F.3d 680, 686-88 (7th Cir. 2003). Administrator brought action seeking to impose constructive trust on funds received by participant in state court personal injury action and currently held in a reserve bank account established by participant in anticipation of litigation. Because the funds were identifiable, had not been dissipated, were still in participant's control, and in good conscience belonged to the administrator, the Seventh Circuit held that administrator's action sought "appropriate equitable relief," not a claim for a legal remedy and could be pursued under ERISA.

Clair v. Harris Tr. & Sav. Bank, 190 F.3d 495, 498-99 (7th Cir. 1999). Participants brought class action against retirement plan administrator under ERISA challenging delay in payment of benefits. The Seventh Circuit stated that plaintiff's plea for the court to impose a constructive trust on the interest that the defendants earned on benefits withheld in violation of the terms of the plan was an equitable remedy and "squarely within the scope of section 502(a)(3)(B)."

See also:

Edmonson v. Lincoln Nat. Life Ins. Co., 725 F.3d 406, 420 (3d Cir. 2013). The Third Circuit explained that disgorgement and accounting for profits are equitable remedies available under § 502(a)(3) when defendants no longer have possession of the retained assets, making a claim for a constructive trust unnecessary.

Rochow v. Life Ins. Co. of N. Am., 780 F.3d 364, 394 (6th Cir. 2015). The Sixth Circuit affirmed the district court's disgorgement and accounting order under § 502(a)(3) because defendants no longer had possession of the retained assets, making a claim for a constructive trust unnecessary.

C. INJUNCTIONS AND SPECIFIC PERFORMANCE

An injunction is one of the specific remedies that Justice Scalia cites in the Mertens decision. Mertens, 508 U.S. at 255. Appellate courts have upheld decisions to grant both preliminary and permanent injunctions. The most common injunction sought for breach of fiduciary duty is reinstatement in the benefit plan. See, e.g., Varity Corp. v. Howe, 516 U.S. 489, 492 (1996); Griggs v. E.I. DuPont de Nemours & Co., 237 F.3d 371, 384-85 (4th Cir. 2001) (Griggs I). An injunction ordering specific performance can function in much the same way as monetary damages when the clause at issue in the plan determines whether or not the plaintiff will receive benefits. For example, in In re Unisys Corp. Retiree Medical Benefit ERISA Litigation, 57 F.3d 1255, 1269 (3d Cir. 1995), the Third Circuit held that an injunction ordering specific performance requiring an employer to continue benefits for its employees after retirement is an equitable remedy available under ERISA that the district court could consider on remand. In Blue Cross & Blue Shield of Alabama v. Sanders, 138 F.3d 1347, 1352 n. 5 (11th Cir. 1998), the Eleventh Circuit held that federal subject matter jurisdiction exists because Blue Cross sought specific performance, which is "appropriate equitable relief" under § 502(a)(3). The court explained that specific performance was appropriate because legal remedies were inadequate due to the fact that ERISA preemption precluded Blue Cross from bringing an action for damages in state court. Id. In Amara, the Supreme Court summarily stated that "[t]he District Court's affirmative and negative injunctions obviously fall within this category [of traditional equitable remedies]." Amara, 563 U.S. at 440.

See:

Blue Cross & Blue Shield of Ala. v. Sanders, 138 F.3d 1347, 1352 n.5 (11th Cir. 1998). Claims administrator brought reimbursement action under ERISA against participants in an employee health benefits plan. Specific performance of a reimbursement provision was an equitable remedy and therefore could constitute "appropriate equitable relief" under 29 U.S.C. § 1132(a)(3).

In re Unisys Corp. Retiree Med. Benefit ERISA Litig., 57 F.3d 1255, 1268-69 (3d Cir. 1995). Retirees brought a class action suit against former employer, as plan administrator, under ERISA seeking post-retirement

medical benefits. Company representatives misinformed employees that once they retired, their medical benefits would “be continued for the rest of your life.” The circuit court relied on Varity and held that reimbursement for back benefits and an injunction ordering specific performance of the assurances Unisys made were remedies which were restitutionary in nature and thus equitable. The case was remanded to the district court for determination of which of these equitable remedies were appropriate.

Beck v. Levering, 947 F.2d 639, 641-42 (2d Cir. 1991). A permanent injunction enjoining defendants from serving as ERISA fiduciaries was an appropriate remedy where \$30 million of assets was invested in companies in which one or more defendants owned an interest and the plan lost more than \$20 million.

N.Y. State Psychiatric Ass’n v. UnitedHealth Grp., 798 F.3d 125, 133-35 (2d Cir. 2015). The Second Circuit reversed and remanded district court’s dismissal of employee’s § 502(a)(3) claims for declaratory and injunctive relief because those remedies are available under § 502(a)(3) and it was not clear if the employee’s claims could be compensated by money damages and injunctive relief.

V. ERISA § 404(a)(1)(A), 29 U.S.C. § 1104(a)(1)(A): THE DUTY TO ACT SOLELY IN THE INTEREST OF PARTICIPANTS AND BENEFICIARIES AND FOR THE EXCLUSIVE PURPOSE OF PROVIDING BENEFITS TO THEM AND DEFRAYING ADMINISTRATIVE COSTS

The Supreme Court has indicated that the ERISA fiduciary duties “have the familiar ring of their source in the common law of trusts,” which “charges fiduciaries with a duty of loyalty to guarantee beneficiaries’ interests.” Pegram v. Herdrich, 530 U.S. 211, 224 (2000). But unlike a common law trustee, who “is not permitted to place himself in a position where it would be for his own benefit to violate his duty to the beneficiaries,” the ERISA scheme recognizes that “a fiduciary may have financial interests adverse to beneficiaries.” Id. at 225 (internal quotation omitted). This duty of loyalty and the permissible range of dual loyalty is established through the strong delineations of the ERISA fiduciary’s specific duties toward the trust. For example, ERISA § 404(a)(1)(A) mandates that a fiduciary “shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and . . . for the exclusive purpose of” providing benefits to the participants and beneficiaries and defraying administrative costs. 29 U.S.C. § 1104(a)(1)(A).

A. ERISA OBLIGATES FIDUCIARIES TO ADHERE TO A STRICT STANDARD OF LOYALTY

Courts have characterized ERISA § 404(a)(1) as establishing either a two- or three- part regime of duties, depending on whether the language “solely in the interest of” and “exclusive purpose” are aggregated as part of one duty or split off into separate obligations. See, e.g., Gregg v. Transp. Workers of Am. Int’l, 343 F.3d 833, 840-41 (6th Cir. 2003); Krohn v. Huron Mem’l Hosp., 173 F.3d 542, 547 (6th Cir. 1999) (finding § 404 sets up a tripartite scheme requiring of fiduciary (a) loyalty, (b) prudent care, (c) action with exclusive purpose of providing benefits/defraying costs); Grindstaff v. Green, 946 F. Supp. 540, 548-49 (E.D. Tenn. 1996) (noting three components of ERISA fiduciary duties), aff’d, 133 F.3d 416 (6th Cir. 1998). But see Braden v. Wal-Mart Stores, Inc., 588 F.3d 585, 595 (8th Cir. 2009) (stating that ERISA imposes “twin duties of loyalty and prudence”); DiFelice v. U.S. Airways, Inc., 497 F.3d 410, 417–18 (4th Cir. 2007) (finding that “in common parlance, ERISA fiduciaries owe participants duties of prudence and loyalty”).

Regardless of the particular architecture of the duties, § 404(a)(1) clearly obligates the fiduciary to devote utmost loyalty to the interests of the trust participants and beneficiaries. See Gregg, 343 F.3d at 840-41 (finding § 404(a)(1) establishes duty of loyalty requiring fiduciary to make all decisions regarding ERISA plan solely in interests of participants and beneficiaries and for exclusive purpose of providing benefits or defraying costs). Such loyalty requires an “eye single to the interest of the participants and beneficiaries.” State St. Bank & Trust Co. v. Salovaara, 326 F.3d 130, 136 (2d Cir. 2003) (citing Donovan v. Bierwirth, 680 F.2d 263, 271 (2d Cir. 1982) (Bierwirth II)); see also Morris v. Winnebago Indus., 936 F. Supp. 1509, 1522 (N.D. Iowa 1996) (finding unwavering duty to make decisions with single-minded devotion to ERISA participants and beneficiaries). This duty includes more than mere fiscal accountability,

as it charges the fiduciary with an “undivided loyalty, not just responsibility for sound stock-picking and bookkeeping.” Int’l Bhd. of Painters & Allied Trades Union & Indus. Pension Fund v. Duval, 925 F. Supp. 815, 823 (D.D.C. 1996). This loyalty requires the fiduciary’s vigorous advocacy on the plan participants’ and beneficiaries’ behalf. See, e.g., Wulf v. Quantum Chem. Corp., 26 F.3d 1368, 1377–78 (6th Cir. 1994) (finding employer violated duties by diminishing payments to vested participants); see also, Dairy Fresh Corp. v. Poole, 108 F. Supp. 2d 1344, 1359-60 (S.D. Ala. 2000) (finding employer violated duties by bringing action against plan trustee to reform plan to divest plan of assets by one-half and to commensurately benefit company and its board members)).

1. A fiduciary may have limited interests adverse to those of plan beneficiaries

Generally, a fiduciary, while acting in that capacity, must not engage in activities or have any interests which conflict with those of the beneficiaries. However, in ERISA plans, a fiduciary may often also represent a union or an employer as an officer, employee, or agent in addition to managing the plan trust. Varity Corp. v. Howe, 516 U.S. 489, 498 (1996). This dual representation thus gives rise to a situation of dual loyalty that could potentially undermine the fiduciary’s commitment to the plan.

To address this potential conflict, ERISA expressly prohibits a plan fiduciary from diverting plan funds to itself or for the interest of anyone other than plan beneficiaries. See 29 U.S.C. §1103(c)(1). In attempting to understand the scope of the duty of loyalty and its concomitant singular interest, one district court concluded that “the obvious intent of Congress is that § 1104(a)(1)(A) shall mean that ‘the assets of a plan shall never inure to the benefit of any employer,’ thus forever forbidding employer self-dealing in the Fund’s assets.” Winpisinger v. Aurora Corp., Precision Castings Div., 456 F. Supp. 559, 565-66 (N.D. Ohio 1978) (quoting 29 U.S.C. §1103(c)); see Freund v. Marshall & Ilsley Bank, 485 F. Supp. 629, 639-40 (W.D. Wis. 1979) (holding where trustees either stood to benefit personally or represented persons who stood to benefit from plan investment choices, ERISA absolutely prohibited trustees from even attempting to act on behalf of plan).

a) The fiduciary must protect the interests of plan beneficiaries

The anti-inurement or “exclusive benefit” policy of ERISA § 403(c) is intended to protect participants’ financial expectations by precluding trustees/employers from diverting funds to themselves. See Maez v. Mountain States Tel. & Tel., Inc., 54 F.3d 1488, 1506 (10th Cir. 1995). However, despite the absolutist interpretation offered by the district courts in Winpisinger and Freund, other courts have formulated a different guideline that provides “the exclusive benefit rule can be violated only if there has been a removal of plan assets for the benefit of the plan sponsor or anyone other than the plan participants.” Resolution Trust Corp. v. Fin. Inst. Ret. Fund, 71 F.3d 1553, 1557 (10th Cir. 1995) (citing Aldridge v. Lily-Tulip, Inc. Salary Ret. Plan Benefits Comm., 953 F.2d 587, 592 n.6 (11th Cir. 1992) and holding violation of exclusive benefit rule occurs

when use of funds does not benefit employees). This formulation permits the kind of dual loyalty arising from trustee decisions to invest in an employer's securities, thus granting a "benefit" to the trustee/employer from the plan assets but not removing assets to do so. See Brown v. Am. Life Holdings, Inc., 190 F.3d 856, 860 (8th Cir. 1999).

Additionally, ERISA § 408(e) specifically allows an ERISA plan to acquire certain "qualifying employer securities", as defined by ERISA § 407(d)(5), if (1) the acquisition is for "adequate consideration"; (2) a commission is not charged; and (3) either the plan is an "eligible individual account plan," as defined by ERISA § 407(d)(3), or the acquisition is not otherwise prohibited by ERISA § 407(a). See 29 U.S.C. § 1108(e). However, courts have held that where an ERISA plan transacts in employer securities, its fiduciary bears the heavy burden of showing that the transaction satisfies the requirements of ERISA § 408(e), particularly as it relates to the fiduciary's determination of "adequate consideration," and that it has otherwise fulfilled its duties of loyalty and care under ERISA. See DeFazio v. Hollister, Inc., 854 F. Supp. 2d 770, 789 (E.D. Cal. 2012) (nothing that "[f]iduciaries are obliged at a minimum to engage in an intensive and scrupulous independent investigation of their options"); Howard v. Shay, 100 F.3d. 1484, 1488-89 (9th Cir. 1996); see also Brundle v. Wilmington Tr., N.A., 919 F.3d 763, 770 (4th Cir. 2019), as amended (Mar. 22, 2019).

b) The fiduciary must make plan decisions independent of conflicting interests

Regarding the potential dual loyalties a fiduciary may have, the Supreme Court has firmly expressed that ERISA requires "that the fiduciary with two hats wear only one at a time, and wear the fiduciary hat when making fiduciary decisions." Pegram, 530 U.S. at 225; see Hughes Aircraft Co. v. Jacobson, 525 U.S. 432, 443-44 (1999); Varity Corp., 516 U.S. at 498.

The "two hats" doctrine relates to situations where the fiduciary has two roles: that of plan fiduciary and then another role potentially adverse to the beneficiaries. The "two hats" doctrine limits an employer's fiduciary duty to three specific situations: (1) when a fiduciary exercises discretion regarding the plan's management or controls the plan's management or the distribution of its assets, (2) when the fiduciary gives investment advice regarding plan property or funds for compensation, and (3) when the fiduciary has the authority or discretionary responsibility for the plan's administration. Martinez v. Schlumberger, Ltd., 338 F.3d 407, 412-13 (5th Cir. 2003) (citing Melissa Elaine Stover, *Maintaining ERISA's Balance: The Fundamental Business Decision v. The Affirmative Fiduciary Duty to Disclose Proposed Changes*, 58 WASH & LEE L. REV. 689, 698 n.44 (2001)).

When the "fiduciary hat" is on, the requirements that decisions be made "solely in the interest" and for "the exclusive purpose" of benefiting participants and beneficiaries place a duty on the trustees to avoid a conflict of interest between what is in the best interest of the beneficiaries and what is in the best interest of the company. Varity Corp., 516 U.S. at 524-25.

2. The fiduciary may make business management decisions that are contrary to the interests of plan beneficiaries when he acts other than in his capacity as a fiduciary

The dual-loyalty doctrine recognizes that every corporate decision, despite the fact that it may be made by a fiduciary and may have a collateral effect on employee benefits, will not necessarily be a “fiduciary act” that requires singular attention to the interests of the plan participants or beneficiaries. Accordingly, a fiduciary may make business management decisions that are contrary to the interests of plan beneficiaries when acting outside of a fiduciary capacity. As the Supreme Court explained, an employer who also acts as a plan’s administrator may have “financial interests adverse to beneficiaries.” Pegram v. Herdrich, 530 U.S. 211, 225 (2000). Employers, for example, may “take actions to the disadvantage of employee beneficiaries, when they act as employers (e.g., firing a beneficiary for reasons unrelated to the ERISA plan), or even as plan sponsors (e.g., modifying the terms of a plan allowed by ERISA to provide less generous benefits).” Id. at 225.

See:

Acosta v. Brain, 910 F.3d 502, 518-21 (9th Cir. 2018). Before concluding that ERISA fiduciary duties were breached, a district court must determine as a threshold matter that the fiduciary was acting in its fiduciary capacity, as opposed to its corporate capacity.

Brooks v. Pactiv Corp., 729 F.3d 758, 766 (7th Cir. 2013). An employer does not act as an ERISA fiduciary when it decides to terminate an employee. Such decisions are inherently not fiduciary in nature when the decision does not involve the administration or management of the Plan, the management or disposition of the Plan’s assets, the dispensation of investment advice, or a benefits determination.

Lanfear v. Home Depot, Inc., 679 F.3d 1267, 1284 (11th Cir. 2012). Employer defendants were acting in their corporate capacity when they filed an SEC filing. Thus, any misrepresentation in those documents did not violate ERISA.

Gearren v. The McGraw-Hill Cos., Inc., 660 F.3d 605, 610–11 (2d Cir. 2011). When a defendant signs or prepares an SEC filing, he is acting in a corporate, rather than an ERISA fiduciary, capacity. Therefore, plaintiffs cannot bring a claim for breach of fiduciary duty under ERISA for false or misleading statements in an SEC filing.

Deluca v. Blue Cross Blue Shield of Mich., 628 F.3d 743, 746–47 (6th Cir. 2010). It is a business decision to negotiate and change plan rates when the rates are generally applicable to a broad range of health-care consumers and not specifically dealing with the individual plan. ERISA

fiduciaries do not act in a fiduciary capacity just because their business decisions have an effect on the ERISA plan.

Kalda v. Sioux Valley Physician Partners, Inc., 481 F.3d 639, 646 (8th Cir. 2007). The business decision to merge with one company over another did not trigger the defendants' fiduciary obligations. Thus, there was no breach of any duty owed the plaintiff beneficiaries of the plan.

Holdeman v. Devine, 474 F.3d 770, 780 (10th Cir. 2007). A CEO/fiduciary acts as a CEO and makes business decisions when choosing whether to allocate company funds to the benefit plan or elsewhere.

Adams v. LTV Steel Mining Co., 936 F.2d 368, 370 (8th Cir. 1991). An employer/trustee's conclusion that early retirements were not in company's interest was a business decision not subject to sole interest and exclusive purpose requirements.

In re Wells Fargo ERISA 401(k) Litig., 331 F. Supp. 3d 868, 876–79 (D. Minn. 2018). A fiduciary has no duty under ERISA to disclose information that might affect the value of the corporation's stock.

In re Express Scripts/Anthem ERISA Litig., 285 F. Supp. 3d 655, 681–84 (S.D.N.Y. 2018). A health benefits company setting prices in its role as a health insurer is not acting as an ERISA fiduciary when those business dealings are not directly associated with the benefits plan at issue but rather are generally applicable to a broad range of health-care consumers.

In re Huntington Bancshares Inc. ERISA Litig., 620 F. Supp. 2d 842, 849–50 (S.D. Ohio 2009). An employer does not violate ERISA when it makes a business decision to acquire another company, even one allegedly overexposed to the subprime market. The court found that such a decision was a business decision and is not governed by ERISA.

Sengpiel v. B.F. Goodrich Co., 970 F. Supp. 1322, 1333 (N.D. Ohio 1997), aff'd, 156 F.3d 660 (6th Cir. 1998). An employer's decision to transfer the participants/beneficiaries to the retirement rolls of a new company as part of the creation of a joint venture was not subject to fiduciary duties.

But see:

Johnson v. Couturier, 572 F.3d 1067, 1077 (9th Cir. 2009). Because employer stock was 100% of the ESOP's assets, the court reasoned that the value of the plan's assets depended on the employer's equity. Therefore, decisions regarding corporate salaries were not solely business decisions. The court held that where an ESOP fiduciary also serves as a corporate director or officer, ERISA fiduciary duties are imposed on the business decisions from which he could directly profit.

Spires v. Sch., 271 F. Supp. 3d 795, 802–03 (D.S.C. 2017). Acts of corporate management can be subject to ERISA’s fiduciary standards. Although mismanagement or malfeasance by executives is not by itself a breach of fiduciary duty under ERISA, failure to take action by placing personal interest in self-dealing above fiduciary duties sufficiently alleges a breach. Thus, plaintiffs sufficiently alleged a breach of ERISA duties for failure of the plan fiduciaries to take action to protect plan assets when they did not respond to managerial malfeasance that depleted plan assets of most of their value.

Hugler v. Byrnes, 247 F. Supp. 3d 223, 229–32 (N.D.N.Y. 2017). A CEO/fiduciary violated the duty of loyalty by investing plan assets in stock of a company in which he had a substantial interest, even though he had a sincere belief in the value of investing in the company. The court found a violation where circumstantial evidence showed that the CEO/fiduciary was completely inactive in managing the plan until the company needed an influx in capital, and that he made a loan of plan assets to himself so he could invest in the company.

a) Fiduciary status during Plan creation and amendment

The distinction between actions of administration and investment subject to fiduciary responsibility and non-fiduciary business decisions gives an employer or trustee broad control over the terms and content of its benefits plans. “Nothing in ERISA requires employers to establish employee benefit plans. Nor does ERISA mandate what kind of benefit employers must provide if they choose to have such a plan.” *Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996). Thus, while ERISA does impose a strict standard of loyalty once a plan is created, “[e]mployers or other plan sponsors are generally free under ERISA, for any reason at any time, to adopt, modify, or terminate” benefit plans. *Id.* at 890 (quoting *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995)).

See also:

Loskill v. Barnett Banks, Inc. Severance Pay Plan, 289 F.3d 734, 737-38 (11th Cir. 2002), *cert. denied*, 537 U.S. 1167 (2003). Citing *Lockheed Corp.*, the Eleventh Circuit held that conditioning benefits on release of all employment-related claims does not violate anti-cutback provision because employer is free to establish any conditions precedent it chooses.

But see:

Warren v. Cochrane, 235 F. Supp. 2d 1, 7 (D. Me. 2002). Although employers are free to modify and amend plans, such modifications are invalid if they are informal or not adopted in accordance with the plan’s procedures. The plaintiff was entitled to benefits when the court

determined that the amendment excluding the plaintiff from a benefit increase was not adopted in accord with the plan's procedures.

Thus, an employer's decisions about the content of a plan are not themselves fiduciary acts and therefore fall outside the scope of ERISA fiduciary duties. Pegram, 530 U.S. at 226-27 (treatment and eligibility decisions by HMO physicians do not generate fiduciary duties). During the plan creation process, no plan exists, and consequently, there are no beneficiaries. Accordingly, the employer's decisions at the time of creation regarding the conditions of eligibility do not need to be "solely in the interest" of the participants and beneficiaries. See Dzinglski v. Weirton Steel Corp., 875 F.2d 1075, 1078 (4th Cir. 1989); Hlinka v. Bethlehem Steel Corp., 863 F.2d 279, 283 (3d Cir. 1988), superseded by statute on other grounds, 29 U.S.C. § 1054(g). But see Section V.B (below and discussing the duty to disclose information).

Similarly, when an employer decides to amend a plan, that decision "concerns the composition or design of the plan itself and does not implicate the employer's fiduciary duties, which consist of such actions as the administration of the plan's assets." Hughes Aircraft, 525 U.S. at 443-44 (holding that employer/trustee's amendment providing for early retirement program and noncontributory benefit structure did not invoke fiduciary duties).

See:

Lee v. Verizon Commc'ns, Inc., 837 F.3d 523, 537-38 (5th Cir. 2016). *The decision to amend a plan and transfer assets into an annuity is not subject to fiduciary duty requirements.*

Myers v. Bricklayers & Masons Local 22 Pension Plan, 629 F. App'x 681, 684-85 (6th Cir. 2015). *The adoption of a plan amendment imposing eligibility conditions is not a fiduciary act because "no breach of . . . fiduciary duties occurs from amending the terms of a plan."*

Coulter v. Morgan Stanley & Co. Inc., 753 F.3d 361, 366-68 (2d Cir. 2014). *Employer's decision to fund employer contributions to defined contribution plan with its company stock was not a fiduciary act because the funding of a plan is a non-fiduciary "settlor" function, rather than a discretionary act undertaken with respect to plan management or administration.*

Loomis v. Exelon Corp., 658 F.3d 667, 671 (7th Cir. 2011). *A claim for breach of fiduciary duty cannot be based on the employer's failure to pay more money into the plan. There is no fiduciary duty requiring employers to make pension plans more valuable to the participants.*

Faber v. Estate of Russell E. Young, 648 F.3d 98, 104-05 (2d Cir. 2011). *A plan sponsor is "afforded wide latitude to design the plan, including the mechanism for distributing benefits, as it sees fit."*

Caltagirone v. NY Cmty. Bancorp, Inc., 257 F. App'x 470, 473–74 (2d Cir. 2007). *A participant cannot sue a fiduciary for breaches solely related to the design of an ERISA plan, even when the plaintiff alleges that the ESOP plan was badly designed because it was not diversified.*

Sears v. Union Cent. Life Ins. Co., 222 F. App'x 474, 481 (6th Cir. 2007). *Employer did not breach any obligation to the employees because it did not act as a fiduciary when the plan was unilaterally amended.*

Loomis v. Fiatallis N. Am., Inc., 401 F.3d 779, 787–88 (7th Cir. 2005). *An employer is free to alter or eliminate unaccrued welfare benefits without considering its employees interests and does not owe its employees a fiduciary duty when it amends or abolishes unaccrued benefits.*

Campbell v. BankBoston, N.A., 327 F.3d 1, 6 (1st Cir. 2003). *A fiduciary is free to amend a severance pay plan. The process of amending the plan will not be the basis of a breach of fiduciary duty claim unless the fiduciary did not follow the steps laid out in ERISA for amending a welfare benefit plan.*

Akers v. Palmer, 71 F.3d 226, 230 (6th Cir. 1995). *Trustee is only subject to fiduciary duties when managing a plan according to its terms, not when it decides what those terms are to be, because “ERISA is simply not involved in regulating conduct affecting the establishment of a plan or with its terms.”*

Milwaukee Area Joint Apprenticeship Training Comm. for Elec. Indus. v. Howell, 67 F.3d 1333, 1338 (7th Cir. 1995). *Fiduciary duties apply solely to plan administration, not its formation, amendment or modification.*

Averhart v. US W. Mgmt. Pension Plan, 46 F.3d 1480, 1488 (10th Cir. 1994). *Selective provision of benefits under amendment was an element of plan design not subject to ERISA’s fiduciary duties.*

Elmore v. Cone Mills Corp., 23 F.3d 855, 862 (4th Cir. 1994). *Fiduciary duties apply only to actions taken in accordance with duty to administer plan, not to the creation of the plan.*

b) The duty of loyalty during Plan creation and amendment

No responsibilities to participants exist during the creation phase, since the plan itself has not yet been established. However, because amendments do impact individuals to whom the fiduciary is already obligated, some amendments can be subject to the duty of loyalty.

See:

Eckert v. Chauffeurs, Teamsters & Helpers Local Union 776 Profit Sharing Plan, 306 F. Supp. 3d 659, 669–70 (M.D. Pa. 2018). When voting to amend a plan, a trustee has an obligation to avoid taking actions that would prevent him from functioning with complete loyalty to plan participants. Even though the trustee benefitted from the amendment, he did not breach his duty of loyalty because he was acting in the best interests of the participants.

Chappel v. Lab. Corp. of Am., 232 F.3d 719, 726-27 (9th Cir. 2000). When a fiduciary writes and implements an arbitration clause, it is constrained by fiduciary duty to create reasonable procedures and to notify participants of changed circumstances.

George v. Duke Energy Ret. Cash Balance Plan, 560 F. Supp. 2d 444, 477 (D.S.C. 2008). Court found a proper breach of fiduciary duty claim where plaintiffs alleged that Duke arbitrarily adjusted opening account balances to circumvent ERISA's notice requirements.

B. THE DUTY TO DISCLOSE INFORMATION AND AVOID MISREPRESENTATIONS

As a general matter, ERISA fiduciaries have a fiduciary duty to communicate truthfully and accurately to plan participants and beneficiaries about their plan benefits. This duty includes a duty not to mislead plan participants in response to plan-relevant questions as well as a duty to supply information not specifically requested in certain circumstances. In some cases, it also may require a fiduciary to give accurate information regarding trustee decisions that impact the plan.

If a fiduciary breaches its duty by making misrepresentations, plan participants may bring claims for individual relief under ERISA § 502(a)(3) (29 U.S.C. § 1132(a)(3)). To prevail, the plaintiff must show that: (1) the defendant was acting in a fiduciary capacity when it made the challenged representations; (2) the representations constituted material misrepresentations; and (3) plaintiff detrimentally relied on those misrepresentations. Burstein v. Ret. Account Plan for Emps. of Allegheny Health, Ed. & Research Found., 334 F.3d 365, 384 (3d Cir. 2003). For more on the procedural considerations in an action under § 502(a)(3), see Section XI.B, and for available remedies in such actions, see Section IV.

1. Duty not to mislead

The fiduciary has a duty not to mislead plan participants and beneficiaries regarding material information about benefits. This duty to avoid misinforming plan participants and beneficiaries recognizes the “disparity of training and knowledge that potentially exists between a lay beneficiary and a trained fiduciary.” Bixler v. Central Pa. Teamsters Health & Welfare Fund, 12 F.3d 1292, 1300 (3d Cir. 1993). When the plan administrator acts as a fiduciary and gives plan participants information about a plan or the participants’ benefits thereunder, the plan administrator must speak truthfully. A

breach of this duty will not be excused merely because a participant or beneficiary “failed to comprehend or ask about a technical aspect of the plan.” *Id.* In addition, as described below, some circuit courts of appeal have held that the duty to mislead can be breached by negligent or unintentional misrepresentations. However, the Seventh Circuit has expressly stated that a negligent misrepresentation is not enough.

See:

Varity Corp. v. Howe, 516 U.S. 489, 506 (1996). *An employer/fiduciary breached its fiduciary duty when it intentionally misled employees about the chance of financial success and the security of benefits of a new subsidiary to persuade them to transfer to the subsidiary with the goal of terminating their benefits and reducing costs. The Court determined that when making these statements, the employer was acting in its fiduciary capacity.*

Mathews v. Chevron Corp., 362 F.3d 1172, 1183 (9th Cir. 2004) (quoting *Wayne v. Pac. Bell*, 238 F.3d 1048, 1055 (9th Cir. 2001)). *The court found that there is no scienter requirement for a breach of fiduciary duty claim; thus, misinformation given to induce participants to act can include “saying . . . something is true when the person does not know whether it is or not.”*

Martinez v. Schlumberger, Ltd., 338 F.3d 407, 425 (5th Cir. 2003). *The court decided that if an employer chooses to communicate about the future of a participant’s plan benefits, he has the fiduciary duty to not make misrepresentations. But an employer does not have the fiduciary duty to affirmatively disclose that it is considering amendments to its plan under certain circumstances, discussed infra.*

Gregg v. Transp. Workers of Am. Int’l, 343 F.3d 833, 844 (6th Cir. 2003). *Employers’ misleading or false statements, regardless of if made negligently or intentionally, violate fiduciary duty of responding completely and accurately regarding the plan.*

Mullins v. Pfizer, Inc., 23 F.3d 663, 669 (2d Cir. 1994). *While a fiduciary does not need to “be perfectly prescient as to all future changes in employee benefits, when the employer/fiduciary makes affirmative material misrepresentations about changes to the employee benefit plan, it breaches its fiduciary duty.*

In re DeRogatis, 904 F.3d 174, 194 (2d Cir. 2018). *ERISA beneficiaries can state a breach of fiduciary claim based on unintentional misrepresentations “about a benefits question on which the summary plan description, too, is unclear.” (citing Estate of Becker v. Eastman Kodak Co., 120 F.3d 5 (2d Cir. 1997)). But, if the SPD is sufficiently clear, the plan will not be culpable for fiduciary breach.*

Deschamps v. Bridgestone Ams., Inc. Salaried Emps. Ret. Plan, 840 F.3d 267, 278-80 (6th Cir. 2016). *It is a breach of fiduciary duty to misrepresent “information about the Plan’s terms and the likely benefits that [a participant] would receive in the future,” including by misrepresenting the participant’s service date from which pension credit would be calculated.*

But see:

Howell v. Motorola, Inc., 633 F.3d 552, 571–72 (7th Cir. 2011). *To find a violation of ERISA’s duty to disclose material information, the Seventh Circuit requires some deliberate misstatement. Negligent misrepresentation of information is not enough to show a violation of ERISA’s disclosure duty.*

Crowley ex rel. Corning, Inc., Inv. Plan v. Corning, Inc., 234 F. Supp. 2d 222, 230 (W.D.N.Y. 2002). *Without applying heightened pleading standard of Rule 9(b), court dismissed claim that fiduciary committee breached duty to disclose information to beneficiaries where plaintiff’s complaint failed to allege that fiduciary had actual knowledge of material information about the value of the employer’s stock.*

a) Materiality defined

A misrepresentation is only actionable if it is material. A misrepresentation is material if the statement would induce a reasonable person to rely upon it. Ballone v. Eastman Kodak Co., 109 F.3d 117, 122–23 (2d Cir. 1997). Materiality is a mixed question of law and fact. Gregg, 343 F.3d at 844 (quoting Krohn v. Huron Mem’l Hosp., 173 F.3d 542, 547 (6th Cir. 1999) and stating something is material “if there is a substantial likelihood that it would mislead a reasonable employee in making an adequately informed decision in pursuing . . . benefits to which she may be entitled”).

b) Duty to disclose future plans or plan amendments

In certain circumstances, a fiduciary may be liable for breach of the duty to inform if the fiduciary does not disclose future plans or plan amendments that are under consideration. There is a circuit split, however, regarding a fiduciary’s duty to inform in such a scenario is triggered. The majority of the circuits—the First, Third, Sixth, Ninth, and Tenth—hold that a fiduciary has a duty to inform beneficiaries of possible changes to a plan or a new plan only when such changes are under “serious consideration.” See Soland v. George Wash. Univ., 60 F. Supp. 3d 60, 66 (D.D.C. 2014) (analyzing circuit law and collecting cases).

The majority view derives from the Third Circuit’s decision in Fischer v. Philadelphia Electric Company, 96 F.3d 1533, 1539 (3d Cir. 1996) (Fisher II). In that case, the Third Circuit announced an “inherently fact-specific” formulation that it characterized as to determine when “serious consideration” of a change to a plan (that could result in a change to the participants’ future benefits) occurs: when (1) a specific proposal (2) is being discussed for purposes of implementation (3) by senior

management with the authority to implement the change.” Id. at 1539. The Third Circuit stated this “flexible” approach “recognizes and moderates the tension between an employee’s right to information and an employer’s need to operate on a day-to-day basis.” Id. at 1539-40 (acknowledging that requiring “[f]ull disclosure of each step in” a business’s decision-making process and a “duty of clairvoyance” is inappropriate).

Other circuits have adopted a similar test. See Mathews v. Chevron Corp., 362 F.3d 1172, 1180-82 (9th Cir. 2004) (utilizing Fischer II test but also citing Wayne v. Pac. Bell, 238 F.3d 1048, 1054 (9th Cir. 2001) and stating that duty not to actively misinform applies even before serious consideration begins); Winkel v. Kennecott Holdings Corp., 3 F. App’x 697, 703 (10th Cir. 2001); Bins v. Exxon Co. U.S.A., 220 F.3d 1042, 1049 (9th Cir. 2000) (adopting Fischer II serious consideration test but also stating that factors should not be applied too rigidly, and courts should consider larger picture of fiduciary’s conduct); McAuley v. IBM Corp., 165 F.3d 1038, 1043 (6th Cir. 1999) (adopting Fischer II serious consideration test ; Vartanian v. Monsanto Co., 131 F.3d 264, 270 (1st Cir. 1997) (adopting Fischer II test but explicitly stating what court felt was an “implicit” requirement in Fischer II: that plaintiff “must show that a specific proposal under serious consideration *would have affected him*”) (emphasis in original).

A minority of circuits—the Second and Fifth Circuits—have refused to adopt the Fisher II test, and have instead articulated a less rigid, more fact-intensive approach. See, e.g., Martinez v. Schlumberger, Ltd., 338 F.3d 407, 428 (5th Cir. 2003) (“we are not to rely on a bright-line test to determine whether a company’s alleged misrepresentations are material. We therefore reject the Fisher II serious consideration approach to materiality and adopt a fact-specific approach...”). For example, the Second Circuit refused to hold that future changes must be under “serious consideration” before an employer may be liable for affirmative misstatements regarding plan changes. Ballone v. Eastman Kodak Co., 109 F.3d 117, 123 (2d Cir. 1997); see also id. at 125 (“‘Serious consideration’ of plan changes is not the sine qua non of materiality.”). The Second Circuit thus emphasized that the materiality inquiry is “fact-specific” and turns on a number of factors including: (1) “how significantly the statement misrepresents the present status of internal deliberations regarding future plan changes,” (2) “the special relationship of trust and confidence between the plan fiduciary and beneficiary,” (3) “whether the employee was aware of other information or statements from the company tending to minimize the importance of the misrepresentation or should have been so aware, taking into consideration the broad trust responsibilities owed by the plan administrator to the employee and the employee’s reliance of the plan administrator for truthful information,” and (4) “the specificity of the assurance.” Id. at 125.

Similarly, the Fifth Circuit expressly rejected the Fischer II test and adopted an approach it too calls “fact-specific.” See Martinez, 338 F.3d at 428. In Martinez, the Fifth Circuit stated that the question courts must ask is “whether there is a substantial likelihood that a reasonable person in the plaintiffs’ position would have considered the information an employer-administrator allegedly misrepresented

important in making a decision to retire.” The court considered the Ballone factors in determining whether the representation was material. Id.

Notably, while both the Second Circuit and Fifth Circuit rejected the “serious consideration test,” both circuits recognized that the “more seriously a plan change is being considered, the more likely a representation is material.” Martinez, 338 F.3d at 428 (noting that the Fifth Circuit’s “reservations with the serious consideration test do not lie in its solid underpinnings” but with a bright-line rule equating the “lack of serious consideration” with lying); Ballone, 109 F.3d at 123 (“Whether a plan is under serious consideration is but one factor in the materiality inquiry.”). Accordingly, in certain situations, the differing approaches adopted by the circuit courts will lead to similar results. See, e.g., Soland, 60 F. Supp. 3d at 66-68 (finding that “[u]nder either proposed test, there is no evidence from which a reasonable jury could conclude that [the employer] breached a duty to disclose because the [future plan change] was in too nascent a stage when [the plan participant] negotiated his retirement.”); Radley v. Eastman Kodak Co., 19 F. Supp. 2d 89, 98-103 (W.D.N.Y. 1998) (on remand in Ballone, applying the fact-specific approach and reaching the same conclusion previously reached under the serious consideration test).

Some circuits—the Fourth, Seventh, Eighth, Eleventh, and DC—have not yet spoken on whether or not they have adopted the Fisher II test. See, e.g., Beach v. Commonwealth Edison Co., 382 F.3d 656, 659-61 (7th Cir. 2004) (noting majority rule but leaving Seventh Circuit standard undecided); Soland, 60 F. Supp. at 66 (analyzing various approaches from circuit courts and stating that the “D.C. Circuit appears not to have spoken on the matter”). It is worth noting that prior to Fisher II, the Eighth and Eleventh Circuits have considered whether a plan amendment or change was under “serious consideration” when deciding if a fiduciary breached its duty to disclose. See, e.g., Wilson v. Southwestern Bell Tel. Co., 55 F.3d 399, 405-06 (8th Cir. 1995) (“a failure to disclose information about a future offering cannot be a misrepresentation unless serious consideration has been given to implementing it.”); Barnes v. Lacy, 927 F.3d 539, 544 (11th Cir. 1991) (considering whether a future plan was under “serious consideration”).

Importantly, Fischer II concerned whether the fiduciary made affirmative misrepresentations to plan participants and beneficiaries by denying or failing to disclose when asked that it was considering an early retirement program. Fisher II, 96 F.3d at 1536. Thus, Fisher II’s holding arguably pertains only to the situation where a plan participant or beneficiary affirmatively inquires about future changes to the plan, or when a fiduciary affirmatively chooses to speak about the plan, but made material misrepresentations. Indeed, some courts have expressly held that a fiduciary does not have a duty to disclose or volunteer information about plan changes absent an inquiry. See, e.g., Bins, 220 F.3d at 1053 (“We hold that, absent such an inquiry, an ERISA fiduciary does not have an affirmative duty prior to final approval and general dissemination of plan changes to volunteer information to employees who have not specifically alerted the fiduciary to the fact that such information is material to them”); Hockett v. Sun Co., 109 F.3d 1515, 1523 (10th Cir. 1997) (holding that Fisher II “narrows the range of instances in which an employer must disclose, in response to employees’

inquiries, its tentative intentions regarding an ERISA plan”); Pocchia v. NYNEX Corp., 81 F.3d 275, 279 (2d Cir. 1996) (“While NYNEX had a fiduciary duty not to make affirmative misrepresentations or omissions, it did not have a duty to disclose proposed changes in the absence of inquiry by [the plan participant]”). Cf Fisher II, 96 F.3d at 1541 (cautioning against “imposing liability too quickly for failure to disclose a potential early retirement plan”). Nevertheless, other courts have suggested that there may be an affirmative duty to advise a beneficiary of potential plan changes, regardless of the existence of an employee inquiry. See McAuley, 165 F.3d at 1043 (noting a fiduciary’s duty to “advise [a beneficiary] of circumstances that threaten interests relevant to the relationship”). Cf Anweiler v. Am. Elec. Power Serv. Corp., 3 F.3d 986, 991 (7th Cir. 1993) (noting a fiduciary’s duty “exists when a beneficiary asks for information, and even when he or she does not.”).

In addition, when a new plan or changes in a plan are being considered, a fiduciary may not purposely keep its benefits counselors uninformed so that they may speak truthfully, yet incorrectly, when stating that no plan or plan changes are under consideration.

See:

Fischer v. Phila. Elec. Co., 994 F.2d 130, 135 (3d Cir. 1993). The employer/fiduciary may not build an informational barrier around the people on whom employees reasonably rely for information and guidance about retirement so that these people can give truthful, yet incorrect, information that they know of no future changes in the benefit plan.

Mullins v. Pfizer, Inc., 147 F. Supp. 2d 95, 109 (D. Conn. 2001). A truthful statement by a benefits counselor that she had no knowledge of forthcoming retirement benefits enhancements constitutes a misrepresentation when the employer/fiduciary purposely withheld the existence of such a plan from the counselor.

2. Duty to disclose other material information

Many courts hold that the fiduciary’s duty to disclose information other than contemplated changes to the plan is not limited only to responding truthfully to questions by the plan participant. In Varity Corp. v. Howe, the Supreme Court expressly declined to rule whether fiduciaries have a duty to disclose information in the absence of inquiry. 516 U.S. 489, 506 (1996). Post-Varity, the circuit courts have debated the extent to which fiduciaries may have an affirmative duty to disclose and the scope of that duty. While the precise scope of the duty has not been defined, as a general matter, many courts have held that the fiduciary must provide information about benefits that it knows or should know would be harmful to withhold based on the fiduciary’s knowledge of the specific participant’s situation. See, e.g., Gregg v. Transp. Workers of Am. Int’l, 343 F.3d 833, 847-48 (6th Cir. 2003); Horvath v. Keystone Plan E., Inc., 333 F.3d 450, 461-62 (3d Cir. 2003); Griggs v. E.I. DuPont de Nemours & Co., 237 F.3d 371, 380 (4th Cir. 2001); Bowerman v. Wal-Mart Stores, Inc., 226 F.3d 574, 590 (7th Cir.

2000); Harte v. Bethlehem Steel Corp., 214 F.3d 446, 452 (3d Cir. 2000); Krohn v. Huron Mem'l Hosp., 173 F.3d 542, 547-48, 550 (6th Cir. 1999); Shea v. Esensten, 107 F.3d 625, 628 (8th Cir. 1997); Barker v. Am. Mobil Power Corp., 64 F.3d 1397, 1403 (9th Cir. 1995); Eddy v. Colonial Life Ins. Co. of Am., 919 F.2d 747, 751 (D.C. Cir. 1990); Kenseth v. Dean Health Plan, 610 F.3d 452, 471 (7th Cir. 2010).

The failure to disclose will not be excused because the plan participant failed to ask precisely the right question. Krohn, 173 F.3d at 548 (“once an ERISA beneficiary has requested information from an ERISA fiduciary who is aware of the beneficiary’s status and situation, the fiduciary has an obligation to convey complete and accurate information material to the beneficiary’s circumstance, *even if that requires conveying information about which the beneficiary did not specifically inquire.*”) (emphasis added); In re Unisys Corp. Ret. Med. Benefits ERISA Litig., 579 F.3d 220, 228–29 (3d Cir. 2009); Eddy, 919 F.2d at 751. See also Vest v. Resolute FP US Inc., 905 F.3d 985, 987-88 (6th Cir. 2018) (finding no breach of fiduciary duty for failure to disclose because the fiduciary had no duty to disclose absent a question from the plan participant, initiative from the fiduciary, or requirement under ERISA or implementing regulations).

For example, in Eddy, the plaintiff found out shortly before he planned to undergo surgery that his health care benefits were to be discontinued the day of the surgery. 919 F.2d at 748. He asked if he had any right to “convert” his coverage, and was told he did not. Id. at 749. In reality, he had the right to “continue” his coverage, and the plan administrator defended the breach of fiduciary duty claim on the ground that the plaintiff did not ask about continuation. Id. The D.C. Circuit found that “[r]egardless of the precision of his questions, once a beneficiary makes known his predicament, the fiduciary is under a duty to communicate . . . all material facts in connection with the transaction which the trustee knows or should know.” Id. at 751 (internal citations omitted).

See:

In re Unisys Corp. Ret. Med. Benefits ERISA Litig., 579 F.3d 220, 228–29 (3d Cir. 2009). When fiduciary did not tell plan participants about retiree medical benefits and used statements to mislead and confuse participants as to the possibility of plan amendments, it breached the duty of disclosure under ERISA.

Horn v. Cendant Ops., Inc., 69 F. App’x 421, 428 (10th Cir. 2003). Even though a plan beneficiary’s questions “were not precise” regarding eligibility requirements for plan benefits, a plan administrator still had a fiduciary duty to “communicate [such] requirement, of which it knew or should have known.” Thus, because the administrator failed to provide the material information during enrollment and thereafter, it breached its “affirmative duty to provide complete and accurate eligibility information.”

Krohn v. Huron Mem'l Hosp., 173 F.3d 542, 548 (6th Cir. 1999). When the husband of a recently-injured employee whose prognosis was uncertain requested general information on benefits for his wife, the employer/fiduciary breached its fiduciary duty by failing to provide information about long-term disability benefits, though the husband did not specifically request this information.

Estate of Becker v. Eastman Kodak Co., 120 F.3d 5, 10 (2d Cir. 1997). The employer/fiduciary breached its fiduciary duty when its benefits counselor provided materially misleading information by advising a seriously ill employee to delay retirement and take disability benefits, failing to mention that the employee could receive a lump sum at retirement, that she could not retire immediately upon election, and that if she died before the effective date of her retirement, she would forfeit the lump sum and her husband would receive considerably less in monthly installments. The fiduciary also breached its fiduciary duty because its summary plan description ("SPD") did not make this benefits information clear.

Anweiler v. Am. Elec. Power Serv. Corp., 3. F.3d 986, 991-92 (7th Cir. 1993). A fiduciary breached his fiduciary duty by failing to tell the plan beneficiary that a reimbursement agreement was revocable at will and that the plan beneficiary was not required to sign it. The court found that the fiduciary's failure to provide the plan beneficiary "full and complete material information," during the execution of the reimbursement agreement suggested that the fiduciary "may have manipulated its position . . . to its own benefit rather than" the plan beneficiary's position.

3. Limitations on the duty to disclose

While ERISA's fiduciary duty imposes significant requirements on fiduciaries to give full and accurate information about the plan and plan benefits to plan participants, there are limits. First, employer/fiduciaries are under no obligation to disclose accurate information about future changes in benefits when those changes are not presently ascertainable. An employer/fiduciary must be forthright in the information it gives, but courts recognize that fiduciaries are not able to tell the future and are not expected to do so. Ballone, 109 F.3d at 123; Fischer, 994 F.2d at 135.

Second, there is no general duty to provide individualized, unsolicited advice. Watson v. Deaconess Waltham Hosp., 298 F.3d 102, 115 (1st Cir. 2002). At times, the fiduciary may be required under the circumstances to provide additional information that the plan participant did not request. Id. However, this duty only arises when the plan participant gives a particular reason that the fiduciary would know the information would be important. Id.; Griggs, 237 F.3d at 381 ("ERISA does not impose a general duty requiring ERISA fiduciaries to ascertain on an individual basis whether each beneficiary understands the collateral consequences of his or her particular election."); Vest v. Resolute FP US Inc., 905 F.3d 985 (6th Cir. 2018) (finding fiduciary

did not owe a duty to disclose when the plan participant did not make an affirmative request for information and the plan administrator did not know of specific facts that would trigger such duty).

Third, courts recognize that employer/fiduciaries wear “two hats” and that some internal deliberations are conducted as a business, while others are conducted as a fiduciary. Hockett v. Sun Co., Inc., 109 F.3d 1515, 1522 (10th Cir. 1997). The employer/fiduciary must disclose certain internal fiduciary deliberations but is under no obligation to disclose the internal deliberations it conducts as a business. Id. at 1522–24; see also Vartanian v. Monsanto Co., 131 F.3d 264, 269 (1st Cir. 1997) (noting a plan administrator who acts as a fiduciary is not “restrict[ed] . . . from pursuing reasonable business behavior.”) (internal citation omitted).

Courts repeatedly recognize that ERISA does not impose affirmative obligations to provide general information about the company or its performance. In re Citigroup ERISA Litig., 662 F.3d 128, 143 (2d Cir. 2011), *abrogated on other grounds*; Fifth Third Bancorp v. Dudenhoeffer, 573 U.S. 409 (2014); In re Lehman Brothers Sec. & ERISA Litig., 113 F. Supp. 3d 745, 767 (S.D.N.Y. 2015) (finding that Citigroup’s holding that plan administrations need not disclose non-public information “remains persuasive even after Dudenhoeffer”); In re Express Scripts/Anthem ERISA Litig., 285 F. Supp. 3d 655, 675 (S.D.N.Y. 2018) (rejecting breach of fiduciary claims based upon failure to disclose of valuation reports and financial information regarding plan investments”); Edgar v. Avaya, Inc., 503 F.3d 340, 350 (3d Cir. 2007), *abrogated on other grounds* Fifth Third Bancorp v. Dudenhoeffer, 573 U.S. 409 (2014); Johnson v. Radian Grp. Inc., No. 08-cv-2007, 2009 WL 2137241, at *19 (E.D. Pa. July 16, 2009); see also Saumer v. Cliffs Natural Resources, Inc., 853 F.3d 855 864 (6th Cir. 2017) (rejecting duty of prudence claim based upon failure to disclose negative inside information).

Fiduciaries also do not have a general duty to share information about any of the plan’s various investments, including information about the company where employer stock is offered as a plan investment option. Lingis v. Motorola, Inc., 649 F. Supp. 2d 861, 876 (N.D. Ill. 2009); see also Slaymon v. SLM Com., 506 F. App’x 61, 64, (2d Cir 2012) (“ERISA fiduciaries do not have a general duty to disclose nonpublic investment information to plan participants beyond what is called for in ERISA’s comprehensive set of reporting and disclosure requirements”); Lanfear v. Home Depot, Inc., 679 F.3d 1267, 1285-86 (11th Cir. 2012) (recognizing the “practical problems” with “convert[ing] fiduciaries into investment advisors” and refusing to require fiduciaries disclose any nonpublic information that could affect the employer’s stock price); In re Bear Stearns Cos. Sec., Derivative, & ERISA Litig., 763 F. Supp. 2d 423, 577 (S.D.N.Y. 2011) (dismissing disclosure claim and holding that any duties to disclose information related to plan benefits do not extend to the investment themselves because ERISA does not require disclosure of information about the employer finances); Wright v. Medtronic, Inc., No. 09-cv-0443, 2011 WL 31501, at *7 (D. Minn. Jan. 5, 2011) (dismissing disclosure claim and rejecting “wide-ranging” duty of disclosure: “ERISA defines when a fiduciary must disclose plan- and benefit-specific information that is of interest to plan participants but not to investors generally.”); In re Wells Fargo ERISA

401(k) Litig., 331 F. Supp. 3d 868, 877 (D. Minn. 2018) (dismissing duty of loyalty claim based on defendants' nondisclosure of inside information about Wells Fargo's present and future financial condition"); but see Terraza v. Safeway, Inc., 241 F. Supp. 3d 1057, 1074 (N.D. Cal. 2017) (finding a plaintiff plausibly alleged a duty of loyalty claim for a fiduciary's failure to disclose information regarding its "common stock fund . . . such as whether an investment manager was appointed [and] the use or availability of short term holdings," and the "exact nature, extent, and identity of investment options").

As courts have observed with respect to ERISA's fiduciary duties, fiduciaries are not "required to inform all Plan participants and beneficiaries of every corporate event, especially contingent events, that might impact the value of the company's common stock." Sweeney v. Kroger Co., 773 F. Supp. 1266, 1269 (E.D. Mo. 1991); see also In re Express Scripts/Anthem, 285 F. Supp. 3d 675 ("it is inappropriate to infer an unlimited disclosure obligation" on ERISA fiduciaries); Lanfear, 679 F. 3d at 1286 ("ERISA does not require that fiduciaries be corporate insiders").

Also, fiduciaries are not required to disclose certain investment information. For example, fiduciaries need not disclose investment guidelines that are not binding on the plan and that do not necessarily affect a participant's rights under the plan. Murphy v. Verizon Comms., Inc., 587 F. App'x 140, 141-45 (5th Cir. 2014). Similarly, fiduciaries are not required to disclose to individual participants names and addresses of other participants since disclosure would not provide information relating to the provision of benefits or defrayment of expenses. Hughes Salaried Retirees Action Comm. v. Adm'r of Hughes Non-Bargaining Ret. Plan, 72 F.3d 686, 690-691 (9th Cir. 1995).

For more information on the duty to disclose information in cases dealing with employer stock, see Section XV.D.2.c of this Handbook.

C. THE DUTY TO MANAGE PLAN FUNDS IN THE INTERESTS OF PARTICIPANTS AND BENEFICIARIES

The duty of loyalty requires that trustees manage all plan funds in the interest of participants and beneficiaries. See Pension Ben. Guar. Corp. ex rel. St. Vincent Catholic Med. Centers Ret. Plan v. Morgan Stanley Inv. Mgmt. Inc., 712 F.3d 705, 715–17 (2d Cir. 2013). But this requirement does not prohibit every indirect benefit to people other than plan beneficiaries or participants, including the fiduciaries themselves, so long as the interests of the plan and those covered were first in mind.

1. Incidental benefit to the fiduciary is allowed.

A number of courts have held that, in some circumstances, a fiduciary may benefit indirectly from plan investments.

See:

Metzler v. Graham, 112 F.3d 207, 213 (5th Cir. 1997). *Fiduciary did not violate duty by buying land near other parcels in which he had interest*

when he reasonably believed that he was acting in the participant's best interests and there was no evidence that fiduciary ever placed his interests over plan's interests.

Schmalz v. Sovereign Bancorp, Inc., 868 F. Supp. 2d 438, 460 (E.D. Pa. 2012). Fiduciaries did not breach duty by investing in the employer's stock based on allegations that the price of stock was tied to the fiduciaries' compensation and tenure and the fiduciaries were indebted to the employer through numerous loans. The mere fact that a fiduciary incidentally benefits from its actions does not show a breach of the duty of loyalty.

*In re State St. Bank & Trust Co. Fixed Income Funds Inv. Litig., No. 07-cv-8488, 2012 WL 333774, at *33–34 (S.D.N.Y. Feb. 1, 2012). It is not a breach of the duty of loyalty when a fiduciary decides to increase the acceptable level of risk in an investment plan, even if such a decision is imprudent and the fiduciary receives an incidental benefit. The benefit was incidental to a decision that was made in the best interest of the plan participants.*

*Tibble v. Edison Int'l, No. 07-cv-5359, 2010 WL 2757153, at *21-*24 (C.D. Cal. July 8, 2010) (reversed on other grounds by Tibble v. Edison Int'l, 843 F.3d 1187 (9th Cir. 2016)). When the investment staff chooses to offer plans that it is aware have a revenue-sharing benefit, it is not a breach of the duty of loyalty to be aware of that benefit. However, the investment staff cannot make its final decision based solely on the benefit to the company.Johnson v. Radian Grp., Inc., No. 08-cv-2007, 2009 WL 2137241, at *22 (E.D. Pa. July 16, 2009). That defendants had an interest in seeing a proposed merger succeed and invested in stock that enhanced that benefit is not enough to prove a breach of the duty of loyalty. The fact that defendants had an adverse interest and received an incidental benefit from a fiduciary decision does not violate the ERISA duty of loyalty.*

*Krackow v. Dr. Jack Kern Profit Sharing Plan, No. 00-cv-2550, 2002 WL 31409362 at *8 (E.D.N.Y. May 29, 2002). An employer does not violate the duty of loyalty by obtaining a release of ERISA claims in return for the payment of employment benefits.*

2. Careful and impartial obligation

The standard of trust requires that in making investment decisions, the trustee must conduct a careful and impartial investigation, with an eye single to the interests of participants and beneficiaries. Flanigan v. Gen. Elec. Co., 242 F.3d 78, 86 (2d Cir. 2001). The duty of loyal management in the sole interest of the participants and beneficiaries and for the exclusive purpose of providing benefits is not a duty focused singularly on the maximization of pecuniary benefits. See Cooke v. Lynn Sand & Stone Co., 70 F.3d 201, 206 (1st Cir. 1995). A fiduciary's actions should be assessed based

on the information available to the fiduciary at the time of the investment, not from the vantage point of hindsight. Pension Ben. Guar. Corp. ex rel. St. Vincent Catholic Med. Centers Ret. Plan v. Morgan Stanley Inv. Mgmt. Inc., 712 F.3d 705, 716–17 (2d Cir. 2013). In particular, investment decisions should be assessed in the context of the whole portfolio, not in isolation. *Id.*

See:

In re Syncor ERISA Litig., 516 F.3d 1095, 1102 (9th Cir. 2008). The Ninth Circuit reversed the district court's order, which granted summary judgment because the district court held that the employer stock remained a financially viable investment. The court opined that mere financial viability of an investment does not meet the "prudent man" standard because an investment could be inflated and dramatically fall in value at a later time. Thus, plan fiduciaries could be liable if they knew or should have known that an "illegal scheme" directly caused the rise in Syncor's "value."

Collins v. Pension & Ins. Comm. of the S. Cal. Rock Products & Ready Mixed Concrete Ass'ns, 144 F.3d 1279, 1282 (9th Cir. 1998). A plan administrator does not have a duty to increase benefits because a plan is overfunded unless instructed by plan documents to do so.

Moench v. Robertson, 62 F.3d 553, 566-67 (3d Cir. 1995) (abrogated on other grounds by Fifth Third Bancorp v. Dudenhoeffer, 573 U.S. 409, 417-419 (2014)). Plan committee was unreasonable in interpreting Employee Stock Ownership Plan to require investment only in employer's common stock, and therefore acted arbitrarily and capriciously and violated duty inasmuch as that interpretation limited ability to act in sole interest of beneficiaries.

Hugler v. Byrnes, 247 F. Supp. 3d 223, 230–34 (N.D.N.Y. 2017). Fiduciary breached duty in investing plan assets in a company's stock where he was personally and financially invested in the company's success and disproportionately relied on the company's responses to his questions instead of conducting a careful and independent investigation.

Perez v. First Bankers Tr. Servs., Inc., No. 12-cv-4450, 2017 WL 1232527, at *79 (D.N.J. Mar. 31, 2017). A fiduciary's lack of negotiation with a seller for the purchase of stock for an ESOP plan is not by itself a breach of the duty of loyalty. However, the fiduciary here breached its duty of loyalty by both failing to negotiate the purchase price and failing to conduct an intensive and scrupulous investigation.

Hugler v. First Bankers Tr. Servs., Inc., No. 12-cv-8649, 2017 WL 1194692, at *10–12 (S.D.N.Y. Mar. 30, 2017). When relying on expert advice to make investment decisions, a fiduciary must conduct a thorough

investigation and ensure that the expert advisor offers independent and impartial advice.

*In re Pfizer Inc. ERISA Litig., No. 04-cv-10071, 2009 WL 749545, at *13 (S.D.N.Y. Mar. 20, 2009). A plaintiff states a claim for relief by alleging that defendants' objectivity to the plan's interest was so compromised by their decision to "engage in the cover up to benefit the corporation, that they could not act with an 'eye single' to the interest of participants and beneficiaries."*

*Pa. Fed'n, Bhd. Of Maint. of Way Emps. v. Norfolk S. Corp. Thoroughbred Ret. Inv. Plan, No. 02-cv-9049, 2004 WL 228685, at *4 (E.D. Pa. Feb. 4, 2004). ERISA does not require fiduciaries to take any action to increase the plan's value, only to take actions that are directed by the language of the plan. The purpose of ERISA is to protect the benefits that are due to an employee under the plan.*

Whitfield v. Cohen, 682 F. Supp. 188, 195 (S.D.N.Y. 1988). Trustee who failed to discern whether investment management company or its manager was registered as investment manager with SEC or what fees company would charge for services acted in violation of fiduciary duties.

IAM Stock Ownership Inv. Trust v. E. Air Lines, Inc., 639 F. Supp. 1027, 1040 (D. Del. 1986). The duty to manage funds for the exclusive purpose of benefiting participants was not violated where fiduciary spent money to determine stock value where there was a contemplated merger, since decision of sale merits independent evaluation.

Dimond v. Ret. Plan for Emps. of Michael Baker Corp. & Affiliates, 582 F. Supp. 892, 898 (W.D. Pa. 1983). Trustee's investment of fund assets in employer without seeing purchase agreement and without seeking independent advice was a violation of duty to manage fund with the exclusive purpose of providing benefits and defraying costs.

Donovan v. Bierwirth, 538 F. Supp. 463, 470 (E.D.N.Y. 1981), order modified by 680 F.2d 263, 269 (2d Cir. 1982). Independent investigation into basis for investment decision which presents potential conflict of interest must be both intensive and scrupulous and must be discharged with greatest degree of care that could be expected under all circumstances by reasonable beneficiaries and participants.

VI. ERISA § 404(a)(1)(B), 29 U.S.C. § 1104(a)(1)(B): THE DUTY OF PRUDENCE

The duty of prudence mandates that a fiduciary's actions with respect to a plan must be performed "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." 29 U.S.C. § 1104(a)(1)(B). Borrowed from the common law of trusts, this duty is also known as the duty of care. Tibble v. Edison Int'l, 575 U.S. 523 (2015); Martinez v. Schlumberger, LTD., 338 F.3d 407, 411 (5th Cir. 2003). The standard is objective and therefore independent of a fiduciary's lack of bad faith. La Scala v. Scrufari, 479 F.3d 213, 219-20 (2d Cir. 2007).

In determining whether a fiduciary has met the duty of prudence, most courts agree that the question is whether a fiduciary has conducted a "thorough, impartial investigation" of the contemplated transaction and made a decision that the fiduciary has reasonably concluded is the best for the beneficiaries. Flanigan v. GE, 242 F.3d 78, 86 (2d Cir. 2001); Bussian v. RJR Nabisco, Inc., 223 F.3d 286, 300 (5th Cir. 2000) (Bussian II). As one court has observed:

[T]he extent of the trustee's investigation and evaluation is often the focus of inquiry in imprudent-investment suits . . . because the determination of whether an investment was objectively imprudent is made on the basis of what the trustee knew *or should have known*; and the latter necessarily involves consideration of what facts would have come to his attention if he had fully complied with his duty to investigate and evaluate.

Fink v. Nat'l Sav. & Trust Co., 772 F.2d 951, 962 (D.C. Cir. 1985) (Scalia, J., dissenting) (citations omitted); see In re Unisys Sav. Plan Litig., 74 F.3d 420, 436 (3d Cir. 1996) (Unisys I).

Accordingly, most courts carefully analyze first whether the fiduciary conducted an adequate investigation. Bussian II, 223 F.3d at 302. If so, courts typically look to whether the decision was reasonable in light of the beneficiaries' interests. Id. at 302-03. Because there is no formal rule or guideline to determine the reasonableness of a fiduciary's behavior, a court must consider "all relevant circumstances." Bunch v. W.R. Grace & Co., 555 F.3d 1, 9-10 (1st Cir. 2009). If a court decides that an investigation was insufficient, the proper inquiry is whether a hypothetical prudent fiduciary would have made the same decision in light of what an investigation would have revealed. Bussian II, 223 F.3d at 303.

A. APPLICATIONS OF THE DUTY OF PRUDENCE

1. The duty to invest prudently

Under the authority given by 29 U.S.C. § 1135, the Secretary of Labor has adopted specific fiduciary responsibility rules with respect to investment duties. See 29

C.F.R. § 2550.404a-1 (2001); Laborers Nat'l Pension Fund v. N. Trust Quantitative Advisors, Inc., 173 F.3d 313, 317 (5th Cir. 1999). The regulation provides a safe-harbor for compliance with § 1104(a)(1)(B) if the fiduciary:

(i) Has given appropriate consideration to those facts and circumstances that, given the scope of such fiduciary's investment duties, the fiduciary knows or should know are relevant to the particular investment or investment course of action involved, including the role the investment or investment course of action plays in that portion of the plan's investment portfolio with respect to which the fiduciary has investment duties; and

(ii) Has acted accordingly.

29 C.F.R. § 2550.404a-1 (b)(1) (2001).

“Appropriate consideration” has an open-ended definition that includes, among other things, contemplating the investment's risk and reward in light of the plan's portfolio. 29 C.F.R. § 2550.404a-1(b)(2) (2001). The Supreme Court has observed that ERISA fiduciaries typically cannot be expected to “have recognized from publically available information alone that the market was over- or undervaluing the stock . . . at least in the absence of special circumstances.” Fifth Third Bancorp v. Dudenhoeffer, 573 U.S. 409, 425 (2014).

Courts do not evaluate the prudence of the fiduciary's conduct based on the investment's performance. Bunch v. W.R. Grace & Co., 555 F.3d 1, 7 (1st Cir. 2009). Rather, “the ultimate outcome of an investment is not proof of imprudence” because such a standard “would convert the [plan] into an account with a guaranteed return and would immunize plaintiffs from assuming any of the risk of loss associated with their investment.” DeBruyne v. Equitable Life Assurance Soc'y of U.S., 920 F.2d 457, 465 (7th Cir. 1990). The fiduciary duty of care “requires prudence, not prescience.” Id.

Courts also do not judge the prudence of a fiduciary's actions from the vantage of hindsight. Instead, courts consider what a reasonable fiduciary would have done at the time. See, e.g., Barchock v. CVS Health Corp., 886 F.3d 43, 46 (1st Cir. 2018) (dismissing case where Plaintiffs offered only a “hindsight critique” of legitimately conservative investment strategy); DiFelice v. U.S. Airways, Inc., 497 F.3d 410, 424 (4th Cir. 2007) (upholding judgment for defendant fiduciaries despite U.S. Airways' bankruptcy because “whether a fiduciary's actions are prudent cannot be measured in hindsight”); Summers v. UAL Corp., No. 03-cv-1537, 2005 WL 2648670, at *6 (N.D. Ill. Oct. 12, 2005) (finding plaintiffs could not say through hindsight that bankruptcy was inevitable because at the time “[t]here were sufficient indications that UAL could recover from its setbacks”).

See:

Pfeil v. State St. Bank & Trust Co., 671 F.3d 585, 597–98 (6th Cir. 2012), *abrogated on other grounds by Fifth Third Bancorp v. Dudenhoeffer*, 573 U.S. 409 (2014). At the motion to dismiss stage, plaintiffs sufficiently alleged that a single imprudent investment offered by a fiduciary was a breach of the fiduciary duty to act as a prudent person would under the circumstances.

Peabody v. Davis, 636 F.3d 368, 375 (7th Cir. 2011). The defendants breached their fiduciary duty of prudence under ERISA by allowing continued investments in employer stock because the court determined after a bench trial that a prudent investor would not have remained heavily invested in the company's stock while it declined over a five-year period.

Renfro v. Unisys Corp., 671 F.3d 314, 322 (3d Cir. 2011). The court reasoned that an ERISA fiduciary must give "appropriate consideration" to the facts and circumstances of an investment. The court considers the range of investment options and the characteristics of those options in deciding whether a fiduciary prudently chose and maintained a mix of investment options.

DiFelice v. U.S. Airways, Inc., 497 F.3d 410, 420-421 (4th Cir. 2007). Plaintiffs sued airline for including employer stock fund in company investment plan, and sought recovery when the stock was cancelled after the airline filed for bankruptcy. The court clarified that the modern portfolio theory cannot be a complete defense to a claim for breach of duty because in a claim for breach of prudence, the court must judge the prudence of the offered investments individually. The court held that the airline did not violate the "prudent man" standard because it hired two independent advisors and employed a non-company fiduciary to determine the future of the company fund.

Flanigan v. Gen. Elec. Co., 242 F.3d 78, 86 (2d Cir. 2001). Trustees acted prudently in investing plan funds earmarked for transfer to corporate successor. Because short-term liquidity was needed to transfer the funds, it was prudent to invest them in solid short-term assets, eliminating the risk that additional plan assets would have to be liquidated to satisfy the contractually required transfer of funds.

Cal. Ironworkers Field Pension Trust v. Loomis Sayles & Co., 259 F.3d 1036, 1044-45 (9th Cir. 2001). Fiduciary was imprudent in investing too much of a trust's assets in risky investments, given the conservative guidelines of the trust.

In re Unisys Sav. Plan Litig., 74 F.3d 420, 435 (3d Cir. 1996) (*Unisys I*). Maturity dates of Guaranteed Investment Contracts should have been discussed by fiduciaries because of importance in assessing the risk of the investment.

Prudential Ret. Ins. & Annuity Co. v. State St. Bank & Tr. Co. (In re State St. Bank & Tr. Co. Fixed Income Funds Inv. Litig.), 842 F. Supp. 2d 614, 646 (S.D.N.Y. 2012) *Fiduciary breached duty of prudence when index funds were managed to accept double the risk disclosed to investment adviser for ERISA retirement plans that had invested in those funds.*

2. Duty to investigate

One court has labeled the duty to investigate “the most basic of ERISA’s . . . fiduciary duties.” Unisys I, 74 F.3d at 435. In fact, most courts focus their analysis wholly on the fiduciaries’ investigation. See, e.g., Eyler v. Commissioner, 88 F.3d 445, 456 (7th Cir. 1996) (lower court was not clearly erroneous in finding fiduciaries had not met the duty of prudence in making a decision the same day they heard of project and relying only on an outdated estimated price range).

To meet the duty of prudence, fiduciaries must demonstrate that they thoroughly investigated the transaction’s merits before entering into it. Howard v. Shay, 100 F.3d 1484, 1488–90 (9th Cir. 1996). A fiduciary can be found to have breached the duty to investigate upon a showing that “adequate investigation would have revealed . . . that the investment at issue was improvident.” Rinehart v. Lehman Bros. Holding Inc., 817 F.3d 56, 67-68 (2d Cir. 2016) (quoting In re Citigroup ERISA Litigation, 662 F.3d 128, 138 (2d Cir.2011)). Conversely, “a fiduciary’s failure to investigate an investment decision alone is not sufficient to show that the decision was not reasonable.” Saumer v. Cliffs Nat. Res. Inc., 853 F.3d 855, 863 (6th Cir. 2017) (quoting Kuper v. Iovenko, 66 F.3d 1447, 1459 (6th Cir. 1995) (determining failure of duty to investigate was not shown where “plaintiffs have not pled what, if anything, the fiduciaries might’ve gleaned from publicly available information that would undermine reliance on the market price.”)

Because fiduciary duty cases where liability is found usually involve loss to the plan that a careful investigation could have been prevented, some courts do not separate the duty to investigate from the duty to invest prudently, and do not consider fully whether a hypothetical prudent fiduciary would have made the same decision. See generally Gilbert v. EMG Advisors, Inc., 172 F.3d 876 (9th Cir. 1999) (Table) (finding that defendant violated his fiduciary duties by failing to investigate investment at all); Howard, 100 F.3d at 1489-90 (9th Cir. 1996) (holding that pension plan fiduciaries acted imprudently in self-dealing transaction by completing transaction without negotiation, relying on independent valuation without questioning it, despite fact that cursory review of valuation revealed carelessness of assessment); Brock v. Robbins, 830 F.2d 640, 646 (7th Cir. 1987) (holding that trustees of employee pension, health and welfare fund acted imprudently in not adequately investigating basis and justification for fee of claims processor before entering contract in connection with conversion to self-funding).

A few cases involve a determination that although a fiduciary’s investigation was inadequate, the fiduciary did not violate § 1104(a)(1)(B) because a hypothetical prudent person would have made the same decision. See Plasterers’ Local Union No. 96 Pension Plan v. Pepper, 663 F.3d 210, 218 (4th Cir. 2011) (remanding because “[e]ven if a trustee failed to conduct an investigation before making

a decision, he is insulated from liability (under § 1109(a)) if a hypothetical prudent fiduciary would have made the same decision anyway”); Herman v. Mercantile Bank, N.A., 143 F.3d 419, 421 (8th Cir. 1998) (although fiduciary did not independently evaluate the merits of a stock buy-back, he paid the same amount a hypothetical prudent fiduciary would have paid; therefore, he was not liable); see also DeFazio v. Hollister, Inc., No. 04-cv-1358, 2012 WL 1158870, at *27 (E.D. Cal. Apr. 6, 2012) (recognizing hypothetical prudent fiduciary standard but holding that while standard may limit damages against fiduciary, it cannot absolve fiduciary from all liability).

Investigation is not all that is required prior to making investment decisions, however; indeed, a fiduciary “acts judiciously. . . in hesitantly exercising an ambiguous power.” Bidwill v. Garvey, 943 F.2d 498, 507 (4th Cir. 1991) (trustees, who owed money to fund depending on whether it was deductible, were prudent in obtaining an IRS ruling and delaying irrevocable payments to fund). The conduct of fiduciaries during the investigation leading to a decision is more important than the result of their decisions. Plasterers’ Local Union No. 96 Pension Plan, 663 F.3d at 218–19; In re Unisys Sav. Plan Litig. (Unisys II), 173 F.3d 145, 153 (3d Cir. 1999). Furthermore, some courts have held the standard is flexible: “the level of knowledge required of a fiduciary will vary with the nature of the plan.” Donovan v. Cunningham, 716 F.2d 1455, 1467 n.26 (5th Cir. 1983). It is clear, however, that a fiduciary’s total ignorance of important features about a particular investment constitutes a breach of the duty of prudence. White v. Martin, 286 F. Supp. 2d 1029, 1041 (D. Minn. 2003).

See:

Rinehart v. Lehman Bros. Holding Inc., 817 F.3d 56, 67-68 (2d Cir. 2016). Affirming the District Court’s decision that Plaintiffs must “explain[] in a non-conclusory fashion how . . . hypothetical investigation would have uncovered the alleged inside information” in order to adequately plead a breach of the duty of prudence for failure to investigate.

White v. Martin, 286 F. Supp. 2d 1029, 1041 (D. Minn. 2003). Fiduciary’s ignorance of the Canadian non-resident tax incurred by the fund as a result of fiduciary’s decision to invest through a Canadian firm constituted a breach of the duty of prudence.

Conner v. Mid S. Ins. Agency, 943 F. Supp. 647, 658-59 (W.D. La. 1995). Whether a plan can pay for an asset is not the only relevant question in evaluating potential plan investments. The opportunity cost of the chosen investment, or the expected return on investments which would be made if the chosen investment was not made, is also important. If investment A will yield X dollars and investment B will yield X+1 dollars, this seriously calls into question investment in A. Not even to consider investment B, however, is certainly imprudent.

Even if a fiduciary’s lack of prudent investigation did not cause a loss to the plan, “[t]he failure to investigate and evaluate a particular investment decision is a

breach of fiduciary duty that may warrant an injunction against or the removal of the trustee.” Tibble v. Edison Int’l, No. 07-cv-5359, 2010 WL 2757153, at *1 (C.D. Cal. July 8, 2010), vacated and remanded on other grounds, 843 F.3d 1187 (9th Cir. 2016); Shaver v. Operating Engineers Local 428 Pension Tr. Fund, 332 F.3d 1198, 1203 (9th Cir. 2003) (“On these facts, removal of the trustees might conceivably be warranted, because trustees may be removed for imprudent but not necessarily improper conduct.”); Robbins, 830 F.2d at 647 (injunctive relief applied to “honest but imprudent trustees” who caused no loss to a plan would be in accordance with the purpose of ERISA); see also DeFazio, 2012 WL 1158870, at *27.

3. Duty to prudently select service providers

Courts that have considered the issue have made it clear that “the failure to exercise due care in selecting . . . a fund’s service providers constitutes a breach of a trustees’ fiduciary duty.” Mahoney v. J.J. Weiser & Co., 564 F. Supp. 2d 248, 255–56 (S.D.N.Y. 2008), aff’d sub nom. Mahoney v. JJ Weiser & Co., 339 F. App’x 46 (2d Cir. 2009) (citing Pineiro v. Pension Benefit Guar. Corp., 318 F. Supp. 2d 57, 93 (S.D.N.Y. 2003)). Such due care is exercised “[t]o the extent possible under the circumstances” by “consider[ing] the plan’s needs, solicit[ing] competing proposals, evaluat[ing] them with due care, and select[ing] the one that could best serve the plan’s needs within budgetary constraints.” Id.

Department of Labor guidance has also emphasized the importance of prudently selecting service providers. DOL Info. Letter to Theodore Konshak (Dec. 1, 1997). Although it appears that courts have not offered extensive guidance on the question, the DOL has observed that, when selecting a service provider, “the responsible plan fiduciary must engage in an objective process.” Id. Such a process must be “designed to elicit information necessary to assess the qualifications of the service provider, the quality of the work product, and the reasonableness of the fees charged in light of the services provided.” Id. Furthermore, “such process should be designed to avoid self-dealing, conflicts of interest or other improper influence.” Id. Although the DOL has offered such general guidance, it has also cautioned that prudent selection of a service provider “will depend upon the particular facts and circumstances.” Id.

4. Prudent loans

Courts determine the prudence of loans by considering the investigation conducted prior to making the loan and whether the loan would be a sound investment according to industry standards. Laborers Nat’l Pension Fund v. Northern Trust Quantitative Advisors, Inc., 173 F.3d 313, 316–17 (5th Cir. 1999). Reliance on the representations of the borrower without more investigation is insufficient to meet the duty of prudence. Chao v. Moore, No. 99-cv-1283, 2001 WL 743204, at *6 (D. Md. June 15, 2001).

See:

Laborers Nat'l Pension Fund v. Northern Trust Quantitative Advisors, Inc., 173 F.3d 313, 316–17 (5th Cir. 1999). Defendant's investment in mortgage backed securities was examined in light of the transaction and loan status at the time of the investment. The court asked whether a prudent person would have made the same independent investment decision.

Chao v. Moore, No. 99-cv-1283, 2001 WL 743204, at *6 (D. Md. June 15, 2001). The defendant's investment imperiled the security of a loan issued by the fund and constituted a breach of the duty of prudence. The court looked at the transaction at the time the decision was made and considered the investment in light of the objectives of the plan, the diversity of the plan, the liquidity relative to cash flow, and the projected return of the portfolio relative to the funding objectives.

Davidson v. Cook, 567 F. Supp. 225, 232 (E.D. Va. 1983), *aff'd*, 734 F.2d 10 (4th Cir. 1984). Imprudence in real estate lending occurred where fiduciaries did not conduct a proper appraisal of the proposed construction, future rental income, or the borrower's finances, and did not obtain assignment of rents, sureties on the loan, or a principal repayment schedule.

Marshall v. Glass/Metal Ass'n & Glaziers & Glassworkers Pension Plan, 507 F. Supp. 378, 384 (D. Haw. 1980). The trustees' honest belief that their conduct was in the plan's best interests is irrelevant in determining whether they failed to meet the prudent man standard. The court denied the trustees' request to be treated more leniently than a larger financial institution. Extending a loan where the plan had the most risk and least potential return of any party involved was imprudent.

5. Prudent management of Employee Stock Ownership Plans

Employee Stock Ownership Plans ("ESOP's") are a unique form of ERISA plan. They were created to encourage employee ownership by investing in the plan-sponsoring company's securities. *Moench v. Robertson*, 62 F.3d 553, 568 (3d Cir. 1995), *abrogated on other grounds* *Dudenhoeffer*, 573 U.S. at 409 (2014). Courts hold that while ESOP fiduciaries are exempt from other provisions of ERISA such as the duty to diversify and restrictions on dealing with interested parties, they must meet the duty of prudence under § 1104(a)(1)(B). *Pugh v. Tribune Co.*, 521 F.3d 686, 699 (7th Cir. 2008). Although several Circuits have previously held that ESOP fiduciaries receive the benefit of the doubt in the form of a presumption of having complied with ERISA, e.g., *Moench*, 62 F.3d at 571, *Wright v. Or. Metallurgical Corp.*, 360 F.3d 1090, 1099 (9th Cir. 2004), the Supreme Court clarified in *Fifth Third Bancorp v. Dudenhoeffer*, 573 U.S. at 409 that ESOP fiduciaries are not entitled to such a presumption of prudence.

For a more detailed discussion of litigation related to ESOPs and employer stock, including cases involving the duty of prudence, see Section X of this Handbook.

a) Investment in the employer's securities

Under 29 U.S.C. § 1108(e), a plan may invest in the securities of its sponsor, the employer of the plan's beneficiaries, in exchange for "adequate consideration." 29 U.S.C. § 1108(e); Howard, 100 F.3d at 1488; In re RadioShack Corp. ERISA Litig., 547 F. Supp. 2d 606, 617 (N.D. Tex. 2008); In re Coca Cola Enters. ERISA Litig., No. 06-cv-0953, 2007 WL 1810211, at *17 (N.D. Ga. June 20, 2007). "Adequate consideration" is defined, "[i]n the case of an asset other than a security for which there is a generally recognized market, [as] the fair market value of the asset as determined in good faith by the trustee or named fiduciary pursuant to the terms of the plan and in accordance with regulations promulgated by the Secretary." 29 U.S.C. § 1002(18)(B). This section works together with ERISA § 404 in that a fiduciary may be found to have violated the duty of prudence if he has failed to conduct a sufficient investigation as to the adequacy of consideration. Howard, 100 F.3d at 1489; cf. Keach v. U.S. Trust Co., 419 F.3d 626, 635–36 (7th Cir. 2005).

In 1988, the Department of Labor proposed a regulation that establishes a two-part test for "adequate consideration" under § 3 (18)(B): (1) whether the consideration properly represents the fair market value of the securities, and (2) whether the fiduciary has made a good faith determination of the adequacy of consideration according to an objective standard. Regulation Relating to the Definition of Adequate Consideration, 53 Fed. Reg. 17632 (proposed May 17, 1988); see Montgomery v. Aetna Plywood, Inc., 39 F. Supp. 2d 915, 936-38 (N.D. Ill. 1998).

In reviewing the adequacy of consideration, a court will normally not determine the appropriate price *de novo*; rather, the important inquiry is into the investigation performed by the fiduciaries in arriving at their decision. Keach, 419 F.3d at 635–36; Montgomery, 39 F. Supp. 2d at 936. But see Mercantile Bank, 143 F.3d at 421 (focusing on stock's price rather than fiduciaries' investigation and concluding that if hypothetical prudent person would have paid same price, level of investigation was irrelevant).

Special considerations, such as nonpublic information, may come into the analysis of investment decisions made in the employer's securities. In Dudenhoeffer, the court considered the question of whether a breach of the duty should be shown connected to an investment in an employer's security on the basis of nonpublic information. 573 U.S. at 427. The Court held that, in order to show such a breach "a plaintiff must plausibly allege an alternative action that the defendant could have taken that would have been consistent with the securities laws and that a prudent fiduciary in the same circumstances would not have viewed as more likely to harm the fund than to help it." Id. The Court later stated that such a violation might be found in connection with a trustee's decision to continue investment in employer's stock, despite knowing that the stock's price was artificially inflated due to improper off-label drug marketing.

See also Amgen Inc. v. Harris, 136 S. Ct. 758, 758 (2016) (ultimately dismissing the case due to Plaintiff's failure to provide sufficient facts and allegations to state a claim under such a theory).

b) Sell-back options

ESOPs often allow beneficiaries to sell their stock back to their employer in exchange for notes repayable over a certain period. Roth v. Sawyer-Cleator Lumber Co., 16 F.3d 915, 916 (8th Cir. 1994). If payments to ESOP beneficiaries who have exercised such a put option to sell the stock owned in the ESOP are deferred, there must be adequate security and a reasonable interest rate. Id. at 916; 29 C.F.R. § 2550.408b-3(1)(4) (2001). A fiduciary breaches the duty of prudence in failing to properly investigate the value of the security over the full payment period. Roth, 16 F.3d at 918.

6. Prudent purchasing of annuities in connection with plan termination

In the context of purchasing an annuity in connection with a plan termination, fiduciaries must take care to conduct a thorough investigation of annuity providers before purchasing the annuity. Bussian v. RJR Nabisco, Inc., 223 F.3d 286, 300 (5th Cir. 2000) (Bussian II). The Department of Labor has issued an interpretive bulletin containing written guidelines for purchasing an annuity; these guidelines have been adopted in part by at least one court as consistent with the fiduciary duty of prudence. 29 C.F.R. § 2509.95-1 (2001); Bussian II, 223 F.3d at 300. Courts have, however, rejected the standard advocated by the Department of Labor that a fiduciary must purchase the "safest available annuity." Id. at 298; Riley v. Murdock, 83 F.3d 415 (table), No. 95-cv-2414, 1996 WL 209613 (4th Cir. Apr. 30, 1996). Instead, as with other duty of prudence cases, the proper analysis concentrates more on the behavior of the fiduciary than the quality of the decision. Bussian II, 223 F.3d at 298.

In particular, fiduciaries may not merely rely on an insurance company's ratings to satisfy the level of investigation under the duty of prudence. Id. at 300; 29 C.F.R. § 2509.95-1(c) (2001). Moreover, "price cannot be the motivating factor until the fiduciary reasonably determines, through prudent investigation, that the providers under consideration are comparable in their ability to promote the interests of participants and beneficiaries." Bussian II, 223 F.3d at 302. Factors on which a fiduciary should base the decision include:

- (a) The quality and diversification of the annuity provider's investment portfolio;
- (b) The size of the insurer relative to the proposed contract;
- (c) The level of the insurer's capital and surplus;
- (d) The lines of business of the annuity provider and other indications of an insurer's exposure to liability;

- (e) The structure of the annuity contract and guarantees supporting the annuities, such as the use of separate accounts;
- (f) The availability of additional protection through state guaranty associations and the extent of their guarantees.

29 C.F.R. § 2509.95-1(c) (2001); Bussian II, 223 F.3d at 300.

B. RELIANCE ON EXPERT ASSISTANCE

Fiduciaries may rely on experts to assist with investigation and evaluation; however, fiduciaries must ultimately rely on their own independent judgment. Bussian II, 223 F.3d at 300-01. Once an expert is retained, “the fiduciary must (1) investigate the expert’s qualifications, (2) provide the expert with complete and accurate information, and (3) make certain that reliance on the expert’s advice is reasonably justified under the circumstances.” Howard, 100 F.3d at 1489. See also Brundle v. Wilmington Tr., N.A., 919 F.3d 763, 774 (4th Cir. 2019), as amended (Mar. 22, 2019).

Reliance may be reasonably justified depending on several factors, including the expert’s reputation and experience, the extensiveness and thoroughness of the expert’s investigation, whether the expert’s opinion is supported by relevant material, and whether the expert’s methods and assumptions are appropriate to the decision at hand.” Bussian II, 223 F.3d at 301. Fiduciaries need not replicate the analysis of hired experts nor hire others to evaluate expert information; however, reports should be reviewed and independently assessed by the fiduciaries themselves. Id. at 301; Unisys II, 173 F.3d at 152; Unisys I, 74 F.3d at 435. Fiduciaries must also supplement expert information to keep it up to date. Unisys I, 74 F.3d at 435.

See:

Brundle v. Wilmington Tr., N.A., 919 F.3d 763, 774 (4th Cir. 2019), as amended (Mar. 22, 2019). Affirming district court’s finding that employee stock ownership plan (ESOP) trustee should have investigated multiple shortcomings in its financial advisor’s analysis. Also, affirming district court’s finding that trustee should have questioned the accuracy of various pieces of information provided to financial advisor.

Perez v. Bruister, 823 F.3d 250, 264 (5th Cir. 2016). ESOP trustees were not reasonably relying on expert appraiser’s valuation where trustees insufficiently investigated expert’s background and qualifications, overlooked communications showing expert was cooperating with appraised company’s lawyer to increase appraisal value, failed to inform expert about significant information, and failed to significantly review expert’s conclusions.

In re Unisys Sav. Plan Litig., 173 F.3d 145 (3d Cir. 1999) (Unisys II). The fiduciaries performed a sufficiently prudent investigation in investing in Guaranteed Income Contracts issued by an insurance company that went

into receivership because the investigation was performed in part by an experienced investment consultant who used reliable information provided by national ratings services. Moreover, the fiduciaries made their own evaluation of the investment risks, and did not “passively” accept the consultant’s appraisal.

1. Retention of additional experts

If expert reports are unclear or seem insufficient after a fiduciary’s careful review, the fiduciary may need to retain additional experts. Howard, 100 F.3d at 1489; but cf. Cunningham, 716 F.2d at 1491 (O’Scannlain, J., dissenting) (“once [fiduciaries] have carefully selected and adequately informed the expert, they should be able to rely on the expert’s conclusions”).

See:

Gregg v. Trans. Workers of Am. Int’l, 343 F.3d 833, 841–43 (6th Cir. 2003). Fiduciaries may use their retention of experts as evidence of fulfilling their duty to investigate. However, when fiduciaries have not hired an independent expert and the fiduciary does not bother to read the policy or have a basic understanding of the plan’s provisions, the duty to investigate is not satisfied.

Howard v. Shay, 100 F.3d 1484, 1488–90 (9th Cir. 1996). Conflicted fiduciaries do not satisfy the duty to investigate nor the duty of prudence by simply hiring an expert. Fiduciaries must “(1) investigate the expert’s qualifications, (2) provide the expert with complete and accurate information, and (3) make certain that reliance on the expert’s advice is reasonably justified under the circumstances.”

Keach v. U.S. Trust Co., 313 F. Supp. 2d 818, 867 (C.D. Ill. 2004). The court held that trustees can only rely on an advisor’s opinion when that reliance is reasonably justified under the circumstances. The fiduciary must conduct a prudent and sufficient investigation, and if that is satisfied, the fiduciary has not breached the duty to investigate by relying on the advisor’s opinion.

Riley v. Murdock, 890 F. Supp. 444, 457-58 (E.D.N.C. 1995), aff’d, 83 F.3d 415 (table), No. 95-cv-2414, 1996 WL 209613 (4th Cir. Apr. 30, 1996). The fiduciaries performed a sufficiently prudent investigation in selecting an insurance company from whom to purchase an annuity because the investigation and decision-making process was performed by a committee of experienced financial managers. The committee sought assistance from attorneys and a top employee benefits consulting firm in addition to performing its own investigation, including conducting financial analyses, personally meeting with the bidding companies’ senior management, reviewing financial documents, hiring specialists in insurance company

evaluation, and asking advice from independent sources and parties who had purchased annuities from the ultimate choice.

Mazur v. Gaudet, 826 F. Supp. 188, 191-92 (E.D. La. 1992). Though granting summary judgment to the plaintiff in an ERISA action for breach of fiduciary duty is rare, the defendant’s conduct was so imprudent that a jury could not reasonably find otherwise. The trustees played no significant managerial role in the fund and, without any investigation, relied on their accountant who committed malpractice by conducting audits wholly out of accord with general accounting principles.

Whitfield v. Cohen, 682 F. Supp. 188, 195 (S.D.N.Y. 1988). Trustee’s investigation of investment manager was imprudent in that trustee did not adequately evaluate the qualifications or the reasonableness of fees of the investment manager. Furthermore, the trustee’s failure to monitor the investment manager’s ongoing behavior once retained was imprudent.

Additionally, fiduciaries should take care that they meet the prudence standard in retaining experts. See Howard, 100 F.3d at 1489.

2. Reliance on non-experts

With respect to persons who are not experts but whose tasks are administrative, fiduciaries “may rely on information, data, statistics or analyses furnished by [them]. . . provided that [the fiduciary] has exercised prudence in the selection and retention of such persons.” 29 C.F.R. § 2509.75-8 FR-11 (2001). Furthermore, the fiduciary must not have any reason to doubt the trustworthiness of the person. Id.

C. CONTINUING DUTY TO MONITOR

In addition to being required to exercise prudence when selecting investments, a trustee is also required to exercise prudence by monitoring those investments and removing them if necessary. In Tibble v. Edison Int’l, 575 U.S. 523, 135 S. Ct. at 1828 (2015), the Supreme Court has clarified that “this continuing duty exists separate and apart from the trustee’s duty to exercise prudence in selecting investments at the outset.” Id. As a result, “a fiduciary is required to conduct a regular review of its investment with the nature and timing of the review contingent on the circumstances.” Id.

Therefore, a violation of the duty of prudence can be shown through allegations that a fiduciary “fail[ed] to monitor investments and remove imprudent ones.” Id. at 1829. In considering whether investments were appropriately monitored, courts will, of course, consider whether investments remained consistent with the goals and strategy of particular plans. See, e.g., Wilson v. Fidelity Management Trust Company, 755 Fed. Appx. 697 (9th Cir. 2019). Similarly, a trustee also is required to exercise prudence by continuing to monitor any service providers that have been selected. See, e.g., Mahoney v. J.J. Weiser & Co., 564 F. Supp. 2d 248, 255–56 (S.D.N.Y. 2008) (stating that “a fiduciary has an ongoing obligation to monitor the . . . services provided

by service providers with whom [it has] an agreement, to ensure that renewal of such agreements is in the best interest of the plan.”) (citations omitted).

For additional discussion of the scope of the duty of prudence, see Section XV.D of this Handbook.

VII. ERISA § 404(a)(1)(C), 29 U.S.C. § 1104(a)(1)(C): THE DUTY TO DIVERSIFY

ERISA requires a fiduciary to act solely in the interests of a retirement plan's participants and beneficiaries by "diversifying the investments of the plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so." 29 U.S.C. § 1104(a)(1)(C). Breach of the duty to diversify constitutes an independent cause of action, separate from a breach of the duty of prudence. Dardaganis v. Grace Capital Inc., 889 F.2d 1237, 1241 (2d Cir. 1989); Liss v. Smith, 991 F. Supp. 278, 301 (S.D.N.Y. 1998). To establish a violation of the duty to diversify, a plaintiff must first show that the plan is not diversified on its face. Once the plaintiff meets the initial burden, the burden shifts to the defendant to prove that the non-diversification was prudent under the circumstances.

29 U.S.C. § 1104(a)(1)(C) does not contain a definition of a properly diversified plan; however, ERISA's legislative history suggests that the level of investment concentration that would violate the duty to diversify cannot be stated as a fixed percentage, because a fiduciary must consider each case's facts and circumstances. Accordingly, the factors to be considered include "(1) The purposes of the plan; (2) The amount of the plan assets; (3) Financial and industrial conditions; (4) The type of investment; (5) Distribution as to geographical location; (6) Distribution as to industries; [and] (7) The dates of maturity." H.R. REP. NO. 1280, 93d Cong., 2d Sess. (1974), reprinted in 1974 U.S.C.C.A.N. 5038, 5084-85. Essentially, a fiduciary should not invest the "whole or an unduly large proportion of the trust property in one type of security or in various types of securities dependent upon the success of one enterprise or upon conditions in one locality, since the effect is to increase the risk of large losses." Id.

A. PURPOSE OF DIVERSIFICATION

Investment diversification is the practice whereby funds are committed to different classes of investments which are characterized by different types of risks. The theory upon which this practice is based is that by allocating funds to different investment types, the potential losses that might occur in one area due to a particular economic event will be offset by gains in another area. Even if such a loss is not offset, its impact is at least limited to a relatively small portion of the fund. Donovan v. Guar. Nat'l Bank of Huntington, No. 81-cv-3154, 1983 U.S. Distr. LEXIS 18042, at *6 (S.D. W. Va. Apr. 1, 1983).

Courts have referenced the legislative history passages and taken up a very fact-sensitive approach in their analysis of a properly diversified plan. Metzler v. Graham, 112 F.3d 207, 209 (5th Cir. 1997) ("[T]he foregoing open-ended facts and circumstances list ought to caution judicial review of investment decisions."); PBGC v. Morgan Stanley Inv. Mgmt., 712 F.3d 705, 717 (2d Cir. 2013) (citing In re Unisys Sav. Plan Litig., 74 F.3d 420, 438 (3d Cir. 1996) ("ERISA's duty to diversify is not measured by hard and fast rules or formulas")); Reich v. King, 861 F. Supp. 379, 383 (D. Md. 1994) ("the appropriate level of diversification in this case must be considered in light of the facts and circumstances particular to it"). Consequently, summary judgment on this

issue is incredibly rare. Liss, 991 F. Supp. at 288, 301-02 (stating that defendants never considered their statutory duty to diversify, but refusing to enter summary judgment on issue).

There is no such thing as a *per se* violation of the duty to diversify. King, 861 F. Supp. at 385. Only when a finding of fact has been entered that non-diversification was not prudent will a court find liability for failure to diversify. Id.

B. ASSETS SUBJECT TO THE DUTY TO DIVERSIFY

Courts have generally found that a lack of diversification claim must challenge the plan's diversity as a whole, rather than focus on individual investment funds. Young v. GM Inv. Mgmt. Corp., 325 Fed. Appx. 31, 33 (2d Cir. 2009) (dismissing a claim for breach of the duty to diversify where the complaint focused on a few individual funds); Harmon v. FMC Corp., No. 16-cv-6073, 2018 U.S. Dist. LEXIS 43222, at *13-14 (E.D. Pa. Mar. 16, 2018) (finding a failure to state a plausible claim where plaintiffs failed to question the plan's diversity as a whole); Yates v. Nichols, 286 F. Supp. 3d 854, 863-64 (N.D. Ohio 2017) (finding no breach of the duty to diversify where plaintiff challenged the purchase of company stock using 6.5% of the plan's assets, but failed to challenge the diversity of the remaining 93.5% of the plan's assets).

However, if a fiduciary is responsible only for a portion of the plan's total assets, some courts have found that the fiduciary must adequately diversify her portion as if it were a separate plan and cannot rely on the total plan's overall diversity as a defense. Unisys Sav. Plan, 74 F.3d at 438-440; In re State St. Bank & Tr. Co. Fixed Income Funds Inv. Litig., 842 F. Supp. 2d 614, 650-51 (S.D.N.Y. 2012) (finding a breach of the duty to diversify the bond portion of the portfolio by primarily investing in securities backed by subprime mortgages); Alco Indus., Inc. v. Wachovia Corp., 527 F. Supp. 2d 399, 406 (E.D. Pa. 2007) (allowing a claim of non-diversification regarding a portfolios' equities portions where the fiduciary managed the equity portfolio); see H.R. REP. NO. 1280, 93d Cong., 2d Sess. (1974), reprinted in 1974 U.S.C.C.A.N. at 5084.

Below are some of the more common areas of dispute associated with certain assets.

1. Final distributions of assets

The duty to diversify extends only to the plan's investments. Section 1104(a)(1)(C) does not require that a fiduciary investigate or insure the diversification of any final asset distribution. Bussian v. RJR Nabisco, Inc., 223 F.3d 286, 294 (5th Cir. 2000) (Bussian II) ("the purchase of an annuity to facilitate plan termination is not an investment of the plan. . . . [A] fiduciary [has no] obligation to . . . ensure the adequate diversification of an annuity provider's portfolio").

2. Investments in employer securities

Investments in employer securities in eligible individual account plans (EIAPs), as defined in 29 U.S.C. § 1107(d), such as employee stock ownership plans

(ESOPs), profit sharing plans, or stock bonus plans, are expressly exempted under ERISA from the duty to diversify. 29 U.S.C. § 1104(a)(2); Fifth Third Bancorp v. Dudenhoeffer, 575 U.S. 409, 419 (2014); Tatum v. RJR Pension Inv. Comm., 761 F.3d 346, 356 (4th Cir. 2014); Lanfear v. Home Depot, Inc., 679 F.3d 1267, 1278 (11th Cir. 2012); Steinman v. Hicks, 352 F.3d 1101, 1103 (7th Cir. 2003). Because Congress intended to permit an ESOP to be used as a corporate finance technique as well as a retirement benefit plan for employees, an ESOP is exempt from ERISA's duty to diversify. Lanfear, 679 F.3d at 1278 (citing Moench v. Robertson, 62 F.3d 553, 569 (3d Cir. 1995)); Brown v. Am. Life Holdings, Inc., 190 F.3d 856, 860 (8th Cir. 1999).

Courts have tried to balance the ESOP's purpose of investing primarily in employer securities with ERISA's duty of prudence. Following years of Circuit conflict, the Supreme Court in Dudenhoeffer, 575 U.S. 409 (2014), rejected a special presumption of prudence in favor of ESOP fiduciaries. The Court stated that ESOP fiduciaries are subject to the same duty of prudence as other ERISA fiduciaries, except that they do not need to diversify the plan's assets. Id. at 412.

Furthermore, courts have generally determined that when a plan completely prohibits diversification of ESOP assets, such a provision will not provide a defense to a fiduciary because a fiduciary may only follow plan terms to the extent they are consistent with ERISA. Summers v. State St. Bank & Tr. Co., 453 F.3d 404, 407 (7th Cir. 2006) (citing Kuper v. Iovenko, 66 F.3d 1447, 1457 (6th Cir. 1995)). Both the Supreme Court and the U.S. Department of Labor (DOL) clarified that the duty of prudence supersedes any plan documents or other plan governing instruments. Dudenhoeffer, 573 U.S., at 421 ("the duty of prudence trumps the instructions of a plan document, such as an instruction to invest exclusively in employer stock even if financial goals demand the contrary"); 29 C.F.R. § 2509.08-2(2). For a more detailed discussion of ESOPs and litigation related to employer stock, see Section XV.

Defined benefit plans, unlike EIAPs, are not subject to the exemption from diversification. In addition, ERISA contains provisions limiting a defined benefit plan to investing no more than 10% of its assets in employer securities and property. 29 U.S.C. § 1107(a). And, even where fiduciaries do not exceed the 10% ceiling, they can still be found to have acted imprudently by purchasing a significant portion of employer stock. Donovan v. Bierwirth, 680 F.2d 263 (2d. Cir. 1982) (holding that the trustees acted imprudently by authorizing the plan's purchase of company shares just short of the 10% limit without seeking expert advice).

3. Annuities

A fiduciary's responsibilities under the duty to diversify may not extend to consideration of the diversification of an annuity portfolio purchased by the plan, but such a duty may exist under the duties of loyalty and care. Bussian II, 223 F.3d at 294. In regard to a plan's use of annuities, one court has stated "[ERISA's] legislative history informs that a plan may invest wholly in insurance or annuity contracts, since generally an insurance company's assets are to be invested in a diversified manner." Unisys Sav. Plan, 74 F.3d at 438.

If a company buys an annuity for part of its plan and makes a reasonably prudent decision in choosing an insurer, it has no further responsibility to the plan. Lee v. Verizon Communs., Inc., 837 F.3d 523, 541-42 (5th Cir. 2016) (citing Bussian II, 223 F.3d at 300); Bussian v. RJR Nabisco, Inc., 21 F. Supp. 2d 680, 684-86 (S.D. Tex. 1998) (Bussian I), rev'd in part and vacated in part on other grounds, 223 F.3d 286, 294 (5th Cir. 2000); See DOL Reg. § 2550.95-1.

4. Real estate and mortgages

ERISA's legislative record indicates that Congress foresaw real estate as being an issue in failure to diversify cases. It offered some guidance on this issue by stating that if a fiduciary invests in mortgages on real property he or she should not invest a disproportionate amount of the trust in mortgages in a particular district or in a particular class of property so that a decline in property values in that district or of that class might cause a large loss. H.R. REP. NO. 1280, 93d Cong., 2d Sess. (1974), reprinted in 1974 U.S.C.C.A.N. at 5084.

The legislative history does not indicate that a fiduciary is prohibited from concentrating in mortgages, but it generally requires the mortgages to be secured by a diverse array of real estate. Id. at 5085.

See:

Brock v. Citizens Bank of Clovis, 841 F.2d 344, 346 (10th Cir. 1988). Finding a breach of duty to diversify where 65% to 85% of plan's assets were devoted to mortgages in the Clovis area.

Donovan v. Mazzola, 716 F.2d 1226 (9th Cir. 1983). Finding a failure to diversify where the trustees invested a large portion of assets in loans tied to real estate and mortgages in the Northern California region.

Donovan v. Guar. Nat'l Bank of Huntington, No. 81-cv-3154, 1983 U.S. Dist. LEXIS 18042 (S.D. W. Va. Apr. 1, 1983). Fiduciaries' investment of virtually all of the plan's assets in real estate mortgages concentrated in the Huntington area resulted in the court ordering the trustees to reinvest assets with no more than one-third of assets allocated to any one type of investment.

Marshall v. Glass/Metal Ass'n & Glaziers & Glassworkers Pension Plan, 507 F. Supp. 378, 383 (D. Haw. 1980). Fiduciaries' decision to commit 23% of plan's assets to a single real estate investment to develop time shares in Hawaii was on its face a violation of duty to diversify, and such violation was not prudent where Plan trustees lacked prior lending experience, did not follow commonly accepted lending procedures, and did not consider other real estate investment vehicles.

But see:

Reich v. King, 867 F. Supp. 341 (D. Md. 1994). Finding non-diversification by investing 70% of the plan's assets in local residential real estate mortgages was nevertheless prudent where the short duration of the investments and the defendants' knowledge of the real estate market did not expose the plan to the risk of large losses.

C. SCOPE OF THE DUTY TO DIVERSIFY

Typically courts rely heavily on the specific facts of a given case and the context of the fiduciary's investment responsibilities to determine whether the duty to diversify has been breached. Unisys Sav. Plan, 74 F.3d at 438. The duty to diversify applies only to a fiduciary who manages or invests plan assets. For participant-directed plans, even though fiduciaries do not make the investment decisions after initially selecting the investment options, they must still ensure that the investment menu provides adequate diversification opportunities. Howell v. Motorola, Inc., 633 F.3d 552, 567 (7th Cir. 2001); Yates, 286 F. Supp. 3d at 863; see DOL Reg. § 2550.404c-1(b)(3).

Courts have traditionally been willing to extend a fair amount of deference to a fiduciary's judgment. Very high percentage allocations have been found to be a prudent non-diversification, while much smaller ones have been found to constitute an imprudent failure to diversify. The key factors seem to be a fiduciary's expertise in the relevant investment field and the extent of pre-investment investigation the fiduciary performed. As the ultimate decision rests on the ability to show that non-diversification is prudent, this area of fiduciary duty mixes a great deal with the prudence standard. Lanka v. O'Higgins, 810 F. Supp. 379, 387 (N.D.N.Y. 1992).

For example, in Hunter v. Caliber Sys., Inc., 220 F.3d 702, 721 (6th Cir. 2000), the plaintiffs brought suit alleging, among other things, that the defendant fiduciaries breached their duty to diversify by not diversifying soon enough in conformity with plan documents. The court rejected this argument, finding that the plan documents in fact did not require the administrator to follow certain exchange dates. Id. Furthermore, the court noted that where plan diversification is achieved by the sudden sale of a subsidiary's stock and that sale may have negative consequences on the parent company's stock and the plan as a whole, non-diversification is prudent. Id. at 722.

See also:

Plasterers' Local Union v. Pepper, 663 F.3d 210, 217 (4th Cir. 2011). The district court did not err when finding a breach of the duty to diversify where the plan's assets were invested exclusively in conservative investments of CDs of less than \$100,000 and one-to-two year Treasury bills. However, the case was remanded for the district court to determine whether any losses resulted from the failure to diversify.

GIW Indus., Inc. v. Trevor, Stewart, Burton, & Jacobsen, Inc., 895 F.2d 729, 731 (11th Cir. 1990). Finding a breach of duty to diversify given cash

flow requirements of plan which investor did not adequately investigate where 70% of plan consisted of 30 year T-Bonds.

Hugler v. Byrnes, 247 F. Supp. 3d 223, 234-35 (N.D.N.Y. 2017). The fiduciary breached the duty to diversify by placing 95% of the plan's assets in a single stock.

*Van Billiard v. Farrell Distrib. Corp., No. 2:09-cv-78, 2009 WL 4729965, at *4–5 (D. Vt. Dec. 3, 2009). The plaintiff had alleged enough to survive a motion to dismiss by claiming that the defendant invested over 90% of plan assets in equities and only 10% in fixed assets.*

Alco Indus., Inc. v. Wachovia Corp., 527 F. Supp. 2d 399, 403–04 (E.D. Pa. 2007). Cross motions for summary judgment were denied where the defendant pursued an investment strategy focusing on “large cap secular growth” stocks and allegedly failed to diversify the equities portion of the plans’ portfolios.

1. The plaintiff’s burden to show lack of diversification

The initial burden of proof lies with the plaintiff. “To establish a violation, a plaintiff must demonstrate that the portfolio is not diversified ‘on its face.’” Metzler v. Graham, 112 F.3d 207, 209 (5th Cir. 1997) (citing H.R. REP. NO. 1280, 93d Cong., 2d Sess. (1974), reprinted in 1974 U.S.C.C.A.N. at 5084) (holding plaintiff Secretary of Labor had not met the initial burden where defendant moved 63% of the plan’s assets into one piece of property, but previously invested all assets in short term CD’s, short term Treasury Securities, cash and cash equivalents); PBGC, 712 F.3d at 725 (finding a lack of evidence to state of claim of breach of the duty to diversify where the fiduciary invested a portion of the fixed income portfolio in non-agency securities).

When determining whether plaintiffs have met their burden, consideration should be given to the seven factors listed in the legislative history discussed above. Demoulis v. Sullivan, No. 91-cv-12533, 1993 U.S. Dist. LEXIS 3250, at *11 (D. Mass. Feb. 26, 1993).

2. The defendant’s burden to show that non-diversification was prudent under the circumstances

Once the plaintiff has established a failure to diversify, the burden shifts to the defendant to show that it was clearly prudent not to diversify under the circumstances. H.R. REP. NO. 1280, 93d Cong., 2d Sess. (1974), reprinted in 1974 U.S.C.C.A.N. at 5084-85; Tatum, 761 F.3d at 363 (adopting, in the ERISA context, the “trust law principle...that once a fiduciary is shown to have breached his fiduciary duty and a loss is established, he bears the burden of proof on loss of causation”); Metzler, 112 F.3d at 209 (assuming *arguendo* that plaintiff met initial burden, defendant proved it was prudent not to diversify because investment in land was an effort to avoid inflation, fiduciary was knowledgeable in relevant real estate market, fiduciary arranged for formal appraisals prior to purchase, and the plan beneficiaries’ youth made retirement

payments unlikely in the near future); Etter v. J. Pease Construction Co., 963 F.2d 1005 (7th Cir. 1992) (finding that it was prudent to invest a majority of plan assets in a single real estate deal where knowledgeable trustees earned annualized returns of 65% on the 18-month investment and many of the plan participants were themselves trustees).

The defendant must generally show not only that the challenged investment is prudent, but that there is no risk of large losses because of a lack of diversification. King, 861 F. Supp. at 383 (quoting Marshall, 507 F. Supp. at 384). When evaluating whether the duty to diversify was breached and if so, whether or not such breach was prudent, courts look to the seven factors cited in the legislative history of the Act. PBGC, 712 F.3d at 717; Metzler, 112 F.3d at 209. The analysis of these factors requires factual findings that are usually established through expert testimony following the trial. Liss, 991 F. Supp. at 301 (citing King, 861 F. Supp. at 385). For a further summary of cases detailing the duty to diversify, see James Lockhart, Annotation, *Fiduciary Duty to Diversify Investments of Benefit Plan as Required by § 404(a)(1)(c) of Employee Retirement Income Security Act (ERISA) 29 U.S.C.A. 1104(a)(1)(c)*, 155 A.L.R. FED. 349 (2019).

VIII. ERISA § 404(a)(1)(D), 29 U.S.C. § 1104(a)(1)(D): THE DUTY TO ACT IN ACCORDANCE WITH THE DOCUMENTS AND INSTRUMENTS GOVERNING THE PLAN

Section 404(a)(1)(D), 29 U.S.C. § 1104(a)(1)(D), requires a fiduciary to act “in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of [Title I] or Title IV.” Typically, the fiduciary must therefore act in accordance with the plan documents, its amendments, SPDs, and other formally issued plan documents.

A. FAILURE TO FOLLOW PROCEDURES DELINEATED IN PLAN DOCUMENTS

Under § 404(a)(1)(D), plan fiduciaries breach their fiduciary duties by failing to follow the plan documents’ terms. Courts will, however, dismiss ERISA claims where fiduciaries acted in accordance with plan documents.

See:

Tatum v. RJR Pension Inv. Comm., 761 F.3d 346, 367 (4th Cir. 2014). A company removed from its plan certain funds that the plan document dictated must “remain as frozen funds in the Plan.” The elimination constituted a fiduciary breach and the failure “to follow plan documents [was] highly relevant in assessing loss causation.” Further, those named in the plan documents as fiduciaries were appropriate parties to name as defendants for fiduciary breach claims.

Ward v. Ret. Bd. of Bert Bell/Pete Rozelle NFL Player Ret. Plan, 643 F.3d 1331, 1334–35 (11th Cir. 2011). An ERISA fiduciary does not violate any provision when it refuses to turn over benefits to third parties who are legally entitled to the funds pursuant to a judgment when to turn over such funds would contravene plan documents.

Boyd v. Metro. Life Ins. Co., 636 F.3d 138, 142 (4th Cir. 2011). Where a husband signed away his right to pension benefits in a divorce settlement but the plan documents still retained him as a primary beneficiary, the plan administrator was correct to follow the plan documents and pay benefits to him as the named beneficiary.

Union Sec. Ins. Co. v. Blakeley, 636 F.3d 275, 276–77 (6th Cir. 2011). When determining whether an individual is considered a domestic partner for the purpose of plan benefits, the court should look to the language in the plan first before resorting to federal common law.

Donovan v. Cunningham, 716 F.2d 1455, 1468 (5th Cir. 1983). A corporation’s CEO and sole shareholder, who also belonged to administrative committee overseeing corporation’s ESOP, violated § 404(a)(1)(D) when he participated in the committee’s decision to pay

\$200 per share for corporation's stock. ESOP plan document provided that "[a]ny Committee member having any interest in a transaction being voted upon by the Committee shall not vote thereon nor participate in the decision."

Iron Workers Local No. 272 v. Bowen, 695 F.2d 531, 534–35 (11th Cir. 1983). Under an ERISA trust fund's agreement, trustees were required to comply with arbitrator's decisions. Management trustees' refusal to comply with arbitrator's decision that the trustees file suit for alleged improprieties in relationship to losses fund had sustained was therefore a breach of fiduciary duty under § 404(a)(1)(D).

Marshall v. Teamsters Local 282 Pension Trust Fund, 458 F. Supp. 986, 991 (E.D.N.Y. 1978). Pension fund trustees violated § 404(a)(1)(D) by committing 36% of fund assets to loan transaction without specifically finding that loan was prudent. Trust agreement prohibited commitment of more than 25% of assets to any single investment absent specific prudence finding.

When plaintiffs do prevail on § 404(a)(1)(D) claims, courts have granted both benefits to which the plaintiffs were entitled under the plan and equitable relief. See, e.g., Iron Workers Local No. 272 v. Bowen, 624 F.2d 1255, 1259–60 (5th Cir. 1980) (holding that district court had jurisdiction to order plan trustees to comply with arbitrator's decree). However, when a plaintiff has an appropriate remedy under § 502(a)(1)(B), that plaintiff cannot also state a claim for equitable relief under § 502(a)(3). Silva v. Metro. Life Ins. Co., 762 F.3d 711, 726–27 (8th Cir. 2014); Jones v. Am. Gen. Life & Accident Ins. Co., 370 F.3d 1065, 1072–73 (11th Cir. 2004).

Where courts grant relief, however, fiduciaries often have not only failed to follow plan documents but have also violated other ERISA fiduciary duties. See, e.g., Donovan v. Cunningham, 716 F.2d 1455, 1473 (5th Cir. 1983) (holding that stock transaction also violated ERISA § 406 as defendants failed to investigate sufficiently whether purchase by ESOP was made for "adequate consideration"). A failure to follow plan documents by itself may be treated as harmless error, not warranting relief. Michael v. First Commer. Bank, 69 F. App'x 801, 806 n.5 (7th Cir. 2003) (finding that plan's failure to follow time requirements is not a breach of fiduciary duty because there was no harm to the plaintiff as a result).

Courts, however, have stressed that § 404(a)(1)(D) imposes a duty of "independent significance" and that compliance with subdivision § 502(a)(1)(B)'s general duty to act with "care, skill, prudence, and diligence" will not excuse a fiduciary who fails to act in accordance with plan documents.

See:

Dardaganis v. Grace Capital Inc., 889 F.2d 1237, 1241 (2d Cir. 1989). Investment advisor violated § 404(a)(1)(D) by exceeding a fifty percent

ceiling on common stock holdings set by plan documents. Advisor was liable for losses sustained by plan without regard to the overall prudence of the advisor's actions.

B. ERISA § 404(a)(1)(D), 29 U.S.C. § 1104(a)(1)(D), IN THE BENEFITS CONTEXT

Some courts have held that ERISA § 502(a), 29 U.S.C. § 1132(a), authorizes suits against fiduciaries for breach of their duties under § 404(a)(1)(D) for improper benefit denials. See Tran v. Minnesota Life Ins. Co., 922 F.3d 380 (7th Cir. 2019) (reviewing § 1132 benefit denial claim *de novo* where “the plan does not grant discretionary authority to the plan fiduciary”); Crawford v. Metro. Life Ins. Co., 756 F. App’x 350, 352 (5th Cir. 2018) (“[w]here a plan vests its administrator with discretion to interpret the plan’s terms, we review the administrator’s decision to deny benefits for an abuse of discretion.”); Pettaway v. Teachers Ins. & Annuity Ass’n of Am., 644 F.3d 427, 433 (D.C. Cir. 2011) (holding that the court could look to the plan document, the summary plan description, and the policy document, considered together, “to determine whether the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan.”). In evaluating such claims, courts have applied the standards prescribed by Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101 (1989).

Under Firestone, a court adjudicating a claim under § 1132(a)(1)(B) considers a fiduciary’s benefit denial *de novo* unless the plan grants the fiduciary discretionary authority to determine benefit eligibility or to construe plan terms, in which case the court reviews the fiduciary’s determination under an arbitrary and capricious standard. Id. at 115. There are several other approaches that circuit courts have taken to create a third intermediate tier of deference. For a more detailed discussion of the review standard, see Section XII.C.

A fiduciary’s duty to act in accordance with plan documents is arguably relevant to any action in which plaintiffs challenge a benefit denial based on a plan language interpretation. Nonetheless, in evaluating such actions, courts typically have undertaken the Firestone analysis without explicitly referencing § 404(a)(1)(D). See, e.g., Sanford v. Harvard Indus., Inc., 262 F.3d 590, 592 (6th Cir. 2001); Cozzie v. Metro. Life Ins. Co., 140 F.3d 1104, 1108 (7th Cir. 1998). Most often, courts invoke the section only when a benefit denial is considered arbitrary and capricious or rendered in bad faith.

See:

Bryant v. Cmty. Bankshares, Inc., 736 F. App’x 841, 847 (11th Cir. 2018). Plan administrator’s refusal to honor participants’ election to diversify their accounts was arbitrary and capricious where the plan document’s plain language stated that participants were entitled to do so.

Morgan v. Indep. Drivers Ass'n Pension Plan, 975 F.2d 1467, 1468-69 (10th Cir. 1992). *Plan trustees who acted in good-faith reliance on expert advice did not breach fiduciary duties under § 404(a)(1)(D) although their amendment terminating the plan was contrary to the governing plan documents' terms. 29 U.S.C. § 1104(a) is not a strict liability statute and its fiduciary provisions are not violated when fiduciaries make a "good faith, albeit erroneous, interpretation" of plan terms.*

Lewis v. Cent. States, Se. & Sw. Areas Pension Fund, No. 09-cv-569, 2010 WL 3603206, at *16 (S.D. Ohio June 24, 2010). *After finding that the trustees' decision was reasonably based on the record, the court concluded that the trustees' decision to deny benefits was not arbitrary and capricious and the plaintiff was not entitled to relief.*

Lusk v. Ameriserv Fin. Inc., No. 06-cv-1820, 2007 WL 2228561, at *5 (S.D. Ind. July 31, 2007). *Plaintiffs attempted to allege a fiduciary duty breach due to defendants' contradictory statements about the trust agreement. The district court held that a mere contradiction, absent bad faith, is insufficient to establish a breach of fiduciary duty.*

But see:

Yochum v. Barnett Banks, Inc. Severance Pay Plan, 234 F.3d 541, 545-46 (11th Cir. 2000). *In declining successor bank's offer of guaranteed employment at same salary for one year and, with more responsibility, employee did not turn down offer of "comparable employment" under ERISA severance pay plan. Plan administrator's determination to the contrary was "arbitrary and capricious" and administrator consequently breached fiduciary duties under § 404(a)(1)(D).*

Markes v. Aluminum Co. of Am., 114 F. Supp. 2d 108, 109 (N.D.N.Y. 2000). *Administrators' determination of proper beneficiary was neither arbitrary nor capricious; consequently, administrators did not breach fiduciary duties under § 404(a)(1)(D).*

Two circumstances in which courts have found violations of § 404(a)(1)(D) are those in which fiduciaries' actions controverted the plan documents' plain language and those where fiduciaries paid benefits to persons other than those the plan documents designate.

- 1. Fiduciaries must act in accordance with the plain meaning of plan documents**

Courts have held that fiduciaries' actions violate § 404(a)(1)(D) when they controvert the plain meaning of a plan.

See:

Pac. Shores Hosp. v. United Behavioral Health, 764 F.3d 1030, 1042 (9th Cir. 2014). The court found defendant “did not follow procedures appropriate to” the circumstances because it construed plan “provisions in a way that conflict[ed] with the plain language of the plan, or fail[ed] to develop facts necessary to its determination.”

Swaback v. Am. Info. Techs. Corp., 103 F.3d 535, 540 (7th Cir. 1996). Plan administrators violated § 404(a)(1)(D) by requiring that disabled worker return to work (which would require medical approval) to opt for lump sum retirement benefits. The court found that the “phantom requirement” was not contained in the plan documents.

Priority Solutions, Inc. v. CIGNA, No. 98-cv-4499, 2000 WL 64884, at *2 (S.D.N.Y. Jan. 25, 2000). Insurance plan administrators violated § 404(a)(1)(D) by refusing to pay nursing agency more than “average wholesale price” for its services. Plan documents stated that plan would pay charges not exceeding the “normal charge made by most providers of such service or supply in the geographic area where the service is received.”

DeSieno v. Am. Home Prods., 26 F. Supp. 2d 209, 215 (D. Mass. 1998). Defendant fiduciary’s interpretation of form titled “Employees Retirement Plan” as referring not to pension benefits but to a pre-retirement death benefit option varied from “unambiguously manifested meaning” of document. Defendant consequently breached § 404(a)(1)(D) duties.

2. Benefits must be granted only to persons designated by the plan documents

Courts have also invoked § 404(a)(1)(D) where plaintiffs alleged defendant fiduciaries paid benefits to persons other than those designated by the plan’s governing documents and instruments.

See:

Riordan v. Commonwealth Edison Co., 128 F.3d 549, 553 (7th Cir. 1997). “[A] plan fiduciary . . . has no right . . . absent a qualified court order . . . to refuse payment of welfare benefits to a beneficiary properly designated according to the terms of the plan.”

Hartford Life & Accident Ins. Co. v. Premium EscrowServ., Inc., No. 04-cv-1768, 2005 WL 6217077, at *10–11 (D. Or. Aug. 3, 2005). Finding that an assignment to a plan fiduciary was invalid and the benefits would go to the beneficiary named in the plan documents.

Conversely, a fiduciary does not violate § 404(a)(1)(D) as a matter of law if it denies benefits to a person not entitled to those benefits under the terms of the plan.

See:

Kennedy v. Plan Adm'r for DuPont Sav. & Inv. Plan, 555 U.S. 285, 300–04 (2009). Even if a divorce decree would be considered a waiver under federal common law, this “waiver” is ineffective where the plan documents specify the process for designating a beneficiary and for the beneficiary’s waiver. Because the process for waiver was not followed, the court held that the administrator acted properly by following the plan documents and paying the benefits according to the submitted beneficiary designation.

Boyd v. Metro. Life Ins. Co., 636 F.3d 138, 142–44 (4th Cir. 2011). The court held that the primary beneficiary’s waiver did not supersede plan documents, and that the defendant “acted properly in disbursing benefits according to the plan documents on file” because the plan administrator was not authorized “to disregard a validly executed beneficiary designation form where the beneficiary has made no effort to disclaim his right to benefits.”

Riordan v. Commonwealth Edison Co., 128 F.3d 549, 552 (7th Cir. 1997). When plan documents allow a beneficiary designation to be changed easily and do not allow for “irrevocable” designations, the last designated beneficiary is entitled to benefits. The court thus held that the fiduciary acted properly in paying benefits to the last designated beneficiary.

Nat’l Auto. Dealers & Assocs. Ret. Trust v. Arbeitman, 89 F.3d 496, 498 (8th Cir. 1996). The court held that it was proper to split the disputed benefits between the former and current spouse according to the plan’s terms from two different plans. The current spouse was entitled to full benefits under the first plan, which did not include a designated beneficiary, and benefits were divided between the former and current spouse under the second plan where the former spouse was the designated beneficiary.

Averhart v. US W. Mgmt. Pension Plan, 46 F.3d 1480, 1489 n.6 (10th Cir. 1994). “Because the plan must be administered according to its terms . . . [the claimant] cannot complain because he is held to those terms; this is true even if the rules were bent for another individual.”

The Supreme Court has held that state statutes that designate beneficiaries other than those designated by plan documents “implicate[] an area of core ERISA concern” and consequently are preempted. *Egelhoff v. Egelhoff*, 532 U.S. 141, 147-48 (2001) (citing 29 U.S.C. 1104(a)(1)(D)). Outside the benefits designation context, however, state statutes may supersede § 404(a)(1)(D) and mandate that fiduciaries act in accordance with plan requirements. See *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358, 360 (1999) (holding that ERISA does not apply), overruled in part on other grounds by *Ky. Ass’n of Health Plans, Inc. v. Miller*, 538 U.S. 329 (2003) (stating that defendant’s argument that California’s notice-prejudice rule, by altering plan

notice provisions, conflicts with § 404(a)(1)(D) requirements “overlooks controlling precedent and makes scant sense”).

C. THE DUTY TO ACT IN ACCORDANCE WITH PLAN DOCUMENTS DOES NOT REQUIRE THE FIDUCIARY TO VIOLATE OTHER ERISA PROVISIONS

A fiduciary is required to act in accordance with plan documents only to the extent that the actions required by the documents are consistent with ERISA. ERISA § 404(a)(1)(D), 29 U.S.C. § 1104(a)(1)(D); Cent. States, Se. & Sw. Areas Pension Fund v. Cent. Transp., Inc., 472 U.S. 559, 568 (1985) (“[T]rust documents cannot excuse trustees from their duties under ERISA and . . . documents must generally be construed in light of ERISA policies.”). Consequently, fiduciaries may act in contravention of the plan documents where acting in accordance with plan documents would violate other ERISA provisions.

See:

Am. Flint Glass Workers Union, AFL-CIO v. Beaumont Glass Co., 62 F.3d 574, 579 (3d Cir. 1995). *Employer did not violate § 404(a)(1)(D) by failing to terminate plan by date set in plan documents; employer could not have terminated plan in accordance with ERISA as insufficient assets precluded actuarial certification required by 29 U.S.C. § 1341(b)(2).*

Conversely, a plan document’s authorization of a certain action does not absolve fiduciaries from liability for taking such action when it violates other ERISA provisions.

Even if plan documents ostensibly *require* fiduciaries to take certain action, fiduciaries cannot take such action if doing so would violate ERISA provisions. See, e.g., *Durand v. The Hanover Ins. Grp., Inc.*, 560 F.3d 436, 442 (6th Cir. 2009) (reasoning that § 1104(a)(1)(D) acts to limit fiduciary power and administrators have authority to disregard unlawful plan provisions because they have duty to comply with law).

See:

Longo v. Trojan Horse Ltd., 208 F. Supp. 3d 700, 706 (E.D. N.C. 2016). “*In the context of ERISA, trust documents cannot excuse trustees from their duties under the statute,*” meaning that a plan fiduciary who had a duty under the plan documents to administer funds once received also had a statutory duty under ERISA to ensure that those contributions were being made.

In re AEP ERISA Litig., 327 F. Supp. 2d 812, 828 (S.D. Ohio 2004). *A fiduciary cannot escape liability merely by pointing to the plan as requiring it to act as it did. Even where a fiduciary acts consistent with the plan’s directives, the fiduciary may be liable if the actions were not in the*

participants' best interests (e.g., if they were found to have been imprudent).

In re Xcel Energy, Inc. Sec., Derivative & ERISA Litig., 312 F. Supp. 2d 1165, 1181 (D. Minn. 2004). A fiduciary cannot "blindly follow plan directives to the obvious detriment of the beneficiary."

In re Sears, Roebuck & Co. ERISA Litig., No. 02-cv-8324, 2004 WL 407007, at *4 (N.D. Ill. Mar. 3, 2004). Plaintiffs stated claims for breach of fiduciary duty where they alleged that fiduciaries blindly followed plan provisions, imprudently investing when the fiduciaries knew or should have known the price of the stock invested in was fraudulently inflated.

Utilicorp United, Inc. v. Kemper Fin. Servs., Inc., 741 F. Supp. 1363, 1366 (W.D. Mo. 1989). Adherence to trust documents does not excuse trustees from duty to act according to prudent man standard.

But see:

Kirschbaum v. Reliant Energy, Inc., 526 F.3d 243, 253 (5th Cir. 2008). The Fifth Circuit held that because the plan required investment in employer stock, fiduciaries had no discretion to terminate the plan's employer stock fund or halt investments in it. Because the defendants lacked any discretion with respect to this aspect of the plan, there were no fiduciary duties under ERISA that were inherent in the plan other than to follow its terms. The court determined that a fiduciary who is bound to follow the trust's terms should not be placed in "the untenable position" of being sued for adhering to the plan's terms.

In re Bear Stearns Cos. Sec., Derivative, & ERISA Litig., 763 F. Supp. 2d 423, 570 (S.D.N.Y. 2011). The defendants were not liable for failing to manage prudently the plan's assets by continuing to allow investments in employer stock because they had no authority or discretion to diversify or divest the employer stock under the plan's terms.

In re Wachovia Corp. ERISA Litig., No. 3:09-cv-262, 2010 WL 3081359, at *9–10 (W.D.N.C. Aug. 6, 2010). A plaintiff class sued defendants for allegedly imprudently allowing continued investments in employer stock when the employer's stock price fell 87%. The court granted the defendants' motion to dismiss because the plan provided that the employer "Stock Fund 'shall be made available to Participants for investment.'" Because the plan terms required that the defendants offer the employer stock as an investment option, they had no fiduciary liability for following the plan.

1. The duty of loyalty

Compliance with plan documents ordinarily will not excuse a fiduciary's violation of duties imposed by other ERISA provisions. However, if the fiduciary acted in accordance with the plan's governing documents and instruments, it cannot be held to have violated its fiduciary duty to act "solely in the interest of the participants and beneficiaries."

See:

Kress v. Food Emp'rs Labor Relations Ass'n, 285 F. Supp. 2d 678, 685 (D. Md. 2003), *aff'd*, 391 F.3d 563 (4th Cir. 2004). *Pointing out the difference between a fiduciary breach claim based on an ERISA-regulated plan and based on ERISA itself, the court held that "an ERISA fiduciary does not breach its fiduciary duty merely by denying a beneficiary's claims pursuant to a Plan because adherence to an ERISA controlled plan is not a breach of fiduciary duty."*

Hunter v. Caliber Sys., Inc., 220 F.3d 702, 721–22 (6th Cir. 2000). *A plan fiduciary's decision to diversify at a specified time was not a failure to follow the plan because the plan language allowed the fiduciary to establish alternate transfer dates. Therefore, there was no breach of fiduciary duty.*

Dzinglski v. Weirton Steel Corp., 875 F.2d 1075, 1080 (4th Cir. 1989). *In denying employee early retirement benefits because doing so would not be in the employer's interest, plan administrator acted in accordance with plan documents. "To adhere to the plan is not a breach of fiduciary duty."*

Courts have also held that the duty to follow plan documents does not require a fiduciary to resolve every plan interpretation issue in favor of a beneficiary or to maximize pecuniary benefits. *Collins v. Pension & Ins. Comm. of S. Cal. Rock Prods. & Ready Mixed Concrete Ass'ns*, 144 F.3d 1279, 1282 (9th Cir. 1998); *cf. Hunt v. Hawthorne Assocs., Inc.*, 119 F.3d 888, 913 (11th Cir. 1997) (holding plan administrators were justified in denying employee benefits when plan documents stressed importance of treating all plan participants alike).

2. Plan provisions that contradict ERISA in part must be followed to the extent that they do not contradict ERISA

As § 404(a)(1)(D) requires fiduciaries to act in accordance with plan documents only to the extent that doing so would comply with other ERISA duties, a plan provision that would be imprudent if followed blindly is not facially invalid; rather, the fiduciary must follow the provision to the extent that doing so would be consistent with ERISA provisions.

See:

Herman v. NationsBank Trust Co. (Georgia), 126 F.3d 1354, 1368–69 (11th Cir. 1997). A “mirror voting provision” instructing trustees to vote unallocated shares in the same proportion as participants vote their allocated shares is not facially invalid. Rather, trustees should follow a mirror voting provision unless doing so leads to an imprudent result.

Cf.:

Ganton Techs., Inc. v. Nat’l Indus. Grp. Pension Plan, 76 F.3d 462, 466–67 (2d Cir. 1996). Plan trustees promulgated a blanket rule against transferring plan assets to plan participants or to another plan. The rule did not violate the trustees’ fiduciary duty to consider the individual merits of each request so long as the trustees periodically reviewed the rule’s wisdom and reasonableness.

Summers v. State St. Bank & Tr. Co., 453 F.3d 404, 406 (7th Cir. 2006). An ESOP directed trustee, which is “subject to proper directions of [the named plan] fiduciary which are made in accordance with the terms of the plan and which are not contrary to [ERISA] under § 1103, that followed plan language requiring investment in a specific stock did not breach its fiduciary duty of prudence in doing so, despite the stock’s foreseeable underperformance. The court stated that “[a]n imprudent direction cannot be a proper direction since the trustee has an express statutory duty of prudence.”

D. GRANTS OF DISCRETIONARY AUTHORITY TO CONSTRUE PLAN TERMS

Plan language may provide trustees broad authority to construe plan terms. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989). If the plan grants the plan administrator such discretion, a reviewing court may reverse the challenged benefit denial only upon a showing of procedural or substantive abuse of discretion. Although the *Firestone* Court expressly limited its holding to “§ 1132(a)(1)(B) actions challenging denials of benefits based on plan interpretations,” other courts have extended the *Firestone* analysis to non-benefits contexts. See generally *Ganton Techs., Inc. v. Nat’l Indus. Grp. Pension Plan*, 76 F.3d 462 (2d Cir. 1996) (considering trustee’s denial of employer’s request to withdraw from plan); *Moench v. Robertson*, 62 F.3d 553, 564 (3d Cir. 1995); *Ershick v. United Mo. Bank of Kansas City, N.A.*, 948 F.2d 660, 668 (10th Cir. 1991); *Green v. UPS Health & Welfare Package for Ret. Emps.*, 746 F. Supp. 2d 921, 927–28 (N.D. Ill. 2009) (determining whether fiduciaries correctly interpreted plan language according to arbitrary and capricious standard). For more discussion of the application of the *Firestone* standard, see Section XII.

1. Language creating discretionary authority

Language granting fiduciaries discretionary authority over benefits eligibility and plan term construction must be incorporated into the plan documents.

Language contained in unincorporated trust agreements—which may constitute “other instruments” for the purpose of determining a trustee’s fiduciary duties—is not sufficient to grant the trustee discretion in defining plan terms.

See:

Gentry v. Ashland Oil, Inc., 42 F.3d 1385 (table), No. 93-1425, 1994 WL 706212, at *3–*4 (4th Cir. Dec. 20, 1994). *Language from trust agreement not incorporated into governing plan document was insufficient to grant plan administrator discretionary authority to determine benefit eligibility or to construe the plan’s terms.*

Bochniarz v. Prudential Ins. Co. of Am., No. 11-cv-0867, 2015 WL 8516432, at *2 (W.D.N.Y. Dec. 11, 2015). *The court held that a SPD that was not part of the plan document, but that included information about the plan administrator’s discretion (where the plan document itself was silent on the matter), was not effective to confer that discretion.* *Besser v. Prudential Ins. Co. of Am.*, No. 07-cv-00437, 2008 WL 4483796, at *2 (D. Haw. Sept. 30, 2008). *A disclosure statement that explained ERISA terms and granted fiduciaries discretion to interpret plan language was not a plan document according to the policy’s integration clause and because the document stated that it was not part of the plan. Therefore, the fiduciaries did not have discretion and their interpretation was analyzed under a de novo standard.*

Cf.:

Fenton v. John Hancock Mut. Life Ins. Co., 400 F.3d 83, 89–90 (1st Cir. 2005). *When plan documents grant discretion to fiduciaries, it does not matter that the SPD does not mention discretion. Fiduciaries are still entitled to arbitrary and capricious review when the SPD’s silence does not directly conflict with any particular plan provision.*

Allison v. Dugan, 951 F.2d 828, 832 (7th Cir. 1992). *When a trust agreement incorporated in the plan documents accords trustees discretionary authority to make binding benefit determinations, a court should not upset the trustees’ benefit determinations unless their decisions or conduct are arbitrary and capricious.*

2. Interpretation of trustee-created rules

Even absent language granting discretionary authority over plan terms, courts will ordinarily accord ERISA trustees considerable discretion to interpret and apply rules they have promulgated pursuant to powers delegated by the basic trust instrument. *See Diaz v. Seafarers Int’l Union*, 13 F.3d 454, 456 (1st Cir. 1994) (drawing “important” distinction between “terms contained in the basic trust instrument” and “rules promulgated by the trustees pursuant to powers delegated by that instrument”) (emphasis removed). Language granting trustees broad authority to promulgate new

rules will suffice to grant trustees discretion in interpreting rules they promulgated earlier. Id. at 457; see also Ganton Tech., Inc. v. Nat'l Indus. Grp. Pension Plan, 76 F.3d 462, 466 (2d Cir. 1996) (finding that although there was no specific language granting discretion, giving fiduciaries the power to resolve all disputes and ambiguities was enough to infer fiduciary discretion and apply deferential review).

3. Inherently ambiguous terms

In evaluating § 404(a)(1)(D) claims, courts have accorded fiduciaries discretion in defining inherently ambiguous terms. See Vendura v. Boxer, 845 F.3d 477, 482 (1st Cir. 2017) (concluding that plan committee reasonably construed ambiguous plan provision regarding a cap on the accrual of years of benefits); Shelby Cnty. Health Care Corp. v. S. Council of Indus. Workers Health & Welfare Trust Fund, 203 F.3d 926, 935 (6th Cir. 2000) (stating that where plan administrators have discretion, they have “great leeway in interpreting ambiguous terms” but such interpretation must be reasonable in the context of the plan language); DeBruyne v. Equitable Life Assurance Soc’y of U.S., 920 F.2d 457, 464 (7th Cir. 1990) (holding that investment manager had “substantial freedom” in determining content of term “balanced fund” for which no “uniform, pre-established definition” existed).

E. ACTIONS EXCEPTED FROM THE DUTY TO COMPLY WITH PLAN DOCUMENTS

Under ERISA, an individual is a fiduciary with respect to a plan if he exercises discretionary authority over the plan’s management or administration. 29 U.S.C. § 1002(21)(A). Therefore, as a matter of law, ERISA’s fiduciary duties do not apply to parties engaged in business decisions or plan design. See Hunter v. Caliber Sys., Inc., 220 F.3d 702, 720 (6th Cir. 2000) (reasoning that “mere fact” that defendants exercised some form of discretion is not enough to transform non-fiduciary act into fiduciary act, and fiduciary obligations only relate to fiduciary functions); Acosta v. Brain, 910 F.3d 502, 519 (9th Cir. 2018) (holding that someone acting as a fiduciary in relation to a plan is a fiduciary, while an entity “acting in its corporate capacity” in relation to a plan is not).

1. Business decisions

Business decisions employers or other parties make are not governed by § 404(a)(1)(D) and other ERISA provisions imposing fiduciary duties. For example, the Third Circuit has held that an employer acted in a management capacity in deciding to reduce an employee’s salary and contemporaneously creating a defined benefit plan. Haberern v. Kaupp Vascular Surgeons Ltd. Defined Benefit Pension Plan, 24 F.3d 1491, 1496 (3d Cir. 1994). Consequently, the court held that the employer was not bound by ERISA’s fiduciary duty provisions. Id. Section 404(a)(1)(D) “imposes a fiduciary duty on a trustee when administering an ERISA plan to act in accordance with the documents and interests governing the plan, but it does not impose fiduciary duties on an employer making a management decision.” Id.; see also, Frank Russell Co. v. Wellington Mgmt. Co., LLP, 154 F.3d 97, 103 (3d Cir. 1998) (finding that § 404 states

that fiduciary obligations only arise when fiduciary “discharges his duties with respect to a plan” and where decision is strictly management decision, no fiduciary duties apply); Scott v. Aon Hewitt Fin. Advisors, LLC, No. 17-cv-679, 2018 WL 1384300, at *9 (N.D. Ill. Mar. 19, 2018) (holding that the decision to sub-contract with a service provider was not a fiduciary function, but rather a business decision, and did not give rise to a claim for breach of fiduciary duty).

2. Plan design activities

The activity of plan design encompasses creation of an ERISA plan, amendment of an existing plan, and termination of an ERISA plan. When a party engages in any of these settler functions, it is not subject to the fiduciary duties § 404(a)(1)(D) and other ERISA provisions impose.

See:

Hughes Aircraft Co. v. Jacobson, 525 U.S. 432, 443–44 (1999). *ERISA’s fiduciary provisions are inapplicable to parties amending ERISA plans. Parties amending ERISA plans are not subject to fiduciary duties regardless of whether the plan is a “pension benefit plan” or a “welfare benefit plan;” whether the plan is “a contributory plan, a noncontributory plan, or any other type of plan.” ERISA, in defining the term “fiduciary,” draws no distinction between persons exercising authority over these different plan types.*

Santomenno v. Transamerica Life Ins. Co., 883 F.3d 833, 837 (9th Cir. 2018). *A service provider is not an ERISA fiduciary when negotiating its compensation with a prospective customer.*

Lee v. Verizon Commc’ns, Inc., 837 F.3d 523, 536 (5th Cir. 2016). *Plan sponsor that decided to amend the plan and transfer pension assets outside ERISA coverage into a group insurance annuity acted as sponsor and not as fiduciary.*

Leimkuehler v. Am. United Life Ins. Co., 713 F.3d 905, 912 (7th Cir. 2013). *A plan service provider’s selection of “both funds and their share classes for inclusion on a menu of investment options offered to 401(k) plan customers does not transform a provider of annuities into a functional fiduciary under Section 1002(21)(A)(i).”*

Jones v. Kodak Med. Assistance Program, 169 F.3d 1287, 1292 (10th Cir. 1999). *If plan criteria is a part of the plan design and structure rather than the fiduciary’s interpretation, the court cannot review those actions for a breach of fiduciary duty. “ERISA does not mandate that employers provide any particular benefits.” An employer does not act as a fiduciary when it sets the plan’s terms.*

McGath v. Auto-Body N. Shore, Inc., 7 F.3d 665, 670–71 (7th Cir. 1993).
“An employer can wear two hats: one as a fiduciary administering a pension plan and the other as the drafter of a plan’s terms. Therefore, because the functions are distinct, an employer does not act as a fiduciary when it amends or otherwise sets the terms of a plan.”

F. DETERMINING WHICH DOCUMENTS AND INSTRUMENTS GOVERN THE PLAN

Because modifications to ERISA plans must be in writing, 29 U.S.C. § 1102(a)(1), and there are required procedures for amending plans, 29 U.S.C. § 1102(b)(3), courts construing § 404(a)(1)(D) have adopted a narrow definition of “documents and instruments governing the plan.” In general, such documents and instruments include “[o]nly representations adopted in accordance with . . . amendment procedures outlined in . . . formal plan documents.” See Elmore v. Cone Mills Corp., 23 F.3d 855, 861 (4th Cir. 1994).

Even an employer representation that “constitute[s] a clear and unambiguous promise of benefits that [is] formal, authorized, and ratified” will ordinarily not qualify as a “document or instrument governing” an employee pension benefit plan. Id.; see also Crosby v. Rohm & Haas Co., 480 F.3d 423, 429 (6th Cir. 2007) (finding that enrollment worksheet that provided personalized estimate of benefits was informal written communication that did not modify plan documents); Friz v. J & H Marsh & McLennan, Inc., 2 F. App’x 277, 283 (4th Cir. 2001) (King, J., dissenting) (“An ERISA plan may be construed *only* by its written terms, without reference to unincorporated ancillary documents.”); Anderson v. Resolution Trust Corp., 66 F.3d 956, 960 (8th Cir. 1995) (rejecting the argument that oral or informal communications can modify written ERISA plan terms). But see Woerner v. Fram Grp. Operations, LLC, 658 F. App’x 90, 95 (3d Cir. 2016) (affirming that, notwithstanding a lack of formality, “[a]n ERISA plan is established if from the surrounding circumstances a reasonable person can ascertain the intended benefits, a class of beneficiaries, the source of financing, and procedures for receiving benefits”).

Consistent with this principle, several courts have held that oral agreements cannot amend a formal plan. See, e.g., Gen. Am. Life Ins. Co. v. Castonguay, 53 F.3d 1078, 1080 (9th Cir. 1995) (holding that § 404(a)(1)(D) precludes trustees’ oral representation to plan participants from altering terms of written ERISA plan).

1. Summary plan descriptions and trust agreements are governing

There are at least two widely recognized exceptions to the rule that “documents and instruments governing the plan” be limited to representations incorporated into the plan through amendment procedures described in formal plan documents.

First, 29 U.S.C. § 1022 requires that employee benefit plan participants and beneficiaries be provided a summary plan description apprising them of their plan rights and obligations. Several courts have recognized SPDs as “documents and instruments governing the plan.” See, e.g., Kennedy v. Plan Adm’r for DuPont Sav. & Inv. Plan, 555 U.S. 285, 304 (2009) (“[i]t is uncontested that the [savings and investment plan] and the summary plan description are documents and instruments governing the plan.”) (internal quotations omitted); Rhea v. Alan Ritchey, Inc. Welfare Benefit Plan, 858 F.3d 340, 346 (5th Cir. 2017) (holding that where the SPD was the only plan document, it constituted the written plan document); Bergt v. Ret. Plan for Pilots Employed By Mark/Air, Inc., 293 F.3d 1139, 1143 (9th Cir. 2002).

In fact, where SPDs differ from or conflict with other plan language, some courts have held that the SPD language will control. Washington v. Murphy Oil USA, Inc., 497 F.3d 453, 458–59 (5th Cir. 2007); Heffner v. Blue Cross & Blue Shield of Ala., Inc., 443 F.3d 1330, 1341 (11th Cir. 2006); Burstein v. Ret. Account Plan for Emps. of Allegheny Health Ed. & Research Found., 334 F.3d 365, 378 (3d Cir. 2003); Mers v. Marriott Int’l Grp. Accidental Death & Dismemberment Plan, 144 F.3d 1014, 1024 (7th Cir. 1998); Barker v. Ceridian Corp., 122 F.3d 628, 633 (8th Cir. 1997); Atwood v. Newmont Gold Co., 45 F.3d 1317, 1321 (9th Cir. 1995), overruled on other grounds by Abatie v. Alta Health & Life Ins. Co., 458 F.3d 955 (9th Cir. 2006).

However, in 2011, the Supreme Court held in Amara that “the summary plan documents, important as they are, provide communication with beneficiaries *about* the plan, but [] their statements do not themselves constitute the *terms* of the plan for purposes of § 502(a)(1)(B) [to recover for benefits due under the plan].” CIGNA Corp. v. Amara, 131 S. Ct. 1866, 1878 (2011) (emphasis in original). Following Amara, other courts have held that where the plan document and the SPD differ, the plan document controls. Manuel v. Turner Indus. Grp., L.L.C., 905 F.3d 859, 865 (5th Cir. 2018) (“where an SPD conflicts with the terms of the plan document, the terms of the plan document control for purposes of ERISA § 502(a)(1)(B)”; Engleson v. Unum Life Ins. Co. of Am., 723 F.3d 611, 620 (6th Cir. 2013) (“SPDs lack controlling effect in the face of plan language to the contrary”); see also Holmes v. Colorado Coal. for Homeless Long Term Disability Plan, 762 F.3d 1195, 1203 (10th Cir. 2014) (holding that an SPD expressly stating that it did “not replace or modify” the plan was not enforceable as part of the plan).

Second, courts have recognized that trust agreements, even when not formally incorporated into a plan, remain “governing documents.” See, e.g., Gard v. Blankenburg, 33 F. App’x 722, 730–31 (6th Cir. 2002); Plumbers & Steamfitters Local No. 150 Pension Fund v. Vertex Const. Co., 932 F.2d 1443, 1450 (11th Cir. 1991).

2. Informal benefit plans may be subject to ERISA

Some courts have allowed employees to recover promised benefits that are not contained in a formal written plan document if the benefits are contained in an informal benefit plan. See, e.g., Donovan v. Dillingham, 688 F.2d 1367, 1372 (11th Cir. 1982) (en banc). In Dillingham, the Eleventh Circuit held that an informal ERISA plan

has been established “if from the surrounding circumstances a reasonable person can ascertain the intended benefits, a class of beneficiaries, the source of financing, and procedures for receiving benefits.” Id. at 1373. An informal plan may exist independent of, and in addition to, a formal plan as long as the informal plan meets all of the elements outlined in Dillingham. See Woerner v. Fram Grp. Operations, LLC, 658 F. App’x 90, 95 (3d Cir. 2016) (affirming that, notwithstanding a lack of formality, “[a]n ERISA plan is established if from the surrounding circumstances a reasonable person can ascertain the intended benefits, a class of beneficiaries, the source of financing, and procedures for receiving benefits”); Kenney v. Roland Parsons Contracting Corp., 28 F.3d 1254, 1257 (D.C. Cir. 1994); Henglein v. Informal Plan for Plant Shutdown Benefits for Salaried Emps., 974 F.2d 391, 400 (3d Cir. 1992).

In the context of informal benefit plans, courts have provided little guidance on what representations may be construed as governing. However, courts have suggested that fiduciaries may be bound by oral representations in the context of an informal plan. See, e.g., Kenney, 28 F.3d at 1259–60 (stating that employer’s representations that plan existed along with any employer action “will ordinarily outweigh the employer’s failure formally to establish a plan”); Henglein, 974 F.2d at 400 (stating that where the written documents “do not clearly limit benefits,” courts should consider other evidence of an informal plan like “internal or distributed documents, oral representations, existence of a fund or account to pay benefits, actual payment of benefits, a deliberate failure to correct known perceptions of a plan’s existence, the reasonable understanding of employees, and the intentions of the putative sponsor”); cf. Brines v. XTRA Corp., 304 F.3d 699, 701–02 (7th Cir. 2002) (recognizing existence of informal plan made through oral representations but finding that not enough evidence existed to determine that informal plan existed).

See:

Deboard v. Sunshine Mining & Refining Co., 208 F.3d 1228, 1238–39 (10th Cir. 2000). Letters from employer to employees considering early retirement offering a lifetime guarantee of insurance benefits constituted an ERISA plan, where a reasonable employee would have perceived an ongoing commitment by the employer to provide employee benefits.

Williams v. Wright, 927 F.2d 1540, 1544–45 (11th Cir. 1991). Letter to an employee outlining pension and insurance benefits the employee would receive upon retirement created both an employee pension benefit plan and an employee welfare benefit plan for ERISA’s purposes.

IX. ERISA § 406(a), 29 U.S.C. § 1106(a): THE PROHIBITION ON TRANSACTIONS BETWEEN THE FIDUCIARY AND A PARTY IN INTEREST

The prohibition on a fiduciary's transactions with a party in interest is codified in ERISA § 406(a), which states as follows:

Except as provided in section 1108 of this title:

- (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 1107(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 1107(a) of this title.

29 U.S.C. § 1106(a).

A. PROHIBITED CONDUCT

Congress adopted ERISA § 406(a) to prevent plans from engaging in certain types of transactions that had been used in the past to benefit other parties at the expense of plan participants and beneficiaries. Harris Trust & Sav. Bank v. Salomon Smith Barney Inc., 530 U.S. 238, 241–42 (2000); Reich v. Compton, 57 F.3d 270, 275 (3d Cir. 1995). Congress specifically prohibited transactions “that are potentially harmful to the plan” and present a special risk of plan underfunding. Lockheed Corp. v. Spink, 517 U.S. 882, 893 (1996); see also Comm’r v. Keystone Consol. Indus., Inc., 508 U.S. 152, 160 (1993) (noting that Congress sought to bar categorically transactions that were likely to injure plan). What all of the transactions identified in § 406 have in

common is that they generally involve the use of plan assets. Lockheed, 517 U.S. at 893.

1. Party in interest

ERISA's long and detailed definition of "party in interest" found at ERISA § 3(14), 29 U.S.C. § 1002(14), was designed to encompass "those entities that a fiduciary might be inclined to favor at the expense of the plan's beneficiaries." Harris Trust & Sav. Bank, 530 U.S. at 242.

The term "party in interest" broadly includes: (1) fiduciaries; (2) plan employees; (3) employers whose employees are covered by the plan; (4) service providers; (5) employee organizations whose members are covered by the plan; (6) owners of more than fifty percent of the stock of these employers and employer organizations; (7) relatives of fiduciaries; (8) majority stock holders; and (9) others who own ten percent or more of entities that are themselves parties in interest. 29 U.S.C. § 1002(14).

Some courts have held that lawyers who provide legal services to the plan can also be parties in interest. See, e.g., Mellon Bank, N.A. v. Levy, 71 F. App'x 146, 149 (3d Cir. 2003); Rutledge v. Seyfarth, Shaw, Fairweather & Geraldson, 201 F.3d 1212, 1221 (9th Cir. 2000), amended and superseded by, 208 F.3d 1170 (9th Cir. 2000), abrogated on other grounds by, Depot, Inc. v. Caring for Montanas, Inc., 915 F.3d 643 (9th Cir. 2019).

Courts strictly interpret the definition of party in interest, deferring to the "carefully crafted and detailed legislative scheme reflected in section 3(14)." Compton, 57 F.3d at 277 (holding that § 406 does not necessarily prohibit transactions between plan and alter ego of party in interest); see also Owen v. SoundView Fin. Grp., Inc., 54 F. Supp. 2d 305, 323 (S.D.N.Y. 1999) (holding that plan beneficiary is not party in interest), aff'd, 208 F.3d 203 (2d Cir. 2000) (table).

The fact that a transaction occurred via a third party is not relevant. Indirect transactions that benefit a party in interest are also prohibited by § 406(a). Compton, 57 F.3d at 276.

2. Actual or imputed knowledge on the part of the fiduciary

Section 406(a) imposes liability only when the fiduciary "knows or should have known" that the transaction benefited a party in interest. However, a fiduciary may be liable where a court finds he or she had constructive knowledge. Harris Trust & Sav. Bank, 530 U.S. at 251 (stating transferee must have had actual or constructive knowledge of circumstances of unlawful transaction). Some courts have held that plan fiduciaries must have knowledge not only of their party in interest status, but also of the transaction's unlawful nature. See e.g., Laborers' Pension Fund v. Arnold, No. 00 C 4113, 2001 WL 197634, at *8 (N.D. Ill. Feb. 27, 2001) (holding that a plaintiff must allege that defendants knew the transaction was prohibited, not just that they knew or should have known they were entering into a transaction with a party in interest); Marks

v. Indep. Blue Cross, 71 F. Supp. 2d 432, 438 (E.D. Pa. 1999) (finding no violation absent evidence that fiduciary knew or should have known that compensation paid to party in interest was unreasonable within meaning of ERISA § 406 and § 408). For a fiduciary to be guilty of a transgression of § 406(a)(1)(D), the Third Circuit requires that the fiduciary “know or should know” that “the transaction ‘uses’ plan assets . . . [and] the transaction’s use of the assets is ‘for the benefit of’ a party in interest.” Saxton v. Cent. Penn. Teamsters Pension Fund, No. 02-CV-986, 2003 WL 22952101, at *20 (E.D. Pa. Dec. 9, 2003).

A fiduciary is obligated to investigate thoroughly the status of any party to a transaction with the plan. Herman v. Mercantile Bank, N.A., 143 F.3d 419, 425–27 (8th Cir. 1998). Knowledge will be imputed to a fiduciary where such an investigation would have revealed the party’s status as a party in interest. Id.

3. Good faith, legitimate business purpose, and lack of harm not relevant

Congress intended § 406(a) to be a *per se* prohibition against the enumerated transactions. Good faith or legitimate business purpose cannot cure an otherwise prohibited transaction. Chao v. Hall Holding Co., 285 F.3d 415, 421 n.12 (6th Cir. 2002); Chao v. Linder, No. 05 C 3812, 2007 WL 1655254, at *7 (N.D. Ill. May 31, 2007); Reich v. Polera Bldg. Corp., No. 95 Civ. 3205, 1996 WL 67172, at *2 (S.D.N.Y. Feb. 15, 1996) (stating “[t]he transactions enumerated in § 406(a)(1) are *per se* violations of ERISA regardless of the motivation which initiated the transaction, the prudence of the transaction, or the absence of any harm arising from the transaction”).

Courts are currently divided as to whether there is a “subjective intent” requirement for § 406(a). Most courts have found there to be no intent requirement under § 406(a). Some courts have interpreted Congress’s *per se* rule as requiring no showing of intent. Gray v. Briggs, 45 F. Supp. 2d 316, 326 (S.D.N.Y. 1999). However, other courts have found there to be a subjective intent requirement for violations under § 406(a)(1)(D). See, e.g., Jordan v. Mich. Conference of Teamsters Welfare Fund, 207 F.3d 854, 860 (6th Cir. 2000).

Likewise, a plaintiff need not show that actual harm to the plan resulted from the challenged transaction. Linder, 2007 WL 1655254, at *7; Reich v. Hall Holding Co., 990 F. Supp. 955, 967 (N.D. Ohio 1998) (finding “proof of harm or loss resulting from a prohibited transaction is not necessary to establish a violation under ERISA § 406”) aff’d by, 285 F.3d 415 (6th Cir. 2002).

B. TRANSACTIONS PROHIBITED BY STATUTE

ERISA Section 406(a) enumerates five types of prohibited transactions involving plan assets. All five of these transactions are “commercial bargains that present a special risk of plan underfunding because they are struck with plan insiders, presumably not at arm’s length.” Lockheed, 517 U.S. at 893. Courts have held that because these provisions describe *per se* ERISA violations, they should be interpreted

narrowly. Jordan v. Mich. Conference of Teamsters Welfare Fund, 207 F.3d 854, 858 (6th Cir. 2000) (stating § 406(a) “should be interpreted narrowly”); Pietrangelo v. NUI Corp., No. 04-3223, 2005 WL 1703200, at *13 (D.N.J. July 20, 2005) (quoting Jordan and reasoning that *per se* violations of § 406(a) should be interpreted narrowly). If a transaction is not specifically listed in the statute, courts will not find it a *per se* violation of fiduciary obligations. Brock v. Citizens Bank of Clovis, 841 F.2d 344, 347 (10th Cir. 1988) (fiduciary’s investment of plan assets in third parties to pay off interim financing received from a party in interest to the plan is not prohibited). Once a court makes the determination that a fiduciary engaged the plan directly or indirectly in a prohibited transaction with a party in interest, the only remaining inquiry is whether the transaction is subject to one of the statutory exemptions provided for in ERISA § 408, 29 U.S.C. § 1108.

1. Sale, exchange, or lease of property and acquisition of employer security or real property

Direct or indirect purchases or sales of goods between plans and parties in interest are prohibited transactions. Compton, 57 F.3d at 276. Stock transactions between a plan and a party in interest may also violate this provision. Herman v. S.C. Nat’l Bank, 140 F.3d 1413, 1418 (11th Cir. 1998). In particular, the purchase of employer securities by a plan is prohibited because of the high risk of self-dealing. Hall Holding, 990 F. Supp. at 962. However, an exemption under § 408(e) allows certain types of transactions, including purchases of employer’s securities by the plan, under certain conditions. 29 U.S.C. § 1108(e).

The acquisition or sale by the plan of employer securities or an employer’s property is exempt from the prohibition under certain circumstances. ERISA § 408, 29 U.S.C. § 1108(e). Such transactions are permissible if they are for adequate consideration, no commission is charged, and the plan is an eligible individual account plan as defined in § 1107(d)(3). Adequate consideration is defined as the “fair market value of the asset as determined in good faith.” 29 U.S.C. § 1002(18)(B). Fair market value is defined as “the price that a willing buyer would pay a willing seller, both having reasonable knowledge of the pertinent facts.” Sommers Drug Stores Co. Emp. Profit Sharing Trust v. Corrigan Enters. Inc., 793 F.2d 1456, 1461 (5th Cir. 1986); see also Keach v. U.S. Trust Co., 419 F.3d 626, 635–36 (7th Cir. 2005). Good faith requires fiduciaries to use a prudent method of determining the value of the transaction. Keach, 419 F.3d at 636 n.5 (citing Eyler v. Comm’r, 88 F.3d 445, 455 (7th Cir. 1996); see also Perez v. Commodity Control Corp., 2017 WL 1293619, *10 (S.D. Fla. Mar. 7, 2017) (finding that the good faith requirement “must be read in the light overriding duties of Section 404 ... [such that] ESOP fiduciaries will carry their burden to prove that adequate consideration was paid by showing that they arrived at their determination of fair market value by way of a prudent investigation in the circumstances then prevailing”); Cosgrove v. Circle K Corp., 915 F. Supp. 1050, 1064 (D. Ariz. 1995) (holding that plan’s sale of property to party in interest was not prohibited transaction where plan received fair market value as determined in good faith for its interest in property and plan trustees acted reasonably and prudently in relying upon third party appraisal), aff’d,

107 F.3d 877 (9th Cir. 1997). See Section XV.D.3 for additional discussion regarding sales of employer securities to a plan.

2. Loans and other extensions of credit

Explicit loan agreements between a plan and a party in interest are prohibited transactions. See, e.g., Chao v. Merino, 452 F.3d 174, 183–84 (2d Cir. 2006) (affirming district court's finding that payment plan between former fiduciary and plan was a prohibited transaction under § 406(a)(1)(B)); Cavellini v. Harris, 188 F.3d 512 (9th Cir. 1999) (finding that unsecured loans to plan participants constituted an ERISA violation); Chao v. Magic P.I. & Sec., Inc., No. 1:04-cv-205, 2007 WL 689987, at *5 (W.D. Mich. Mar. 2, 2007) (finding that by using Plan assets to pay parties-in-interest's general expenses and give loans, the fiduciary participated in a prohibited transaction).

Where fiduciaries have failed to enforce loan agreements adequately, courts have characterized such behavior as an indirect extension of credit. Huffer, 168 F. Supp. 2d at 818; Donovan v. Schmoutey, 592 F. Supp. 1361, 1391 (D. Nev. 1984) (holding that by failing to exercise their rights to accelerate principal and interest and to foreclose on collateral for loans owed by party in interest, fiduciaries indirectly extended further credit).

Breaking the party in interest relationship before the dispersal of funds under a loan agreement does not cleanse the transaction. As long as the borrower was a party in interest at the time the contract was negotiated, the transaction violates ERISA. M & R Inv. Co., Inc. v. Fitzsimmons, 685 F.2d 283, 286-87 (9th Cir. 1982) (finding *ex ante* disposal of subsidiary and removal of party in interest standing not sufficient to legitimize transaction); see also Rutland v. Comm'r, 89 T.C. 1137, 1144-45 (T.C. 1987) (finding that goals of ERISA would not be served by allowing an otherwise disqualified person to avoid liability by changing status after engaging in a prohibited transaction).

Loans made by the plan to parties in interest who are participants in or beneficiaries of the plan are, under certain circumstances, exempt from this prohibition under ERISA § 408, 29 U.S.C. § 1108(b)(1). Such loans are permissible if: (1) they are available to all participants and beneficiaries on a reasonably equivalent basis; (2) they are not made available to highly compensated employees in an amount greater than the amount made available to all employees; (3) they are made in accordance with any relevant provisions of the plan; (4) they bear a reasonable interest rate; and (5) they are adequately secured. Id.

3. Furnishing goods, services or facilities

Section 406(a)(1)(C) forbids fiduciaries from causing the plan to engage in a transaction that constitutes contracting for goods, services or facilities with a party in interest. See, e.g., Hamby v. Morgan Asset Mgmt., Inc., 692 F. Supp. 2d 944, 961 (W.D. Tenn. 2010) (finding that plan cannot make investment where fiduciary knows party-in-interest will be paid advisory fees, operation expense, or other related fees for services

to plan from such funding); N.Y. State Teamsters Council Health & Hosp. Fund v. DePerno, 816 F. Supp. 138, 145 (N.D.N.Y. 1993) (finding fiduciary may not hire parties in interest as employees of fund), aff'd in part 18 F.3d 179 (2d Cir. 1994). However, contracting with a party in interest for office space, legal, accounting, or other necessary services is permissible if no more than reasonable compensation is paid. ERISA § 408, 28 U.S.C. § 1108(b)(2); see Jordan, 207 F.3d 854, 861 (holding reimbursement for funds expended by party in interest in support of fund participants' lawsuit was permissible transaction falling within § 408(b)(2)). Such services must be necessary for the plan's operation. DePerno, 816 F. Supp. at 146 (finding hiring of particular cooks who were parties in interest was not necessary for the plan's operation).

4. Transfer or use of plan assets

Courts have construed ERISA's definition of "plan assets" broadly. Assets of the plan are not limited to financial holdings. See Kayes v. Pac. Lumber Co., 51 F.3d 1449, 1466-67 (9th Cir. 1995) (finding vested right to receive future residual distributions of plan surplus is plan asset); Reich v. Polera Bldg. Corp., No. 95 Civ. 3205, 1996 WL 67172, at *3 (S.D.N.Y. Feb. 15, 1996) (finding giving up means of collecting repayment on loan by releasing certain loan guarantees constitutes improper use of plan assets). But see Phillips v. Amoco Oil Co., 799 F.2d 1464, 1471 (11th Cir. 1986) (employer's contingent and non-vested future retirement liabilities under a plan are not assets of the plan); Owens v. Storehouse, Inc., 773 F. Supp. 416, 419 (N.D. Ga. 1991) (employer's contingent and non-vested future health insurance benefits are not assets of the plan).

The Ninth Circuit has adopted a two-prong test for determining whether an item is a plan asset. Under the first prong, the court inquires whether the item may be used to the benefit, financial or otherwise, of the fiduciary. Under the second prong, the court inquires whether such use is at the expense of the plan participants or beneficiaries. Kayes, 51 F.3d at 1467; Acosta v. Pac. Enters., 950 F.2d 611, 620 (9th Cir. 1991); see In re Consolidated Welfare Fund ERISA Litig., 839 F. Supp. 1068, 1073 (S.D.N.Y. 1993) (adopting Ninth Circuit's test).

Direct transfers of plan assets to a party in interest are quintessential violations of this provision. See, e.g., Pension Benefit Guar. Corp. v. Morin, No. 99-246-P-C, 2000 WL 760737, at *4-5 (D. Me. Apr. 24, 2000) (granting summary judgment against trustee who wrote checks from pension fund accounts to himself and his company). Transactions held to be prohibited under this provision are often explicitly prohibited in some other provision of § 406(a). For example, payment of wages to parties in interest violates this provision, even though payment for services is explicitly prohibited under § 406(a)(1)(C). DePerno, 816 F. Supp. at 145. Stock transactions between a plan and a party in interest violate this provision, as well as § 406(a)(1)(A). S.C. Nat'l Bank, 140 F.3d at 1418; Leigh v. Engle, 727 F.2d 113, 126-27 (7th Cir. 1984) (finding fiduciary may not buy shares in party in interest corporation to help corporation's management fend off hostile takeover).

Similarly, although loans and extensions of credit to parties in interest are explicitly prohibited under § 406(a)(1)(B), courts have also invalidated such transactions under this provision, particularly where the facts do not conclusively establish the existence of a formal loan agreement. See, e.g., Whitfield v. Tomasso, 682 F. Supp. 1287, 1302 (E.D.N.Y. 1988) (holding trustees liable for transferring employer contributions intended for fund to party in interest); Marshall v. Mercer, No. 4-79-390, 1983 U.S. Dist. LEXIS 16656, at *38-39 (N.D. Tex. May 27, 1983) (finding violation of both § 406(a)(1)(B) and § 406(a)(1)(D) in absence of formal loan agreement), rev'd in part on other grounds 747 F.2d 304 (5th Cir. 1984).

Some courts have held that failure to use fund leverage to enforce a loan agreement against a party in interest is an impermissible use or transfer of fund assets. See Schmoutey, 592 F. Supp. at 1391 (finding trustees liable for failing to pursue party in interest on loan guaranty). But see Davidson v. Cook, 567 F. Supp. 225, 238 (E.D. Va. 1983) (holding failure to raise interest rates on loans to party in interest and waiver of penalties for prior failure to make interest payments does not constitute transfer of assets).

The payment of benefits under a plan is not a prohibited transaction. Lockheed, 517 U.S. at 892-93 (finding early retirement programs which conditioned payment of increased benefits upon retirees' release of employment-related claims against employer were not prohibited transfers of assets under ERISA). "Section 406(a)(1)(D) simply does not address what an employer can and cannot ask an employee to do in return for benefits." Id. at 894.

Section 406(a)(1)(D) prohibits two kinds of transactions: (1) a transfer of plan assets to a party in interest; and (2) the use of plan assets for the benefit of the party in interest. The latter prohibition requires proof that the fiduciary acted with the subjective intent to benefit the party in interest. Voluntary Emps. Beneficiary Ass'n v. Ross, 191 F.3d 462 (9th Cir. 1999) (table) (stating "liability under this theory will require proof that [the fiduciary] acted with the intent to benefit [the party in interest]"); Compton, 57 F.3d at 279 (holding rule is not meant to prohibit transactions that "would be highly advantageous for the plan" where "the benefit for the party in interest would be unintended, indirect, and slight"). The intent to benefit test is meant to protect transactions that are likely to benefit rather than injure the plan. Jordan, 207 F.3d at 860 (finding remittance of attorney fees to party in interest is permissible where there is no intent to benefit and failure to remit would discourage such parties in interest from "assisting plan members to right the wrongs committed by fiduciaries"); Etter v. J. Pease Constr. Co., 963 F.2d 1005, 1009 (7th Cir. 1992) (holding that investment of plan assets in venture involving party in interest was permissible where parties in interest had enabled plan to take advantage of valuable investment opportunity and venture resulted in annual return of nearly 65%).

X. ERISA § 406(b), 29 U.S.C. § 1106(b): SELF-DEALING EXPRESSLY PROHIBITED BY ERISA

In addition to detailing the general fiduciary duties of loyalty and prudence, ERISA specifically prohibits fiduciaries from engaging or causing their plans to engage in two types of “self-dealing” transactions. These provisions, set out at ERISA § 406, prohibit certain transactions between a plan and a party in interest or between a plan and a fiduciary. 29 U.S.C. § 1106. Transactions between a plan and parties in interest that ERISA § 406(a) prohibits are discussed in Section IX.

This Section X addresses the transactions between the plan and a fiduciary that are prohibited under ERISA § 406(b). ERISA § 406(b) provides that: “A fiduciary with respect to a plan shall not (1) deal with the assets of the plan in his own interest or for his own account, (2) in his individual 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 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.” 29 U.S.C. § 1106(b).

Fiduciary duties and ERISA’s prohibited transaction rules apply only to decisions made by a person acting in a fiduciary capacity. See 29 U.S.C. §§ 1104(a), 1106(a). The scope of fiduciary status may be broad, and whether a person can be held liable as a fiduciary requires courts to ask whether the person is a fiduciary with respect to the particular activity the plaintiff seeks to challenge. Nat’l Sec. Sys., Inc. v. Iola, 700 F.3d 65, 97 (3d Cir. 2012). In any case based on fiduciary duty, “the threshold question is not whether the actions of some person employed to provide services under a plan adversely affected a plan’s beneficiary interest, but whether that person was acting as a fiduciary (that is, was performing a fiduciary function) when taking the actions subject to complaint.” Pegram v. Herdrich, 530 U.S. 211, 226 (2000). For example, because business decisions regarding the plan’s composition or design are not made in a fiduciary capacity, those decisions do not implicate ERISA’s fiduciary duties or prohibited transaction rules. Hughes Aircraft Co. v. Jacobson, 525 U.S. 432, 443–44 (1994). Furthermore, any action an employer takes to establish, modify, or terminate an ERISA-covered plan is not an action in the fiduciary capacity. Lockheed Corp. v. Spink, 517 U.S. 882, 890 (1996).

See:

*Murphy v. Verizon Commc’n, Inc., No. 3:09-cv-2262, 2013 WL 5206451, at *15 (N.D. Tex. Sept. 16, 2013). Defendants’ actions taken in pursuit of amending plan to accomplish a spinoff were not actions performed in a fiduciary capacity.*

Union v. Bjorkedal, 516 F.3d 719, 732 (8th Cir. 2008). An employer’s failure to make plan payments with company assets in a timely fashion due to cash flow problems is a business decision that does not breach a fiduciary duty.

Flanigan v. Gen. Elec. Co., 242 F.3d 78, 87 (2d Cir. 2001). *Employer's decision to spin off a division of the company, along with its pension plan, was a corporate business decision, and not one of a plan administrator.*

Hunter v. Caliber Sys., Inc., 220 F.3d 702, 719 (6th Cir. 2000). *The transfer of assets from one plan to another was not a decision subject to ERISA's fiduciary obligations.*

King v. Nat'l Human Res. Comm., Inc., 218 F.3d 719, 723 (7th Cir. 2000). *The creation of an employee plan when a division of the company has been spun-off is a business decision, not a fiduciary decision.*

Ames v. Am. Nat'l Can Co., 170 F.3d 751, 757 (7th Cir. 1999). *Employer's decision regarding how to structure plan was not a fiduciary decision.*

Sys. Council EM-3 v. AT&T Corp., 159 F.3d 1376, 1379–80 (D.C. Cir. 1998). *Employer's allocation of a restructured plan's excess was not a fiduciary decision.*

Waller v. Blue Cross of Cal., 32 F.3d 1337, 1345-46 (9th Cir. 1994). *Despite in-firm bidding process and alleged improper motives, the purchase of replacement annuities as a part of a plan termination was not a transaction covered by § 406.*

A. TRANSACTIONS PROHIBITED UNDER ERISA § 406(b).

Generally, courts have found two types of transactions involving fiduciaries to be likely prohibited under ERISA § 406(b): loans or extensions of credit and investment of plan assets.

1. Loans or Extensions of Credit

Courts have generally held that fiduciaries that serve on both sides of a loan from plan assets to another entity engage in prohibited transactions under ERISA. At the heart of the fiduciary relationship is the duty of complete and undivided loyalty to the beneficiaries of the trust when performing fiduciary functions. Pegram v. Hendrich, 530 U.S. 211, 224 (2000). Courts generally consider fiduciaries acting on both sides of a loan transaction to be unable to negotiate the best terms for either plan. Cutaiar v. Marshall, 590 F.2d 523, 530 (3d Cir. 1979); Sweda v. Univ. of Penn, 923 F.3d 320, 336 (3d Cir. 2019); see Felber v. Estate of Regan, 117 F.3d 1084, 1086–87 (8th Cir. 1997) (finding that loan from the plan to fiduciary was prohibited even when plan earned money on transaction); but see Brock v. Citizens Bank of Clovis, 841 F.2d 344, 347 (10th Cir. 1988) (finding no violation of § 406(b)(1) when a bank, as plan trustee, made loans to borrowers that enabled the borrowers to repay commercial loans to the bank because the transaction did not literally fall within the text of § 406(b)). Thus, courts have held that certain loans from plan assets to various other entities violate § 406(b).

a) Loans from plan assets to another plan

Courts have differed in determining whether certain loans from plan assets to another plan violate ERISA's prohibited transactions provisions. In Cutaiar, the Third Circuit held that when identical trustees of two employee benefit plans whose participants and beneficiaries are not identical effect a loan between plans without a § 408 exemption, a *per se* violation exists. Cutaiar, 590 F.2d at 529. The court reasoned that the extensive procedural requirements to receive a § 408 exemption demonstrate that Congress intended to create a blanket prohibition on certain transactions, no matter how fair. Id. at 529–30. In addition, the Cutaiar court reasoned that the statutory language of § 406(b)(2) speaks of the “interests of the plan or the interests of its participants or beneficiaries.” Id. at 530. It does not speak of “some” or “many” or “most” participants. Id. Thus, if a single member participates in only one plan, his plan must be administered without regard for the interests of any other plan. Id.

See:

Donovan v. Mazzola, 716 F.2d 1226, 1238 (9th Cir. 1983). Holding that the district court did not err in not permitting the defendant fiduciaries to offer proof that the two plans had “substantial identity” in their participants and beneficiaries. The Court thus agreed with the reasoning in Cutaiar, holding that if there is a single member who participates in only one plan, his interests are not being represented in any loan transaction between the plans.

The Third Circuit has also held that the Cutaiar holding was not limited to circumstances when the trustees of each plan are identical. Reich v. Compton, 57 F.3d 270, 288 (3d Cir. 1995). The Third Circuit held that the duty imposed by § 406 is for each individual fiduciary, not just for fiduciaries as a group. Id. at 289. Thus, a fiduciary may act on behalf of, or represent, an adverse party even if the group controlling the plan and the adverse party are not identical. Id.

b) Loans from plan assets to the sponsor/employer

Where the fiduciary makes a loan from the assets of the plan to the employer or plan sponsor, the transaction constitutes a deal with plan assets in the fiduciary's own interest in violation of § 406(b)(1) and an action on behalf of a party with interests adverse to those of the plan in violation of § 406(b)(2).

See:

Solis v. Tomco Auto Prods. Inc., 12-cv-00618, 2013 WL 12114739, at *7 (C.D. Cal. Jan. 31, 2013) (vacated on other grounds). Defendants violated § 406(b) by acting on both sides of a transfer of funds from the plan to the company.

White v. Martin, 286 F. Supp. 2d 1029, 1042 (D. Minn. 2003). *Guaranties of loans to employer constituted improper transfer of funds under § 406(a).*

Reich v. Hosking, 94-CV-10363-BC, 1996 WL 182226, at *3–4 (E.D. Mich. Mar. 7, 1996). *A plan fiduciary cannot delegate responsibility for prudence. Therefore, fiduciary is liable where plan made loan to plan sponsor and employer even if fiduciary claims that he retained no oversight of the transaction.*

Freund v. Marshall & Ilsley Bank, 485 F. Supp. 629, 638 (W.D. Wis. 1979). *The court found a violation of both § 406(b)(1) and (b)(2) where the plan fiduciaries engaged in a series of loans of plan assets to each of several sponsoring employers. Each fiduciary served as a top management official in one of the sponsoring companies. Furthermore, the court held that although each of the defendant fiduciaries did not hold an ownership interest in each of the borrowing companies, the companies were so interrelated that each fiduciary had an interest in each borrower and thus represented both sides in all of the transactions.*

c) Loans from plan assets to plan fiduciary

When a fiduciary has caused a plan to make a loan from plan assets to himself, courts have held that such a transaction violates ERISA's self-dealing provisions.

See:

Raff v. Belstock, 933 F. Supp. 909, 915–16 (N.D. Cal. 1996). *Prohibited transactions between an ERISA plan and fiduciary include loans from the plan to the fiduciary. The fact that the alleged violation did not cause any harm to the plan was irrelevant; such a loan is a per se violation of 406(b).*

Brock v. Gillikin, 677 F. Supp. 398, 401–402 (E.D.N.C. 1987). *An employee benefit plan trustee acted with the assets of the plan in his own interest, in violation of § 406(b)(1), when he executed a loan of plan assets to a corporation that he owned. The court also held that the loan constituted action with a party whose interests are adverse, in violation of § 406(b)(2).*

1. Investments of Plan Assets

The various circuit courts have varied in how they treat investments of plan assets in the plan sponsor or affiliated entities. In *Donovan v. Bierwirth*, 680 F.2d 263, 270 (2d Cir. 1982), the Second Circuit held that the plan fiduciaries' decision to purchase stock in the sponsoring employer for whom they served in an executive capacity was not a prohibited transaction under § 406(b)(1). The court implied that the sponsoring employer was not a party having an adverse interest, and reasoned that Congress could not have intended the expansive interpretation of the specific

prohibitions of § 406(b) because of the sweeping requirements of prudence and loyalty contained in § 404. Id. But see Reich v. Hosking, 94-cv-10363, 1996 WL 182226, at *3–4 (E.D. Mich. Mar. 7, 1996) (finding that plan sponsor was *per se* party in interest and plan could not make loan to plan sponsor under ERISA).

In contrast, the Seventh Circuit in Leigh v. Engle, 727 F.2d 113, 126–27 (7th Cir. 1984), held that the prohibited transaction provisions were to be interpreted broadly. That court reasoned that ERISA’s entire statutory scheme demonstrates Congress’s overriding concern with the protection of plan beneficiaries, and thus it would be illogical to narrowly construe the protective provisions. Id. at 126. In that case, the court held that the plan trustees’ use of plan assets to purchase stock in a corporate control battle was clearly within § 406(b)(1)’s “own interest” and was therefore prohibited. Id. at 132.

See:

Krueger v. Ameriprise Fin., Inc., No. 11-cv-02781, 2012 WL 5873825, at *16 (D. Minn. Nov. 20, 2012). *Holding that plaintiffs adequately stated a § 406(b) claim where they alleged that fiduciary invested plan assets in companies affiliated with the plan sponsor.*

Martin v. Nat’l Bank of Alaska, 828 F. Supp. 1427, 1436 (D. Alaska 1992). *The court held that ERISA § 406(b) should be interpreted broadly, agreeing with the majority of circuits who had ruled on the issue.*

Lowen v. Tower Asset Mgmt. Inc., 829 F.2d 1209, 1214 (2d Cir. 1987). *Fiduciaries’ investment of plan assets in companies that they owned substantial equity interests in violated 405(b)(1).*

B. PLAN ASSETS UNDER § 406(b)(1), 29 U.S.C. § 1106(b)(1)

In Acosta v. Pacific Enterprises, 950 F.2d 611, 620–21 (9th Cir. 1991), the Ninth Circuit held that “assets of the plan” under § 406(b)(1) has a broader scope than just financial contributions received by plan administrators. The Court reasoned that the sweeping duty of loyalty upon plan fiduciaries indicates that Congress intended to effect a more functional approach. Id. at 620. The court held that the determinative test is whether the item in question may be used, financially or otherwise, for the benefit of the fiduciary at the expense of plan participants or beneficiaries. Id. at 620. However, the court held that no violation of § 406 occurred unless the fiduciary “actually used its power . . . for its own benefit or account.” Id. at 621.

Courts have also found that there is no compensation exception to the rule against self-dealing. In Patelco Credit Union v. Salini, 262 F.3d 897, 909–11 (9th Cir. 2001), the Ninth Circuit determined that stop-loss benefit checks were “plan assets” and that the § 408 exception for reasonable compensation did not apply if the fiduciary’s self-dealing led to the payment. Therefore, fiduciaries are liable for self-dealing under § 406(b) if they provide themselves with any compensation, regardless if the

compensation was reasonable or not. This is not true for transactions with parties in interest under § 406(a) where the exception does apply.

C. ADVERSE INTERESTS UNDER § 406(b)(2), 29 U.S.C. § 1106(b)(2)

Under § 406(b)(2), the general trend has been to attribute broad meaning to the term “adverse,” and to hold that interests need not be “antithetical,” only “different.” Solis v. Hartmann, No. 10-cv-123, 2012 WL 3779050, at *7 (N.D. Ill. Aug. 31, 2012); Acosta v. Finishing Prof’ls, LLC, No. 18-cv-00978, 2018 WL 6603641, at *7 (D. Colo. Nov. 20, 2018); see also Reich v. Compton, 57 F.3d 270, 289 (3d Cir. 1995) (holding that § 406(b)(2) speaks more broadly than “party in interest” and therefore covers a party whose interests are adverse to the plan even when he is not a party in interest). However, courts have held that a violation of § 406(b)(2) “requires more than a secret loyalty to the adverse party, but instead relies upon a formal relationship with the adverse party.” Innis v. Bankers Tr. Co. of S. Dakota, No. 4:16-cv-00650, 2017 WL 4876240, at *8 (S.D. Iowa Oct. 13, 2017). Courts have generally refused to find a violation where a fiduciary employed by the sponsoring employer in a corporate capacity takes action adverse to the plan. Thus, violations have been found most frequently in the context of loans or extensions of credit from plan assets where courts have held that parties on both sides of the loan cannot negotiate the terms most favorable to each individual entity. See Cutaiar, 590 F.2d at 530. However, courts have also found violations of § 406(b)(2) in other instances.

See:

*Acosta v. Finishing Prof’ls, LLC, No. 18-cv-00978, 2018 WL 6603641, at *7 (D. Colo. Nov. 20, 2018). Finding a violation of § 406(b) where fiduciary transferred plan assets to a party in interest that was also an adverse party because “its interest in the transaction—using the money for its own benefit—was incompatible with the Plan’s expectation that the money would inure to it.”*

*Chao v. USA Mining Inc., No. 1:04-cv-1, 2007 WL 208530, at *11–12 (E.D. Tenn. Jan. 24, 2007). Where there were multiple transactions between the Plan and companies in which a Plan fiduciary had majority stake, a violation of § 406(b) occurred even though the companies were not “parties in interest.”*

New York State Teamsters Council Health & Hosp. Fund v. Estate of DePerno, 816 F. Supp. 138, 147 (N.D.N.Y. 1993). When a trustee has an interest in the success of his son’s restaurant and directed the hiring of cooks using plan assets to advance that interest, the cooks and trustee had an interest adverse to the Plan. Therefore, although the trustee received no direct benefit, the actions were still a violation of § 406(b).

Arakelian v. Nat’l W. Life Ins. Co., 680 F. Supp. 400, 406–07 (D.D.C. 1987). Fiduciary insurer violated § 406(b)(2) where his “interests” were

adverse to the plan since it controlled the amount of investment return to be paid under insurance contract purchased by the plan.

Iron Workers Local No. 272 v. Bowen, 624 F.2d 1255, 1261 (5th Cir. 1980). Trustee would violate § 406(b)(2) by participating in decision whether plan should sue him.

XI. CLAIMS FOR BREACH OF FIDUCIARY DUTY BROUGHT ON BEHALF OF PLAN OR BY INDIVIDUALS

A. ERISA § 502(a)(2), 29 U.S.C. § 1132(a)(2): ACTIONS ON BEHALF OF THE PLAN

ERISA § 502(a)(2), 29 U.S.C. § 1132(a)(2), allows civil actions by participants and beneficiaries for relief for breaches of ERISA fiduciary provisions under ERISA § 409, 29 U.S.C. § 1109. Consequently, this language permits benefit plan participants and beneficiaries to argue that the plan suffered losses due to alleged fiduciary duty breaches. In Massachusetts Mutual Life Insurance Co. v. Russell, the Supreme Court held that an action under § 409 is limited to relief for the plan and does not provide individual relief, which severely limits ERISA § 502(a)(2)'s effectiveness in litigation involving individual benefit claims. 473 U.S. 134, 140 (1985). But see LaRue v. DeWolff, Boberg & Assoc., Inc., 552 U.S. 248, 255-56 (2008) (holding that Russell's interpretation of Section 409 does not apply to defined contribution plans).

1. Appropriate parties

A civil claim under ERISA § 502(a)(2) can be brought by the Secretary of Labor, a participant, beneficiary, or fiduciary against “any person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations, or duties imposed” upon that fiduciary. 29 U.S.C. § 1109. Most courts have held that only the parties expressly named in ERISA § 502(a)(2) are authorized to institute a civil action to enforce ERISA. See, e.g., Pilkington PLC v. Perelman, 72 F.3d 1396, 1401 (9th Cir. 1995) (noting that Ninth Circuit has moved toward a stricter reading of § 502(a)(2) and parties granted standing); Coleman v. Champion Intern. Corp./Champion Forest Prods., 992 F.2d 530, 534 (5th Cir. 1993) (explaining the break down of circuits that only allow enumerated parties to sue, which includes the 2d, 3d, 5th, 6th, 7th, 11th, and D.C. Circuits); Giardono v. Jones, 867 F.2d 409, 413 (7th Cir. 1989); see also Bridge v. Am. Elec. Power Co., Inc., 498 F.3d 442, 445 (6th Cir. 2007) (“502(a)(2) provides, however, that only certain actors may sue a plan fiduciary to enforce these duties: the Secretary of Labor, participants, beneficiaries, and fiduciaries.”); Coan v. Kaufman, 457 F.3d 250, 258 (2d Cir. 2006) (describing how “the frequent references in [ERISA] and its legislative history to ‘participants, beneficiaries and fiduciaries,’” renders “untenable” the proposition that any other parties would have standing to bring suit). However, the way those enumerated classes are defined can expand the universe of parties with standing to bring an ERISA action. For example, while employers are not expressly named in ERISA, employers who are working owners of their businesses, may also be defined as “participants.” Raymond B. Yates Profit Sharing Plan v. Hendon, 541 U.S. 1, 5 (2004).

a) Definition of Participant

A “participant” is defined under 29 U.S.C. § 1002(7) as “any employee or former employee . . . , or any 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.” That a person

bringing a § 502(a)(2) suit is a “participant” is both a standing requirement and a subject-matter jurisdiction requirement. See Braden v. Wal-Mart Stores, Inc., 588 F.3d 585, 591–92 (8th Cir. 2009).

The Supreme Court has read the term “participant” “naturally,” claiming that it means either an “employee in, or reasonably expected to be in, currently covered employment or a former employee who has a reasonable expectation of returning to covered employment or a colorable claim to vested benefits.” Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 117 (1989). The Supreme Court, however, has found ERISA’s definition of the term “employee” circular and inadequate. Instead of looking to § 1002(6) for the definition, courts must use the “common-law test for determining who qualifies as an ‘employee’ under ERISA.” Nationwide Mut. Ins. Co. v. Darden, 503 U.S. 318, 323 (1992). The common-law test looks to agency principles instead of the law of any particular state. Id. at 323 n.3; see also Section XIV.

Once the court determines whether the plaintiff is an “employee” or “former employee,” it must determine whether that party “is or may become eligible to receive benefits.” § 1002(7). To establish this, the Supreme Court requires the claimant to have a “colorable claim that (1) he will prevail in a suit for benefits, or that (2) eligibility requirements will be fulfilled in the future.” Firestone Tire, 489 U.S. at 117-18. For example, when plaintiff retirees have received a lump-sum payment of everything they would be entitled to under the plan, then there is no standing. Vaugh v. Bay Envtl. Mgmt., 567 F.3d 1021, 1025–26 (9th Cir. 2009). However, if plaintiff retirees who received a lump-sum distribution payment are suing for money that would have been included in the lump-sum but for the fiduciary’s negligence, those plaintiffs have standing as participants. Id.

In 2004, the Supreme Court rejected the position that a working owner of a business may rank only as an “employer” and not also as an “employee” for purposes of ERISA plan participation. Yates, 541 U.S. at 5. This position, adopted by several lower courts, missed a key point—under ERISA, a working owner can wear “two hats.” Id. at 14. That is, he can be an employee entitled to participate in a plan and, at the same time, the employer who established the plan. Id. As long as 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. Id. at 5. Under Yates, “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.” Id. It remains clear, however, that plans covering only sole owners or partners and their spouses do *not* fall under ERISA’s domain. Id. at 21.

As a general rule, a person who gives up his right to belong to a plan cannot be a “participant.” Swinney v. Gen. Motors Corp., 46 F.3d 512, 518 (6th Cir. 1995), abrogated on other grounds by Daft v. Advest, Inc., 658 F.3d 583 (6th Cir. 2011). Some courts, however, have found an exception to this rule and held that “if the employer’s breach of fiduciary duty causes the employee to either give up his right to benefits or to fail to participate in a plan, then the employee has standing to challenge that fiduciary breach.” Id.; see also Leuthner v. Blue Cross & Blue Shield of NE Pa.,

454 F.3d 120, 128–29 (3d Cir. 2006); McBride v. PLM Int'l, Inc., 179 F.3d 737, 743 (9th Cir. 1999); Mullins v. Pfizer, Inc., 23 F.3d 663, 668 (2d Cir. 1994); Vartanian v. Monsanto Co., 14 F.3d 697, 703 (1st Cir. 1994); Christopher v. Mobil Oil Corp., 950 F.2d 1209, 1221 (5th Cir. 1992). Other courts have rejected this “but for” test. See, e.g., Hansen v. Harper Excavating, Inc., 641 F.3d 1216, 1225 (10th Cir. 2011) (describing circuit split). One court held that “to say that but for [the employer’s] conduct, plaintiffs would have standing is to admit that they lack standing and to allow those who merely *claim* to be participants to be deemed as such.” Raymond v. Mobil Oil Corp., 983 F.2d 1528, 1536 (10th Cir. 1993); see also Sanson v. Gen. Motors Corp., 966 F.2d 618, 619, 621 (11th Cir. 1992); Stanton v. Gulf Oil Corp., 792 F.2d 432, 435 (4th Cir. 1986) (rejecting “but for” test for participant status).

b) Definition of Beneficiary

A “beneficiary” is defined under 29 U.S.C. § 1002(8) 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.” Like a “participant,” a beneficiary must have a reasonable or colorable claim to vested benefits. Neuma, Inc. v. AMP, Inc., 259 F.3d 864 (7th Cir. 2001); Crawford v. Roane, 53 F.3d 750, 754 (6th Cir. 1995). Merely claiming to be a beneficiary is insufficient to grant standing. Crawford, 53 F.3d at 754. Furthermore, circuits are divided on the question whether beneficiary standing is granted to any person within the “zone of interests” that ERISA was designed to protect. Compare Baldwin v. Univ. of Pittsburgh Med. Ctr., 636 F.3d 69, 75 (3d Cir. 2011) (evaluating whether a party was a “beneficiary” by reference to the zone of interests test), with Coleman v. Champion Int'l Corp., 992 F.2d 530, 534 (5th Cir. 1993); Giardono v. Jones, 867 F.2d 409, 413 (7th Cir. 1989); Grand Union Co. v. Food Emprs. Labor Relations Ass'n, 808 F.2d 66, 71 (D.C. Cir. 1987); Dime Coal Co. v. Combs, 796 F.2d 394, 396 (11th Cir. 1986) (rejecting the “zone of interests” test).

Some courts have held that ERISA was passed to protect the entire family, thus the term “beneficiary” should be interpreted in a broad sense. See, e.g., Vogel v. Independence Fed. Sav. Bank, 728 F. Supp. 1210, 1220 (D. Md. 1990); Cartledge v. Miller, 457 F. Supp. 1146, 1156 n.53 (S.D.N.Y. 1978). But see Harris Trust & Sav. Bank v. Solomon Smith Barney, 530 U.S. 238, 241 (2000) (stating that language in § 502 limits the universe of potential plaintiffs, which afterwards resulted in Circuit Courts reading the language of § 502 more strictly). A person need not be a family member or a dependent, however, to be considered a beneficiary. Any person that a participant or the plan’s terms designates can bring suit to enforce ERISA on behalf of the plan. Peterson v. Am. Life & Health Ins. Co., 48 F.3d 404, 409 (9th Cir. 1995). Moreover, an assignee of plan benefits may be considered a “beneficiary” for standing purposes so long as that person has an arguable claim. Neuma, 259 F.3d at 878. Jurisdiction is lacking “[o]nly if the language of the plan is so clear that any claim as an assignee must be frivolous.” Id.

c) Definition of Fiduciary

A “fiduciary” is defined under 29 U.S.C. § 1002(21)(A) as a person “with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or . . . disposition of its assets, (ii) [he] renders investment advice for a fee or other compensation . . . or (iii) [] has any discretionary authority or . . . responsibility in the administration of such plan.”

When determining whether a person is a fiduciary, courts focus on the “function performed, rather than on the title held.” *DeRogatis v. Bd. of Trs. of the Welfare Fund of the Int’l Union of Operating Eng’rs Local 15, 15A, 15C & 15D, AFL-CIO* (In re *DeRogatis*), 904 F.3d 174, 191 (2d Cir 2018). Furthermore, having absolute discretion over a plan is not required; a person will be considered a fiduciary to the extent he performs a fiduciary task. *Id.*; see also *Pegram v. Herdrich*, 530 U.S. 211, 226 (2000) (“In every case charging breach of ERISA fiduciary duty, . . . the threshold question is . . . whether [the defendant] was acting as a fiduciary (that is, was performing a fiduciary function) when taking the action subject to complaint.”) Therefore, just because a person is a fiduciary for one purpose does not automatically make that person a fiduciary for every purpose. “A person ‘is a fiduciary to the extent that’ he performs one of the described duties,” allowing that person to act in his own interests in certain circumstances. *Johnson v. Georgia-Pacific Corp.*, 19 F.3d 1184, 1188 (7th Cir. 1994); see also *John Hancock Mut. Life Ins. Co. v. Harris Tr. & Sav. Bank*, 510 U.S. 86, 94-99 (1993); *Leimkuehler v. Am. United Life Ins. Co.*, 713 F.3d 905, 914 (7th Cir. 2013); *McGath v. Auto-Nody N. Shore, Inc.*, 7 F.3d 665, 670 (7th Cir. 1993) (“Fiduciary duties under ERISA attach not just to particular persons but to particular persons performing particular functions.”). Thus, a fiduciary has standing only to bring claims related to those fiduciary responsibilities it possesses. In other words, a fiduciary does not have standing for all purposes. *Coyne & Delany Co. v. Selman*, 98 F.3d 1457, 1465 (4th Cir. 1996). Courts do not consider those who perform merely ministerial or mechanical duties fiduciaries because they exercise no discretion. See, e.g., *Kenseth v. Dean Health Plan, Inc.*, 610 F.2d 452, 465 (7th Cir. 2010).

Courts are presently divided on the question of whether a former fiduciary has standing to bring claims on behalf of the plan to recover for plan losses. See *Trujillo v. Am. Bar Ass’n*, 706 F. App’x 868, 870 (7th Cir. 2017) (describing, but not joining, the circuit split). Compare *Corbin v. Blankenburg*, 39 F.3d 650, 655 (6th Cir. 1994) (en banc); *Chemung Canal Trust Co. v. Sovran Bank/Md.*, 939 F.2d 12, 14 (2d Cir. 1991); *Blackmar v. Lichtenstein*, 603 F.2d 1306, 1310 (8th Cir. 1979) (all finding no standing for former fiduciaries) with *Trujillo v. Landmark Media Enters., LLC*, 689 F. App’x 176, 178-79 (4th Cir. 2017); *Hashimoto v. Bank of Haw.*, 999 F.2d 408, 411–12 (9th Cir. 1993).

For additional discussion on how courts determine who is a fiduciary under ERISA, see Section III of this Handbook.

2. Jurisdiction

29 U.S.C. § 1132(e) and § 1132(f) provide the federal jurisdictional basis for a § 502(a)(2) action. Section 1132(e) states that for § 502(a)(2) actions, “the district courts of the United States shall have exclusive jurisdiction of civil actions under this subchapter brought by the Secretary or by a participant, beneficiary, fiduciary” 29 U.S.C. § 1132(e)(1). Section 1132(f) provides that the federal district courts will have jurisdiction “without respect to the amount in controversy or the citizenship of the parties.” 29 U.S.C. § 1132(f).

While it is clear that federal courts will exclusively hear § 502(a)(2) claims, a circuit split exists concerning personal jurisdiction. The controversy arises from § 1132(e)(2), which provides for nationwide service of process and states “process may be served in any other district where a defendant resides or may be found.” Several courts read this language to say that personal jurisdiction lies in any federal district court so long as the defendant has minimum contacts with the United States as a whole. Courts refer to this as the “national contacts test.” Under the national contacts test, whether a connection exists between the defendant and the forum state in which the court sits is irrelevant. Instead, the personal jurisdiction inquiry focuses on whether the defendant in the proceeding has sufficient contacts within the United States. Aetna Life & Cas. v. Owen, No. 3:04-cv-817, 2004 WL 2381744, at *2 (D. Conn. Oct. 13, 2004). This would, for example, allow a defendant in Florida to be haled into court in Alaska even though he has no contact with Alaska.

For courts following the national contacts test, the minimum contacts analysis of International Shoe Co. v. Washington, 326 U.S. 310 (1945), which examined the sufficiency of the contacts between the defendant and the forum to establish personal jurisdiction, does not apply. Rather, as set forth by the Sixth Circuit, the due process inquiry of International Shoe applies only when a state long-arm statute is applied to reach out-of-state defendants. Med. Mut. of Ohio v. DeSoto, 245 F.3d 561, 567 (6th Cir. 2001). If Congress provided for national service of process, as it did in § 1132(e)(2), the district court is able to exercise jurisdiction nationwide because the extra-territorial concerns for state courts are simply not present.

See:

Med. Mut. v. DeSoto, 245 F.3d 561, 566–67 (6th Cir. 2001). The national contacts test was the appropriate means to determine personal jurisdiction. The court also held that where nationwide service is appropriate under the statute, national contacts will establish personal jurisdiction.

Bd. of Trs., Sheet Metal Workers’ Nat’l Pension Fund v. Elite Erectors, Inc., 212 F.3d 1031 (7th Cir. 2000). The national contacts test was the appropriate test for personal jurisdiction under ERISA and explicitly disagreeing with Peay.

Aetna Life & Cas. v. Owen, No. 3:04-cv-817, 2004 WL 2381744, at *1-2 (D. Conn. Oct. 13, 2004). Where defendant resided in the United States, worked in the United States, and received benefits from a disability plan administered in the United States, personal jurisdiction in an ERISA case was proper under the national contacts test even though defendant's contacts with the forum state were minimal.

Abercrombie v. Cont'l Cas. Co., 295 F. Supp. 2d 604, 606-07 (D.S.C. 2003). Applying the national contacts test, the court found that personal jurisdiction in an ERISA case was proper even if the parties had no contacts at all with the forum state, as sufficient contacts anywhere in the United States are enough to confer personal jurisdiction.

Vivien v. WorldCom, Inc., No. 02-cv-01329 WHA, 2002 WL 31640557, at *2-*3 (N.D. Cal. July 26, 2002). Where individual defendants resided in Mississippi and Florida and worked for the corporate defendant in Mississippi, personal jurisdiction in an ERISA case was proper under the national contacts test.

DeFelice v. Daspin, No. 01-cv-1760, 2002 WL 1373759, at *4 (E.D. Pa. June 25, 2002). The Third Circuit has not squarely adopted the national contacts test but has recognized the test's legitimacy. Even where the national contacts test applies, courts must not discard notions of fundamental fairness. Personal jurisdiction in an ERISA case existed under the national contacts test even though defendants lived in New Jersey, Connecticut, and South Carolina and had no presence or property in Pennsylvania. Defendants held management positions in a company which employed the Pennsylvania plaintiffs and in a company which administered the payroll; thus, defendants' activities had an impact in Pennsylvania and could reasonably anticipate being called to answer there for the use of their positions to deprive persons in Pennsylvania of rights earned under a benefit plan.

Hudson County Carpenters Local Union No. 6 v. V.S.R. Constr. Corp., 127 F. Supp. 2d 565 (D.N.J. 2000). The court applied the national contacts standard in an ERISA case, citing *Max Daetwyler Corp. v. R. Meyer*, 762 F.2d 290, 294 n.3 (3d Cir. 1985) which stated "The constitutional validity of national contacts as a jurisdictional base is confirmed by those statutes which provide for nationwide service of process"

See also:

Pinker v. Roche Holdings, Ltd., 292 F.3d 361, 369 (3d Cir. 2002), overruled on other grounds by *Phillips v. County of Allegheny*, 515 F.3d 224 (3d Cir. 2008). The Third Circuit applied the national contacts test to a suit brought under the Securities and Exchange Act of 1934. The court also stated that where Congress has authorized nationwide service of

process, the national contacts test would suffice for granting personal jurisdiction according to the fundamental notions of justice and fair play.

In re Fed. Fountain, Inc., 165 F.3d 600, 602 (8th Cir. 1999). *The Eighth Circuit adopted the national contacts test for personal jurisdiction in a Chapter 7 bankruptcy proceeding.*

Busch v. Buchman, Buchman & O'Brien Law Firm, 11 F.3d 1255, 1258 (5th Cir. 1994). *The national contacts test was applied in a suit brought under the Securities Exchange Act of 1934.*

Lisak v. Mercantile Bancorp, Inc., 834 F.2d 668, 671-72 (7th Cir. 1987). *The Seventh Circuit held that the national contacts test would be applied for personal jurisdiction in RICO cases.*

Schrader v. Trucking Emps. of N.J. Welfare Fund, Inc., 232 F. Supp. 2d 560, 571 (M.D.N.C. 2002). *The court noted that while the Fourth Circuit has not expressly ruled on whether the national contacts test is applicable in ERISA cases, it has clearly held the test applicable in RICO and Bankruptcy Act cases, both of which provide for nationwide service of process.*

Cole v. Cent. States Se. & Sw. Areas Health & Welfare Fund, 225 F. Supp. 2d 96, 97 (D. Mass. 2002). *The district court ruled that the First Circuit follows the national contacts test, but nonetheless questioned the test's validity under the Due Process Clause.*

Other courts have rejected the national contacts test and instead held that the Fifth Amendment's Due Process Clause governs personal jurisdiction where a nationwide service of process statute exists. These courts hold that Congress cannot circumvent the traditional due process requirement simply by enacting nationwide service of process rules.

As the Tenth Circuit stated in an ERISA case, "the Fifth Amendment requires the plaintiff's choice of forum to be fair and reasonable to the defendant." *Peay v. BellSouth Med. Assistance Plan*, 205 F.3d 1206, 1212 (10th Cir. 2000). The *Peay* court found the Fifth Amendment virtually identical to the Fourteenth Amendment (where *International Shoe* applies), and ruled that a defendant "must first demonstrate 'that his liberty interests actually have been infringed'" to establish that jurisdiction offends the Due Process Clause. *Id.* "The burden is on the defendant to show that the exercise of jurisdiction in the chosen forum will 'make litigation so gravely difficult and inconvenient that he unfairly is at a severe disadvantage in comparison to his opponent.'" *Id.* The *Peay* court also listed several factors district courts must consider when determining inconvenience, such as: "(1) the extent of the defendant's contacts with the place where the action was filed; (2) the inconvenience to the defendant of having to defend in a jurisdiction other than that of his residence or place of business . . . ; (3) judicial economy; (4) the probable situs of the discovery . . . ; and (5) the nature of the regulated

activity in question and the extent of impact that the defendant's activities have beyond the borders of his state of residence or business." *Id.* The court further noted that only in very rare cases will the inconvenience "rise to a level of constitutional concern," and that inconvenience can normally be accommodated through a change of venue. *Id.* at 1212-13. Finally, even if the defendant can show such undue inconvenience, personal jurisdiction will satisfy due process "only if the federal interest in litigating the dispute in the chosen forum outweighs the burden imposed on the defendant." *Id.* at 1213.

See also:

Republic of Panama v. BCCI Holdings (Lux.) S.A., 119 F.3d 935, 945 (11th Cir. 1997). *The Eleventh Circuit favored the due process inquiry for personal jurisdiction over the national contacts test in a RICO case.*

Bellaire Gen. Hosp. v. Blue Cross & Blue Shield of Mich., 97 F.3d 822, 825 (5th Cir. 1996). *The Fifth Circuit applied the national contacts test due to Busch*, 11 F.3d at 1258, *but disagreed with the test, noting that, "We fail to apprehend how personal jurisdiction can be separated from due process by Congressional enactment of nationwide service of process provisions."*

I.A.M. Nat'l Pension Fund v. Wakefield Indus., Inc., 699 F.2d 1254, 1258 (D.C. Cir. 1983). *"[F]or service of process on a corporation to be valid under Section 1132(e)(2), a corporation's contacts with the district of service must meet the International Shoe test."*

Willingway Hosp., Inc. v. Blue Cross & Blue Shield of Ohio, 870 F. Supp. 1102, 1106 (D. Ga. 1994). *The court criticized the national contacts test for providing defendants with inadequate due process protection and noted that "[t]o allow Congress to dictate personal jurisdiction through the enactment of nationwide service of process provisions, unquestioned by the judiciary, is nonsensical."*

The Supreme Court has twice declined to rule on this issue. *See Omni Capital Int'l v. Rudolf Wolff & Co.*, 484 U.S. 97, 103 n.5 (1987); *Asahi Metal Indus. Co., Ltd. v. Sup. Ct. of Cal.*, 480 U.S. 102, 111 (1987).

3. Venue

29 U.S.C. § 1132(e)(2) provides the venue requirements for a § 502(a)(2) action. That provision allows any action under ERISA to be brought in the federal district court for "the district where the plan is administered, where the breach took place, or where a defendant resides or may be found." Moreover, "process may be served in any other district where a defendant resides or may be found.

"Congress intended in ERISA cases to give a plaintiff's choice of forum somewhat greater weight than would typically be the case, as evidenced by ERISA's liberal venue provision." *Trs. of Plumbers & Pipefitters Nat'l Pension Fund v. Plumbing Servs., Inc.*, 791 F.3d 436, 444 (4th Cir. 2015) (internal quotation marks omitted). In

addition, courts have generally upheld “venue selection” clauses in plan documents. Smith v. Aegon Comps. Pension Plan, 769 F.3d 922, 932-33 (6th Cir. 2014) (upholding such a clause); Manuel-Clark v. Manpowergroup Short-Term Disability Plan, 2019 WL 5558406, at *1 (E.D.N.C. Oct. 28, 2019) (same).

Courts have construed the term “found” in § 1132(e)(2) liberally, holding that it means any court that has personal jurisdiction over the defendant. See, e.g., Varsic v. United States Dist. Court for the Cent. Dist. of Cal., 607 F.2d 245, 248 (9th Cir. 1979); see also Waeltz v. Delta Pilots Ret. Plan, 301 F.3d 804, 810 (7th Cir. 2002) (following Varsic); I.A.M. Nat’l Pension Fund v. Wakefield Indus., Inc., 699 F.2d 1254, 1257 (D.C. Cir. 1983) (same); Bd. of Trs. of the Health & Welfare Dep’t of the Const. & Gen. Laborers’ Dist. Counsel of Chicago and Vicinity v. Kruzan, No. 11-cv-03233, 2011 WL 6140530, at *2–3 (N.D. Ill. Dec. 8, 2011) (following Waeltz). For venue purposes, personal jurisdiction is determined under the minimum contacts test of International Shoe v. Washington, 326 U.S. 310 (1945). To establish minimum contacts under International Shoe, a defendant must have “purposefully avail[ed] itself of the privilege of conducting activities within the [district], thus invoking the benefits and protections of its law[.]” Hanson v. Denckla, 357 U.S. 235, 253 (1958), so that it “should reasonably anticipate being haled into court there.” World-Wide Volkswagen Corp. v. Woodson, 444 U.S. 286, 297 (1980). In sum, a defendant “can be found” in a judicial district if it has the sort of minimum contacts with that district that would support the exercise of personal jurisdiction under International Shoe. Waeltz, 301 F.3d at 810; see also Abercrombie v. Cont’l Cas. Co., 295 F. Supp. 2d 604, 607-08 (D.S.C. 2003) (even though plaintiff’s employer was located in North Carolina and plan administered in Pennsylvania, defendant’s contacts satisfied International Shoe where defendant insured welfare benefit plans for other employers in forum state of South Carolina).

It is important to note that the use of International Shoe for venue purposes is completely separate from the concept of personal jurisdiction in which many courts use the “national contacts test.” See supra Section XI.A.2. At least one court has collapsed the personal jurisdiction and venue analysis, however. Moore v. St. Paul Co., Inc., No. 94-cv-1329, 1995 WL 11187, at *2 (D.N.J. Jan. 3, 1995). The court in Moore claimed that if the defendant had sufficient personal contact with the district court to satisfy International Shoe, then it must have sufficient personal contact with the United States as a whole to satisfy the personal jurisdiction requirement. Id.

Under § 1132(e)(2), “where the breach took place” is considered by courts to be the “district where the beneficiary receives his benefits.” Shrader v. Trucking Employees of N. J. Welfare Fund, Inc., 232 F. Supp. 2d 560, 573 (M.D.N.C. 2002); see also Cole v. Cent. States Se. & Sw. Areas Health & Welfare Fund, 225 F. Supp. 2d 96, 98 (D. Mass. 2002) (“[T]he place of breach is the place where payment was to be received.”). Alternatively, some courts have found the place “where the breach took place” is the place “where the decision to deny benefits is made.” Brown Sch., Inc. v. Fl. Power Corp., 806 F. Supp. 146, 149 (W.D. Tex. 1992) (citing Helder v. Hitachi Power Tools, USA Ltd., 764 F. Supp. 93, 95 (E.D. Mich. 1991)). Brown notes that “breach of fiduciary duty, as opposed to the plan itself, takes place ‘where the defendants commit or fail to commit the actions their duties require.’” Id.

4. Applicable statute of limitations

The statute of limitations for a § 502(a)(2) breach of fiduciary duty action is set out in 29 U.S.C. § 1113. Under § 1113, no action for breach of fiduciary duty may be brought after the earlier of the following:

(1) six years after (A) the date of the last action which 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 of such breach or violation.

In interpreting part (1) in 2015, the Supreme Court held in Tibble v. Edison International that the “action” or “omission” from which the limitations period begins to run must be assessed by reference to the fiduciary’s duty under ERISA and the “common law of trusts” from which much of ERISA substantive duties are derived. 575 U.S. 523, 135 S. Ct. 1823, 1827-28 (2015). Tibble reversed the Ninth Circuit which had held a fiduciary breach claim barred by the statute of limitations because it was brought more than six years after the fiduciary selected the plan investments at issue. Id. at 1827. But, as the Supreme Court recognized, ERISA also imposes a duty on fiduciaries to monitor plan investments and take action when such investments become imprudent. Id. at 1828. This “continuing duty” meant that the limitations period must be assessed from some date later than the date of selecting the investments. Id.

For part (2), the statutory period begins not when the violation or breach occurred, but when the plaintiff obtained “actual knowledge.” Intel Corp. Inv. Policy Comm. v. Sulyma, 140 S. Ct. 768, 773 (2020). That means that “the plaintiff must in fact have become aware of that information,” regardless of whether he or she had access to that information. Id. at 777. “Actual knowledge” has been defined as “knowledge of the essential facts of the transaction or conduct constituting the violation.” Rush, 83 F.3d at 896 (citing Martin v. Consultants & Adm’rs, Inc., 966 F.2d 1078, 1086 (7th Cir. 1992)). The plaintiff need not know of every last detail of the transaction or of its illegality. Id.; see also Wright v. Heyne, 349 F.3d 321, 330 (6th Cir. 2003); Brock v. Nellis, 809 F.2d 753, 755 (11th Cir. 1987). Though an ERISA plaintiff brings suit on the plan’s behalf, the statute of limitations begins to run when the *person bringing suit* had knowledge of the breach or violation; not when the covered plan, through any of its agents, learns of the breach. Landwehr v. DuPree, 72 F.3d 726, 732 (9th Cir. 1995).

Importantly, constructive knowledge is insufficient to establish actual knowledge. Browning v. Tiger’s Eye Benefits Consulting, Inc., 313 F. App’x 656, 661 (4th Cir. 2009). Likewise, actual knowledge means more than simple knowledge that something is awry. Instead, specific knowledge of the facts giving rise to a breach of

duty is required. Fetterhoff v. Liberty Life Assurance Co., 282 F. App'x 740, 742 (11th Cir. 2008); see also Maher v. Strachan Shipping Co., 68 F.3d 951, 955 (5th Cir. 1995).

The circuits are split over the application of the “fraud or concealment” portion of the six-year standard. The generally-accepted rule most circuits have adopted is been that this six-year period applies only where the defendant allegedly concealed the breach (i.e., fraudulent concealment). See, e.g., Brown v. Owens Corning Inv. Review Comm., 622 F.3d 564, 573 (6th Cir. 2010); Kurz v. Phila. Elec. Co., 96 F.3d 1544, 1552 (3d Cir. 1996); J. Geils Band Emp. Benefit Plan v. Smith Barney Shearson, Inc., 76 F.3d 1245, 1253 (1st Cir. 1996); Barker v. Am. Mobil Power Corp., 64 F.3d 1397, 1401-02 (9th Cir. 1995); Larson v. Northrop Corp., 21 F.3d 1164, 1172-73 (D.C. Cir. 1994); Radiology Ctr., 919 F.2d at 1220; Shaefer v. Ark. Med. Soc’y, 853 F.2d 1487, 1491-92 (8th Cir. 1988). The Second Circuit, however, holds that this six-year period is not limited to cases of fraudulent concealment. Instead, it reads the text literally to refer to either fraud or concealment so that “the six-year statute of limitations should be applied to cases in which a fiduciary: (1) breached its duty by making a knowing misrepresentation or omission of a material fact to induce an employee/beneficiary to act to his detriment; or (2) engaged in acts to hinder the discovery of a breach of fiduciary duty.” Osberg v. Foot Locker, Inc., 862 F.3d 198, 210-11 (2d Cir. 2017) (quoting Caputo v. Pfizer, Inc., 267 F.3d 181, 190 (2d Cir. 2001))

Because courts have inferred that ERISA claimants must exhaust any administrative remedies before bringing an action in federal court, see infra Part XI.B.6, this creates tolling concerns for the statute of limitations. In the context of a § 502(a)(3) action, the Fifth Circuit held that § 1113 is a statute of repose setting an outside limit on when suit can be brought, and that courts need not “toll the statute of limitations pending the exhaustion of administrative remedies.” Radford v. Gen. Dynamics Corp., 151 F.3d 396, 400 (5th Cir. 1998). While Radford was a case under § 502(a)(3), it is likely that a court would approach the § 1113 statute of limitations under § 502(a)(2) in the same way.

5. Availability of a jury trial

There is a split in district courts about whether the right to a jury trial exists for § 502(a)(2) ERISA claims. Most courts have held there is never a right to a jury trial in ERISA actions because such actions are equitable in nature. Some district courts, however, have disagreed with the majority. For instance, in Cunningham v. Cornell University, a Southern District of New York district judge held that plaintiffs had a right to a jury trial in a suit for compensatory damages for breach of fiduciary duty. No. 16-cv-6525, 2018 WL 4279466, at *3-4 (S.D.N.Y. Sept. 6, 2018). These cases were decided after the Supreme Court’s ruling in Great West Life & Annuity Insurance Co. v. Knudson, 534 U.S. 204 (2002) (dealing with § 502(a)(3) claims), and suggests that a right to a jury trial may exist for ERISA § 502(a)(2) claims.

The right to a jury trial is available in an ERISA action only when a legal remedy is sought. Graham v. Hartford Life & Accident Ins. Co., 589 F.3d 1345, 1355 (10th Cir. 2009). A simple request for monetary relief is not enough, in itself, for a claim

to be considered “legal” in nature. *Id.* at 1357; see also *Borst v. Chevron Corp.*, 36 F.3d 1308, 1324 (5th Cir. 1994). A “request for monetary recovery sounds in equity . . . when it is restitutionary in nature or is intertwined with claims for injunctive relief.” *Borst*, 36 F.3d at 1324 (citing *Chauffeurs, Teamsters & Helpers, Local No. 391 v. Terry*, 494 U.S. 558, 570-71 (1990)).

Several years before its decision in *Knudson*, the Supreme Court held that “ERISA abounds with the language and terminology of trust law. ERISA’s legislative history confirms that the Act’s fiduciary responsibility provisions ‘codify and make applicable to ERISA fiduciaries certain principles developed in the evolution of the law of trusts.’” *Firestone*, 489 U.S. at 110. As the Fifth Circuit noted, because ERISA is so analogous to trust law, this is “an area within the exclusive jurisdiction of the courts of equity,” and thus “ERISA claims do not entitle a plaintiff to a jury trial.” *Borst*, 36 F.3d at 1324.

The Second Circuit likewise has ruled that no right to a jury trial exists in ERISA claims seeking the equitable remedy of restitution. *Katsaros v. Cody*, 744 F.2d 270, 278-79 (2d Cir. 1984). As one lower court noted, § 502(a)(2) actions are “restitutional in nature,” and therefore no right to a jury trial exists. *Raff v. Travelers Ins. Co.*, No. 90-cv-7673, 1996 WL 154171 (S.D.N.Y. Apr. 3, 1996).

See also:

O’Hara v. Nat’l Union Fire Ins. Co., 642 F.3d 110, 116 (2d Cir. 2011). “[T]here is no right to a jury trial in a suit brought to recover ERISA benefits.”

Ponsetti v. GE Pension Plan, 614 F.3d 684, 689 (7th Cir. 2010). “In the same order, the district court denied the Trust’s motion for a jury trial, which is unavailable under ERISA.”

Reese v. CNH Am. LLC, 574 F.3d 315, 327 (6th Cir. 2009). “[W]e have held that the Seventh Amendment does not guarantee a jury trial in ERISA and LMRA cases because the relief is equitable rather than legal.”

Mathews v. Sears Pension Plan, 144 F.3d 461, 468 (7th Cir. 1998). “[T]here is no right to a jury trial in an ERISA case.”

Stewart v. KHD Deutz of Am. Corp., 75 F.3d 1522, 1527 (11th Cir. 1996). “[N]o Seventh Amendment right to a jury trial exists in actions brought pursuant to ERISA.”

Houghton v. SIPCO, Inc., 38 F.3d 953, 957 (8th Cir. 1994). “[T]here is no right to money damages or to a jury trial under ERISA.”

White v. Martin, No. 99-cv-1447, 2002 WL 598432 (D. Minn. Apr. 12, 2002). The district court found no right to a jury trial under § 502(a)(2)

because the plaintiff's action sought the equitable relief of restitution that did not fit into definition of "legal" under Knudson.

Pereira v. Cogan, No. 00-cv-619, 2002 WL 989460 (S.D.N.Y. May 10, 2002). The court, in a bankruptcy case, held that notwithstanding Knudson, suits for breaches of fiduciary duty are necessarily equitable in nature and thus no right to a jury trial exists.

Broadnax Mills, Inc. v. Blue Cross & Blue Shield of Va., 876 F. Supp. 809, 816 (E.D. Va. 1995). The court held that § 502(a)(2) is equitable in nature despite the availability of damages, and thus denied the right to a jury trial.

With the Supreme Court's decision in Knudson, however, some courts have concluded that the possibility that the right to a jury trial may exist for plaintiffs seeking "legal" restitution under ERISA § 502(a). Knudson, 534 U.S. at 213. In Knudson, the Court held that restitution actions are "legal" in nature when the plaintiff seeks to impose "merely personal liability upon the defendant to pay a sum of money" such as in a breach of contract case. Id. Restitution actions are "equitable" in nature where the action seeks to "restore to the plaintiff particular funds or property in the defendant's possession." Id. at 214. Thus, under Knudson, not all remedies when sought for breach of fiduciary duty, are equitable in nature. See Rego v. Westvaco Corp., 319 F.3d 140, 145 (4th Cir. 2003).

Applying Knudson, at least one court has found a right to a jury trial under ERISA § 502(a)(2). A federal district court ruled that after Knudson, plaintiffs who seek money damages in § 502(a)(2) claims are seeking a legal remedy and are therefore entitled to a jury trial. Bona v. Barasch, No. 01-cv-2289, 2003 WL 1395932, at *34-35 (S.D.N.Y. Mar. 20, 2003). In Bona, the court stated that because the plaintiffs were suing on behalf of the plan under § 502(a)(2), they could seek either damages or equitable relief. Id. at *34. After noting that the Second Circuit repeatedly holds that no jury trial is available when plaintiffs seek equitable relief, the district court in Bona stated that the plaintiffs sought monetary damages. Id. at *35. Despite Bona's holding, however, most courts have continued to deny a jury trial in § 502(a)(2) cases.

See also:

Utilicorp United, Inc. v. Kemper Fin. Servs., Inc., 741 F. Supp. 1363, 1367 (W.D. Mo. 1989). The court stated that the controlling Eighth Circuit decision denying a right to a jury trial in ERISA actions applied only to actions brought under § 502(a)(1), and therefore allowed a jury trial due to lack of binding precedent and "the strong federal policy favoring jury trials."

B. ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3): ACTIONS FOR INDIVIDUAL RELIEF

1. Permissible causes of action

ERISA § 502(a)(3) provides causes of action for any plaintiff seeking: (1) to enjoin any act or practice which violates any provision of ERISA Title I or the terms of the benefit plan, and (2) to obtain other appropriate equitable relief to address such violations, to enforce any provision of Title I, or to enforce the terms of the plan. 29 U.S.C. § 1132 (a)(3). It is well settled that a plaintiff “may file a civil action [under § 502(a)(3)] to ‘enjoin any act or practice’ which violates ERISA or the terms of the plan.” Patterson v. Shumate, 504 U.S. 753, 760 (1992); see also Franchise Tax Bd. v. Constr. Laborers Vacation Trust, 463 U.S. 1, 19-20 (1983) (holding that § 502(a)(3) specifically grants trustees of ERISA-covered plans cause of action for injunctive relief when rights and duties under ERISA are at issue), superseded by statute on other grounds, 28 U.S.C. § 1441(e). The extent of a plaintiff’s ability to obtain “other appropriate equitable relief” and what qualifies as equitable relief under § 502(a)(3) is still debated. Currently, courts strictly follow the textual guidelines of the statute and limit claims for “other appropriate equitable relief” to causes of action that seek a traditionally equitable remedy. See, e.g., Great-West Life & Annuity Ins. Co. v. Knudson, 534 U.S. 204, 210 (2002); Mertens v. Hewitt Assocs., 508 U.S. 248, 255 (1993); see also CIGNA Corp. v. Amara, 563 U.S. 421, 438 (2011) (speculating that equitable remedies allowed under § 502(a)(3) could include reformation, estoppel, and imposition of surcharge). A variety of claims qualify as actions for appropriate equitable relief under § 502(a)(3).

See:

Schwartz v. Gregori, 45 F.3d 1017, 1023 (6th Cir. 1995). Plaintiff seeking back pay in § 510 claim brought under § 502(a)(3) sought appropriate equitable relief because the back pay was restitution.

But see:

Novak v. Andersen Corp., 962 F.2d 757, 759 (8th Cir. 1992). Plaintiff seeking injunction requiring defendant to pay monetary damages to compensate him for defendant’s alleged breach of the plan did not state a claim for equitable relief under § 502(a)(3).

a) Equitable relief requirement

The controversy as to the scope of the “other appropriate equitable relief” provision results largely from Justice Brennan’s concurrence in Massachusetts Mutual Life Insurance Co. v. Russell, 473 U.S. 134, 148 (1985) (Brennan, J., concurring) (holding that extracontractual damages for breach of fiduciary duty are not allowed under § 502(a)(2)). In his concurrence, Justice Brennan emphasized that the Russell holding was tailored narrowly to causes of action under § 502(a)(2) and that extracontractual damages are not foreclosed for suits under § 502(a)(3). Id. at 150.

Justice Brennan further argued that the legislative history of ERISA and § 502(a)(3)'s broad wording—"appropriate equitable relief"—counsel against the Russell majority's constrictive view of the judicial role in enforcing ERISA's remedial scheme. Id. at 155-56.

While Justice Brennan's construction of this provision essentially opened the door to judicial discretion in determining which causes of action are allowed as "other appropriate equitable relief," see id. at 155, this approach has been greatly constrained by subsequent Supreme Court decisions. See, e.g., Mertens, 508 U.S. at 255. Even though the Supreme Court has not expressly repudiated Brennan's expansive construction, many of its more recent holdings have chipped away at the judicial discretion inherent in Brennan's reading of the provision.

In Mertens, the Supreme Court held that a suit for monetary damages against a nonfiduciary who knowingly assists in a fiduciary's breach of duty is outside the scope of "appropriate equitable relief" under § 502(a)(3) because such relief is based on compensatory damages, which, rather than being a traditional equitable remedy, is a classic form of legal relief. Mertens, 508 U.S. at 255. The Supreme Court reaffirmed its "unwillingness to infer causes of action in the ERISA context, since that statute's carefully crafted and detailed enforcement scheme provides 'strong evidence that Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly.'" Id. at 254 (quoting Russell, 473 U.S. at 146). Thus, where the relief sought is traditionally of a legal nature, the suit cannot be maintained under the "other appropriate equitable relief" clause of § 502(a)(3).

The Supreme Court further limited judicial discretion by adding an additional caveat that § 502(a)(3) "does not . . . 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." Id. at 253 (alteration in original). In other words, the equitable relief sought must be necessary to enforce ERISA or a benefit plan, or to remedy a violation of ERISA or a benefit plan.

In Knudson, the Supreme Court bolstered its Mertens precedent by holding that a suit based on a contractual obligation to pay money is also traditionally based on legal relief and is thus outside the scope of 502(a)(3). Knudson, 534 U.S. at 214. The Supreme Court reasoned that for the term "equitable" not to be rendered superfluous, "equitable relief" in § 502(a)(3) must refer to "those categories of relief that were *typically* available in equity . . ." Id. at 210 (quoting Mertens, 508 U.S. at 256) (emphasis added). Accordingly, the plaintiff may not circumvent the equitable requirement by seeking an injunction to enforce a contractual obligation to pay money, as that would render the limitation "utterly pointless." Id. at 216. Mertens and Knudson show that where the statutory instructions are open-ended, the Supreme Court will seek to use judicial tradition as a limiting factor for judicial discretion in the enforcement of the provision.

While the general trend in the case law has supported the more restrictive Mertens construction, one way the Supreme Court backtracked on an aspect of its

Mertens holding was its clarification of the “other appropriate equitable relief” provision. In Harris Trust & Savings Bank v. Salomon Smith Barney Inc., the Supreme Court unanimously held that because § 502(a)(5) allows for “other persons” (including nonfiduciaries) to be sued, nonfiduciaries can be sued under the similarly-worded § 502(a)(3). 530 U.S. 238, 248-49 (2000). This holding clarifies the scope of Mertens by removing any limitation on who can be sued under § 502(a)(3). Essentially, the Supreme Court wanted to ensure that future litigants understand that Mertens is intended as a limitation to causes of action under § 502(a)(3), not as a limitation on possible defendants. Because the cause of action in Harris Trust was equitable, namely restitution, the Supreme Court upheld a suit against a nonfiduciary defendant under § 502(a)(3). See id. at 253 (citing Mertens, 508 U.S. at 260). A discussion of claims against non-fiduciaries can be found in part C of this section.

Knudson reinforces the proposition that the dispositive issue is whether the relief sought is equitable in nature. In Knudson, the Supreme Court distinguished Harris Trust by drawing a distinction between legal restitution and equitable restitution. Knudson, 534 U.S. at 213-14. The court held that because the restitution the plaintiff sought was based on a legal obligation, it was unavailable under § 502(a)(3). Id. at 214. Thus, after Knudson, every cause of action—besides injunctive causes of action which are explicitly authorized—is examined to ensure that it is equitable in nature notwithstanding the label litigants attach to it.

Following Knudson, courts struggled to determine when a claim for restitution is equitable (permissible under § 503(a)(3)) or legal (impermissible under § 503(a)(3)). Circuits were split on whether an action for restitution by an ERISA fiduciary is equitable if the participant or beneficiary has recovered from another entity and possesses that recovery in an identifiable fund. Compare Bombardier Aerospace Emp. Welfare Benefits Plan v. Ferrer, Poirot & Wansbrough, 354 F.3d 348, 355-57 (5th Cir. 2003) (concluding that action sought equitable relief because funds paid to participant were held in a bank account in name of participant’s attorneys); Admin. Comm. of the Wal-Mart Stores, Inc. Assocs. Health & Welfare Plan v. Varco, 338 F.3d 680, 686-88 (7th Cir. 2003) (concluding that action sought equitable relief because funds paid to participant were placed in a reserve account bearing participant’s name); see also Primax Recoveries, Inc. v. Sevilla, 324 F.3d 544, 547-48 (7th Cir. 2003) (concluding that action sought equitable relief because plan participant possessed only uncashed check from insurer and money remained with insurer; therefore, participant did not possess identifiable fund); Bauhaus USA, Inc. v. Copeland, 292 F.3d 439, 445 (5th Cir. 2002) (concluding that action sought legal relief because settlement money had been paid into registry of Mississippi Chancery Court; therefore, the beneficiary did not possess identifiable fund) with Westhaff (USA), Inc. v. Arce, 298 F.3d 1164, 1166 (9th Cir. 2002) (participant’s possession of identifiable fund did not alter nature of what court determined was legal action), cert. denied, 537 U.S. 1111 (2003).

The Supreme Court eventually resolved this disagreement in Sereboff v. Mid Atlantic Medical Services., Inc., 547 U.S. 356, 361 (2006). The facts in Sereboff are very similar to Knudson. In Sereboff, a plan fiduciary was seeking an equitable lien against funds that a plan beneficiary recovered in a settlement against third party

tortfeasors. Id. at 359-60. The Court held that obtaining an equitable lien on a specifically identified fund was an “appropriate equitable remedy.” Id. at 369. The key distinguishing feature between the outcome in Sereboff and Knudson was that in Sereboff the fiduciary sought “to recover a particular fund from the defendant.” Id. at 363. Although the fiduciary alleged a breach of contract and sought money, the fiduciary did not seek to “impose personal . . . liability for a contractual obligation to pay money” like in Knudson. Id. (quoting Knudson, 534 U.S. at 210).

The Supreme Court returned to this topic in U.S. Airways v. McCutcheon, where the Court held that equitable defenses cannot override an ERISA plan’s reimbursement provision. 569 U.S. 88, 94 (2013). McCutcheon was a follow-on to Sereboff. Id. at 97-98. McCutcheon suffered injuries from an auto accident and U.S. Airways’ health benefits plan—of which McCutcheon was a member—paid him \$66,866 in medical expenses. Id. at 92. After McCutcheon recovered money from another party in the accident and his insurer, U.S. Airways sought reimbursement of the money it had paid under the terms of the plan. Id. at 92-93. McCutcheon refused to reimburse U.S. Airways, which then brought suit under § 502(a)(3) seeking reimbursement. Id. at 93. McCutcheon raised defenses sounding in unjust enrichment and eventually it fell to the Supreme Court to determine what role such defenses would play in a suit under § 502(a)(3). The Court held that in such an action seeking reimbursement, “the terms of the ERISA plan govern. Neither general principles of unjust enrichment nor specific doctrines reflecting those principles—such as the double-recovery or common-fund rules—can override the applicable contract.” Id. at 106.

In 2016, the Supreme Court considered yet another question left unanswered by Sereboff: what if the plan is seeking reimbursement not from an identifiable fund, but from the plan participant’s general assets? Montanile v. Bd. of Trs. of Nat’l Elevator Indus. Health Benefit Plan, 577 U.S. 136, 141 (2016). The plan in Montanile sought reimbursement of over \$120,000 in medical expenses it paid in connection with an accident from settlement proceeds that the plan participant had entered into. Id. at 655-57. The participant responded that he had spent all of the settlement money by the time the plan sought reimbursement and thus there was no identifiable fund for the plan to seek reimbursement from. Id. at 656. The Supreme Court held that a § 502(a)(3) suit did not reach this situation because seeking to enforce an “equitable lien” against a participant’s general assets was a “legal” remedy as opposed to an equitable one. Id. at 658-59.

The Supreme Court also considered the scope of the equitable remedies under § 502(a)(3) in CIGNA Corp. v. Amara, 563 U.S. 421 (2011). As a remedy for the violation at issue, the district court changed the language of a benefit plan pursuant to § 502(a)(1)(B) to provide benefits that the plaintiffs sought. The court also ordered CIGNA Corp. to implement the new language. The district court did not consider whether § 502(a)(3) authorized that relief. The Supreme Court held that § 502(a)(1)(B) did not authorize the district court to modify the plan. It remanded the case, however, so the district court could determine whether its rewrite of the plan was available under § 502(a)(3) as “other appropriate equitable relief.” Id. at 438. The Supreme Court suggested that that remedy could fall within the remedies of reformation, estoppel, and

the imposition of a surcharge, each of which the Court considered to be a traditional equitable remedy. *Id.* at 440-42. It left it to the district court to make that determination, however. Despite the Court’s discussion of equitable relief, the lower courts might not be inclined to follow the reasoning because, as Justice Scalia says in his concurrence, the discussion is dictum. *Id.* at 448 (Scalia, J., concurring).

b) Catchall requirement

The Supreme Court has also constrained the application of § 502(a)(3) by holding that equitable relief under the provision is only appropriate where other ERISA provisions do not provide redress. *Varity Corp.*, 516 U.S. at 515. In *Varity*, the Supreme Court interpreted § 502(a)(3) as a “catchall provision” that provides relief for injuries that are not adequately remedied by other sections of § 502. *Id.* at 512. Accordingly, potential plaintiffs must not only ask whether the relief they are seeking is traditionally equitable in nature, but whether the relief they are seeking is available under other provisions in the statute. One court has interpreted this to mean that a plaintiff is only precluded from seeking equitable relief under § 502(a)(3) when a court determines that plaintiff *will certainly receive or actually receives* adequate relief for her injuries under another ERISA section; in other words, the mere availability of potential alternate relief is not enough. *Parente v. Bell Atl. Penn.*, No. 99-cv-5478, 2000 WL 419981, at *3 (E.D. Pa. Apr. 18, 2000). Other courts have disagreed, holding that claims under ERISA § 502(a)(3) are precluded where there are “appropriate and sufficient grounds for relief elsewhere.” *Boyles v. Am. Heritage Life Ins. Co.*, No. 15-cv-374, 2016 WL 4031295, at *9 (W.D. Pa. July 26, 2016). In addition, the failure of a plaintiff’s contract-based benefits claim may not foreclose a claim for relief based on a breach of fiduciary duty. *See, e.g., Curcio v. John Hancock Mut. Life Ins. Co.*, 33 F.3d 226, 228 (3d Cir. 1994); *see also Jones v. Am. Gen. Life & Accident Ins. Co.*, 370 F.3d 1065, 1074 (11th Cir. 2004) (“[P]articipants in an ERISA-governed plan that rely to their detriment on a fiduciary’s misrepresentations of the plan’s terms may state a claim for ‘appropriate equitable relief’ under § 502(a)(3) if they have no adequate remedy elsewhere in ERISA’s statutory framework.”). *See* further discussion in Chapter XIV, *supra*.

2. Proper defendants

After the Supreme Court declared in *Harris Trust* that “§ 502(a)(3) admits of no limit (aside from the “appropriate equitable relief” caveat . . .) on the universe of possible defendants,” *Harris Trust*, 530 U.S. at 246, lower courts have diligently followed this broad instruction. *See, e.g., Dakotas & W. Minn. Elec. Indus. Health & Welfare Fund by Stainbrook & Christian v. First Agency, Inc.*, 865 F.3d 1098, 1101 (8th Cir. 2017) (“§ 502(a)(3) does not limit the universe of possible defendants.”) (internal quotation marks omitted); *Bombardier*, 354 F.3d at 354 (refusing to impose any limitations on proper defendants to § 502(a)(3) action because Congress chose, in text of § 502(a)(3), to place limits on proper plaintiffs to suit for equitable relief and did not include any similar limitations on proper defendants to such actions); *Lyons v. Philip Morris Inc.*, 225 F.3d 909, 913 (8th Cir. 2000) (finding it well-settled that because other ERISA provisions specifically address who may be sued, omission of such instructions in § 502(a)(3) implies potential defendants under provision should not be limited).

In McDannold v. Star Bank, N.A., 261 F.3d 478, 486 (6th Cir. 2001), the Sixth Circuit elaborated the limiting principles that follow from the Harris Trust dictum. While finding that the fiduciary/nonfiduciary distinction is no longer dispositive after Harris Trust, the court stated that any cause of action against a nonfiduciary is limited to “appropriate equitable relief” (which excludes legal relief) for damages from the nonfiduciary’s “knowing participation” in a fiduciary’s breach, and to the nonfiduciary’s role as a party-in-interest to the prohibited transaction (although this last limitation may be limited to the facts of Harris Trust). Id. Thus, the current state of the law allows nonfiduciaries to be sued under § 502(a)(3) as long as the suit falls within the limitations stated in McDannold. Section XI.C provides a discussion of claims for knowing participation against non-fiduciaries.

3. Standing

A corollary to the broad inclusive construction of possible defendants under Harris Trust is the Supreme Court’s narrow construction of possible plaintiffs. Section 502(a)(3) names plan “participant[s], beneficiar[ies], or fiduciar[ies]” as proper plaintiffs under the section and the case law considers this list to be exclusive. See, e.g., Am. Psych. Ass’n v. Anthem Health Plans, Inc., 821 F.3d 352, 360 (2d Cir. 2016) (“ERISA carefully enumerates the parties entitled to seek relief under [§ 502(a)(3)]; it does not provide anyone other than participants, beneficiaries, or fiduciaries with an express cause of action....”) (quoting Franchise Tax Bd. of the State of Calif. v. Constr. Laborers Vacation Tr., 463 U.S. 1, 27 (1983); Connecticut v. Physicians Health Servs. of Conn., Inc., 287 F.3d 110, 121 (2d Cir. 2002) (holding state cannot sue *in parens patriae* because Congress “carefully drafted” § 502(a)(3) so parties other than those named in statute may not bring suit); McBride v. PLM Int’l, Inc., 179 F.3d 737, 742 (9th Cir. 1999) (finding potential claimants in § 502 suits limited). In Harris Trust, the Supreme Court contrasts § 502(a)’s lack of textual instructions for possible defendants with its detailed lists of possible plaintiffs. 530 U.S. at 247. It follows that because the failure to specify proper defendants manifests an intent not to limit the class of possible defendants, the detailed specification of proper plaintiffs manifests an intent to create an exclusive list.

Accordingly, most courts, even prior to Harris Trust, hold that the list of proper plaintiffs under § 502(a) is limited to the parties explicitly named in the statute. See, e.g., Cripps v. Life Ins. Co. of N. Am., 980 F.2d 1261, 1265 (9th Cir. 1992); Jamail, Inc. v. Carpenters Dist. Council of Houston Pension & Welfare Trusts, 954 F.2d 299, 302 (5th Cir. 1992). Further, the case law indicates that only the classes specifically identified within the particular section of ERISA can bring a cause of action under that section. See, e.g., Allstate Ins. Co. v. 65 Sec. Plan, 879 F.2d 90, 94 (3d Cir. 1989) (holding that only participants and beneficiaries can sue under § 502(a)(1)(b) because Congress made no provision allowing other parties to sue under that section). While no court had previously held that only participants, beneficiaries, and fiduciaries can sue under § 502(a)(3), the narrow reading on which Allstate relies was based on a general interpretation of § 502 suits. See Ne. Dep’t ILGWU Health & Welfare Fund v. Teamsters Local Union No. 229 Welfare Fund, 764 F.2d 147, 153 (3d Cir. 1985). In sum, only plan participants, beneficiaries, and fiduciaries will be able to sue under § 502(a)(3). See, e.g., Longaverger Co. v. Kolt, 586 F. 3d 459, 468 (6th Cir. 2009) (holding that the

Supreme Court's holding in Harris limits the universe of potential plaintiffs); Local 153 Health Fund v. Express Scripts, Inc., No. 4:05-MD-01672, 2007 WL 4333380, at *4–5 (E.D. Mo. Dec. 7, 2007) (holding that a non-enumerated party does not have standing to sue under § 1132(a)); Jon Suk Park v. Trs. of the 1199 SEIU Health Care Emps. Pension Fund, 418 F. Supp. 2d 343, 351–52 (S.D.N.Y. 2005) (same).

Only the Ninth Circuit has ruled that the list is not necessarily exclusive. See Fentron Indus., Inc. v. Nat'l Shopmen Pension Fund, 674 F.2d 1300, 1305 (9th Cir. 1982). The Ninth Circuit has effectively overruled Fentron, however, acknowledging that the Supreme Court and all other circuits had rejected its holding. Cripps, 980 F.2d at 1265; see also Pilkington PLC v. Perelman, 72 F.3d 1396, 1401 (9th Cir. 1995) (acknowledging subsequent Supreme Court authority has largely undermined Fentron). Currently, all circuits agree that the list provided in the statute is exclusive. See Physicians Health Servs., 287 F.3d at 121 (finding that, absent claim assignment, courts have consistently read [§ 502(a)(3)] to strictly limit “the universe of plaintiffs who may bring certain civil actions”). The way each plaintiff class is defined, however, may open the door to a larger class of possible plaintiffs.

a) Definition of participant

29 U.S.C. § 1002(7) defines “participant” as “any employee or former employee . . . or any member or former member of an employee organization, who is or may become eligible to receive . . . [any benefit] from a[] plan . . . or whose beneficiaries may be eligible to receive any such benefit.” 29 U.S.C. § 1002(7). In addressing the proper definition of “employee” under ERISA, the Supreme Court has held that because 29 U.S.C. § 1002(6) does not define “employee” adequately, it will interpret the term according to traditional common law agency law criteria. Nationwide Mut. Ins. Co. v. Darden, 503 U.S. 318, 323 (1992). These criteria are based on many factors, and “all of the incidents of the relationship must be assessed and weighed with no one factor being decisive.” Id. at 324 (quoting NLRB v. United Ins. Co. of Am., 390 U.S. 254, 258 (1968)). The Supreme Court has also prevented an overly broad interpretation of benefit eligibility. To foreclose a barrage of plaintiffs suing under the remote possibility that they may be eligible for benefits, the Supreme Court in Firestone Tire & Rubber Co. v. Bruch required that for plaintiffs to “establish that [they] ‘may become eligible’ for benefits, [they] . . . must have a colorable claim that (1) [they] will prevail in a suit for benefits, or that (2) eligibility requirements will be fulfilled in the future.” 489 U.S. 101, 117-18 (1989). Thus, after realizing the uncertainty inherent in “who may become eligible for benefits,” the Supreme Court imposed a requirement designed to limit the possible class of plaintiffs suing as plan participants.

Where benefits are paid in the course of litigation, courts remain split as to whether a participant loses standing. Compare Crotty v. Cook, 121 F.3d 541, 545 (9th Cir. 1997) (holding that standing is not lost) with Crawford v. Lamantia, 34 F.3d 28, 32 (1st Cir. 1994) (holding that standing is lost).

b) Definition of beneficiary

29 U.S.C. § 1002(8) defines the term “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.” 29 U.S.C. § 1002(8). A “broad consensus” of courts have interpreted this definition to allow benefits to be assigned, thereby broadening the scope of plaintiffs who can sue as “beneficiaries” of a plan. Brown v. BlueCross BlueShield of Tenn., 827 F.3d 543, 547 (6th Cir. 2016); Physicians Multispecialty Grp. v. Health Care Plan of Horton Homes, Inc., 371 F.3d 1291, 1294 (11th Cir. 2004) (stating that “neither § 1132(a) nor any other ERISA section prevents derivative standing based upon an assignment of rights from [ERISA participants or beneficiaries]”); Tango Transp. v. Healthcare Fin. Servs. LLC, 322 F.3d 888, 893–94 (5th Cir. 2003) (holding that assignment of rights from participant to health care provider could then be validly assigned to another health care provider); St. Francis Reg’l Med. Ctr. v. Blue Cross & Blue Shield of Kansas, Inc., 49 F.3d 1460, 1464 (10th Cir. 1995) (finding that “Congress did not intend to enact a policy precluding [welfare plan benefits] assignability”); Davidowitz v. Delta Dental Plan of Cal., Inc., 946 F.2d 1476, 1478 (9th Cir. 1991) (holding that ERISA does not preclude welfare plan benefit assignments). Importantly, however, the grant of standing to assignees is not unqualified. See, e.g., City of Hope Nat’l Med. Ctr. v. Healthplus, Inc., 156 F.3d 223, 229 (1st Cir. 1998) (holding that, while ERISA does not prohibit assignment of benefits, assignment is invalid if it violates plan terms); Allstate Ins. Co., 879 F.2d at 94 (holding that subrogated insurer lacks standing under § 502(a)). Thus, third party assignees have standing where there is a bargained-for assignment of benefits, see City of Hope, 156 F.3d at 229, but third party assignees do not have standing where the bargained-for contract prohibits the assignment of benefits (as when assignment would violate the terms of the plan) or where there is no bargained-for assignment (as in the case of subrogated insurers).

c) Definition of fiduciary

29 U.S.C. § 1002(21)(A) defines a fiduciary as anyone who “[1] exercises any discretionary authority or discretionary control respecting management of [the] plan or . . . its assets, [2] 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 responsibility to do so, or [3] has any discretionary authority or discretionary responsibility in the administration of such plan.” 29 U.S.C. § 1002(21)(A). Courts have generally held that the term should be construed broadly. See, e.g., Humana Health Plan v. Nguyen, 785 F.3d 1023, 1026 (5th Cir. 2015); Bricklayers & Allied Craftworkers Local 2, Albany, N.Y. Pension Fund v. Moulton Masonry & Constr., LLC, 779 F.3d 182, 189 (2d Cir. 2015). In applying this definition, courts have adopted a textualist approach, evaluating whether the party seeking fiduciary status fits within any of the § 1002(21)(A) subsections. See Reich v. Lancaster, 55 F.3d 1034, 1046 (5th Cir. 1995). Interestingly, any plaintiff who seeks to sue as a fiduciary exposes himself to liability since the other party may file a counterclaim for breach of fiduciary duty. Consequently, where a plaintiff has the option to sue under another plaintiff class (i.e., as a participant

or a beneficiary), the plaintiff should carefully consider choosing the class over suing as a fiduciary.

4. Proper jurisdiction and venue

Federal district courts have exclusive jurisdiction over ERISA § 502(a)(3) claims. See 29 U.S.C. § 1132(e)(1) (stating that federal district courts have exclusive jurisdiction over all ERISA claims except for claims under § 502(a)(1)(B)); 29 U.S.C. § 1132(f) (stating district courts have exclusive jurisdiction without regard to amount in controversy or parties' citizenship). Where state law claims are combined with ERISA claims, federal courts will often assert supplemental jurisdiction over the state claims. See, e.g., Montefiore Med. Ctr. v. Teamsters Local 272, 642 F.3d 321, 332-333 (2d Cir. 2011). Supplemental jurisdiction is proper when a district court has original jurisdiction over one claim and all other claims are so related to the original claim that they form part of the same case or controversy. 28 U.S.C. § 1367(a). A district court's decision to assert supplemental jurisdiction is reviewed under an abuse of discretion standard. Dahl v. Charles F. Dahl, M.D., P.C. Defined Benefit Pension Tr., 744 F.3d 623, 629 (10th Cir. 2014). Further, the case may be removed to federal court where a "well-pleaded complaint" in state court results in a federal question under ERISA. See Aetna Health Inc. v. Davila, 542 U.S. 200, 207 (2004). If removal is proper, the entire case may be removed to federal court, including any state law claims. See Giles v. NYLCare Health Plans, Inc., 172 F.3d 332, 337 (5th Cir. 1999). Removal is not proper where the plaintiff lacks standing under ERISA. Hansen v. Harper Excavating, Inc., 641 F.3d 1216, 1225-26 (10th Cir. 2011) (finding no federal cause of action where employee did not meet requirements to sue under ERISA and remanding with instructions for district court to remand case to state court). However, if dismissal of ERISA claims is on the merits (rather than a lack of subject matter jurisdiction), the supplemental state law claims may still be adjudicated by the district court. Soehrlen v. Fleet Owners Ins. Fund, 844 F.3d 576, 588-89 (6th Cir. 2016).

Claims under § 502(a)(3) are subject to ERISA's general venue provision, which allows suits to be brought in any one of the following three forums: "[1] where the plan is administered, [2] where the breach took place, or [3] where a defendant resides or may be found." 29 U.S.C. § 1132(e)(2). Courts have construed this provision liberally, finding that "Congress intended to open the federal forum to ERISA claims to the fullest extent possible." Retirement Plan of Unite Here Nat'l Retirement Fund, No. 08-cv-4249, 2009 WL 255860, at *3 (S.D.N.Y. Feb. 3, 2009). Because the provision allows suit in any one of the three designated forums, the plaintiff enjoys the ability to "forum shop." See Wallace v. Am. Petrofina, Inc., 659 F. Supp. 829, 830 (E.D. Tex. 1987) (denying defendant's motion to dismiss because of improper venue where forum was one of those ERISA designates).

5. Applicable statute of limitations

Plaintiffs suing for a breach of a fiduciary duty under ERISA § 502(a)(3) must be aware of two important issues: when the limitations period begins to run, and how long it will run before it expires. The statute of limitations period differs between

§ 502(a)(3) claims and other ERISA claims. For § 502(a) claims not alleging a breach of fiduciary duty, such as claims under § 502(a)(1)(B) for wrongful denial of benefits, courts apply the statute of limitations for the most analogous state law action because § 502(a) does not provide a limitations period. See Redmon v. Sud-Chemie Inc. Retirement Plan for Union Employees, 547 F.3d 531, 534-35 (6th Cir. 2008); Syed v. Hercules, Inc., 214 F.3d 155, 159 (3d Cir. 2000); Johnson v. State Mut. Life Assurance Co. of Am., 942 F.2d 1260, 1261-62 (8th Cir. 1991). For claims alleging a breach of fiduciary duty, like § 502(a)(3) however, ERISA does provide a limitations period. 29 U.S.C. § 1113; Tibble v. Edison Int'l, 575 U.S. 523, 135 S. Ct. 1823, 1826 (2015). Under § 1113, plaintiffs must bring these claims within the earlier of six years after the last action that constituted the breach or three years after the earliest date the plaintiff had actual knowledge of the breach. 29 U.S.C. § 1113. Section 1113 determines when the period begins to run and provides its length.

6. Possible exhaustion requirement

ERISA requires every benefit plan to include provisions establishing procedures for reviewing employees' claims under the plan. 29 U.S.C. § 1133. See Section XII.A-B and Appendix A of this handbook for a detailed discussion of claims exhaustion. While ERISA does not expressly require plan claimants to exhaust these procedures, courts have "universally" inferred from the above provision and ERISA's legislative history that Congress intended for courts to apply an exhaustion requirement. Stephens v. Pension Ben. Guar. Corp., 755 F.3d 959, 964-65 (D.C. Cir. 2014). There exists a circuit split on whether exhaustion is required when plaintiffs "seek to enforce statutory ERISA rights rather than contractual rights created by the terms of a benefit plan." Id. at 965 (emphasis omitted). Six circuits hold that exhaustion is not required under these circumstances. Id. at 965-66 (joining the Third, Fourth, Fifth, Ninth, and Tenth Circuits in this ERISA exhaustion interpretation) (citing Zipf v. AT&T, 799 F.2d 889, 891-94 (3d Cir.1986); Smith v. Sydnor, 184 F.3d 356, 364-65 (4th Cir.1999); Galvan v. SBC Pension Benefit Plan, 204 Fed. Appx. 335, 338-39 (5th Cir. 2006); Amaro v. Cont'l Can Co., 724 F.2d 747, 751-52 (9th Cir.1984); Held v. Mfrs. Hanover Leasing Corp., 912 F.2d 1197, 1204-05 (10th Cir.1990)). Meanwhile, the Seventh and Eleventh Circuit hold that ERISA plaintiffs must exhaust internal remedies even when seeking to enforce statutory rights. Id. (citing Lindemann v. Mobil Oil Corp., 79 F.3d 647, 649-50 (7th Cir.1996); Mason v. Cont'l Grp., 763 F.2d 1219, 1226-27 (11th Cir.1985)). This split is especially relevant in the § 502(a)(3) context which provides a cause of action for the enforcement of ERISA's statutory terms. The Supreme Court has not yet acted to reconcile this rift in the case law and, therefore, a circuit-by-circuit approach is the most appropriate way to determining how this issue is resolved. Where the plan's claims review procedures include an arbitration provision, courts apply the same contractual/statutory distinction. See Zipf v. AT&T, Inc., 799 F.2d 889, 892 (3d Cir. 1986) (holding that plan's arbitration provision will be enforced only for claims based on terms of plan; if claim is statutory plaintiff may go directly to court). Accordingly, arbitration procedures are treated similarly to the plan's internal claims review procedures.

Exhaustion will not be required if the plan does not contain a claims procedure that applies to the particular plaintiff, however. See Anderson v. Alpha Portland Indus., Inc., 752 F.2d 1293, 1299 (8th Cir. 1985) (reversing dismissal for lack of exhaustion where claims procedure identifies only “employees” and plaintiff was “retiree”). Thus, courts require plaintiffs who are suing to enforce plan provisions under § 502(a)(3) to exhaust the plan’s claim review procedures.

If the court applies an exhaustion requirement, the plaintiff must plead and prove that he either has met the exhaustion requirement or that he qualifies for an exhaustion exemption, otherwise the complaint will be dismissed. See Angevine v. Anheuser-Busch Cos. Pension Plan, 646 F.3d 1034, 1037 (8th Cir. 2011); Leak v. Cigna Healthcare, 423 F. App’x 53, 53 (2d Cir. 2011); Edwards v. Briggs & Stratton Ret. Plan, 639 F.3d 355, 365 (7th Cir. 2011). The plaintiff bears the burden of making a “clear and positive showing” that his claim is exempt from exhaustion. Makar v. Health Care Corp. of the Mid-Atl. (Carefirst), 872 F.2d 80, 83 (4th Cir. 1989); see also Fizer v. Safeway Stores, Inc., 586 F.2d 182, 183 (10th Cir. 1978) (considering exhaustion under § 301 of LMRA). The plaintiff is exempted from the exhaustion requirement in a variety of ways.

See:

Angevine v. Anheuser-Busch Cos. Pension Plan, 646 F.3d 1034, 1037 (8th Cir. 2011). A plaintiff’s allegations must show that it would have been futile for him to pursue an administrative remedy. Where the plaintiff fails to do this, the court can dismiss for failure to exhaust administrative remedies.

Leak v. Cigna Healthcare, 423 F. App’x 53, 53 (2d Cir. 2011). Plaintiff must exhaust administrative procedures provided by the plan unless such attempts would be futile. A plaintiff cannot argue futility where she admits in court that she did not attempt to use the administrative procedures.

Edwards v. Briggs & Stratton Ret. Plan, 639 F.3d 355, 365 (7th Cir. 2011). Where plaintiff failed to timely appeal her administrative review, the court held that she did not exhaust her administrative remedies and therefore, could not sustain a claim against the plan in federal court.

Byrd v. MacPapers, Inc., 961 F.2d 157, 160 (11th Cir. 1992). Plaintiff need not exhaust internal procedures where exhaustion would be futile.

Horan v. Kaiser Steel Ret. Plan, 947 F.2d 1412, 1416 (9th Cir. 1991). Courts have discretionary authority to waive the exhaustion requirement due to the exceptions to the exhaustion requirement.

Springer v. Wal-Mart Assocs. Grp. Health Plan, 908 F.2d 897, 899 (11th Cir. 1990). No exhaustion required where the remedy sought is not available through the claims procedure.

Curry v. Contract Fabricators Inc. Profit Sharing Plan, 891 F.2d 842, 846 (11th Cir. 1990) abrogated on other grounds in Murphy v. Reliance

Standard Life Ins. Co., 247 F.3d 1313, 1314 (11th Cir. 2001). Plaintiffs are exempted from exhaustion requirements if they have not been informed of the procedures or have been denied access to the procedures.

Hall v. Tyco Int'l Ltd., 223 F.R.D. 219, 237 (M.D.N.C. 2004). Plaintiffs may be exempted from exhaustion requirements where defendants have failed to comply with the provisions of 29 C.F.R. § 2560.503-1(g)(1) requiring notification of any adverse benefits determination.

Tomczyszyn v. Teamsters Local 115 Health & Welfare Fund, 590 F. Supp. 211, 213 (E.D. Pa. 1984). Exhaustion is not required if delay would result in irreparable harm to the plaintiff, especially because irreparable harm is also a requirement for injunctive relief.

Where the plaintiff must exhaust the plan's procedures but has failed to do so, courts may dismiss the case without prejudice and remand the claim to the plan's review procedure. See *Byrd v. MacPapers, Inc.*, 961 F.2d 157, 161 (11th Cir. 1992); *Makar*, 872 F.2d at 83. Additionally, where the plaintiff makes both contractual and statutory claims based on the same facts, the court may stay the statutory claim pending resolution of the contractual claim. *Amaro*, 724 F.2d at 752.

7. Availability of a jury trial

Suits under ERISA § 502(a)(3) are consistent with the well-settled doctrine that limits the right to a jury trial to legal, and not equitable, causes of action. Because a jury trial may be available only for legal causes of action, a jury trial is inappropriate in equitable causes of action under § 502(a)(3). See *Graham v. Hartford Life & Accident Ins. Co.*, 589 F.3d 1345, 1355 (10th Cir. 2009); *Sullivan v. LTV Aerospace and Def. Co.*, 82 F.3d 1251, 1258 (2d Cir. 1996) (noting distinction between §§ 502(a)(1) and 502(a)(3) and finding no jury trial right under the latter because it provides only for equitable relief); *Cox v. Keystone Carbon Co.*, 861 F.2d 390, 393 (3d Cir. 1988) (noting § 502(a)(3), which provides for explicitly equitable relief, does not supply one with right to jury trial); *Bona v. Barasch*, No. 01-cv-2289(MBM), 2003 WL 1395932, at *33 (S.D.N.Y. Mar. 20, 2003) (holding no right to a jury trial on § 503(a)(3) claims); *Gieger v. UNUM Life Ins. Co. of Am.*, 213 F. Supp. 2d 813, 818 (N.D. Ohio 2002) (same); *Pickering v. USX Corp.*, 809 F. Supp. 1501, 1509 (D. Utah 1992) (same). When faced with a constitutional challenge to this position, courts have found that the Seventh Amendment is limited to suits at common law, and therefore does not come into play in suits under § 502(a)(3) which are based in equity. *Nat'l Sec. Sys., Inc. v. Iola*, 700 F.3d 65, 79 n.10 (3d Cir. 2012). Thus, it is well-settled that there is no right to a jury trial for suits under § 502(a)(3).

8. Effect of failure to comply with procedural rules under ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3)

When discussing procedural issues related to ERISA § 502(a)(3) claims, it is important to distinguish between procedural considerations which prove fatal if the

plaintiff fails to satisfy them, and procedural considerations which are curable. For example, the plaintiff may amend the pleading to claim an equitable remedy or to name a defendant properly. Further, a suit dismissed so that the plan's claims review procedures may be exhausted can be reheard once the exhaustion requirement is met, and a suit not brought in the proper federal jurisdiction may be removed to the federal district court. In contrast, the absence of a right to a jury trial is absolute, and once the statute of limitations has expired, the ability to bring suit expires with it.

The standing requirement occupies a more tenuous position within this framework. A plaintiff who clearly does not fit within the three designated classes of a plan will not be able to sue under that plan; however, a plaintiff who may not be able to sue under one class may be able to sue under another. In other words, because the standing provision allows for three classes of plaintiffs, the suit will fail if the plaintiff cannot qualify under any of the three classes, but the plaintiff's failure to qualify under one class does not necessarily preclude the plaintiff from suing as a member of another class. In sum, § 502(a)(3) is replete with procedural obstacles, but only some of which bring an immediate end to the case.

C. ERISA § 502(a)(3) CLAIMS FOR KNOWING PARTICIPATION AGAINST NON-FIDUCIARIES

As discussed above, § 502(a)(3) claims may be brought against any defendant, including against non-fiduciaries. Because it is axiomatic that claims for breach of fiduciary duty may be brought only against "fiduciaries," § 502(a)(3) claims against non-fiduciaries are often claims for "knowingly participating" in an alleged breach of duty by a fiduciary. Although they are not claims for breach of fiduciary duty like those discussed in parts A and B of this section, the knowing participation claims against non-fiduciaries are discussed here because they often raise similar issues and are frequently added to complaints asserting claims against fiduciaries.

The Supreme Court has held that ERISA allows claims against non-fiduciaries who knowingly participate in prohibited transactions under § 503(a)(3). Harris Trust & Sav. Bank v. Salomon Smith Barney, Inc., 530 U.S. 238, 251 (2000). Thus a non-fiduciary can be liable where a plaintiff can prove that the non-fiduciary knew that the transaction was prohibited and that the non-fiduciary participated in the transaction. Although it was not directly considered in Harris Trust, which considered ERISA § 406, some courts have extended the Supreme Court's reasoning in that case to allow plaintiffs to sue non-fiduciaries for knowing participation in breaches of fiduciary duties established by ERISA § 404(a). See Daniels v. Bursey, 313 F. Supp. 2d 790, 806-07 (N.D. Ill. 2004).

Courts have held that "knowing participation" includes means "actual or constructive knowledge of the circumstances that rendered the transaction unlawful." Harris Trust, 530 U.S. at 251. In other words, the non-fiduciary must know of the fiduciary's failure to fulfill his or her obligations. Teets v. Great-West Life & Annuity Ins. Co., 921 F.3d 1200, 1223 (10th Cir. 2019). Where plaintiffs allege only that the non-fiduciary benefitted from the transaction but do not allege any *knowing* participation in

the breach, there is no claim for knowing participation. Pfahler v. Nat'l Latex Prods. Co., 517 F.3d 816, 834-35 (6th Cir. 2007); McDannold v. StarBank, N.A., 261 F.3d 478, 486 (6th Cir. 2001). In addition, the defendant must have actual knowledge of the breach. The ability to discover the breach, rather than actual knowledge, is not enough. Chauvet v. Local 1199 Drug, Hosp. & Health Care Employees Union, Nos. 96-cv-2934, 96-cv-4622, 1996 WL 665610, at *14, *16 (S.D.N.Y. Nov. 18, 1996). In Harris Trust, the Supreme Court explained that equity limits the class of non-fiduciaries who can be held liable to those who “knew or should have known . . . the circumstances that rendered the transfer [of plan assets to the non-fiduciary] in breach of the trust.” Harris Trust, 530 U.S. at 251.

In addition to the knowledge requirement, claims against non-fiduciaries require plaintiffs to establish that the non-fiduciary somehow participated in the ERISA violations. Non-fiduciaries must deal with an ERISA plan or its assets to have “participated” in a prohibited transaction. See Harris Trust, 530 U.S. at 241–43; Reich v. Compton, 57 F.3d 270, 272–73, 285–86 (3d Cir. 1995); Solis v. Couturier, No. 2:08-cv-02732, 2009 WL 1748724, at *1, *4 (E.D. Cal. June 19, 2009); Daniels, 313 F. Supp. 2d at 809. “Participation” means “affirmative assistance – or a failure to act when required to do so – that enables a breach [of fiduciary duty] to proceed.” DeLaurentis v. Job Shop Technical Servs., Inc., 912 F. Supp. 57, 64 (E.D.N.Y. 1996) (dismissing knowing participation claim).

In addition, because claims against non-fiduciaries are authorized under § 502(a)(3), plaintiffs are limited to claims for “other appropriate equitable relief.” 29 U.S.C. § 1132(a)(3); see Harris Trust, 530 U.S. at 251; McDannold, 261 F.3d at 486; Spinedex Physical Therapy USA Inc. v. United Healthcare of Ariz., Inc., 661 F. Supp. 2d 1076, 1097 (D. Ariz. 2009). Therefore, non-fiduciaries are likely not liable for monetary damages. Section 502(a)(3) is also allowed “only to the extent that such relief is not otherwise available under [ERISA].” See Peabody v. Davis, 636 F.3d 368, 373 (7th Cir. 2011). Therefore, some courts will dismiss § 502(a)(3) claims where a plaintiff seeks the same relief under §502(a)(1)(B), or the plaintiff’s claims under the two ERISA subsections rely on the same factual allegations. See, e.g., Zuckerman v. United of Omaha Life Ins. Co., No. 09-cv-4819, 2010 WL 2927694, at *7 (N.D. Ill. July 21, 2010) (dismissing § 502(a)(3) claim where plaintiff did not allege injury “separate and distinct from the denial of benefits”); Erikson v. Ungaretti & Harris-Exclusive Provider Plan, No. 03-cv-5466, 2003 WL 22836462, at *3 (N.D. Ill. Nov. 24, 2003) (dismissing § 502(a)(3) claim that “rest[ed] on the exact same basis as [the plaintiff’s] claims for denial of benefits,” and where both claims would result in “the full amount of money due to [the plaintiff] under her plan”).

The applicable statute of limitations for a § 502(a)(3) claim against a non-fiduciary may be different from the limitations period for a § 502(a)(3) claim against a fiduciary. ERISA’s statute of limitations at 29 U.S.C. § 1113 applies only to breach of fiduciary claims. All other § 502 claims, including § 502(a)(3) claims against non-fiduciaries, borrow the applicable limitations period from the forum state’s “most analogous cause of action.” See Hakim v. Accenture United States Pension Plan, 656 F. Supp. 2d 801, 817 (N.D. Ill. 2009). For example, federal courts in Illinois considering

ERISA claims have applied either that state's five-year "catch all" limitations period or its ten-year limitations period for claims relating to written contracts. E.g., Dail v. Sheet Metal Workers' Local 73 Pension Fund, 100 F.3d 62, 65 (7th Cir. 1996) (applying 10-year period to ERISA § 502(a)(1)(B) claim); Hakim, F. Supp. 2d at 818 (applying 10-year period to claim brought under ERISA § 204(h)); Pohl v. McCaffrey, No. 04 C 6223, 2006 WL 208710, at *4 (N.D. Ill. Jan. 25, 2006) (applying 5-year period for claim for overpayment). Accordingly, the proper statute of limitations period will vary depending upon the forum state as well as the precise nature of the claim against the non-fiduciary.

XII. CLAIMS RELATED TO A DENIAL OF PLAN BENEFITS

Under ERISA § 502, 29 U.S.C. § 1132, employee benefit plan participants and beneficiaries can challenge benefits claim denials by plan administrators. ERISA § 502(a)(1)(B) provides participants and beneficiaries a contractual cause of action to recover benefits, enforce rights, or clarify rights to future benefits. 29 U.S.C. § 1132(a)(1)(B). These claims typically arise when the plan administrator or other plan fiduciary denies or partially pays a welfare or pension benefits claim. Typical welfare benefits litigation includes claims for medical and health benefits, disability benefits, life insurance and death benefits. 29 U.S.C. § 1002(1). Most pension benefits disputes involve claims seeking retirement income or deferred income. 29 U.S.C. § 1002(2).

ERISA establishes minimum procedural requirements that plans must follow in processing benefit claims. ERISA requires that every plan provide adequate written notice with “specific reasons” to any participant or beneficiary that his or her claim for benefits under the plan has been denied, and afford the claimant a reasonable opportunity for a full and fair review of the denial. 29 U.S.C. § 1133. Department of Labor (“DOL”) regulations require that plan administrators set up reasonable procedures for processing benefits claims, including consideration of such claims, notification of the denial or partial denial of a benefits claim, and internal procedures for appeal and review in the plan. 29 C.F.R. § 2560.503-1 (2002). A claims procedure is reasonable only if it:

1. Complies with specific requirements relating to claim filing, initial determination and notification, and review of denied claims;
2. Is described in the plan’s summary plan description;
3. Does not contain any provision, and is not administered in a way, that unduly inhibits or hampers the initiation or processing of claims; and
4. Provides for informing participants in writing, in a timely fashion, of the various time limits with respect to claims processing.

29 C.F.R. § 2560.503-1(b)(1).

Except for so-called Taft-Hartley plans that are maintained by more than one employer, plans that are established and maintained under collective bargaining agreements comply with the regulations if the agreement provides a procedure for the filing and initial disposition of benefits claims and a grievance or arbitration procedure for denied or partially denied claims. 29 C.F.R. § 2560.503-1(b)(6).

The claims procedure need not be written into the plan itself nor communicated in written form to participants or beneficiaries, except by means of the summary plan description (“SPD”). It is sufficient to explain the claims procedure orally to a claimant and to give the claimant an opportunity to submit evidence to the benefits committee to support the claim. Abraha v. Colonial Parking, Inc., 243 F. Supp. 3d 179, 191 (D.D.C. 2017) (29 U.S.C. § 1133(2) may not literally require a written claims review procedure but it does require a full and fair review); Sage v. Automation, Inc. Pension

Plan & Tr., 845 F.2d 885, 893 (10th Cir. 1988) (statute 29 U.S.C. § 1133(2) may not literally require a written claims review procedure but it does require a full and fair review meaning knowing what evidence the decision-maker relied upon, the opportunity to address the accuracy and reliability of the evidence, and having the decision-maker consider the evidence presented by both parties prior to reaching and rendering his decision) (quoting Grossmuller v. Int'l Union, United Auto. Aerospace & Agric. Implement Workers of Am., Local 813, 715 F.2d 853, 858 n. 5 (3rd Cir.1983)); Brown v. Ret. Comm. of Briggs & Stratton Ret. Plan, 797 F.2d 521, 533-34 (7th Cir. 1986) (where plan lacked written rules and claim procedures, letters between administrator and claimant and her attorney clearly set forth applicable review procedure).

Failure by a plan to set forth or adhere to claims procedures can serve as a basis for successful challenges of decisions denying benefits. On the other hand, a claimant's failure to exhaust procedural requirements may preclude an action in court.

Often claimants challenging a benefits denial seek to allege additional violations of ERISA, the federal common law, or non-preempted state laws. These claims are considered in other sections of this Handbook but are also discussed briefly here due to their effect on options available to participants and beneficiaries for recovery in cases where benefits were denied.

A. PREREQUISITES TO AN ACTION FOR DENIED BENEFITS

Generally, ERISA actions based on a denial of benefits accrue once a claim for benefits is made and has been formally denied. See, e.g., White v. Sun Life Assurance Co. of Canada, 488 F.3d 240, 246 (4th Cir. 2007) (stating circuit precedent holds ERISA claim accrues when benefits are requested and formally denied) abrogated on other grounds by Heimeshoff v. Hartford Life & Acc. Ins. Co., 571 U.S. 99 (2013); Harris Methodist Fort Worth v. Sales Support Servs. Inc. Emp. Health Care Plan, 426 F.3d 330, 337 (5th Cir. 2005) (stating “[u]nder ERISA, a cause of action accrues after a claim for benefits has been made and formally denied.”); Hackett v. Xerox Corp. Long-Term Disability Income Plan, 315 F.3d 771, 774 (7th Cir. 2003) (holding that ERISA claim accrues when benefits are denied); Grosz-Salomon v. Paul Revere Life Ins. Co., 237 F.3d 1154, 1159 (9th Cir. 2001) (stating circuit precedent holds “ERISA cause of action based on a denial of benefits accrues [when] benefits are denied”); Hall v. Nat'l Gypsum Co., 105 F.3d 225, 230 (5th Cir. 1997) (holding that ERISA claim accrues when benefits are denied).

1. Filing a claim

A “claim” is a request by a participant or beneficiary for a plan benefit. 29 C.F.R. § 2560.503-1(e). The claim is properly filed when all of the requirements of the plan's claims filing procedure have been met. Id. An employee's failure to submit a claim properly may excuse a plan's compliance with statutory and regulatory procedures for the handling of claims. See Tolle v. Carroll Touch, Inc., 23 F.3d 174, 181 (7th Cir. 1994) (Tolle II) (employer not required to comply with procedural requirements for denying claim where claim was never denied due to employee's failure to properly

submit it for consideration). But see Easter v. Cayuga Med. Ctr. at Ithaca Prepaid Health Plan, 217 F. Supp. 3d 608, 629 (N.D.N.Y. 2016) (recognizing that post-Tolle II changes to ERISA require additional notice procedures where claimant fails to properly submit a claim).

A claim may be filed through a written or oral request for benefits made to: (1) the officer or the department who handles employee benefits matters; (2) the committee administering the plan or the organizational unit that handles plan matters if more than one employer contributes or the plan is established by employee organizations; or (3) the insurer or organizational unit which handles the claims for benefits under the plan if an insurer provides or administers the plan.

2. Denial of claim

A denial of plan benefits is lawful only if the plan administrator provides employees with written notice that follows the minimum requirements ERISA and its regulations establish. 29 U.S.C. § 1133; 29 C.F.R. § 2560.503-1. Under the DOL's regulations, the initial claim denial notice must include (1) the specific reason(s) for the denial; (2) specific reference to the plan provisions on which the denial is based; (3) a description of additional material or information the claimant may need to perfect the claim and an explanation of why such material or information is necessary; and (4) information as to the steps the claimant must take to submit the claim for review. 29 C.F.R. § 2560.503-1(f).

3. Internal appeal procedures

ERISA § 503(2) and the Secretary's regulations require that plans provide an internal appeal process to review denials of benefits. 29 U.S.C. § 1133(2); 29 C.F.R. § 2560.503-1(g)-(h). Every plan must provide "claimant[s] . . . a reasonable opportunity to appeal [a denied claim] to an appropriate named fiduciary, and under which there will be a full and fair review of the claim." 29 C.F.R. § 2560.503-1(h)(1). A claimant must have at least 60 days from the receipt of the written notice of the denial of benefits to appeal the denial to the plan administrator or fiduciary. 29 C.F.R. § 2560.503-1(h)(2). Claimants who fail to appeal during the prescribed period risk losing their ability to challenge the benefits denial. See, e.g., Del Greco v. CVS Corp., 337 F. Supp. 2d 475, 486 (S.D.N.Y. 2004) (holding failure to appeal within plan's specified time barred claim under § 502(a)(1)(B) due to failure to exhaust); Allen v. Unionmutual Stock Life Ins. Co., 989 F. Supp. 961, 964 (S.D. Ohio 1997) (holding failure to appeal within 60 day period barred claim under § 502(a)(1)(B) due to failure to exhaust where plaintiff could not show it would be futile). However, substantial failure of a plan to comply with ERISA procedures might prevent the triggering of the 60-day appeal period. White v. Aetna Life Ins. Co., 210 F.3d 412, 416 (D.C. Cir. 2000) (holding deadline not triggered if administrator failed to substantially comply with § 1133).

A plan's review procedure must allow claimants to (1) request a review upon written application to the plan; (2) review pertinent documents; and (3) submit issues and comments in writing. 29 C.F.R. § 2560.503-1(h)(2). Otherwise, the review of

denied claims must be conducted by the “appropriate named fiduciary,” who is defined as “the plan administrator or any other person designated by the plan.” 29 C.F.R. § 2560.503-1(h)(1). Courts hold that § 503(2) does not require the examination be performed by a second or new party. See Sweatman v. Commercial Union Ins. Co., 39 F.3d 594, 598 (5th Cir. 1994) (holding that plan administrator’s reconsideration of its prior decision satisfies § 503(2)); Ret. Comm. of Briggs & Stratton, 797 F.2d 521, 534-35 (7th Cir. 1986) (holding committee’s review of its own decision “satisfied the § 1133 requirement of ‘a full and fair review by the appropriate named fiduciary’”); Wade v. Life Ins. Co. of N. Am., 245 F. Supp. 2d 182, 189-90 (D. Me. 2003) (holding that § 502(3) does not require review by outside arbitrator or independent source, and review by plan administrator was sufficient).

The regulations require that a decision on appeal be made within 60 days of the filing, or within 120 days in special circumstances (e.g., when the hearing is required). 29 C.F.R. § 2560.503-1(i)(1)(i). If, under the plan, benefit denials are reviewed by a committee or board that meets at least quarterly, decisions on review must be issued at the board meeting after the appeal unless the appeal is filed within 30 days of the meeting. 29 C.F.R. § 2560.503-1(i)(1)(ii).

4. Exhaustion of administrative procedures and plan remedies

ERISA § 503, 29 U.S.C. § 1133, provides that plans must establish a claims procedure providing any participant “a reasonable opportunity . . . for a full and fair review by the appropriate named fiduciary of the decision denying the claim.”

a) Exhaustion is required for actions brought under ERISA § 502, 29 U.S.C. § 1132

While ERISA does not expressly mandate exhaustion of administrative remedies, the prevailing view among courts is that before an ERISA plan participant may commence a legal action challenging a benefit denial under § 502(a)(1)(B), he must exhaust the plan’s claims procedures. See, e.g., Angevine v. Anheuser-Busch Companies Pension Plan, 646 F.3d 1034, 1037 (8th Cir. 2011); Moyle v. Golden Eagle Ins. Corp., 239 F. App’x 362, 363–64 (9th Cir. 2007); Wert v. Liberty Life Assur. Co. of Bos., 447 F.3d 1060, 1062 (8th Cir. 2006); Boivin v. U.S. Airways, Inc., 446 F.3d 148, 154 (D.C. Cir. 2006); Smith v. Local No. 25 Iron Workers’ Pension Plan, 99 F. App’x 695, 699 (6th Cir. 2004); McGowin v. ManPower Int’l, Inc., 363 F.3d 556, 559 (5th Cir. 2004); Whitehead v. Okla. Gas & Elec. Co., 187 F.3d 1184, 1190 (10th Cir. 1999); Morais v. Cent. Beverage Corp. Union Emps.’ Supplemental Ret. Plan, 167 F.3d 709, 712 n.4 (1st Cir. 1999) (noting firmly established federal policy favoring exhaustion of administrative remedies in ERISA cases); Doe v. Blue Cross & Blue Shield United, 112 F.3d 869, 873 (7th Cir. 1997) (requiring plaintiff to exhaust internal remedies as matter of federal common law of ERISA). There are multiple justifications for the exhaustion requirement. Courts have noted, for example, that by incorporating claims resolution procedures into ERISA’s statutory scheme, Congress intended to “reduce the number of frivolous lawsuits under ERISA; to promote the consistent treatment of claims for benefits; to provide a nonadversarial method of class settlement, and to minimize the

cost of claims settlement” Amato v. Bernard, 618 F.2d 559, 567 (9th Cir. 1980); see also Thygeson v. U.S. Bancorp, No. 03-cv-467, 2004 WL 2066746, at *7 (D. Or. Sept. 15, 2004) (observing that courts can be assisted by requirement of exhaustion because courts then have available trustees’ interpretation of their own plans). Reducing settlement and litigation costs, in turn, serves the congressional aim of encouraging employers to offer employee benefits plans. The doctrine “is necessary to keep from turning every ERISA action, literally, into a federal case.” Hall v. Nat’l Gypsum Co., 105 F.3d 225, 231 (5th Cir. 1997) (quoting Denton v. First Nat’l Bank, 765 F.2d 1295, 1300 (5th Cir. 1985)).

Some courts hold that to best effectuate Congress’s intent, district courts should have discretion to require administrative exhaustion before allowing a federal suit. Noren v. Jefferson Pilot Financial Ins. Co., 378 F. App’x 696, 697 (9th Cir. 2010); Gallegos v. Mount Sinai Med. Ctr., 210 F.3d 803, 808 (7th Cir. 2000). Other courts have declined to impose a judicially-created exhaustion requirement and require exhaustion only when the particular plan terms require it. See Conley v. Pitney Bowes, Inc., 34 F.3d 714, 716 (8th Cir. 1994); Kennedy v. Empire Blue Cross & Blue Shield, 989 F.2d 588, 594 (2d Cir. 1993). Whether to require exhaustion is a question of law that is considered *de novo*. Diaz v. United Agric. Emp. Welfare Benefit Plan & Trust, 50 F.3d 1478, 1483 (9th Cir. 1995). But if that question is answered affirmatively, the district court’s decision not to grant an exception to the application of those principles is reviewed for abuse of discretion. *Id.*; see also Vaught v. Scottsdale Healthcare Corp. Health Plan, 546 F.3d 620, 626 (9th Cir. 2008) (quoting Bernard, 618 F.2d at 569); Costantino v. TRW, Inc., 13 F.3d 969, 974 (6th Cir. 1994). But see Wert v. Liberty Life Assurance Co. of Boston, Inc., 447 F.3d 1060, 1066 (8th Cir. 2006) (modifying the Costantino rule and holding that exhaustion is required when plaintiff is provided with notice of the administrative procedures and denial letter or plan document employs permissive language to describe relevant procedures).

Exhaustion of administrative remedies is not a prerequisite to a federal court’s jurisdiction, however. Galvan v. SBC Pension Benefit Plan, 204 F. App’x 335, 338 (5th Cir. 2006); Hager v. NationsBank, N.A., 167 F.3d 245, 248 n.3 (5th Cir. 1999).

Claimants should exercise their right to administrative remedies in a timely fashion. Failure to comply with reasonable time constraints prescribed by a plan’s review procedure may preclude judicial review of a benefits claim. See Graham v. Fed. Express Corp., 725 F. Supp. 429, 437-38 (W.D. Ark. 1989) (barring action where plan language unambiguously required claimant to seek administrative review of claim within 60 days of written notice and claimant failed to do so); Helton v. Jim Walter Res. Inc., 724 F. Supp. 866, 868 (N.D. Ala. 1989) (dismissing action due to failure to exhaust); Ridens v. Voluntary Separation Program, 610 F. Supp. 770, 778 (D. Minn. 1985) (finding benefits claim failed because administrative procedures were not exhausted).

b) Consequences of the failure to exhaust

If the claimant fails to exhaust available review procedures before filing a lawsuit, a court may dismiss the case with prejudice or grant a defendant’s motion for

summary judgment. See, Hill v. Blue Cross & Blue Shield, 409 F.3d 710, 721-22 (6th Cir. 2005) (affirming dismissal where district court ruled that claimant failed to exhaust administrative remedies); Counts v. Am. Gen. Life & Accident Ins. Co., 111 F.3d 105, 109 (11th Cir. 1997) (affirming summary judgment where the district court ruled the claimant failed to exhaust administrative remedies and failure was not excused); Baxter v. C.A. Muer Corp., 941 F.2d 451, 453-56 (6th Cir. 1991) (upholding summary judgment where district court ruled that claimant failed to exhaust appeal procedures plan prescribed and such exhaustion was prerequisite to suit).

Alternatively, courts have often remanded actions to the plan administrator for further consideration, dismissing lawsuits without prejudice, or staying them until the administrative proceedings' completion. See, e.g., D'Amico v. CBS Corp., 297 F.3d 287, 290 (3d Cir. 2002) (noting district courts have discretion to stay case to allow exhaustion); Lindemann v. Mobil Oil Corp., 79 F.3d 647, 650-51 (7th Cir. 1996) (Lindemann I) (noting that district court has discretion to stay case pending completion of administrative review or grant summary judgment); Grant-Bullens v. New Jersey Bldg. Laborers Statewide Annuity Fund, No. 09-cv-5363, 2011 WL 540879, at *4 (D.N.J. Feb. 8, 2011) (granting summary judgment for defendant without prejudice and allowing claimant to refile once administrative remedies are exhausted).

Failure to exhaust administrative remedies is generally an affirmative defense subject to waiver. McCoy v. Bd. of Trs. of the Laborers' Int'l Union Local No. 222 Pension Plan, 188 F. Supp. 2d 461, 467 (D.N.J. 2002); see also 5 C. WRIGHT & A. MILLER, FEDERAL PRACTICE & PROCEDURE § 1278 (3d ed.) (citing Massey v. Helman, 196 F.3d 727 (7th Cir. 1999)). A defendant bears the burden of proving exhaustion as an affirmative defense by a preponderance of the evidence. Jones v. State Wide Aluminum, Inc., 246 F. Supp. 2d 1018, 1023 (N.D. Ind. 2003).

c) Exceptions to the exhaustion requirement

Plaintiffs in benefits denial cases brought under a plan's terms who wish to avoid the exhaustion requirement, or who missed the deadline to file a timely appeal with the plan, might rely on several exceptions to the exhaustion requirement that courts have recognized. Courts have recognized four situations in which a claimant may be excused from exhausting the administrative remedies: (1) futility, (2) denial of meaningful access to the review process, (3) the likelihood of irreparable harm, and (4) failure to comply with the ERISA § 503's notice requirements.

i. Futility

The first exception applies if resorting to a plan's administrative procedure provided would be futile or the remedy would be inadequate. See Hitchcock v. Cumberland Univ. 403(b) DC Plan, 851 F.3d 552, 560 (6th Cir. 2017); Hall v. Nat'l Gypsum Co., 105 F.3d 225, 232 (5th Cir. 1997) (holding no need to exhaust when plan's review scheme has been abolished and plan is equitably estopped from defending action based upon alleged failure to exhaust administrative remedies); Wilczynski v. Lumbermens Mut. Cas. Co., 93 F.3d 397, 405 (7th Cir. 1996) (excusing plaintiff from

failure to exhaust administrative remedies where exhaustion of internal remedies would be futile); Diaz v. United Agric. Emp. Welfare Benefit Plan, 50 F.3d 1478, 1485 (9th Cir. 1995) (noting that futility exception “is designed to avoid the need to pursue in administrative review what is demonstrably doomed to fail”). This exception is a narrow one, however. The claimant must make a “clear and positive’ showing of futility” before the exhaustion doctrine will be suspended. See, e.g., Coomer v. Bethesda Hosp., Inc., 370 F.3d 499, 505 (6th Cir. 2004); Makar, 872 F.2d at 83; Davis v. Featherstone, 97 F.3d 734, 737 (4th Cir. 1996) (clear and positive showing of futility is required). The claimant has to show that it is certain that his claim will be denied on appeal and not that it merely is doubtful that the appeal will result in a different decision. Ames v. Am. Nat’l Can Co., 170 F.3d 751, 756 (7th Cir. 1999); Lindemann I, 79 F.3d at 650.

For example, in Coomer, the claimant demonstrated that the plan limited disbursements above \$5,000, and the plan had denied another claimant’s requested disbursement exceeding \$5,000. 370 F.3d at 505. The claimant argued that requiring exhaustion in his case would be futile, because the court could infer that his requested disbursement, also in excess of \$5,000, similarly would be rejected. Id. However, because the plan provided that plan administrators had the right to amend it at any time, the court found that exhaustion would not be futile, as the administrators were never given an opportunity to determine whether the claimant’s request involved special circumstances that might warrant an amendment. Id. As such, the claimant did not demonstrate clear and positive evidence of the futility of exhaustion. Id. at 506.

The Third Circuit has identified several factors that influence its futility analysis, including: “(1) whether plaintiff diligently pursued administrative relief; (2) whether plaintiff acted reasonably in seeking immediate judicial review under the circumstances; (3) existence of a fixed policy denying benefits; (4) failure of the insurance company to comply with its own internal administrative procedures; and (5) testimony of plan administrators that any administrative appeal was futile.” Harrow v. Prudential Ins. Co. of Am., 279 F.3d 244, 250 (3d Cir. 2002). In Harrow, the court rejected plaintiff’s futility argument on the basis that the plaintiff was aware of the plan’s procedures for administrative review and was given the impression by the plan itself that internal procedures would *not* be futile, and made only one phone call to the plan before instituting an ERISA suit. Id. at 252.

See also:

Stark v. PPM Am., Inc., 354 F.3d 666, 672 (7th Cir. 2004). When a claimant fails to exhaust his administrative remedies and proceeds directly to federal court, the fact that the plan defended itself in the lawsuit is not evidence of futility.

*Preston v. Am. Fed’n of Television & Radio Artists Health Fund, No. 90 Civ. 7094, 2002 WL 1009458, at *4 (S.D.N.Y. May 16, 2002), aff’d, 63 F. App’x 536 (2d Cir. 2003). Because the facts and circumstances surrounding each claimant’s eligibility are unique, “the futility of any one*

claim cannot be assumed based upon the Fund's denial of any other claim."

ii. Denial of meaningful access to review process

The second exception applies if a claimant has been denied meaningful access to the plan's administrative review procedures. Wilczynski, 93 F.3d at 402; Curry v. Contract Fabricators, Inc. Profit Sharing Plan, 891 F.2d 842, 846 (11th Cir. 1990) abrogated on other grounds by Murphy v. Reliance Standard Life Ins. Co., 247 F.3d 1313 (11th Cir. 2001). To invoke this exception, a claimant must show that his attempt or ability to obtain administrative review was impeded by the person or entity who would have conducted the review. Curry, 891 F.2d at 846.

In McGowin v. Manpower Int'l, Inc., 363 F.3d 556, 560 (5th Cir. 2004), the plaintiff claimed that she was denied "meaningful access" to her plan's administrative process because her status as a third-party employee left her ineligible to receive a copy of the governing plan documents. As a result, she did not know how, or to whom, her claims should be presented. Id. The court rejected plaintiff's "meaningful access" claim on the basis that there was no indication that she requested the plan documents or was told specifically that she could not obtain them. Id. Moreover, the court observed that "it [strained] credulity to think that [plaintiff] – whether through counsel or not – [possessed] the sophistication to pursue a lawsuit in state and federal courts but [lacked] the basic capacity to ask a plan administrator for information on the filing of a claim." Id.

Estoppel may also preclude a failure to exhaust administrative remedies defense. Gallegos, 210 F.3d at 810 (noting "estoppel may . . . preclude the assertion of failure to exhaust administrative remedies as a defense where that failure results from the claimant's reliance on written misrepresentations by the insurer or plan administrator"). The Eleventh Circuit adopted a similar rule, though it refused to rely on estoppel. See Watts v. BellSouth Telecomms., Inc., 316 F.3d 1203, 1209-10 (11th Cir. 2003). Rather, it held that "[i]f a plan claimant reasonably interprets the relevant statements in the summary plan description as permitting her to file a lawsuit without exhausting her administrative remedies, and as a result she fails to exhaust those remedies, she is not barred by the court-made exhaustion requirement from pursuing her claim in court." Id.

iii. Irreparable harm

The third exception applies if, due to exceptional circumstances, irreparable harm would ensue from requiring a claimant to exhaust internal plan procedures, especially when urgent medical treatment is necessary. Dawson Farms, LLC v. Farm Serv. Agency, 504 F.3d 592, 607 (5th Cir. 2007); Campbell v. Prudential Ins. Co. of Am., No. Civ. A. 01-5229, 2002 WL 1020811, at *3 (E.D. Pa. May 17, 2002); Nierenberg v. Heart Ctr. of Sw. Fla., P.A., 835 F. Supp. 1404, 1407 (M.D. Fla. 1993).

iv. Failure to comply with notice requirement of ERISA § 503, 29 U.S.C. § 1133

Finally, a claimant may be excused from exhausting administrative remedies when the claim administrator fails to comply with ERISA § 503's notice requirements. See, e.g., Hall v. Tyco Int'l Ltd., 223 F.R.D. 219, 237 (M.D.N.C. 2004) (observing that plaintiffs may be exempted from exhaustion requirements where defendants have failed to comply with 29 C.F.R. § 2560.503-1(g)(1) requiring notification of any adverse benefits determination); McLean Hosp. Corp. v. Lasher, 819 F. Supp. 110, 123-25 (D. Mass. 1993) (excusing failure to exhaust administrative remedies due to inadequate denial letter). Some courts also have ruled that while deficiencies in the denial letter do not absolve a claimant from the exhaustion requirement, they may toll the time for requesting administrative review. See, e.g., White v. Jacobs Eng'g Grp. Long-Term Disability Benefit Plan, 896 F.2d 344, 351-52 (9th Cir. 1989) (reversing lower court with instructions to remand to plan appeals board for adjudication on merits because inadequate notice did not trigger plan's time bar to appeal); Neal v. Christopher & Banks Comprehensive Maj. Med. Plan, 651 F. Supp. 2d 890, 900-03 (E.D. Wis. 2009) (holding plaintiff's claims were not untimely because defendant did not provide proper notice).

d) The requirement of arbitration

According to federal regulations, "a plan established and maintained pursuant to a collective bargaining agreement" complies with ERISA's requirements for a reasonable claims procedure if it "sets forth or incorporates by specific reference:"

- (A) provisions concerning the filing of benefit claims and the initial disposition of benefit claims, and
- (B) a grievance and arbitration procedure to which denied claims are subject.

29 C.F.R. § 2560.503-1(b)(6)(i)(A)-(B).

Courts generally require benefit claimants to pursue relief through these collectively bargained grievance and arbitration procedures. Smith v. Gen. Motors Corp., 809 F. Supp. 555, 556 (S.D. Ohio 1992). Failure to follow the arbitration process when required may violate the exhaustion requirement. Kilkenny v. Guy C. Long, Inc., 288 F.3d 116, 122 (3d Cir. 2002) ("Under ERISA, internal administrative remedies like the arbitration procedures mandated in labor agreements must be exhausted prior to bringing suit in federal court."); Chappel v. Laboratory Corp. of Am., 232 F.3d 719, 724-25 (9th Cir. 2000) (affirming dismissal of § 502(a)(2) action for failure to follow plan's arbitration procedure); Perrino v. S. Bell Tel. & Tel. Co., 209 F.3d 1309, 1318-19 (11th Cir. 2000) (affirming summary judgment on plaintiff's ERISA claims for plaintiff's failure to pursue arbitration as mandated by collective bargaining agreement with employer).

e) Distinguishing contractual from statutory causes of action

The federal circuits are currently split as to whether claims for violation of ERISA's statutory causes of action, such as claims for breach of fiduciary duty or claims for unlawful interference under ERISA § 510, are excused from an exhaustion requirement or binding arbitration. See *Stephens v. Pension Ben. Guar. Corp.*, 755 F.3d 959, 966 (D.C. Cir. 2014) (noting split); *Perrino*, 209 F.3d at 1316 n.6 (same); *Smith v. Sydnor*, 184 F.3d 356, 364 (4th Cir. 1999) (*Sydnor I*) (collecting cases).

For claims brought under ERISA § 510, several courts require exhaustion or at least that the district court should have discretion to require exhaustion. See, e.g., *Lindemann I*, 79 F.3d at 650; *Mason v. Cont'l Grp., Inc.*, 763 F.2d 1219, 1226-27 (11th Cir. 1985); see also *Burds v. Union Pacific Corp.*, 223 F.3d 814, 817 (8th Cir. 2000) ("where resolution of the §510 issue turns on an interpretation of the ERISA benefits plan at issue, a district court does not abuse its discretion in requiring plaintiffs to exhaust their administrative remedies."). These courts require exhaustion because the requirement builds a factual record that would assist the court if it later had to hear the case and because Congress intended to promote internal claims procedures as cheaper options to litigation. See *Lindemann I*, 79 F.3d at 650. These advantages outweigh the "minor inconvenience" exhaustion imposes on the plaintiff. Id. Other courts, however, hold that exhaustion is not required prior to filing a § 510 claim. See, e.g., *Richards v. Gen. Motors Corp.*, 991 F.2d 1227, 1235 (6th Cir. 1993); *Horan v. Kaiser Steel Ret. Plan*, 947 F.2d 1412, 1416 n.1 (9th Cir. 1991); *Held v. Mfrs. Hanover Leasing Corp.*, 912 F.2d 1197, 1205 (10th Cir. 1990); *Blessing v. J.P. Morgan Chase & Co.*, No. 02-cv-3874, 2003 WL 470338 (S.D.N.Y. Feb. 24, 2003) ("exhaustion is not required for claims under section 510.").

A similar disagreement exists regarding exhaustion in breach of fiduciary duty claims. Compare, e.g., *Lanfear v. Home Depot, Inc.*, 536 F.3d 1217, 1224 (11th Cir. 2008) (holding district court did not abuse discretion in requiring exhaustion), and *Hickey v. Digital Equip. Corp.*, 43 F.3d 941, 945 (4th Cir. 1995) (same) with *Milofsky v. Am. Airlines, Inc.*, 442 F.3d 311, 313 (5th Cir. 2006) (en banc) (holding exhaustion is not required), and *Sydnor I*, 184 F.3d at 365. Some courts that require exhaustion, however, still allow district courts discretion to excuse a failure to exhaust for the reasons stated above. See *Fallick v. Nationwide Mut. Ins. Co.*, 162 F.3d 410, 419 (6th Cir. 1998); see also *Hitchcock*, 851 F.3d at 564 (6th Cir. 2017) (collecting cases); *Williams v. Rohm and Haas Pension Plan*, No. 02-cv-2003 WL 22271111, *2-3 (S.D. Ind. Sept. 26, 2003) (citing *Kross v. Western Elec. Co.*, 701 F.2d 1238, 1244 (7th Cir. 2003)).

B. ERISA § 503, 29 U.S.C. § 1133: ACTIONS TO ENFORCE ERISA'S PROCEDURAL REQUIREMENTS

Unlike contractual claims under ERISA § 502(a)(1)(B), claims asserted under ERISA § 503, 29 U.S.C. § 1133, are procedural. Substantial compliance is sufficient to establish that a plan complied with ERISA § 503 and applicable regulations. See, e.g., *Testa v. Hartford Life Ins. Co.*, 483 Fed.Appx. 595, 597 (2d Cir. 2012);

Brehmer v. Inland Steel Indus. Pension Plan, 114 F.3d 656, 662 (7th Cir. 1997); Brogan v. Holland, 105 F.3d 158, 165 (4th Cir. 1997). Courts determine substantial compliance on a case-by-case basis and assess the information provided by the insurer in the context of the beneficiary's claim. See, e.g., Schnur v. CTC Communications Corp. Group Disability Plan, 413 Fed.Appx. 377, 380 (2d Cir. 2011); Kinkead v. Sw. Bell Corp. Sickness & Accident Disability Benefit Plan, 111 F.3d 67, 69 (8th Cir. 1997); see also White, 210 F.3d at 414. Consequently, before ERISA plan administrators fully enjoy the deference to which they are statutorily entitled, courts mandate that they comply with the requirements embodied in procedural regulations. Booton v. Lockheed Med. Benefit Plan, 110 F.3d 1461, 1465 (9th Cir. 1997). Whether a denial notice is consistent with ERISA regulations is a question of law reviewed *de novo*. Brogan, 105 F.3d at 165.

Numerous courts have addressed the specific procedural issues that arise in the course of procedural compliance review. The most important ones relate to specificity of reasons for denial, sufficiency of denial notices, and opportunities for full and fair review of denied benefits.

1. Specificity of reasons for denial

A plan administrator must give the "specific reason or reasons" for the denial of benefits. 29 U.S.C. § 1133(1); 29 C.F.R. § 2560.503-1(g)(1); Herman v. Cent. States, 423 F.3d 684, 693 (7th Cir. 2005). "Specific reasons" differ from both the reasoning and the interpretive process that generated the reason for the denial. Gallo v. Amoco Corp., 102 F.3d 918, 922 (7th Cir. 1996) (holding because plan administrator is not administrative agency, administrator need not articulate grounds for its interpretation) overruled on other grounds by Diaz v. Prudential Ins. Co. of America, 424 F.3d 635, 638 (7th Cir. 2005).

Plan administrators can defend their interpretations with any arguments that bear upon its rationality. Id. at 923. While the administrative record generally cannot be augmented with new facts bearing upon the benefit application such as earnings or years of service, Voliva v. Seafarers Pension Plan, 858 F.2d 195, 196 (4th Cir. 1988), the administrator is not limited to repeating what it told the applicant. It need merely give the applicant the reason for the denial and need not explain why it is a good reason. The justification is undermined if the justification that the plan administrator offers in court is inconsistent with the reason the applicant received, however. Bernstein v. CapitalCare, Inc., 70 F.3d 783, 790 (4th Cir. 1995).

In 2003, the Supreme Court resolved a circuit split regarding ERISA's procedural requirements in one specific context—a plan administrator's consideration of a treating physician's opinion in denying benefits. Black & Decker Disability Plan v. Nord, 538 U.S. 822, 834 (2003). While under ERISA § 503 an administrator must give specific reasons for a benefits denial, administrators do not have a heightened burden of explanation when they reject a treating physician's opinion and credit reliable evidence that conflicts with such an opinion. Id. at 834. The Supreme Court therefore rejected the application of the treating physician rule, which applies in social security cases, to benefit denials under ERISA.

The plan administrator also must provide the claimant with its reasons for denial at the time of the denial, and may not litigate its case piecemeal by providing, for the first time, additional reasons in support of the denial while the case is on appeal. Reich v. Ladish Co., 306 F.3d 519, 524 n.1 (7th Cir. 2002); see also Glista v. UNUM Life Ins. Co. of Am., 378 F.3d 113, 130 (1st Cir. 2004) (administrator “violated ERISA and its regulations by relying on a reason [for denying benefits] in court that had not been articulated to the claimant during its internal review”); Vega v. Nat’l Life Ins. Servs., Inc., 188 F.3d 287, 302 n.13 (5th Cir. 1999) (allowing administrator to supplement the record causes case to oscillate between courts and administrative process, prolonging litigation of matters that can be resolved quickly) abrogated on other grounds by Metro. Life Ins. Co. v. Glenn, 128 S. Ct. 2343, 2350 (2008).

See:

Morningred v. Delta Family-Care & Survivorship Plan, 526 F. App’x 217, 220 (3d Cir. 2013). Denial letter met ERISA standards where it “clearly explain[ed]” why the claim failed, and included sufficient information for claimant to “clarify her application on appeal.”

Hillstrom v. Kenefick, 484 F.3d 519, 527 (8th Cir. 2007). While original letter to claimant was not specific, plan administrator provided claimant with specific reasons and relevant policy terms in later letters and, therefore, substantially complied with § 503.

Marks v. Newcourt Credit Grp., Inc., 342 F.3d 444, 460-61 (6th Cir. 2003). Letters to claimant substantially complied with § 503, even though they did not set forth specific reasons for denying certain of claimant’s claims, where claimant did not clearly express that those claims were distinct and required independent analysis.

Booton v. Lockheed Med. Benefit Plan, 110 F.3d 1461, 1463 (9th Cir. 1997). “In simple English, what this regulation calls for is a meaningful dialogue between ERISA plan administrators and their beneficiaries. If benefits are denied . . . the reason for the denial must be stated in reasonably clear language . . . [and]if the plan administrators believe that more information is needed to make a reasoned decision, they must ask for it. There is nothing extraordinary about this: it’s how civilized people communicate with each other regarding important matters.”

Donato v. Metro. Life Ins. Co., 19 F.3d 375, 382 (7th Cir. 1994). Insurer’s letter was sufficient because it specifically referenced pertinent plan provision and information on the steps to be taken to submit the claim for review. While letter failed to meet all requirements of regulations, it was sufficiently in substantial compliance with the regulations because the information the insurer supplied provided claimant with a sufficiently clear understanding of the benefits decision and afforded her a later opportunity for a full, fair and effective review.

But see:

Miller v. Am. Airlines, Inc., 632 F.3d 837, 852 (3d Cir. 2011).
Administrator's response was not substantially compliant with ERISA because its letter contained conclusory statements and did not provide factual support.

Rakoczy v. Travelers Ins. Co., 914 F. Supp. 166, 172 (E.D. Mich. 1996). A
merely conclusory statement that benefits should be denied does not constitute a "specific reason" for the denial.

2. Sufficiency of written denial notice

Generally, courts hold that a plan administrator's substantial compliance with ERISA § 503's notice requirements is sufficient. *Davis v. Combes*, 294 F.3d 931, 941 (7th Cir. 2002); *Donato*, 19 F.3d at 382. To determine what constitutes substantial compliance, "the purpose of [§ 503] and its implementing regulations . . . serve as [a] guide: was the beneficiary supplied with a statement of reasons that, under the circumstances of the case, permitted a sufficiently clear understanding of the administrator's position to permit effective review." *Combes*, 294 F.3d at 941. "[T]he rule is that a harmless, technical slip-up on the plan administrator's part is not enough to undermine the legal sufficiency of her actions; a similarly minor inadvertence on the employee's part should lead to a parallel result." *Id.* at 941-42.

"ERISA's notice requirement obligates plan administrators 'to set out in opinion form the rationale supporting [the decision to deny benefits] so [claimants] could adequately prepare . . . for any further administrative review, as well as an appeal to the federal courts.'" *Davidson v. Prudential Ins. Co. of Am.*, 953 F.2d 1093, 1096 (8th Cir. 1992) (quoting *Richardson v. Cent. States, Se. & Sw. Areas Pension Fund*, 645 F.2d 660, 665 (8th Cir. 1981)); see also *Matuszak v. Torrington Co.*, 927 F.2d 320, 323 (7th Cir. 1991) (quoting *Richardson*, 645 F.2d at 665). The notice of the decision on review must include specific reasons for the denial of benefits, be written in a manner calculated to be understood by the claimant, and contain specific references to the pertinent plan provisions on which the decision is based. 29 C.F.R. § 2560.503-1(g)(1). For the review to be full and fair requires "knowing what evidence the decision-maker relied upon, having an opportunity to address the accuracy and reliability of that evidence, and having the decision maker consider the evidence presented by both parties prior to reaching and rendering his decision." *Ret. Comm. of Briggs & Stratton*, 797 F.2d at 534.

The sufficiency of the written denial notice is often the subject of individual inquiry by courts and the decisions are based on judicial assessment of the actions and language employed by the fiduciaries to inform the beneficiaries or participants adequately.

See:

Diaz v. United Agric. Emp. Welfare Benefit Plan & Trust, 50 F.3d 1478, 1484-85 (9th Cir. 1995). A plan is not required to notify the participants in language other than English of the reason for the denial of benefits.

Dutton v. UNUM Provident Corp., 170 F. Supp. 2d 754, 760-61 (W.D. Mich. 2001). Administrator gave claimant sufficient notice even though it did not include full medical records or explain the medical information claimant needed to perfect her claim in its letters.

But see:

Schneider v. Sentry Grp. Long Term Disability Plan, 422 F.3d 621, 628-29 (7th Cir. 2005). Administrator's response was not substantially compliant with § 1133 because it did not set out the specific reasons for the denial, the specific plans provisions on which the decision was based, and the process for perfecting a claim.

Thompson v. J.C. Penney Co., No. 00-cv-3504, 2001 WL 1301751, at *4 (6th Cir. Aug. 7, 2001). Telephone call denying benefits did not substantially comply with § 1133, because the administrator's statement that plaintiff was not a participant in the plan did not give sufficient reasons for the denial, and there was no information about his right to appeal.

Reedstrom v. Nova Chems., Inc., 234 F. Supp. 2d 787, 802 (S.D. Ohio 2002), aff'd, 96 F. App'x 331 (6th Cir. 2004). Notice denying benefits did not substantially comply with § 1133 where plaintiff was told he was not eligible for plan, but was not referred to any section of the plan documents or provided with information about how to appeal that determination.

Olive v. Am. Express Long Term Disability Benefit Plan, 183 F. Supp. 2d 1191, 1197 (C.D. Cal. 2002). Plan administrator's letter denying benefits did not substantially comply with § 1133 because it failed to make clear whether claim was being denied as procedurally deficient as a result of certain required records being missing, or whether it was substantively deficient because participant's medical condition was not disabling, or both; the letter merely presented four conclusory statements as to the reasons for denial, without indicating sufficiency of any reason by itself.

Schaub v. Consol. Freightways, Inc. Extended Sick Pay Plan, 895 F. Supp. 1136, 1143 (S.D. Ind. 1995). Notice denying disability benefits was inadequate when plan had evidence in file raising doubts as to its conclusion and plan failed to address those doubts in its notice.

Rutledge v. Am. Gen. Life & Accident Ins. Co., 871 F. Supp. 272, 277 (N.D. Miss. 1994). Notices and communications were conclusory where they did not specifically alert the beneficiary what medical evidence would assist his claim.

3. Opportunity for full and fair review by fiduciary

The plan administrator must communicate specific reasons for a benefit denial to the claimant to afford him a “full and fair review.” Ellis v. Metro. Life Ins. Co., 126 F.3d 228, 236-37 (4th Cir. 1997) abrogated on other grounds by Metro. Life Ins. Co. v. Glenn, 128 S. Ct. 2343, 2350 (2008). The “full and fair review” procedural requirements serve two complementary purposes. First, they permit plan administrators to resolve disputes in an efficient, streamlined, non-adversarial manner. Second, the procedures protect plan participants from arbitrary or unprincipled decision-making. See Ellis, 126 F.3d at 236. Courts interpret the procedural review and notice requirements of 29 C.F.R. § 2560.503-1 so that once the administrator conducts a full and fair review, a claimant may prepare an appeal for further administrative review or recourse to the federal courts, and the courts may perform the task entrusted to them by ERISA and review claim denials. See Wilczynski, 93 F.3d at 402 n.3 (interpreting 29 C.F.R. § 2560.503-1); see also DuMond v. Centex Corp., 172 F.3d 618, 622 (8th Cir. 1999). ERISA does not require extensive initial claim denial notice, and a denial notice satisfies ERISA if it explains a basis for the adverse initial decision sufficiently to permit claimant to prepare an informed request for further review. Kinkead, 111 F.3d at 69.

Compliance that substantially fulfills these goals suffices. Ellis, 126 F.3d at 237; see also Militello v. Cent. States, Se. & Sw. Areas Pension Fund, 360 F.3d 681, 690 (7th Cir. 2004) (where claimant failed to show that failure of fund to follow its own appeal procedures resulted in arbitrary or unsupported decision, plan administrator offered claimant full and fair review of denial of benefits), cert. denied, 125 S. Ct. 106 (2004). But see Krodel v. Bayer Corp., 345 F. Supp. 2d 110, 115 (D. Mass. 2004) (plan administrator’s request that insurer provide “only pertinent back-up information that *supports* your summary and decision” demonstrated that administrator intended merely to “rubber-stamp” denial of benefits and cannot be said to have offered claimant a full and fair review). A notice of denial that does not provide claimants and courts with a sufficiently precise explanation of the benefit denial’s grounds so as to permit the reasonable possibility of meaningful review is inadequate. Rossi v. Precision Drilling Oilfield Servs. Corp. Employee Benefits Plan, 704 F.3d 362, 366 (5th Cir. 2013) (employee benefits plan did not substantially comply with ERISA’s full and fair review requirement in denying plan beneficiary benefits where the plan relied on an entirely different ground for denial on administrative appeal); Schleibaum v. Kmart Corp., 153 F.3d 496, 499-500 (7th Cir. 1998) (finding denial inadequate where it neglected to provide specific reason for denial and failed to advise that additional information could perfect claim or that right to appeal adverse finding existed). Furthermore, a failure to provide the notice of required appeals procedures might excuse the claimant’s failure to exhaust the plan remedies, despite receipt of a plan booklet that detailed the appeal procedure. Conley v. Pitney Bowes, 34 F.3d 714, 718-19 (8th Cir. 1994).

The Second, Third, Seventh, and Eighth Circuits will also consider the process afforded the plaintiff when deciding whether to defer to the plan administrator’s interpretation. Pinto v. Reliance Standard Life Ins. Co., 214 F.3d 377, 394 (3d Cir. 2000) (considering “procedural anomalies” in applying “high degree of skepticism” to arbitrary and capricious review) abrogated on other grounds by Metro. Life Ins. Co. v. Glenn, 554

U.S. 105, 115 (2008); Marolt v. Alliant Techsystems, Inc., 146 F.3d 617, 621 (8th Cir. 1998) (holding that denial of benefits based on obscure passage in 115-page divestiture document that only lawyers will read and understand was arbitrary and capricious); Crocco v. Xerox Corp., 137 F.3d 105, 108 (2d Cir. 1998) (holding that denial of “full and fair” review constituted arbitrary and capricious decision so conflict of interest need not be considered); Chalmers v. Quaker Oats Co., 61 F.3d 1340, 1344 (7th Cir. 1995) (listing process afforded claimant as one factor under arbitrary and capricious standard). The Second Circuit has also held that the denial of a “full and fair review” to the participant is evidence that the plan administrator’s decision was arbitrary and capricious. Crocco, 137 F.3d at 108.

The Supreme Court has clarified that while plan administrators must give claimants a full and fair review of benefit denials benefits, plan administrators need not accord special deference to the opinions of treating physicians. Black & Decker Disability Plan v. Nord, 538 U.S. 822, 831 (2003) (resolving circuit split). So long as a plan administrator does not arbitrarily refuse to credit a claimant’s reliable evidence, which may include the opinion of a treating physician, the administrator is free to rely on other conflicting evidence. Id. at 834.

4. Remedies for procedural defects

Generally, a claimant who successfully shows a technical failure of the plan’s fiduciary to comply with ERISA’s procedural requirements is not automatically entitled to a substantive remedy, i.e., the award of the denied benefits. Lafleur v. La. Health Serv. & Indem. Co., 563 F.3d 148, 157 (5th Cir. 2009); McKenzie v. Gen. Tel. Co. of Cal., 41 F.3d 1310, 1315 (9th Cir. 1994) overruled on other grounds by Saffon v. Wells Fargo & Co. Long Term Disability Plan, 522 F.3d 863, 873 (9th Cir. 2008).

Commonly, the courts have remedied violations of claims handling procedures by remanding the case with instructions for the plan fiduciary to make a proper review of the claim. See Lafleur, 563 F.3d at 157-58 (“Remand to the plan administrator for full and fair review is usually the appropriate remedy when the administrator fails to substantially comply with the procedural requirements of ERISA.”); Marks v. Newcourt Credit Grp., Inc., 342 F.3d 444, 461 (6th Cir. 2003) (“Where administrators have failed to comply with the procedural requirements of § 503, it is ordinarily appropriate to reverse the denial of benefits and to remand the case to the plan administrators or the district court.”); Gallo, 102 F.3d at 923 (holding remedy when administrator fails to make adequate findings or to explain its grounds adequately is to send case back for further findings or explanation unless case is so clear cut that it would be unreasonable for plan administrator to deny benefits on any ground). A *de novo* review of all the evidence a fiduciary might have considered would transfer the administration of benefit and pension plans from their designated fiduciaries to federal judges whose exposure to these issues is “episodic and occasional.” Johannssen v. Dist. No. 1-Pacific Coast Dist., MEBA Pension Plan, 292 F.3d 159, 169 (4th Cir. 2002) (citing Berry v. Ciba-Geigy Corp., 761 F.2d 1003, 1006 (4th Cir. 1985)).

In some circumstances, even if remand is generally proper in cases of an administrator's procedural noncompliance, a court might find it unnecessary and award benefits, especially when it finds that the fiduciary abused its discretion or failed to meet its burden of proof.

See:

Robinson v. Aetna Life Ins. Co., 443 F.3d 389, 397 (5th Cir. 2006).
Remand to the plan administrator was unnecessary when the administrator failed to substantially comply with procedural requirements, abused its discretion in terminating the claimant's benefits, and failed to develop its factual record at the administrative level.

Caldwell v. Life Ins. Co. of N. Am., 287 F.3d 1276, 1289 (10th Cir. 2002).
Remand for further action is unnecessary only if the evidence clearly shows that the administrator's actions were arbitrary and capricious, or where the case is so clear cut that it would be unreasonable for the plan administrator to deny the application for benefits on any ground.

Clark v. Metro. Life Ins. Co., 67 F.3d 299 (table), No. 94-cv-3840, 1995 WL 592102, at *3-*4 (6th Cir. Oct. 5, 1995). *Benefits denial was reversed and remanded when the plan administrator failed to meet the plan's burden to establish an exclusion from coverage and failed to provide specific reasons as to why it considered the claimant's condition to be pre-existing.*

Furthermore, where "[s]ignificant procedural deficiencies occur[]," and the plan's decision terminates benefits previously granted, a court may order those benefits be reinstated. *Halpin v. W.W. Grainger, Inc.*, 962 F.2d 685, 697 (7th Cir. 1992) (reinstating benefits terminated four years before).

Courts have held that a plan administrator's violation of ERISA § 503 does not impose liability on the plan administrator pursuant to ERISA § 502(c), because violations of duties stated in § 503 are not violations that § 502(c) seeks to remedy. See Brown v. J.B. Hunt Transp. Servs., 586 F.3d 1079, 1089 (6th Cir. 2009) (violation of § 503 cannot form basis for penalties under § 502(c)); Wilczynski, 93 F.3d at 407 (same); Groves v. Modified Ret. Plan for Hourly Paid Emps. of Johns Manville Corp. & Subsidiaries, 803 F.2d 109, 116 (3d Cir. 1986) (noting that plan's failure to comply with § 503 duty does not create liability for plan administrator under § 502(c), because "plan" and "plan administrator" refer to two entirely distinct actors and § 502(c) imposes liability only for failure to release information that ERISA specifically requires plan administrator to release).

C. ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B): ACTIONS TO ENFORCE SUBSTANTIVE BENEFIT RIGHTS UNDER ERISA

ERISA § 502(a)(1)(B) specifically provides the civil causes of action by which participants and beneficiaries can challenge benefits claim denials. 29 U.S.C. § 1132(a)(1)(B). As discussed in other sections of this Handbook, § 502 also may allow

participants and beneficiaries to bring causes of action alleging fiduciary duty violations by plan administrators, claims for interference with protected rights under ERISA § 510 and claims of misrepresentation and estoppel under the federal common law of ERISA. Actions under other federal statutes and certain non-preempted state laws might also be available.

1. Standard of review applicable to decisions denying benefits

a) Firestone standard

In Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989), the United States Supreme Court held that “a denial of benefits challenged under [§ 502(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.” In that case, because Firestone, the plan administrator, was not expressly given power to construe the ambiguous terms in its severance plan, it was also not entitled to the deference inherent in the arbitrary and capricious standard. The Court agreed that a deferential standard of review was appropriate where the plan administrator or fiduciary was given discretion with respect to the interpretation of the plan. Id. Referring to the principles of trust law, however, the Court noted that “if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a ‘facto[r]’ in determining whether there is an abuse of discretion.” Id.

The Supreme Court reinforced the Firestone standard in Conkright v. Frommert, 559 U.S. 506 (2010). In Conkright, the Court held a court must give deference to a plan administrator’s interpretation of plan terms even if the administrator’s original good-faith interpretation of that language was an abuse of discretion. Id. at 512. In doing so, the Court rejected the Second Circuit’s exception to Firestone that stripped a plan administrator of deference if a court held the plan’s original interpretation was unreasonable. Id. The Court concluded that deference promotes efficiency, predictability, and uniformity by avoiding a “patchwork of different interpretations of a plan” and costly litigation. Id.

Conkright and Firestone thus established four guiding principles:

1. When the plan’s language does not give discretion to a fiduciary to determine eligibility or construe the plan’s terms, a claims denial by a fiduciary should be reviewed under *de novo* standard;
2. If the plan’s language gives the fiduciary discretion to determine eligibility or construe the plan’s terms, a court should not disturb the decision unless it constitutes an abuse of discretion;
3. If a court holds a fiduciary’s first, good-faith plan interpretation is an abuse of discretion, the court still

must give deference to the fiduciary's subsequent interpretation.

4. If a plan fiduciary could sustain a gain as a result of denying a claim, the potential conflict of interest should be considered as a factor in determining whether there has been an abuse of discretion.

Despite the Supreme Court's decisions, litigants continue to wrestle with unsettled issues concerning language necessary to delegate discretionary authority to a plan's administrators, and the scope of a court's review under the *de novo* and abuse of discretion standards, especially when a plan's fiduciary operates under a conflict of interest. In addition, the Court has left open the question of whether a court may not give deference to a plan administrator's interpretation if it finds the administrator acted in bad faith or dishonestly.

b) Application of the Firestone standard

In applying the Firestone standard, courts must determine whether a "benefit plan gives the administrator discretionary authority to determine eligibility for benefits or to construe the terms of the plan." Firestone, 489 U.S. at 115. If the plan confers discretion on the administrator, the abuse of discretion standard is applied. If no discretion was conferred, the court considers the denial of benefits on a *de novo* standard. The Firestone Court directed courts to use contract law in construing the terms of the plan and other manifestations of the parties' intent. Firestone, 489 U.S. at 112-13.

A grant of discretion must be included in the terms of plan documents, and cannot come from a plan decision maker's exercise of discretion. Id.; Brigham v. Sun Life of Canada, 317 F.3d 72, 80-81 (1st Cir. 2003). Some courts maintain that the discretionary authority must be expressly granted in the language of the plan. See, e.g., Chevron Chem. Co. v. Oil, Chem. & Atomic Workers Local Union 4-447, 47 F.3d 139, 142 (5th Cir. 1995) (holding administrator has no discretion to determine eligibility or interpret plan unless plan language expressly confers such authority).

There are, however, a few courts that have held that a grant of discretion might be inferred from a plan. See, e.g., Gutta v. Standard Select Trust Ins. Plans, 530 F.3d 614, 619 (7th Cir. 2008) (finding magic words unnecessary); see also Post v. KidsPeace Corp., 98 F. App'x 116, 120 n.2 (3d Cir. 2004); Rego v. Westvaco Corp., 319 F.3d 140, 146 (4th Cir. 2003).

No "magic words" are necessary to grant a trustee discretion, but the plan must offer "unambiguous indication" that the trustee has discretion. Kosakow v. New Rochelle Radiology Assoc., P.C., 274 F.3d 706, 739 (2d Cir. 2001); Jordan v. Ret. Comm. of Rensselaer Polytechnic Inst., 46 F.3d 1264, 1271 (2d Cir. 1995). The Seventh Circuit has introduced a "safe harbor" provision which, in that Circuit, is certainly sufficient to establish discretion: "Benefits under this plan will be paid only if the

plan administrator decides in his discretion that the applicant is entitled to them.” Herzberger v. Standard Ins. Co., 205 F.3d 327, 331 (7th Cir. 2000); see also Brigham, 317 F.3d at 80-81 (fully endorsing Seventh Circuit’s safe harbor provision). The courts have found a variety of language sufficient to confer discretion on the plan’s administrator or fiduciary.

See:

Foster v. Sedgwick Claims Mgmt. Servs., Inc., 842 F.3d 721, 732 (D.C. Cir. 2016). Administrator was granted discretion where there the language allows the administrator to construe critical terms and phrases in assessing eligibility, such as “objective medical documentation,” “unable to perform,” “material duties,” and “satisfactory proof.”

Frazier v. Life Ins. Co. of N. Am., 725 F.3d 560, 567 (6th Cir. 2013). Policy that required claimants to “provide the Insurance Company, at his or her own expense, satisfactory proof of Disability before benefits will be paid” was sufficiently clear to grant discretionary authority to plan administrator and fiduciary under ERISA to review claims; although policy could have more clearly expressed grant of discretion, mere fact that language could have been clearer did not necessarily mean that it was not clear enough.

Carden v. Aetna Life Ins. Co., 559 F.3d 256, 260 (4th Cir. 2009). Discretion was granted in language stating that a fiduciary “shall have discretionary authority to . . . construe any disputed or doubtful terms of this policy.”

Gismondi v. United Techs. Corp., 408 F.3d 295, 298 (6th Cir. 2005). Discretion was explicitly granted in language stating that a fiduciary “shall have the following specific discretionary powers and duties. . . .”

Cook v. Liberty Life Assurance Co. of Boston, 320 F.3d 11, 19 (1st Cir. 2003). The policy plan phrase “to construe the terms of this policy and to determine benefit eligibility hereunder” was sufficient to confer discretion.

HCA Health Servs. of Ga., Inc. v. Emplrs. Health Ins. Co., 240 F.3d 982, 995 (11th Cir. 2001) overruled on other grounds by Doyle v. Liberty Life Assurance Co., 542 F.3d 1352 (11th Cir. 2008). Discretion was granted through language stating that the fiduciary “shall have discretionary authority to 1) interpret policy provisions, 2) make decisions regarding eligibility for coverage and benefits, and 3) resolve factual questions relating to coverage benefits.”

Hightshue v. AIG Life Ins. Co., 135 F.3d 1144, 1147 (7th Cir. 1998). Discretion was granted by language stating that the “[a]dministrator shall be entitled to use its discretion in good faith in reviewing claims submitted under this [p]lan, and its decisions shall be upheld absent any arbitrary and capricious action on the part of the [c]laims [a]dministrator.”

Cagle v. Bruner, 112 F.3d 1510, 1517 (11th Cir. 1997). Discretion can be granted by plan provision reserving to administrator the “full and exclusive authority to determine all questions of coverage and eligibility,” and “full power to interpret [ambiguous] provisions.”

Yeager v. Reliance Standard Life Ins. Co., 88 F.3d 376, 381 (6th Cir. 1996). Discretion established where it was required that the claimant submit “satisfactory” proof of disability to the plan administrator.

Ganton Tech., Inc. v. Nat’l Indus. Grp. Pension Plan, 76 F.3d 462, 466 (2d Cir. 1996). Plan granted discretion by stating that trustees had authority to “resolve all disputes and ambiguities relating to the interpretation of the [p]lan.”

Donaho v. FMC Corp., 74 F.3d 894, 898 (8th Cir. 1996), overruled on other grounds by Black & Decker Disability Plan v. Nord, 538 U.S. 822 (2003). Provision granting the administrator power to “construe” or “interpret” the plan was sufficient to provide discretion.

Bailey v. Blue Cross & Blue Shield of Va., 67 F.3d 53, 56 (4th Cir. 1995). Statement that administrator had “sole discretion” was sufficient.

Chevron Chem. Co. v. Oil, Chem. & Atomic Workers Local Union 4-447, 47 F.3d 139, 142-43 (5th Cir. 1995). Discretion was properly provided where the administrator “[had] the authority to control and manage the administration and operation of the [p]lan” and to “prescribe such forms, make such rules, regulations, interpretations and computations and . . . take such other action to administer the [p]lan as [the administrator] may deem appropriate.”

Kennedy v. Georgia-Pacific Corp., 31 F.3d 606, 609 (8th Cir. 1994). Discretion conferred by language stating that the administrator “shall be solely responsible for the administration and interpretation” of the plan.

Diaz v. Seafarers Int’l Union, 13 F.3d 454, 457 (1st Cir. 1994). A trust document conferred discretion by giving trustees “without limitation . . . the power . . . to . . . promulgate and establish rules . . . and formulate and establish conditions of eligibility” and to do all acts they deem necessary. The court construed the power to create “rules” governing “conditions of eligibility as carrying with it a similarly broad implied power to interpret those rules.”

Although the grant of discretion must appear in the plan documents, several cases have found that the required discretion can be derived from a number of plan documents, including insurance contracts and trust instruments. Jackman Fin. Corp. v. Humana Ins. Co., 641 F.3d 860, 864 (7th Cir. 2011) (ERISA contract plan document); Groves v. Metro. Life Ins. Co., 438 F.3d 872, 874 (8th Cir. 2006) (plan booklet). When a trust agreement incorporated in the plan documents accords trustees

discretionary authority to make binding benefit determinations, the court generally will not upset the trustees' determinations unless their decisions or conduct are arbitrary and capricious. Militello v. Cent. States, Se. & Sw. Areas Pension Fund, 360 F.3d 681, 385-86 (7th Cir. 2004) (trust agreement).

If, however, the language regarding discretion can only be derived from a number of documents which have not been incorporated into the plan agreements, it is likely to be insufficient to grant the plan administrator discretion to determine eligibility for benefits or to construe the terms of the plan. Gentry v. Ashland Oil, Inc., 42 F.3d 1385 (table), No. 93-1425, 1994 WL 706212, at *4 (4th Cir. 1994).

Absent additional language conferring discretion, plan provisions that merely describe the decision maker's responsibility for making benefit determinations or categorically require certain benefits to be paid will not confer the level of discretion necessary to apply a deferential standard of review. See Aramony v. United Way Replacement Benefit Plan, 191 F.3d 140, 149 (2d Cir. 1999). A wide variety of other provisions have been held insufficient to grant discretion to the administrator.

See:

Woods v. Prudential Ins. Co. of Am., 528 F.3d 320, 323-24 (4th Cir. 2008). *"When [the administrator] determines' or 'determined by [the administrator]' language did not give discretion to the administrator, only authority.*

Sperandeo v. Lorillard Tobacco Co., 460 F.3d 866, 871-72 (7th Cir. 2006) *Plan provision stating "plan fiduciaries have discretionary authority to determine [claimant's] eligibility for and entitlement to benefits" not sufficient to grant administrator discretion.*

Gallagher v. Reliance Standard Life Ins. Co., 305 F.3d 264, 269 (4th Cir. 2002). *Where plan would "pay monthly benefits if the Insured . . . submits satisfactory proof of 'Total Disability,'" language did not give discretion to the plan administrator.*

Perugini v. Homestead Mortgage Co., 287 F.3d 624, 626-27 (7th Cir. 2002). *Plan requirement of "satisfactory proof of 'Total Disability'" not sufficient to grant discretion to the plan administrator.*

Thomas v. Oregon Fruit Prods. Co., 228 F.3d 991, 994 (9th Cir. 2000). *Plan provision requiring "satisfactory proof of Total Disability to us" did not grant unambiguous discretion to the plan administrator.*

Feder v. Paul Revere Life Ins. Co., 228 F.3d 518, 522 (4th Cir. 2000). *Plan provision requiring "written notice" and "written proof" not sufficient to grant discretion to the plan administrator.*

Postma v. Paul Revere Life Ins. Co., 223 F.3d 533, 539 (7th Cir. 2000). Plan provisions requiring written proof of loss not sufficient to grant discretion to plan administrator.

Kearney v. Standard Ins. Co., 175 F.3d 1084, 1089-90 (9th Cir. 1999). Where plan would pay benefits upon “receipt of satisfactory written proof [of total disability],” there was an ambiguity resolved against trustee and discretion was not conferred to trustee.

Brown v. Seitz Foods, Inc. Disability Benefit Plan, 140 F.3d 1198, 1200 (8th Cir. 1998). The proper way to secure deferential court review of an ERISA plan administrator’s claims decisions is through express discretion-granting language; requiring written proof of loss does not suffice.

Wulf v. Quantum Chem. Corp., 26 F.3d 1368, 1373-74 (6th Cir. 1994). Discretion was not provided to plan administrator where plan provision merely stated that rules, rather than benefits determinations, administrator made were to be “conclusive.”

Kirwan v. Marriott Corp., 10 F.3d 784, 789 (11th Cir. 1994). Discretion not provided where administrator had power to grant or deny benefits in accordance with the terms of the plan.

But see:

Rego v. Westvaco Corp., 319 F.3d 140, 147 (4th Cir. 2003). Plan giving administrator the responsibility for “determination of participants’ eligibility to receive benefits,” among other things, was sufficient to give discretion to plan administrator.

Brigham v. Sun Life of Canada, 317 F.3d 72, 81-82 (1st Cir. 2003). When plan administrator “may require proof in connection with the terms or benefits of [the] Policy,” the administrator has sufficient discretion.

c) Considerations under *de novo* standard

When a court considers a denial of benefits *de novo* under the Firestone standard, the examining court interprets the governing plan documents without any deference to interpretation by either party to the dispute. Firestone, 489 U.S. at 112-13. The Supreme Court indicated that a court should review the claims of employees under a benefits plan as it would “any other contract claim—by looking to the terms of the plan and other manifestations of the parties’ intent.” Id.

i. Scope of *de novo* standard

Whether an ERISA plan is ambiguous is a question of law. E.g., Lettrich v. J.C. Penney Co., 90 F. App’x 604, 608 (3d Cir. 2004); State St. Bank & Trust Co. v. Denman Tire Corp., 240 F.3d 83, 87 (1st Cir. 2001); Bill Gray Enters., Inc. Emp. Health

& Welfare Plan v. Gourley, 248 F.3d 206, 218 (3d Cir. 2001). Similarly, benefit determinations made by non-fiduciary providers of administrative services are analyzed *de novo*. Baker v. Big Star Div. of Grand Union Co., 893 F.2d 288, 292 (11th Cir. 1989). ERISA's statutory language is always interpreted under the *de novo* standard. Rhorer v. Raytheon Eng'rs & Constructors, Basic Life, Optional Life, Accidental Death & Dependant Ins. Plan, 181 F.3d 634, 638 (5th Cir. 1999).

Circuits are split on whether the *de novo* standard applies only to issues of plan interpretation or whether it also applies to a plan administrator's factual determinations as well. The Fifth Circuit held that factual determinations should be reviewed under a deferential standard of review. Chacko v. Sabre Inc., 473 F.3d 604, 609 (5th Cir. 2006); Vercher v. Alexander & Alexander, Inc., 379 F.3d 222, 226 (5th Cir. 2004). Other circuits have held, however, that factual determinations should be analyzed under a *de novo* standard unless the plan documents give the administrator discretion. Hodges v. Life Ins. Co. of N. Am., 920 F.3d 669, 675 (10th Cir. 2019); Locher v. UNUM Life Ins. Co. of Am., 389 F.3d 288, 293 (2d Cir. 2004); Shaw v. Conn. Gen. Life Ins. Co., 353 F.3d 1276, 1285 (11th Cir. 2003); Riedl v. Gen. Am. Life Ins. Co., 248 F.3d 753, 756 (8th Cir. 2001); Kinstler v. First Reliance Standard Life Ins. Co., 181 F.3d 243, 250-51 (2d Cir. 1999); Ramsey v. Hercules Inc., 77 F.3d 199, 204-05 (7th Cir. 1996); Luby v. Teamsters Health, Welfare, & Pension Trust Funds, 944 F.2d 1176, 1183 (3d Cir. 1991) (holding ERISA plan administrator's decision as to entitlement between beneficiary claimants based solely on factual determinations is reviewed *de novo*).

ii. Interpretation of plan provisions under *de novo* standard

Whether an ERISA plan is ambiguous is a question of law. Lettrich v. J.C. Penney Co., 90 F. App'x 604, 608 (3d Cir. 2004); State St. Bank & Trust Co., 240 F.3d at 87; Bill Gray Enters., Inc., 248 F.3d at 218.

Difficulties arose concerning the proper interpretive principles courts should use while interpreting plan documents. The Supreme Court in Firestone pointed to the Restatement (Second) of Trusts, stating that "[t]he terms of trusts created by written instruments are 'determined by the provisions of the instrument as interpreted in light of all the circumstances and such other evidence of the intent of the settlor with respect to the trust as is not inadmissible.'" Id. at 112 (quoting Restatement (Second) of Trusts § 4, comment d (1959)). Other courts explicitly or implicitly turned to state law contract principles in interpreting plan documents. See, e.g., Scharff v. Raytheon Co. Short Term Disability Plan, 581 F.3d 899, 904 (9th Cir. 2009); Cassidy v. AKZO Nobel Salt, Inc., 308 F.3d 613, 615 (6th Cir. 2002); Kamler v. H/N Telecomm. Servs., 305 F.3d 672, 680 (7th Cir. 2002), cert. denied, 538 U.S. 946 (2003); Wheeler v. Dynamic Eng'g, Inc., 62 F.3d 634, 638 (4th Cir. 1995). Other courts fashioned their own set of interpretive principles based both on trust and contract law, and referred to the final result as "federal common law." See, e.g., Dixon v. Life Ins. Co. of N. Am., 389 F.3d 1179, 1183 (11th Cir. 2004); Critchlow v. First UNUM Life Ins. Co. of Am., 378 F.3d 246, 255-56 (2d Cir. 2004); Wahlin v. Sears, Roebuck & Co., 78 F.3d 1232, 1235 (7th Cir. 1996); Wheeler, 62 F.3d at 638.

Differing interpretation rules have led to varying results by ascribing a different meaning to the terms of a contract under construction. For example, the application of the state insurance law principle of *contra proferentem* leads a court to construe the ambiguous terms of a contract against the insurer under a *de novo* standard. See, e.g., Perreca v. Gluck, 295 F.3d 215, 223 (2d Cir. 2002); HCA Health Servs. of Ga., Inc. v. Employees Health Ins. Co., 240 F.3d 982, 994 n.24 (11th Cir. 2001); Vizcaino v. Microsoft Corp., 97 F.3d 1187, 1196 (9th Cir. 1996). The rule of *contra proferentem* is a device for determining the intended meaning of a contract term that, in the context of ERISA, provides that ambiguous terms in benefit plans should be construed in favor of beneficiaries. This principle, although not part of the common law trust doctrine, has often been incorporated by courts into the federal common law and applied in ERISA litigation. See, e.g., Vercher v. Alexander & Alexander, Inc., 379 F.3d 222, 228 n.8 (5th Cir. 2004); Morton v. Smith, 91 F.3d 867, 871 n.1 (7th Cir. 1996). Other courts have disagreed, holding that construing ambiguities against insurers under common law contract principles is not appropriate in cases under ERISA. See, e.g., Bernards v. United of Omaha Life Ins. Co., 987 F.2d 486, 489 n.1 (8th Cir. 1993); see also Bond v. Cerner Corp., 309 F.3d 1064, 1067-68 (8th Cir. 2002) (construing terms against drafters only as a last step).

iii. Admissibility of extrinsic evidence in plan's interpretation

The interpretive principles a court uses also affect the type and extent of extrinsic evidence that it allows when construing a plan's language. Generally, courts analyzing the denial *de novo* allow extrinsic evidence to construe ambiguous terms of an employee benefit plan to determine intent of the parties. See, e.g., Stockman v. GE Life, Disability & Med. Plan, 625 F. App'x 243, 252 (6th Cir. 2015) (federal law permits the use of traditional methods of contract interpretation to resolve ambiguity, including introduction of extrinsic evidence); Opeto v. Nw. Airlines Pension Plan, 484 F.3d 1211, 1217 (4th Cir. 2007) (extrinsic evidence may only be used when circumstances clearly establish it is necessary to conduct *de novo* review); Critchlow v. First UNUM Life Ins. Co. of Am., 378 F.3d 246, 261 (2d Cir. 2004) (evidence regarding plan interpretation is authorized on a *de novo* review); Johannssen v. Dist. No. 1-Pacific Coast Dist., 292 F.3d 159, 171-72 (4th Cir. 2002) (court may allow additional evidence to interpret the terms of the plan at its discretion); Wilson v. Moog Auto., Inc., 193 F.3d 1004, 1009 (8th Cir. 1999) (extrinsic evidence may be used to interpret conflicting and ambiguous provisions); Schachner v. Blue Cross & Blue Shield, 77 F.3d 889, 893 (6th Cir. 1996) (requiring patent ambiguity in plan before admitting evidence of intent, but holding that courts cannot create ambiguity by using extrinsic evidence; after finding ambiguity, extrinsic evidence is admissible to aid interpretation).

Some courts, however, have questioned whether under the *de novo* standard, the evidence considered should be limited to that contemplated by the administrator, or whether the evidence not presented to the administrator can be considered by a court. See, e.g., Viera v. Life Ins. Co. of N. Am., 642 F.3d 407, 418 (3d Cir. 2011) (stating that under *de novo* standard a "determination may be based on any information before the administrator initially, as well as any supplemental evidence.").

But see Daft v. Advest, Inc., 658 F.3d 583, 595 (6th Cir. 2011) (stating “a court’s review of a plan administrator’s decision, even when de novo, is confined to the evidence in the administrative record.”); Jones v. Metro. Life Ins. Co. of N.Y., 385 F.3d 654, 660 (6th Cir. 2004); Wilkins v. Baptist Healthcare Sys. Inc., 150 F.3d 609, 619 (6th Cir. 1998) (limiting evidence to that presented to administrator).

Some circuit courts require a showing of good cause before admitting evidence the administrator did not consider. Opeta, 484 F.3d at 1217 (extrinsic evidence may only be used when circumstances clearly establish it is necessary to conduct de novo review); Sloan v. Hartford Life & Accident Ins. Co., 475 F.3d 999, 1004 (8th Cir. 2007) (affirming district court’s decision to use extrinsic evidence and finding of good cause); Kearney v. Standard Ins. Co., 175 F.3d 1084, 1090-91 (9th Cir. 1999); see also Locher v. UNUM Life Ins. Co. of Am., 389 F.3d 288, 294 (2d Cir. 2004) (conflict of interest in administrator not *per se* good cause); DeFelice v. Am. Int’l Life Assurance Co., 112 F.3d 61, 65-66 (2d Cir. 1997) (stating that under *de novo* standard, even purely factual interpretation cases may provide district court with good cause to exercise its discretion to admit evidence not available at administrative level if administrator was not disinterested); Ravenscraft v. Hy-Vee Emp. Benefit Plan & Trust, 85 F.3d 398, 402 (8th Cir. 1996) (allowing “parties to introduce evidence in addition to that presented to the fiduciary” under *de novo* standard of review if good cause is shown to district court); Donatelli v. Home Ins. Co., 992 F.2d 763, 765 (8th Cir. 1993) (allowing district court to consider evidence in addition to that presented to fiduciary if necessary for adequate *de novo* review of fiduciary’s decision and court has good cause to do so).

d) Considerations when review is for abuse of discretion

Under Firestone, an abuse of discretion standard of review applies when “the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan.” Firestone, 489 U.S. at 115. Consequently, where a plan gives an administrator or other fiduciary discretion limited to particular circumstances, an abuse of discretion standard should be applied only to the decisions of the administrator with respect to which the discretion has been expressly given. See, e.g., Postma v. Paul Revere Life Ins. Co., 223 F.3d 533, 539 (7th Cir. 2000) (holding plan administrator does not have discretion under one provision just because he has discretion under another provision); Anderson v. Great W. Life Assurance Co., 942 F.2d 392, 395 (6th Cir. 1991) (noting that fiduciary or administrator does not have discretion with respect to all aspects of plan simply because administrator has discretion to interpret some provisions). Even if a court holds the plan administrator’s original good-faith interpretation was an abuse of discretion, the court still must review the administrator’s subsequent interpretation of plan terms under an abuse of discretion standard if the plan gives discretion to the administrator. Conkright, 130 S. Ct. at 1646-47.

The Supreme Court explained in Firestone that the abuse of discretion standard should apply in accordance with common law trust principles, which make a deferential standard of review appropriate when a trustee exercises discretionary powers. 489 U.S. at 111. Under these principles, when a plan grants discretion to a

fiduciary to interpret the terms of the plan, a court should not disturb the fiduciary's interpretation if it is reasonable and made in good faith. Id.; Flinders v. Workforce Stabilization Plan of Phillips Petroleum Co., 491 F.3d 1180, 1189 (10th Cir. 2007); Smith v. United Television, Inc. Special Severance Plan, 474 F.3d 1033, 1035-36 (8th Cir. 2007); Semien v. Life Ins. Co. of N. Am., 436 F.3d 805, 812 (7th Cir. 2006); Dewitt v. Penn-Del Directory Corp., 106 F.3d 514, 520 (3d Cir. 1997). An incorrect application of law is an abuse of discretion. See Belot v. Burge, 490 F.3d 201, 206 (2d Cir. 2007); see also Koon v. United States, 518 U.S. 81, 100 (1996) (holding error of law is abuse of discretion), superseded by statute on other grounds, 18 U.S.C. § 3742(e).

The post-Firestone judicial decisions have not developed a uniform methodology for applying a deferential standard of review. Courts have focused on the evidence that they may consider in applying the abuse of discretion standard, factors relevant in deciding whether the decision of the plan's decision maker was reasonable, and the standard to apply when the administrator or other fiduciary acted under the conflict of interest.

i. Scope of evidence considered on deferential review

Most courts of appeals hold that when review under ERISA is deferential, courts are limited to the information submitted to the plan's administrator. See, e.g., Robinson v. Aetna Life Ins. Co., 443 F.3d 389, 394 (5th Cir. 2006); Jones v. Metro. Life Ins. Co., 385 F.3d 654, 660 (6th Cir. 2004); Finley v. Hewlett-Packard Co. Emp. Benefits Org. Income Prot. Plan, 379 F.3d 1168, 1176 (10th Cir. 2004); Vercher, 379 F.3d at 222, 231 n.11 (5th Cir. 2004); Militello v. Cent. States, Se. & Sw. Areas Pension Fund, 360 F.3d 681, 686 (7th Cir. 2004), cert. denied, 125 S. Ct. 106 (2004); Vega v. Nat'l Life Ins. Servs., 188 F.3d 287, 299-300 (5th Cir. 1999) (stating that Fifth Circuit permits only evidence that was available to administrator before filing of lawsuit in a way that he had a fair opportunity to evaluate it); see also Perlman v. Swiss Bank Corp. Comprehensive Disability Protection Plan, 195 F.3d 975, 981-82 (7th Cir. 1999).

Some courts, however, note that the plan's administrator or other fiduciary might abuse his discretion by failing to obtain necessary information. See, e.g., Holland v. Int'l Paper Co. Ret. Plan, 576 F.3d 240, 250 (5th Cir. 2009) (allowing reviewing courts to decide on case-by-case basis whether under particular facts plan administrator abused discretion by not obtaining opinion of vocational rehabilitation expert); Camerer v. Cont'l Cas. Co., 76 F. App'x 837, 840 (9th Cir. 2003). Moreover, if a court considers the record to be incomplete, it can remand a case for further administrative review. See Saffle v. Sierra Pac. Power Co. Bargaining Unit Long Term Disability Income Plan, 85 F.3d 455, 461 (9th Cir. 1996) (holding remand for reevaluation of claim's merits is correct course when plan administrator with discretion to apply plan misconstrues plan and applies wrong standard to determination); see also Schadler v. Anthem Life Ins. Co., 147 F.3d 388, 398-99 (5th Cir. 1998) (remanding case to administrator to develop full factual record and to decide whether to grant or deny benefits on basis of intentionally self-inflicted injury); Miller v. United Welfare Fund, 72 F.3d 1066, 1073-74

(2d Cir. 1995) (noting remand is proper when uncertain whether only proper determination was to grant claim).

The Circuits are split about whether remand orders are appealable. Remand orders are usually held non-appealable. See, e.g., Rekstad v. First Bank Sys., Inc., 238 F.3d 1259, 1262 (10th Cir. 2001) (stating in administrative context remand order is “generally considered a non-final decision . . . not subject to immediate review in the court of appeals”); see also Papotto v. Hartford Life & Acc. Ins. Co., 731 F.3d 265, 270 (3d Cir. 2013) (ERISA remand orders are generally “not final and appealable” unless “(1) the remand ‘finally resolves’ an issue, (2) the legal issue is ‘important,’ and (3) denial of immediate review will ‘foreclose appellate review’ in the future”). However, some courts have held that remand orders are final and appealable. See Perlman, 195 F.3d at 979-80 (holding in Seventh Circuit that ERISA remands should be treated like statutorily governed Social Security Administration remands and that administrative remands in general are normally appealable); see also Kistler v. Fin. Am. Grp. Long Term Disability Plan, 35 F. App’x 516, 517 (9th Cir. 2002); Schikore v. BankAmerica Supplemental Ret. Plan, 269 F.3d 956, 959 n.1 (9th Cir. 2001) (remand orders are appealable and final orders) (citing Hensley v. N.W. Permanente P.C. Ret. Plan & Trust, 258 F.3d 986 (9th Cir. 2001)). But see Zervos v. Verizon N.Y., Inc., 277 F.3d 635, 646 n.8 (2d Cir. 2002) (stating appealability is unresolved question in the Second Circuit).

Courts have also held that the plan administrator’s determination must be supported by substantial evidence to be sustained under the deferential review. Buzzard v. Holland, 367 F.3d 263, 268-69 (4th Cir. 2004) (when plan grants discretion, denial of benefits will be upheld if supported by substantial evidence); Roberts v. Union Pac. R.R., 16 F. App’x 730, 733 (9th Cir. 2001) (when plan grants discretion, court upholds denial of benefits unless it was “arbitrary, capricious, made in bad faith, not supported by substantial evidence, or erroneous on question of law”); United Welfare Fund, 72 F.3d at 1072 (allowing court to reverse only if fiduciary’s decision was arbitrary and capricious or without reason, unsupported by substantial evidence or erroneous as matter of law); Pagan v. NYNEX Pension Plan, 52 F.3d 438, 442 (2d Cir. 1995). “Substantial evidence” is evidence that a reasonable mind might accept as adequate to support the determination made, and it requires more than a scintilla but less than a preponderance of the evidence. Celardo v. Gny Auto. Dealers Health & Welfare Trust, 318 F.3d 142, 146 (2d Cir. 2003); United Welfare Fund, 72 F.3d at 1072.

ii. Reasonableness justifies deference

Under the deferential standard of review, most circuits affirm the plan administrator’s decision unless it was arbitrary, capricious, made in bad faith, or not supported by substantial evidence. See, e.g., Brogan v. Holland, 105 F.3d 158, 161 (4th Cir. 1997); Donaho v. FMC Corp., 74 F.3d 894, 898 (8th Cir. 1996), overruled on other grounds by Black & Decker Disability Plan v. Nord, 538 U.S. 822 (2003). The standard has been equated to one that affirms the administrator’s decision unless “whimsical, random, or unreasoned,” or “downright unreasonable.” Teskey v. M.P. Metal Prods. Inc., 795 F.2d 30, 32 (7th Cir. 1986); see also Gingold v. UNUM Life Ins. Co. of Am., 74 F.

App'x 660, 662 (7th Cir. 2003) (quoting Carr v. Gates Health Care Plan, 195 F.3d 292, 294 (7th Cir. 1999)).

Thus, the most important inquiry underlying the application of an abuse of discretion standard focuses on whether the interpretation by a plan decision-maker is reasonable, not on whether it is a “correct” decision that a court would have made based on its own interpretation of the plan. See Till v. Lincoln Nat'l Life Ins. Co., 678 F. App'x 805, 808 (11th Cir. 2017); Neumann v. AT&T Commc'n, Inc., 376 F.3d 773, 781 (8th Cir. 2004); McGee v. Reliance Standard Life Ins. Co., 360 F.3d 921, 924 (8th Cir. 2004); Jordan, 46 F.3d at 1271-73. The court must not disturb the administrator's decision if it is reasonable, even if the court itself would have reached a different conclusion. Celardo, 318 F.3d at 146; Feder v. Paul Revere Life Ins. Co., 228 F.3d 518, 522 (4th Cir. 2000). Likewise, if the plan administrator's decision is reasonable, a court should not overturn the administrator merely because the claimant has an equally reasonable interpretation. See Florence Nightingale Nursing Serv., Inc. v. Blue Cross/Blue Shield, 41 F.3d 1476, 1481 (11th Cir. 1995) (holding that where no conflict of interest is present, administrator's wrong but reasonable interpretation will not be arbitrary and capricious).

The arbitrary and capricious standard of review is highly deferential to a plan administrator. A plan administrator's decision is reasonable if it is: (1) the result of a deliberate, principled reasoning process; and (2) supported by substantial evidence. See Williams v. Metro. Life Ins. Co., 609 F.3d 622, 630 (4th Cir. 2010). The question before a reviewing court under this standard is whether the decision was based on a consideration of the relevant factors and whether there has been a clear error of judgment. Jordan, 46 F.3d at 1271-73; see also Kirk v. Readers Digest Ass'n Inc., 57 F. App'x 20, 23 (2d Cir. 2003). The court may not upset a reasonable interpretation by the administrator even if the claimant's competing interpretation was equally reasonable. Jordan, 46 F.3d at 1272-73.

Even though ERISA plans are subject to regulation, they are also contractual documents, meaning their interpretation is governed by established principles of contract and trust law. See Firestone, 489 U.S. at 110; Haley v. Paul Revere Life Ins. Co., 77 F.3d 84, 88 (4th Cir. 1996). Like other contractual documents, courts construe the plan's terms without deferring to either party's interpretation. Wheeler, 62 F.3d at 638 (stating that ERISA plans are interpreted “under ordinary principles of contract law”). To decide whether an administrator has abused its contractually conferred discretion, a court may consider:

- (1) the scope of the discretion conferred;
- (2) the purpose of the plan provision in which the discretion is granted;
- (3) any external standard relevant to the exercise of that discretion;
- (4) the administrator's motives; and
- (5) any conflict of interest under which the administrator operates in making its decision.

Haley, 77 F.3d at 89 (quoting Restatement (Second) of Trusts § 187 cmt. d (1957)).

The Fifth Circuit has considered additional factors: (1) the internal consistency of the plan under the administrator's interpretation; (2) any appropriate regulations formulated by the appropriate administrative agencies; and (3) the factual background of the determination and any inferences of lack of good faith. Ellis v. Liberty Life Assurance Co. of Boston, 394 F.3d 262, 272 n.23 (5th Cir. 2004).

A starting point in evaluating the reasonableness of the administrator's interpretation is the plan's plain language because, in most cases, a plan administrator's interpretation will be overturned if it is inconsistent with the plan's plain meaning. See, e.g., Shelby County Health Care Corp. v. S. Council of Indus. Workers Health & Welfare Trust, 203 F.3d 926, 934 (6th Cir. 2000); Wald v. Sw. Bell Corp. Customcare Med. Plan, 83 F.3d 1002, 1007-08 (8th Cir. 1996). On the other hand, if the plan's language is reasonably susceptible to more than one interpretation, the court will have to determine whether the plan decision maker's determination is reasonable, although not necessarily in accord with the one which the court would have reached on its own. Although courts are not uniform as to the particular factors they consider in each case, commonly-invoked factors include consistency with plan terms and purposes, consistency with prior interpretations of the plan language, and the logic (or lack thereof) of the decision.

See:

D&H Therapy Assocs., LLC v. Boston Mut. Life Ins. Co., 640 F.3d 27, 40-41 (1st Cir. 2011). Under a general reasonableness inquiry, the court found an abuse of discretion when plan administrator's definition of a disputed term was inconsistent with other plan provisions.

DuPerry v. Life Ins. Co. of N. Am., 632 F.3d 860, 874-75 (4th Cir. 2011). Courts should consider eight factors in determining reasonableness, including the adequacy of supporting materials and fiduciary's potential conflict of interest.

Howley v. Mellon Fin. Corp., 625 F.3d 788, 795 (3d Cir. 2010). When reviewing for abuse of discretion, a court considers five factors: "(1) whether the interpretation is consistent with the goals of the Plan; (2) whether it renders any language in the Plan meaningless or internally inconsistent; (3) whether it conflicts with the substantive or procedural requirements of the ERISA statute; (4) whether the [relevant entities have] interpreted the provision at issue consistently; and (5) whether the interpretation is contrary to the clear language of the Plan."

Chacko v. Sabre, Inc., 473 F.3d 604, 611 (5th Cir. 2006). In reviewing for abuse of discretion, the court considers (1) whether the administrator has given the plan a uniform construction; (2) whether the interpretation is consistent with a fair reading of the plan; and (3) any unanticipated costs resulting from different interpretations of the plan.

Fought v. UNUM Life Ins. Co. of Am., 379 F.3d 997, 1003 (10th Cir. 2004) (citing Kennedy, *Judicial Standard of Review in ERISA Benefit Claim Cases*, 50 AM. U. L. REV. 1083, 1135 (2000)). Once court finds administrator has discretion, it reviews the administrator's interpretation as (a) a "result of a reasoned and principled process (b) consistent with any prior interpretations by the plan administrator (c) reasonable in light of any external standards and (d) consistent with the purposes of the plan."

Butts v. Cont'l Cas. Co., 357 F.3d 835, 838-39 (8th Cir. 2004). When reviewing for an abuse of discretion, courts consider whether the interpretation was "consisten[t] with ERISA plan goals," and was "consistent or contrary to the plan's clear language" and whether the administrator has interpreted similar provisions consistently in the past.

Tillery v. Hoffman Enclosures, Inc., 280 F.3d 1192, 1199 (8th Cir. 2002). In reviewing an administrator's decision, courts should consider whether: (1) the interpretation is consistent with ERISA plan goals, (2) the interpretation renders any plan language "meaningless or internally inconsistent," (3) the interpretation conflicts with substantial or procedural requirements of ERISA, (4) the administrator interprets words consistently, and (5) the interpretation is contrary to clear language of the plan.

Booth v. Wal-Mart Stores, Inc. Assocs. Health & Welfare Plan, 201 F.3d 335, 342 (4th Cir. 2000). Among factors court considered was how consistent plan administrator's interpretation was with the underlying purposes of the plan under an eight-factor test.

Chojnacki v. Georgia-Pacific Corp., 108 F.3d 810, 816 (7th Cir. 1997). Court compared the consistency of the interpretation at issue with the previous interpretations of the plan.

Butler v. Encyclopedia Britannica, Inc., 41 F.3d 285, 290 (7th Cir. 1994). Court considered the consistency of the administrator's interpretation with the relevant regulations promulgated by the appropriate administrative agencies.

Krawczyk v. Harnischfeger Corp., 41 F.3d 276, 279 (7th Cir. 1994). Court determined whether current interpretation gives rise to substantial unanticipated costs to the plan.

Saltarelli v. Bob Baker Grp. Med. Trust, 35 F.3d 382, 386-87 (9th Cir. 1994). Court determined whether the interpretation comported with the reasonable expectations of the insured because "courts will protect the reasonable expectations of . . . insureds . . . even though a careful examination of the policy provisions indicates that such expectations are contrary to the expressed intention of the insurer."

DiCioccio v. Duquesne Light Co., 911 F. Supp. 880, 900 (W.D. Pa. 1995). Court considered, among other factors, the factual background of the case, any relevant regulations and any indications that the administrator did not act in good faith.

Various permutations of these factors have been used in different circuits. See, e.g., Wald, 83 F.3d at 1007 (considering whether interpretation (1) is consistent with plan goals; (2) renders other plan language meaningless or inconsistent; (3) conflicts with ERISA's substantive and procedural requirements; (4) interprets words consistently; and (5) is contrary to plan's clear language); Chalmers v. Quaker Oats Co., 61 F.3d 1340, 1344 (7th Cir. 1995) (considering "the impartiality of the decision-making body, the complexity of the issues, the process afforded the parties, the extent to which the decision makers utilized the assistance of experts where necessary, and finally the soundness of the fiduciary's ratiocination"); Costantino v. Wash. Post Multi-Option Benefits Plan, 404 F. Supp. 2d 31, 42 (D.D.C. 2005) (considering whether plan administrator's interpretation was (1) contrary to plan's clear language or rendered other provisions superfluous; (2) consistent with plan's purposes; (3) consistent with purpose of provision in question; and (4) consistent with prior interpretations and that participants had notice of such interpretation).

iii. Review when the trustee acts under a conflict of interest

A conflict of interest can have a tremendous impact on the evaluation of the fiduciary's actions. In Firestone, the Court recognized that where a plan fiduciary exercising its discretion operates under "a conflict of interest," the conflict is an important "factor" in determining whether discretion has been abused. 489 U.S. at 115. The court in Firestone did not provide lower courts with guidance as to how to apply this factor. This led to significant confusion and variation among the circuit courts as to what constitutes a conflict and how the factor is to be weighed. See, e.g., Armstrong v. Aetna Life Ins. Co., 128 F.3d 1263, 1265 (8th Cir. 1997) (finding conflict and reviewing decisions *de novo*); Chambers v. Family Health Plan Corp., 100 F.3d 818, 825-26 (10th Cir. 1996) (adopting sliding scale approach); Sullivan v. LTV Aerospace & Def. Co., 82 F.3d 1251, 1255 (2d Cir. 1996) (placing burden on claimant to prove conflict and how it improperly motivated decision).

The Supreme Court did not revisit this issue until almost 20 years later in MetLife Insurance Co. v. Glenn. In Glenn, the court stated that "the significance of th[is] factor will depend upon the circumstances of the particular case." 128 S. Ct. 2343, 2346 (2008); see Burke v. Pitney Bowes Inc. Long-Term Disability Plan, 544 F.3d 1016, 1025-27 (9th Cir. 2008); see also Durbin v. Columbia Energy Grp. Pension Plan, 522 F. App'x 341, 345 (6th Cir. 2013); Durakovic v. Bldg. Serv. 32 BJ Pension Fund, 609 F.3d 133, 139 (2d Cir. 2010); Holland v. Int'l Paper Co. Ret. Plan, 576 F.3d 240, 247 n.3 (5th Cir. 2009).

1. Courts must first determine whether a conflict of interest exists.

In Glenn, the Court held that where a plan administrator “both determines whether an employee is eligible for benefits and pays benefits out of its own pockets” that dual role creates a conflict of interest. 128 S. Ct. at 2346. In Pinto, the Third Circuit held that two types of funding arrangements do not, in themselves, present a conflict of interest: (1) where the employer funds a plan but hires a third party to interpret it, or (2) where the employer funds the plan and creates an internal benefits committee that interprets the plan. 214 F.3d at 383. It did find a conflict of interest, however, where a third-party insurer is hired to both fund and interpret the plan. Id. at 383-84. The Sixth Circuit also held that designating the partners of a law firm, or a committee appointed by the plan sponsor’s board of directors, as plan administrator constituted a conflict of interest. Univ. Hosps. of Cleveland v. Emerson Elec. Co., 202 F.3d 839, 846 (6th Cir. 2000); Borda v. Hardy, Lewis, Pollard & Page, P.C., 138 F.3d 1062, 1069 (6th Cir. 1998). But see Kimber v. Thiokol Corp., 196 F.3d 1092, 1098 (10th Cir. 1999) (refusing to presume *per se* conflict merely because administrator who managed plan was employee of employer that funded plan); Smathers v. Multi-Tool Inc., 298 F.3d 191, 197 (3d Cir. 2002) (risk of conflict less when administrator and funder is employer because it has incentives to pay benefits rather than having employees be discontent or having increased wages).

Most conflict of interest cases involve either the insurance company as plan administrator and insurer of the benefits under the plan, or the employer as plan administrator of a self-funded plan. See Pinto, 214 F.3d at 382-83 (comparing respondent insurance company, which both funded and administered plan, with employer in Firestone, who was also plan administrator). An apparent conflict of interest may also exist if the plan’s administrator also funds or pays benefits under the plan. See Friedrich v. Intel Corp., 181 F.3d 1105, 1109-10 (9th Cir. 1999); Chambers, 100 F.3d at 826. This inherent conflict usually is premised on the “perpetual conflict with [a] profit-making role as business.” Pinto, 214 F.3d at 384. But see Pegram v. Herdrich, 530 U.S. 211, 226-28 (2000) (retreating from sole use of economic analysis).

See also:

Nord v. Black & Decker Disability Plan, 356 F.3d 1008, 1010 (9th Cir. 2004), on remand from 538 U.S. 822 (2004). Finding apparent conflict of interest when same entity both funds and administers plan.

Marks v. Newcourt Credit Grp., Inc., 342 F.3d 444, 457 (6th Cir. 2003). Finding a conflict of interest exists where same entity funds and administers plan.

Tillery v. Hoffman Enclosures Inc., 280 F.3d 1192, 1197 (8th Cir. 2002). Eighth Circuit allows a rebuttable presumption of a conflict exists when an entity both funds and administers a plan.

Holder v. Woodmen of the World/Omaha Woodmen Life Ins. Soc’y Long-Term Disability Plan for Field Assocs., 11 F. App’x 103, 105 (4th Cir. 2001). Finding a self-funded plan constituted a conflict of interest.

Also, most courts have held that an insurance company acting both as a plan’s insurer and administrator was inherently self-interested. See, e.g., Welch v. UNUM Life Ins. Co. of Am., 382 F.3d 1078, 1087 (10th Cir. 2004) (inherent conflict if Insurer is also administrator) (citing Pitman v. Blue Cross & Blue Shield, 217 F.3d 1291, 1296 n.4 (10th Cir. 2000)); Evans v. Metro. Life Ins. Co., 358 F.3d 307, 311 (4th Cir. 2004) (when decision maker is both insurer and administrator there is an inherent conflict); Lemaire v. Hart Life & Accident Ins. Co., 69 F. App’x 88, 91 (3d Cir. 2003) (conflict is presumed if insurer both funds and administers plan); Peruzzi v. Summa Med. Plan, 137 F.3d 431, 433 (6th Cir. 1998) (finding conflict of interest inherent in self-funded plans); Lee v. Blue Cross/Blue Shield, 10 F.3d 1547, 1552 (11th Cir. 1994) (finding that insurer’s desire to maintain competitive rates constitutes conflict of interest). But see Farley v. Ark. Blue Cross & Blue Shield, 147 F.3d 774, 777 n.5 (8th Cir. 1998) (noting that where administrator was nonprofit corporation plaintiff failed to show palpable conflict of interest even though disability decision maker was also insurer); de Nobel v. Vitro Corp., 885 F.2d 1180, 1191 (4th Cir. 1989) (finding that plan administrators’ decisions which had favorable impact on trust’s balance sheet suggested no conflict).

In 2008, the Supreme Court held that when the administrator determines eligibility and pays the benefits out of its own pockets, a conflict of interest arises. Glenn, 128 S. Ct. at 2346. Since Glenn, courts continued to hold that an inherent conflict of interest exists if the plan administrator also pays the benefits. See, e.g., Williby v. Aetna Life Ins. Co., 867 F.3d 1129, 1138 (9th Cir. 2017) (“when a plan administrator is also the payor of the employee’s benefits and thus has a direct financial incentive to deny claims, the resulting ‘conflict of interest’ becomes a significant contextual factor in the abuse of discretion analysis”); McDonough v. Aetna Life Ins. Co., 783 F.3d 374, 379 (1st Cir. 2015) (where an entity both resolves benefits claims and pays meritorious claims, the entity suffers from a structural conflict of interest); Schwalm v. Guardian Life Ins. Co. of Am., 626 F.3d 299, 311 (6th Cir. 2010) (inherent conflict of interest if payor is also administrator); Anderson v. Cytec Indus., 619 F.3d 505, 512 (5th Cir. 2010) (finding conflict of interest when plan administrator is also payor); Murphy v. Deloitte & Touche Grp. Ins. Plan, 619 F.3d 1151, 1151 (10th Cir. 2010) (noting plan administrator who was also insurer had inherent conflict of interest).

2. Various approaches Circuit Courts take in reviewing decisions by conflicted fiduciaries post-Glenn.

Once a conflict is alleged or found, court must consider how the administrator’s conflict will impact the court’s review. After Firestone, the circuit courts had adopted a variety of standards of review. These approaches are being reevaluated following the Supreme Court’s holding in Glenn and greater uniformity is beginning to

develop among the circuits regarding the review of decisions by a conflicted administrator.

a. Combination of Factors Method of Review

Prior to 2008, both the Ninth and Eleventh Circuits had adopted a “heightened arbitrary and capricious” or “presumptively void” standard. However, since Glenn and a more recent Ninth Circuit decision, the Ninth and Eleventh Circuits have abandoned the use of the “heightened arbitrary and capricious” or “presumptively void” standards. Doyle v. Liberty Life Assurance Co. of Boston, 542 F.3d 1352, 1359 (11th Cir. 2008) (“Glenn implicitly overrules and conflicts with precedent requiring courts to review under the heightened standard a conflicted administrator’s benefits decision.”); Abatie v. Alta Health & Life Ins. Co., 458 F.3d 955, 965-69 (9th Cir. 2006) (rejecting the prior Ninth Circuit analysis and adopting a test that considers the conflict as a factor in the abuse of discretion analysis); see Burke v. Pitney Bowes Inc. Long-Term Disability Plan, 544 F.3d 1016, 1024 (9th Cir. 2008) (noting that the Abatie decision is similar to Glenn). Both Circuits now consider a conflict as merely a factor in the decision. See Doyle, 542 F.3d at 1360; Burke, 544 F.3d at 1025. Under this standard, courts should review whether the conflict of interest tainted the administrator’s benefit decision on a case by case basis under a abuse of discretion standard. Blankenship v. Metro. Life Ins. Co., 644 F.3d 1350, 1356-57 (11th Cir. 2011) (finding no evidence plan administrator was improperly motivated by short-gain when denying benefit claim).

Additionally, the Second Circuit held Glenn overruled its previous standard, which required *de novo* review when the plaintiff can demonstrate that the conflict actually influences the benefits determination. McCauley v. First UNUM Life Ins. Co., 551 F.3d 126, 128 (2d Cir. 2008). The court used the Glenn approach and considered the conflict as one factor in the overall analysis. Id.

b. “Sliding scale” standard

Prior to Glenn, the Third, Fourth, Fifth, Seventh, and Tenth Circuits used a sliding scale approach, under which the reviewing court applies the abuse of discretion standard, but the court would decrease the level of deference afforded the conflicted administrator’s decision in proportion to the seriousness of the apparent conflict. See, e.g., Chojnacki v. Georgia-Pacific Corp., 108 F.3d 810, 815 (7th Cir. 1997); see also Lemaire v. Hartford Life & Accident Ins. Co., 69 F. App’x 88, 92 (3d Cir. 2003); Doe v. Grp. Hospitalization & Med. Servs., 3 F.3d 80, 87 (4th Cir. 1993). The Seventh Circuit, for example, noted that “the more serious the conflict, the less deferential our review becomes” and that a court should not interfere with an administrator’s benefit decision unless the administrator “not only made the wrong call, but [also] a ‘downright unreasonable’ one.” Chojnacki, 108 F.3d at 815, 816.

Since Glenn, several of these courts have reevaluated the application of the sliding scale standard. The Third and Fourth Circuits have repudiated the sliding scale approach and now state that in light of Glenn, the conflict of interest should not

change the standard the court applies and should merely be considered as a factor. Estate of Schwing v. Lilly Health Plan, 562 F.3d 522, 525 (3d Cir. 2009); Champion v. Black & Decker (U.S.) Inc., 550 F.3d 353, 359 (4th Cir. 2008). The Fifth Circuit has also stated that while in light of Glenn, it will no longer apply a sliding scale standard, much of the circuit's existing "sliding scale" precedent is compatible with Glenn. Holland v. Int'l Paper Co. Ret. Plan, 576 F.3d 240, 246 n.2 (5th Cir. 2009) (citing Dunn v. GE Grp. Life Assurance Co., 289 F. App'x 778, 782 n.2 (5th Cir. 2008)). The Tenth Circuit, however, has held that its sliding scale approach mirrors Glenn. Murphy v. Deloitte & Touche Grp. Ins. Plan, 619 F.3d 1151, 1158 n.1 (10th Cir. 2010); Weber v. GE Grp. Life Ins. Co., 541 F.3d 1002, 1010 (10th Cir. 2008). The Seventh Circuit has concluded Glenn was an extension of already established principles of Firestone and emphasized that a conflict of interest will be analyzed as one factor under an arbitrary and capricious standard. Black v. Long Term Disability Ins., 582 F.3d 738, 744-45 (7th Cir. 2009).

c. Modified "sliding scale" approach

Prior to 2008, courts in the Eighth Circuit applied the sliding scale once the participant presented "material, probative evidence demonstrating that (1) a palpable conflict of interest of a serious procedural irregularity existed, which (2) caused a serious breach of the plan administrator's fiduciary duty to her." Barnhart v. UNUM Life Ins. Co. of Am., 179 F.3d 583, 588 (8th Cir. 1999); Woo v. Deluxe Corp., 144 F.3d 1157, 1160 (8th Cir. 1998). Under this approach, once the claimant showed a "palpable conflict of interest or serious procedural irregularity, he had to show the conflict or irregularity caused a serious breach of the plan administrator's fiduciary duty," i.e., "serious doubts as to whether the result reached was the product of an arbitrary decision or the plan administrator's whim." Tillery v. Hoffman Enclosures, Inc., 280 F.3d 1192, 1198 (8th Cir. 2002). In Woo, for example, the claimant satisfied her burden when she showed that the plan administrator had a financial conflict of interest and that a serious breach of fiduciary duty occurred when the insurer only used an in-house medical reviewer to review her disability claims. See 144 F.3d at 1161.

For a time, it was unclear how the Eighth Circuit would respond to Glenn as the court applied both a modified sliding scale approach and the combination of factors method under Glenn. Wakkinen v. UNUM Life Ins. Co. of Am., 531 F.3d 575, 581-82 (8th Cir. 2008).

More recently, however, the Eighth Circuit has abandoned the sliding scale approach in light of Glenn. Wrenn v. Principal Life Ins. Co., 636 F.3d 921, 925 n.1 (8th Cir. 2011) (noting that the "Woo sliding-scale approach is no longer triggered by a conflict of interest, because the Supreme Court clarified that a conflict is simply one of several factors considered under the abuse of discretion standard."). The Eighth Circuit has recognized that under its pre-Glenn precedents such as Woo, a financial conflict of interest would not trigger less-deferential review unless the claimant could show that the conflict was causally connected to the specific decision at issue, but that Glenn made clear that "while a causal connection might be important in determining the appropriate level of scrutiny for a plan administrator's decisionmaking, such a connection is not required." Chronister v. UNUM Life Ins. Co. of Am., 563 F.3d 773, 775 (8th Cir.

2009). Instead, under Glenn, courts must analyze the facts of the case at issue, taking into consideration not only the conflict of interest, but also other factors that might bear on whether the administrator abused its discretion. Id. Recent Eighth Circuit decisions have only analyzed a conflict of interest under the combination of factors method and have not discussed the sliding scale approach. See, e.g., Wrenn, 636 F.3d at 92; Khoury v. Grp. Health Plan, Inc., 615 F.3d 946, 953-54 (8th Cir. 2010); Manning v. Am. Republic Ins. Co., 604 F.3d 1030, 1038-39 (8th Cir. 2010).

d. Reasonableness approach

Historically, the First and Sixth Circuits applied a reasonableness approach. Gannon v. Metro. Life Ins. Co., 360 F.3d 211, 212-13 (1st Cir. 2004); Pari-Fasano v. ITT Hartford Life & Accident Ins. Co., 230 F.3d 415, 419 (1st Cir. 2000); Univ. Hosps. of Cleveland v. Emerson Elec. Co., 202 F.3d 839, 846 (6th Cir. 2000); see also Roumeliote v. Long Term Disability Plan for Emps. of Worthington Indus., 292 F. App'x 472, 473 (6th Cir. 2008) (noting that Glenn did not change analysis).

The First Circuit has held that this approach is generally consistent with Glenn. Denmark v. Liberty Life Assurance Co., 566 F.3d 1, 9 (1st Cir. 2009) (“Glenn’s baseline principle [is] consistent with this circuit’s prior precedent.”). Glenn, however, refined First Circuit precedent in two ways. First, a court cannot disregard a structural conflict without further analyzing its affect on a plan administrator. Id. (concluding “courts are duty-bound to inquire into what steps a plan administrator has taken to insulate the decisionmaking process against . . . structural conflicts.”). Second, a court can find a decision arbitrary and capricious if a conflict has affected the decision. Id.

In the First Circuit, the reasonableness of the insurer’s decision determines whether or not the insurer abused its discretion. Pari-Fasano, 230 F.3d at 419. A possible conflict of interest necessarily affects the court’s determination of what was reasonable conduct by the insurer under the circumstances. Id. Courts in the First Circuit ask whether the circumstances indicate that the insurer was improperly motivated and, if it finds no impropriety, determines whether the benefits decision is objectively unreasonable considering the available evidence. Id.

Under the Sixth Circuit’s analysis, a court upholds a benefit determination if it is “rational in light of the plan’s provisions,” but this review is tempered by evidence of a conflict of interest. Univ. Hosps., 202 F.3d at 846; see also Roumeliote, 292 F. App'x at 473 (stating Glenn did not change analysis). When it is possible to offer a reasoned explanation, based on the evidence, for a particular outcome, that outcome is not arbitrary or capricious. While the court’s review mandates consideration of the administrator’s self-interest, the Sixth Circuit has rejected the notion that the conflict of interest inherent in a self-funded and self-administered plan alters the standard of review. Instead, that fact should be taken into account as a factor in determining arbitrariness or capriciousness. See Peruzzi v. Summa Med. Plan, 137 F.3d 431, 433 (6th Cir. 1998). If the plan’s language is susceptible to more than one interpretation, the Sixth Circuit applies the rule of *contra proferentem* and construes any ambiguities

against the insurers as the drafting parties. Univ. Hosps., 202 F.3d at 847 (citing Perez v. Aetna Life Ins. Co., 150 F.3d 550, 557 n.7 (6th Cir. 1998)).

- e. Courts may not impose “treating physician rule” on administrators

The Supreme Court has made it clear that courts may not require plan administrators to defer to a plan participant’s treating physician’s opinion when the administrator must determine whether the participant is disabled. Black & Decker Disability Plan v. Nord, 538 U.S. 822, 834 (2003). Under the regulations that the Commissioner of Social Security has adopted for determining whether a person is eligible for Social Security disability payments, the Commissioner must defer to the claimant’s treating physician. Id. at 825. The Ninth and Eighth Circuits had decided that this treating physician rule should also apply in cases where the administrator of an ERISA benefits plan must determine whether a plan participant is disabled. See id. at 828-30. These circuits held that an administrator could reject the treating physician’s opinion only if it provided an adequate justification for rejecting that opinion. Id. Other circuits did not impose the treating physician rule, and the Supreme Court granted *certiorari* to resolve the circuit split.

The Court unanimously concluded that courts could not require administrators to defer to the treating physician’s opinion for four reasons. First, no language in ERISA requires administrators to defer to the treating physician’s opinion or imposes a heightened burden on administrators to explain why they are rejecting it. See id. at 831. Second, unlike the Commissioner of Social Security, the Secretary of Labor has not adopted a regulation requiring the treating physician rule. Id. As neither Congress nor the Secretary has required the treating physician rule, the Court was reluctant to allow courts to impose such a rule. Id. Third, the court was skeptical of the Ninth Circuit’s conclusion that a treating physician rule would “increase the accuracy of disability determinations” and that Congress or the Secretary were in a better position than courts to determine whether such a rule would make determinations more accurate. See id. at 832.

Finally, and “of prime importance,” because the Social Security system is an “obligatory, nationwide” program, it is more necessary that a presumption such as the treating physician rule be adopted for efficient benefits administration. Id. Because ERISA benefit programs are smaller, varied and more likely to turn on the terms of the plan, however, the Court concluded that plan administrators should be given more flexibility to make disability determinations. Id. at 833-34. While recognizing that administrators cannot arbitrarily refuse to credit a treating physician’s opinion, the Court concluded that federal courts cannot require administrators to defer to such opinions and cannot impose on administrators a heightened standard to explain why they rejected the opinions. Id.

2. Remedies available to claimants in actions for denial of benefits

A participant or beneficiary who successfully asserts a claim for wrongful denial of benefits may recover the benefits in an action brought under ERISA § 502(a)(1)(B). 29 U.S.C. § 1132(a)(1)(B). The availability of additional relief, including consequential and punitive damages, has been more problematic since the Supreme Court in Massachusetts Mutual Life Insurance Co. v. Russell admonished lower courts to resist reading into ERISA remedies not expressly incorporated into an enforcement scheme that had been “crafted with such evident care.” 473 U.S. 134, 147 (1985). The lower courts have grappled to reconcile this directive with the Supreme Court’s statement in Firestone Tire & Rubber Co. v. Bruch that the courts are to “develop a federal common law of rights and obligations under ERISA-regulated plans.” 489 U.S. 101, 110 (1989) (quoting Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 56 (1987) (holding that ERISA does not apply), overruled in part on other grounds by Ky. Ass’n of Health Plans, Inc. v. Miller, 538 U.S. 329 (2003)). Although certain general tendencies can be identified, the lower courts continue to disagree over available ERISA remedies.

a) Recovery is limited to benefits owed under a plan

ERISA § 502(a)(1)(B) expressly provides participants and beneficiaries of employee benefit plans with a private right of action to recover benefits owed under a plan. See Gables Ins. Recovery, Inc. v. Blue Cross & Blue Shield of Fla., Inc., 813 F.3d 1333, 1337 (11th Cir. 2015); Bast v. Prudential Ins. Co. of Am., 150 F.3d 1003, 1008 (9th Cir. 1998); Lake v. Metro. Life Ins. Co., 73 F.3d 1372, 1375 n.3 (6th Cir. 1996); Kemmerer v. ICI Ams., Inc., 70 F.3d 281, 289 (3d Cir. 1995). Any money judgment against a benefit plan is enforceable only against the plan and not against any other person unless liability in an individual capacity is established. 29 U.S.C. § 1132(d)(2); see also Madden v. ITT Long Term Disability Plan for Salaried Emps., 914 F.2d 1279, 1287 (9th Cir. 1990).

b) Other forms of monetary relief generally unavailable

Under ERISA § 502(a)(1)(B), a participant or beneficiary only enjoys a right to recover benefits. Therefore, claimants’ efforts to recover other monetary relief, including consequential and punitive damages, have focused on other ERISA civil enforcement provisions, common law remedies, or state-law based causes of action. Generally, with a few exceptions, courts preclude the recovery of such monetary damages.

In Russell, the Supreme Court ruled that an individual claimant could not recover punitive damages as a result of a denial of benefits in an ERISA § 502(a)(2) action for breach of fiduciary duty. 473 U.S. at 144. The Court held that relief in actions for breach of fiduciary duty brought under §§ 502(a)(2) and 409 was expressly limited to relief for a plan as distinguished from individual claimants. Id. The Court cautioned against awarding remedies that Congress did not expressly provide under ERISA’s civil enforcement provisions. Id. at 147-48.

Following Russell, most courts have held that consequential and punitive damages are not available under § 502(a)(3) as “other appropriate equitable relief” to remedy a violation or to enforce rights under ERISA. See, e.g., Mertens v. Hewitt Assocs., 508 U.S. 248, 257-58 (1993) (holding monetary damages not recoverable under § 502(a)(3) as equitable relief); Callery v. United States Life Ins. Co., 392 F.3d 401, 405 (10th Cir. 2004) (holding § 502(a)(1)(B) does not provide for compensatory damages); Gerosa v. Savasta & Co., Inc., 329 F.3d 317, 321 (2d Cir. 2003) (compensatory and punitive damages are not available within the rubric of “other appropriate equitable relief”); Nero v. Indus. Molding Corp., 167 F.3d 921, 931 (5th Cir. 1999) (ruling out-of-pocket expenses and mental anguish damages not recoverable under ERISA); Medina v. Anthem Life Ins. Co., 983 F.2d 29, 32 (5th Cir. 1993) (holding § 502(a)(1)(B) does not provide extra-contractual or punitive damages). Courts have also refused to award consequential or punitive damages under a federal common law theory. See, e.g., U.S. Steel Mining Co. v. Dist. 17, United Mine Workers, 897 F.2d 149, 152-53 (4th Cir. 1990); Openshaw v. Cohen, Klingenstein & Marks, Inc., 320 F. Supp. 2d 357, 362 n.8 (D. Md. 2004). Claimants seeking compensatory or punitive damages under state law also have failed due to ERISA’s preemption provisions. See Metro. Life Ins. Co. v. Taylor, 481 U.S. 58, 66-67 (1987); Pilot Life, 481 U.S. at 57; Hampers v. W.R. Grace & Co., 202 F.3d 44, 51 (1st Cir. 2000). A minority of courts have awarded compensatory damages under certain circumstances. See, e.g., Warren v. Soc’y Nat’l Bank, 905 F.2d 975, 980 (6th Cir. 1990), overruling recognized by Fraser v. Lintas, 56 F.3d 722, 725 (6th Cir. 1995).

The Supreme Court’s decision in Ingersoll-Rand Co. v. McClendon, 498 U.S. 133 (1990), has caused some confusion over this issue, however. Although the Court held that ERISA preempted the claimant’s state law tort and contract claims for mental anguish, compensatory and punitive damages, the majority opined that:

[t]here is no basis in § 502(a)’s language for limiting ERISA actions to only those which seek ‘pension benefits.’ It is clear the relief requested here is well within the power of federal courts to provide. Consequently, it is no answer to a pre-emption argument that a particular plaintiff is not seeking recovery of pension benefits.

Ingersoll-Rand, 498 U.S. at 145.

Relying on this language, several lower courts have expanded the scope of remedies available under ERISA § 502(a). See, e.g., East v. Long, 785 F. Supp. 941, 943 (N.D. Ala. 1992); UAW v. Midland Steel Prods. Co., 771 F. Supp. 860, 863-64 (N.D. Ohio 1991); Blue Cross & Blue Shield of Ala. v. Lewis, 753 F. Supp. 345, 347 (N.D. Ala. 1990). Most courts, however, have decided to wait for stronger language from the Supreme Court before expanding recovery beyond the line established by Russell. See, e.g., Millsap v. McDonnell Douglas Corp., 368 F.3d 1246, 1251 (10th Cir. 2004); Kemmerer, 70 F.3d at 289-91; Zimmerman v. Sloss Equip., Inc., 72 F.3d 822, 827-28 (10th Cir. 1995); Buckley Dement, Inc. v. Travelers Plan Adm’rs, of Ill. Inc., 39 F.3d 784, 789-90 (7th Cir. 1994).

c) Equitable relief in actions for denial of benefits does not include monetary damages

As noted above, the Supreme Court ruled that monetary damages are not available under ERISA § 502(a)(3) as “other appropriate equitable relief.” Mertens, 508 U.S. at 257-58. Some courts, however, provide claimants other forms of equitable relief

Interest is available as equitable relief. Skretvedt v. E.I. DuPont de Nemours, 372 F.3d 193, 209-10 (3d Cir. 2004). But see Flint v. ABB, Inc., 337 F.3d 1326, 1330-31 (11th Cir. 2003) (casting doubt on interest based on Knudson but not holding that interest is unavailable).

Rescission is available “even if a full restoration of the benefits conferred in the transaction cannot be accomplished.” Griggs v. E.I. DuPont de Nemours & Co., 385 F.3d 440, 499 (4th Cir. 2004) (beneficiary’s suit to rescind benefit selection that was only partial because it involved switching from lump sum to monthly payments but not repaying the entirety of the lump sum was still equitable and valid under ERISA).

See:

Rochow v. Life Ins. Co. of N. Am., 780 F.3d 364, 375 (6th Cir. 2015):
Although ERISA does not address propriety of awarding prejudgment interest, prejudgment interest may be awarded in district court’s discretion.

Varity Corp. v. Howe, 516 U.S. 489, 515 (1996). *Individual participants and beneficiaries were allowed to bring actions to obtain relief under ERISA § 502(a)(3) for breach of fiduciary duty.*

Tobin v. Liberty Mut. Ins. Co., 553 F.3d 121, 145 (1st Cir. 2009). *Court held district court had broad discretion in determining prejudgment interest rate.*

Cottrill v. Sparrow, Johnson & Ursillo, Inc., 100 F.3d 220, 225 (1st Cir. 1996) *abrogated on other grounds by* Hardt v. Reliance Standard Life Ins. Co., 560 U.S. 242 (2010). *Court held that trial court had broad discretion in choosing a rate for computing prejudgment interest and awarded prejudgment interest on wrongfully withheld benefits.*

In re Unisys Corp. Retiree Med. Benefit “ERISA” Litig., 57 F.3d 1255, 1269 (3d Cir. 1995) *modified by* Great-West Life & Annuity Ins. Co. v. Knudson, 534 U.S. 204 (2002). *Court would allow § 502(a)(3) plaintiffs to seek an injunction barring fiduciaries from violating the terms of a plan because such relief was equitable.*

Blue Cross & Blue Shield of Ala. v. Weitz, 913 F.2d 1544, 1549 (11th Cir. 1990). *Fiduciaries were allowed to recover erroneously paid benefits under § 502(a)(3).*

d) Award of costs and attorney's fees

Under ERISA § 502(g)(1), the court has the discretion to award either party in a benefits action reasonable attorney's fees and costs. 29 U.S.C. § 1132(g)(1). To be entitled to attorneys' fees, the Supreme Court held a party need only establish "some success on the merits" to recover fees. Hardt v. Reliance Standard Ins. Co., 130 S. Ct. 2149, 2158 (2010).

In Hardt, the Court specifically rejected the view that a party has to be a "prevailing party" to recover fees under § 502(g)(1). Id. at 2156. A party only has to show "some success on the merits" to recover fees. Id. at 2158. Relying on statutory interpretation, the Court explained that the words "prevailing party" did not appear in the text of § 502(g)(1), and that, instead, the provision "expressly grants district courts 'discretion' to award attorney's fees 'to either party.'" Id. at 2156.

The Court defined "some success on the merits" as more than "trivial success on the merits or a purely procedural victory." Id. at 2158. A claimant meets the requirements, however, "if the court can fairly call the outcome of the litigation some success on the merits without conducting a lengthy inquiry into the question whether a particular party's success was substantial or occurred on a central issue." Id. The Court specifically rejected using the five-factor test used by some circuits to determine whether a party achieved some success on the merits. Id.; see, e.g., Eaves v. Penn, 587 F.2d 453, 465 (10th Cir. 1978).

Although it rejected using the five factors to determine whether fees could be awarded, the Court in Hardt stated that a court can still consider the factors after the court has determined a party has achieved some success on the merits. Id. at 2158 n.8. Relying on this language, circuit courts have held district courts should still use the five-factor test to guide their discretion. See, e.g., Plasterers' Local Union No. 96 Pension Plan v. Pepper, 663 F.3d 210, 222-23 (4th Cir. 2011); Toussaint v. JJ Weiser, Inc., 648 F.3d 108, 111 (2d Cir. 2011); McKay v. Reliance Standard Life Ins. Co., 428 F. App'x 537, 546 (6th Cir. 2011). These courts reasoned that Hardt did not foreclose the possibility a court may consider the five factors once the court decided a party is eligible for fees. Toussaint, 648 F.3d at 111; Gastronomical Workers Union Local 610 v. Dorado Beach Hotel Corp., 617 F.3d 54, 66 (1st Cir. 2010); Simonia v. Glendale Nissan/Infiniti Disability Plan, 608 F.3d 1118, 1120-21 (9th Cir. 2010). The five factors are:

1. the offending parties' culpability or bad faith;
2. the offending parties' ability to satisfy personally a fee award;
3. whether an attorneys' fees award against the offending parties would deter other persons acting under similar circumstances;
4. the benefit amount conferred on pension plan members as a whole;
5. the relative merits of the parties' position.

Under the five-factor test, no single factor is determinative. Riley v. Adm'r of the Supersaver 401(k) Capital Accumulation Plan for Emps. of Participating AMR Corp. Subsidiaries, 209 F.3d 780, 782 (5th Cir. 2000); see also Locher v. UNUM Life Ins. Co. of Am., 389 F.3d 288, 298-99 (2d Cir. 2004) (failure to satisfy fifth factor does not preclude award of attorney's fees); Heffernan v. UNUM Life Ins. Co. of Am., 101 F. App'x 99, 108 (6th Cir. 2004) (only three factors weighed for awarding fees but court analyzed parties' behavior and affirmed); Sheehan v. Guardian Life Ins. Co., 372 F.3d 962, 968 (8th Cir. 2004) (affirming fee award even though fourth factor weighed against granting fees). Most of these factors, however, place emphasis upon the behavior of the offending or losing party, which tends to lead courts to award the prevailing party its costs.

The Seventh Circuit has recognized two tests for determining whether a prevailing party should be granted attorney's fees. The Seventh Circuit will grant fees to a party if either the five factors weigh in favor of their being granted or unless the losing party's position was "substantially justified." Quinn v. Blue Cross & Blue Shield Ass'n, 161 F.3d 472, 478 (7th Cir. 1998) (internal citations omitted). Quinn also stated that the basic question asked in the Seventh Circuit, which underlies each test, is whether the losing party's position was substantially justified and taken in good faith or whether it was taken to harass the plaintiff. Id.; see also Stark v. PPM Am. Inc., 354 F.3d 666, 673 (7th Cir. 2004) (asking basic question stated in Quinn); Fritcher v. Health Care Serv. Corp., 301 F.3d 811, 818 (7th Cir. 2002). In the second test, a party is entitled to attorney's fees unless the court determines that the losing party's position was "substantially justified." Harris Trust & Sav. Bank v. Provident Life & Accident Ins. Co., 57 F.3d 608, 616-17 (7th Cir. 1995). Under this standard, a court may decline to award fees and costs if it finds that (1) the losing party's position had a reasonable or "solid" basis in law and fact; or (2) special circumstances make an award unjust. Id.; see also Prod. & Maint. Emps.' Local 504 v. Roadmaster Corp., 954 F.2d 1397, 1405 (7th Cir. 1992) (finding modest presumption in favor of awarding fees to prevailing party unless losing party's position had solid basis). The Seventh Circuit has continued to apply the two tests after Hardt, although no longer requiring a party to be a prevailing party. See Pakovich v. Verizon Ltd. Plan, 653 F.3d 488, 494 (7th Cir. 2011).

Generally, courts have been willing to award attorney's fees to participants and beneficiaries in actions for benefits. A minority of circuits has even mandated a presumption favoring prevailing beneficiaries. See, e.g., Camerer v. Cont'l Cas. Co., 76 F. App'x 837, 841 (9th Cir. 2003) (citing Canseco v. Constr. Laborers Pension Trust, 93 F.3d 600, 609-10 (9th Cir. 1996) and stating that ordinarily the prevailing participant/beneficiary should get attorney's fees award unless there is a showing that it is unjust to do so); see also Senese v. Chicago Area Int'l Bhd. of Teamsters Pension Fund, 237 F.3d 819, 826 (7th Cir. 2001) (modest presumption in favor of prevailing parties); Kayes v. Pac. Lumber Co., 51 F.3d 1449, 1468 (9th Cir. 1995) (stating that § 502(g)(1) "should be read broadly to mean that a [prevailing] plan participant or beneficiary . . . should ordinarily recover an attorney's fee unless special circumstances would render such an award unjust"). Most circuits have rejected such a mandatory presumption. See, e.g., Byars v. Coca-Cola Co., 517 F.3d 1256, 1268 (11th Cir. 2008) (refusing to create a presumption in favor of awarding fees); Janeiro v. Urological

Surgery Prof'l Ass'n, 457 F.3d 130, 143 (1st Cir. 2006) (noting that there is no presumption favoring prevailing parties in ERISA action); Martin v. Ark. Blue Cross & Blue Shield, 299 F.3d 966, 971 (8th Cir. 2002) (describing majority rule holding Eighth Circuit no longer has presumption and factors for granting a fee are not determinative; courts should also consider other financial aspects of the parties), cert. denied, 537 U.S. 1159 (2003).

In addition, some courts tend not to award fees to defendants who prevail against plan beneficiaries and participants unless the suit was frivolous or brought in bad faith. See Flanagan v. Inland Empire Elec. Workers Pension Plan & Trust, 3 F.3d 1246, 1253 (9th Cir. 1993) (rejecting defendants' fee request and finding no reason to displace court's common perception that attorney's fees should not be charged against ERISA plaintiffs); see also Credit Managers Ass'n of S. Cal. v. Kennesaw Life & Accident Ins. Co., 25 F.3d 743, 752 (9th Cir. 1994). But see Herman v. Cent. States, 423 F.3d 684, 695 (7th Cir. 2005) (noting either party, including a defendant, may be awarded fees); Gettings v. Bldg. Laborers Local 310 Fringe Benefits Fund, 349 F.3d 300, 310 (6th Cir. 2003) (defendant can get fees if plaintiff's actions were frivolous, unreasonable or without foundation, and only if the plaintiff's action was groundless at the outset or plaintiff continued litigation after cause of action was apparently groundless); Senese, 237 F.3d at 826 (defendant can get fees in Seventh Circuit unless plaintiff's claim was substantially justified (more than non-frivolous) and plaintiff acted in good faith or unless special circumstances make it unjust to provide fees); FirsTier Bank, N.A. v. Zeller, 16 F.3d 907, 913-14 (8th Cir. 1994) (awarding attorney's fee from plan for defending against participants' claims).

Lower court decisions awarding or refusing to award the costs or fees are given deference on appeal. See, e.g., Laborers' Pension Fund v. Lay-Com, Inc., 580 F.3d 602, 615 (7th Cir. 2009); Dabertin v. HCR Manor Care, Inc., 373 F.3d 822, 834 (7th Cir. 2004); Florence Nightingale Nursing Serv., Inc., 41 F.3d at 1485 (reviewing district court's denial of fees for abuse of discretion). But see Bellaire Gen. Hosp. v. Blue Cross & Blue Shield of Mich., 97 F.3d 822, 833 (5th Cir. 1996) (vacating trial court's decision on fee amount and remanding case for recalculation where record contained no discussion of how court arrived at fee award).

3. Due process issues related to actions under ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B)

a) Proper party defendants

Courts are split over whether a party other than an ERISA plan can properly be named as a defendant in suits under ERISA § 502(a)(1)(B). The United States Supreme Court decided not to settle a circuit split on the issue in Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355 (2002) (holding that ERISA does not apply), overruled in part on other grounds by Ky. Ass'n of Health Plans, Inc. v. Miller, 538 U.S. 329 (2003). Compare Riordan v. Commonwealth Edison Co., 128 F.3d 549, 551 (7th Cir. 1997) (noting "ERISA permits suits to recover benefits only against the plan as an entity"), with Garren v. John Hancock Mut. Life Ins. Co., 114 F.3d 186, 187

(11th Cir. 1997) (labeling proper defendant in ERISA action “party that controls [plan’s] administration”) and Leonelli v. Pennwalt Corp., 887 F.2d 1195, 1199 (2d Cir. 1989) (“In a recovery of benefits claim, only the plan and the administrators and trustees of the plan in their capacity as such may be held liable.”). The list of potential defendants is fairly extensive.

See:

LifeCare Mgmt. Servs. LLC v. Ins. Mgmt. Adm’rs Inc., 703 F.3d 835, 843 (5th Cir. 2013). *A claimant may bring a suit directly against an employer, under ERISA, when plan has no meaningful existence apart from the employer, and when the employer made the decision to deny benefits. The proper party defendant in an action concerning ERISA benefits is the party that controls the plan’s administration and if an entity or person other than the named plan administrator takes on the responsibilities of the administrator, that entity may also be liable for benefits.*

Cyr v. Reliance Standard Life Ins. Co., 642 F.3d 1202, 1207 (9th Cir. 2011) (*en banc*). *A third-party insurer could be sued because it allegedly made the decision to deny benefits.*

Mein v. Carus Corp., 241 F.3d 581, 585 (7th Cir. 2001). *The employer or employee organization sponsoring the plan can be properly named as defendant under certain circumstances, although ordinarily the plaintiff should name the ERISA plan as defendant.*

Garren v. John Hancock Mut. Life Ins. Co., 114 F.3d 186, 187 (11th Cir. 1997). *All named fiduciaries and plan administrators, including party that controls the administration of the plan, are properly named as defendants in the benefits action.*

But see:

Krauss v. Oxford Health Plans, Inc., 517 F.3d 614, 630 (2d Cir. 2008). *A third party health care plan cannot be held liable for statutory violations because it is not the plan administrator as defined by § 502.*

Gore v. El Paso Energy Corp. Long Term Disability Plan, 477 F.3d 833, 843 (6th Cir. 2007). “[T]he law in this Circuit is clear that ‘only a plan administrator can be held liable under section § 1132(c).’”

ERISA defines a plan “administrator” as (i) the person the plan instrument specifically designates as the administrator; (ii) the plan sponsor if the instrument does not designate an administrator, or (iii) a person prescribed by the Secretary in regulations if no administrator is designated and a plan sponsor cannot be identified. 29 U.S.C. § 1002(16)(A). The Seventh Circuit noted a split among the circuit courts of appeals as to whether a party other than the one designated in the plan instrument can be a *de facto* administrator of the plan. See Rud v. Liberty Life Assurance Co., 438 F.3d

772, 774 (7th Cir. 2006). The significance of this distinction is that an entity not designated in ERISA plan documents, such as an insurance company who merely processes the claims, could be sued under § 502(a)(1)(B) as a *de facto* plan administrator.

The First, Fifth and Eleventh Circuits are likely to consider these non-administrators *de facto* administrators. See Gomez-Gonzalez v. Rural Opportunities, Inc., 626 F.3d 654, 665 (1st Cir. 2010); Garren v. John Hancock Mut. Life Ins. Co., 114 F.3d 186, 187 (11th Cir. 1997); Fisher v. Metro. Life Ins. Co., 895 F.2d 1073, 1077 (5th Cir. 1990) (finding idea of *de facto* administrator had intuitive appeal, but not deciding issue). The other circuits that have decided the issue will not. See Mondry v. Am. Family Mut. Ins. Co., 557 F.3d 781, 794 (7th Cir. 2009); Krauss v. Oxford Health Plans, Inc., 517 F.3d 614, 630 (2d Cir. 2008); Gore v. El Paso Energy Corp. Long Term Disability Plan, 477 F.3d 833, 843 (6th Cir. 2007); Thorpe v. Ret. Plan of the Pillsbury Co., 80 F.3d 439, 444 (10th Cir. 1996); Coleman v. Nationwide Life Ins. Co., 969 F.2d 54, 62 (4th Cir. 1992); Davis v. Liberty Mut. Ins. Co., 871 F.2d 1134, 1138 (D.C. Cir. 1989).

The Third and Eighth Circuits remain undecided on the issue. See Slayhi v. High-Tech Inst., Inc., No. 06-CV-2210, 2007 WL 4284859, at *8 (D. Minn. Dec. 3, 2007). The Third Circuit discussed the issue in Evans v. Employee Benefit Plan, Camp Dresser & McKee, Inc., 311 F. App'x 556, 558-59 (3d Cir. 2009). In Evans, the court concluded the “proper defendant is the plan itself or a person who controls the administration of benefits under the plan.” Id. at 558-59 (affirming dismissal of defendant because defendant did not administer benefits or determine eligibility). Evans is an unpublished case, however. District courts are split in whether Evans expanded the scope of proper defendants. Compare Miller v. Mellon Long Term Disability Plan, 721 F. Supp. 2d 415 (W.D. Pa. 2010) (holding Evans was not binding and poorly reasoned) with Franco v. Conn. Gen. Life Ins. Co., 818 F. Supp. 2d 792, 818 (D.N.J. 2011) (acknowledging Evans is not precedential but concludes its logic is persuasive) vacated in part on other grounds, 647 F. App'x 76, 83 (3d Cir. 2016).

In 2011, the Ninth Circuit held that defendants in a claim for benefits are not limited to the plan and the plan administrators. Cyr v. Reliance Standard Life Ins. Co., 642 F.3d 1202, 1207 (9th Cir. 2011) (en banc). Instead, a proper defendant is the entity who decides whether to deny benefits. Id. In Cyr, the Ninth Circuit, sitting en banc, concluded a third party insurer of the plan could be sued because the third party insurer allegedly made the decision to deny benefits. Id. Relying on Harris Trust & Savings Bank v. Salomon Smith Barney, Inc., 530 U.S. 238 (2008), the court did not find any limit on potential defendants in the language of § 502(a)(1)(B). Id. at 1206. Cyr explicitly overruled all previous Ninth Circuit decisions that limit proper defendants to plan administrators. Id. at 1207.

b) Right to trial by jury

Most circuits hold that there is no right to a jury trial in actions for benefits brought under ERISA § 502(a)(1)(B) because these claims are equitable rather than

legal and thus the Seventh Amendment to the United States Constitution does not guarantee the right to a jury trial. See, e.g., Adams v. Cyprus Amax Minerals Co., 149 F.3d 1156, 1162 (10th Cir. 1998) (describing ERISA's remedies as primarily equitable, so that there is no right to jury trial under 7th Amendment); Tischmann v. ITT/Sheraton Corp., 145 F.3d 561, 568 (2d Cir. 1998) (labeling claims for ERISA benefits inherently equitable in nature, not contractual, and denying right to jury trial); Hunt v. Hawthorne Assocs., Inc., 119 F.3d 888, 907 (11th Cir. 1997); see also Muller v. First UNUM Life Ins. Co., 341 F.3d 119, 124 (2d Cir. 2003); Thomas v. Or. Fruit Prods. Co., 228 F.3d 991, 996-97 (9th Cir. 2000) (because the remedies available to participants or beneficiaries are equitable, there is no Seventh Amendment right to a jury).

A few district courts in the mid-1990s, however, questioned the majority position by suggesting that the Supreme Court's opinion in Firestone implies a contrary result. See, e.g., Williams v. UNUM Life Ins. Co. of Am., 940 F. Supp. 136, 141 (E.D. Va. 1996) (stating "courts must look beyond simple categorizations, to the nature of both the issue presented and the remedy" to determine if the 7th Amendment requires a jury trial); Hulcher v. United Behavioral Sys., 919 F. Supp. 879, 885 (E.D. Va. 1995) (stating "action[s] to recover [ERISA] benefits under the subject plan are legal in nature" and plan beneficiaries are "constitutionally entitled to trial by jury on any claim raised under [§ 502](a)(1)(B)"); Vaughn v. Owen Steel Co., 871 F. Supp. 247, 250 (D.S.C. 1994) (finding that § 502 claims are most analogous to state law contract claims and consequently must be tried before jury). Some courts have found a right to a jury trial by concluding that certain benefits claims have both legal and equitable elements. See Weems v. Jefferson-Pilot Life Ins. Co., 663 So. 2d 905, 913-14 (Ala. 1995) (holding that right to recover compensation and punitive damages leads inexorably to right to jury trial); Blue Cross & Blue Shield v. Lewis, 753 F. Supp. 345, 347-48 (N.D. Ala. 1991); see also Cunningham v. Cornell Univ., 2018 WL 4279466, *4 (S.D.N.Y. Sept. 6, 2018) (denying motion to strike jury demand as to fiduciary duty claims seeking legal damages).

In addition, hybrid claims brought under other federal statutes or state law and joined with ERISA action for benefits may be tried before a jury. See, e.g., Stewart v. KHD Deutz of Am. Corp., 75 F.3d 1522, 1528 (11th Cir. 1996) (finding claimant entitled to jury trial in hybrid action under Labor Management Relations Act ("LMRA") and ERISA). If a case requires bifurcation of jury and non-jury claims, the jury's resolution of factual issues in common with the non-jury ERISA claims will have a binding effect on the non-jury claims. Menovcik v. BASF Corp., No. 09-12096, 2011 WL 4945764, at *7 (E.D. Mich. Oct. 18, 2011); see also Brown v. Sandimo Materials, 250 F.3d 120, 127-28 (2d Cir. 2001) (court must heed any factual determination jury makes and determine if any equitable remedy is available as they are only available if the legal remedies are inadequate). In Golden v. Kelsey-Hayes Co., however, the Sixth Circuit denied a jury trial in a hybrid action brought under the LMRA and ERISA on the ground that the LMRA claim was an equitable one and thus not triable by jury. 73 F.3d 648, 662-63 (6th Cir. 1996).

c) Applicable statute of limitations

For ERISA § 502(a)(1)(B) claims for wrongful denial of benefits, courts will apply the most closely analogous statute of limitations under state law because § 502(a) does not provide an express statute of limitations. See Redmon v. Sud-Chemie Inc. Ret. Plan for Union Emps., 547 F.3d 531, 534-35 (6th Cir. 2008); Syed v. Hercules, Inc., 214 F.3d 155, 159 (3d Cir. 2000) (noting 28 U.S.C. § 1658, which established four-year statute of limitations for all federal acts, does not apply to statutes enacted before 1990). Most courts have found that the most closely analogous state statute of limitations is that for a state contract action. Syed, 214 F.3d at 159; see also, e.g., Shaw v. McFarland Clinic P.C., 363 F.3d 744, 747 (8th Cir. 2004); Harrison v. Digital Health Plan, 183 F.3d 1235, 1239-40 (11th Cir. 1999); Dailly v. Sheet Metal Workers' Local 73 Pension Fund, 100 F.3d 62, 65 (7th Cir. 1996). In ERISA § 502(a)(1)(B) cases, the limitations period begins to run “when a request for benefits is denied.” Hall v. Nat'l Gypsum Co., 105 F.3d 225, 230 (5th Cir. 1997); see also Stafford v. E.I. DuPont de Nemours & Co., 27 F. App'x 137, 140-141 (3d Cir. 2002).

If the plan expressly provides a reasonable statute of limitations, however, the court will enforce it. Northlake Reg'l Med. Ctr. v. Waffle House Sys. Emp. Benefit Plan, 160 F.3d 1301, 1303 (11th Cir. 1998) (following Doe, 112 F.3d at 874-75). In Northlake Regional Medical Center, a contractual limitations period was found to be reasonable (1) where there was no evidence that the limitations period was a “subterfuge to prevent lawsuits;” (2) where the limitations period was commensurate with other claim processing provisions; and (3) where there was adequate opportunity to investigate the claim and file a suit because the limitations period did not run until after the plan's internal appeals process was exhausted. Id. at 1304. Thus, a suit under § 502(a)(1)(B) must be filed after the benefits claims procedure has been exhausted, i.e. the request for benefits is denied, but before the contractual limitations period or the most closely analogous state limitations period expires.

4. Other actions to recover denied ERISA benefits

a) Actions for equitable relief

Participants and beneficiaries may also seek equitable relief under ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3). Section 502(a)(3) enables benefit claimants to bring civil actions (1) to enjoin any act or practice that violates Title I of ERISA or the terms of the plan, or (2) to obtain other appropriate equitable relief to redress such violations or enforce any provisions of Title I of ERISA or the terms of the plan.

The Supreme Court ruled in Mertens v. Hewitt Associates that monetary damages are not recoverable as equitable relief under ERISA § 502(a)(3). The Third Circuit suggested, however, that equitable restitution might encompass monetary damages. See Ream v. Frey, 107 F.3d 147, 153 n.5 (3d Cir. 1997).

In Great West Life & Annuity Ins. Co. v. Knudson, 534 U.S. 204 (2004), however, the Supreme Court reaffirmed that only equitable remedies are available

under ERISA. In Knudson, Great West and the plan sought “restitution” for payments made to a beneficiary when the beneficiary subsequently recovered compensation from the car manufacturer whose car she alleged caused her accident. The Court, however, said that they were seeking inherently legal relief as they were seeking monetary relief, which was not available in equity. The Court distinguished between equitable restitution, seeking to restore particular funds or property (by constructive trust or equitable lien), and restitution at law, where the petitioner is seeking to impose personal liability on the defendant. 534 U.S. at 213-14. As the petitioners in Knudson were attempting to obtain solely monetary restitution, their actions were for legal restitution and ERISA did not provide any remedy.

For more on the scope of equitable relief under § 502(a)(3), refer to Sections IV.B. and XI.B of this Handbook.

b) Estoppel and misrepresentation

Plan administrators or other fiduciaries routinely provide participants and beneficiaries with ERISA-required written disclosures, employment-related literature, and oral statements about employee benefits. Disputes arise when this information is not correct. Under such circumstances, claimants often argue that a plan should be estopped from denying claims that are at odds with the actual plan provisions. In some cases, courts have ruled that state law estoppel claims are generally preempted. See Cromwell v. Equicor-Equitable HCA Corp., 944 F.2d 1272, 1278-79 (6th Cir. 1991) (ruling ERISA preempted action for misrepresentation to former plan beneficiary about whether or not she was still covered); see also Mello v. Sara Lee Corp., 431 F.3d 440, 446 (5th Cir. 2005); Caffey v. UNUM Life Ins. Co., 302 F.3d 576, 582 (6th Cir. 2002); Aetna Life Ins. Co. v. Bayona, 223 F.3d 1030, 1034 (9th Cir. 2000). On the other hand, many courts have recognized a federal common law of estoppel as applicable to denial of benefits, which prevents a party from benefiting from its misleading conduct.

See:

Griffin v. S. Co. Servs., 635 F. App'x 789, 795 (11th Cir. 2015): *Under ERISA, equitable estoppel applies only when “the plaintiff can show that (1) the relevant provisions of the plan at issue are ambiguous, and (2) the plan provider or administrator has made representations to the plaintiff that constitute an informal interpretation of the ambiguity.”*

Burstein v. Ret. Account for Emps. of Allegheny Health Educ. and Research Found., 334 F.3d 365, 383 (3d Cir. 2003). *To prevail on equitable estoppel theory, plaintiff must show (1) material representation, (2) reasonable reliance upon that representation, and (3) damage resulting from that representation.*

Bowerman v. Wal-Mart Stores, Inc., 226 F.3d 574, 587 (7th Cir. 2000). *Estoppel arises “where the claimant was misled by written representations*

of the insurer or plan administrator into failing to take an action that would have enabled the claimant to receive benefits.”

Gallegos v. Mount Sinai Med. Ctr., 210 F.3d 803, 811 (7th Cir. 2000).

“[E]stoppel arises when one party has made a misleading representation to another party and the other has reasonably relied to his detriment on that representation.”

Some Circuits have stated that whether there is an equitable estoppel claim available under ERISA is an open question. *Livick v. Gillette Co.*, 524 F.3d 24, 30-31 (1st Cir. 2008).

c) State law causes of action are limited

The Supreme Court and lower courts have broadly applied the ERISA preemption provisions of § 514, 29 U.S.C. § 1144, to preclude actions for recovery of benefits and damages brought under state common law of tort and contract, state unfair insurance practices, employment, civil rights, disability, and other state statutes that “relate to employee benefit plans” or are perceived as inconsistent with ERISA’s statutory enforcement scheme.

See:

Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 145 (1990). *ERISA preempted employee’s state law wrongful discharge claim based on allegation that his discharge was based on his employer’s desire to avoid making contributions to his pension fund.*

Mackey v. Lanier Collection Agency & Serv. Inc., 486 U.S. 825, 829 (1988). *ERISA preempted Georgia statute that singled out ERISA welfare plan benefits for protective treatment under state garnishment procedures, but ERISA did not forbid garnishment of welfare benefits plan even where it collected judgments against plan participants.*

Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 57 (1987) (holding that ERISA does not apply), *overruled in part on other grounds by Ky. Ass’n of Health Plans, Inc. v. Miller*, 538 U.S. 329 (2003). *Federal law preempted a state lawsuit asserting improper processing of claim for benefits under ERISA-regulated plan where state common-law cause of action did not regulate insurance, within meaning of saving clause in ERISA preemption provision, and Congress clearly expressed intent that ERISA’s civil enforcement scheme be exclusive.*

Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 108-09 (1983). *New York’s Human Rights Law was preempted with respect to ERISA benefit plans only insofar as it prohibited practices lawful under federal law but state Disability Benefits Law was not preempted by ERISA, although New York*

could not enforce its provisions through regulation of ERISA-covered benefit plans.

But see:

Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724, 758 (1985) (holding that ERISA does not apply), overruled in part on other grounds by Ky. Ass'n of Health Plans, Inc. v. Miller, 538 U.S. 329 (2003). Massachusetts statute requiring certain minimum mental health care benefits be provided to those covered by an insurance policy was not preempted by either ERISA or National Labor Relations Act (NLRA).

Laborers' Pension Fund v. Miscevic, 880 F.3d 927, 933 (7th Cir. 2018). ERISA does not preempt family law, which is a traditional area of state regulation.

Geweke Ford v. St. Joseph's Omni Preferred Care Inc., 130 F.3d 1355, 1360 (9th Cir. 1997). An employer's state contract claim against health plan third-party administrator and excess insurer for failure to process reimbursement was not preempted as traditional state law claim.

Geller v. County Line Auto Sales, Inc., 86 F.3d 18, 23 (2d Cir. 1996). ERISA does not preempt fraud claims.

Smith v. Texas Children's Hosp., 84 F.3d 152, 156-57 (5th Cir. 1996). State fraudulent inducement claim not preempted.

Padeh v. Zagoria, 900 F. Supp. 442, 448 (S.D. Fla. 1995). ERISA does not preempt state law negligence and negligent misrepresentation claims against an investment advisor and insurance representative.

XIII. PROCEDURAL CONSIDERATIONS FOR ERISA LITIGATION

A. AVAILABILITY OF A JURY IN ACTIONS UNDER ERISA

ERISA does not create a statutory right to a jury trial, but the Seventh Amendment allows for jury trials in “suits at common law where the value in controversy shall exceed twenty dollars.” U.S. CONST. amend. VII. “Suits at common law’ refers to legal actions involving the determination of legal, rather than equitable rights and remedies.” Termini v. Life Ins. Co. N. Am., 474 F. Supp. 2d 775, 777 (E.D. Va. 2007) (citing Chauffeurs, Teamsters & Helpers, Local No. 391 v. Terry, 494 U.S. 558, 565 (1990)). Therefore, the right to a jury trial can be available only when a legal remedy is sought. In re Iron Workers Local 25 Pension Fund, No. 04-cv-40243, 2011 WL 1256657, at *15-*16 (E.D. Mich. Mar. 31, 2011).

To determine whether the remedy is legal or equitable courts will examine both (1) “the nature of the issues involved,” to determine if they would have historically been brought in a court of law or a court of equity, and (2) “the remedy sought.” The second prong is the more important of the analysis. Termini, 474 F. Supp. 2d at 777 (citing Chauffeurs, 494 U.S. at 565). A simple request for monetary relief is not enough, in itself, for a claim to be considered “legal” in nature. Borst v. Chevron Corp., 36 F.3d 1308, 1324 (5th Cir. 1994). A “request for monetary recovery sounds in equity . . . when it is restitutionary in nature or is intertwined with claims for injunctive relief.” Id. (citing Chauffeurs, 494 U.S. at 570-71).

The majority of courts have held that no right to a jury trial exists for ERISA actions. Since the Supreme Court’s 2002 decision in Great-West Life & Annuity Ins. Co. v. Knudson, 534 U.S. 204 (2002), however, some courts have considered the possibility that the right to a jury trial may exist for plaintiffs seeking restitution under § 502(a). See Chao v. Meixner GPTA, No. 1:07-cv-0595, 2007 WL 4225069, at *5 (N.D. Ga. Nov. 27, 2007); Bona v. Barasch, No. 01-cv-2289, 2003 WL 1395932, at *34-*35 (S.D.N.Y. Mar. 20, 2003). In Knudson, the Court held that restitution actions are “legal” in nature when the plaintiff seeks to impose “merely personal liability upon the defendant to pay a sum of money” such as in a breach of contract case. Id. Restitution actions are “equitable” in nature where the action seeks to “restore to the plaintiff particular funds or property in the defendant’s possession.” Id. at 214. Thus, under Knudson, not all remedies sought for breach of fiduciary duty are equitable. See Rego v. Westvaco Corp., 319 F.3d 140, 145 (4th Cir. 2003).

Many courts have been reluctant to read Knudson to grant a right to jury trials in ERISA litigation. See George v. Kraft Foods Global, Inc., Nos. 07 C 1713, 07 C 1954, 2008 WL 780629, at *3-*5 (N.D. Ill. Mar. 20, 2008); Cherepinsky v. Sears Roebuck & Co., 455 F. Supp. 2d 470, 476 (D.S.C. 2006).

See also:

Thomas v. Oregon Fruit Prods. Co., 228 F.3d 991, 995-96 (9th Cir. 2000). The Ninth Circuit applied the Seventh Amendment analysis and determined the relief plaintiff was seeking was equitable in nature.

Adams v. Cyprus Amax Minerals Co., 149 F.3d 1156, 1160-62 (10th Cir. 1998). The Tenth Circuit applied the Seventh Amendment analysis and denied the right to a jury trial in a § 502(a)(1)(B) claim. Applying the Seventh Amendment analysis, the court found the first prong weighed against a jury trial because the “ERISA action [was] analogous to a trust action and therefore equitable in nature.” The relief sought was equitable because it was “intertwined with equitable relief” and it was more restitutionary relief than legal or compensatory relief.

Borst v. Chevron Corp., 36 F.3d 1308, 1323-24 (5th Cir. 1994). The court applied the Seventh Amendment analysis and determined that the nature of the issue was analogous to trust law and therefore equitable, and the relief sought was equitable because the monetary relief was “intertwined with claims for injunctive relief.”

Termini v. Life Ins. Co. of N. Am., 474 F. Supp. 2d 775, 777 (E.D. Va. 2007). The court applied the Seventh Amendment analysis to claims under § 502(a)(1)(B) and (a)(2) and denied the right to jury trial in both. The § 502(a)(1)(B) claim was equitable because the “plaintiff’s claim for monetary relief [was] intertwined with equitable relief.” The § 502(a)(2) claim was denied because it turned on the breach of a fiduciary duty so the nature and relief sought were equitable in nature.

But see:

Cunningham v. Cornell University, 2018 WL 4279466, at *2-*4 (S.D.N.Y. Sept. 6, 2018). While acknowledging that “equitable relief predominates” “the types of relief sought” by the plaintiffs, the court concluded that the plaintiffs’ demand for an entry of money judgment for the amount of (1) allegedly unreasonable fees paid by the plans to third parties and (2) the difference paid by beneficiaries for higher-cost investment options, neither of which were ever “personally paid to the defendants,” entitled the plaintiffs to a jury trial as to those claims under Pereira v. Farace, 413 F.3d 330, 339 (2d Cir. 2005).

Lamberty v. Premier Millwork & Lumber Co., 329 F. Supp. 2d 737, 744-45 (E.D. Va. 2004). The court held that there was a right to a jury trial after applying the Seventh Amendment analysis. The court held that “while the overall ERISA action is equitable in nature, the particular issues involved in that action may be legal. [In this case] . . . plaintiff’s suit to recover what is due and owing under a benefits plan essentially presents an action at law to recover a legal entitlement.” The remedy sought was also legal

because the plaintiff sought compensatory damages that were not intertwined with equitable relief.

Several years before its Knudson decision, the Supreme Court held that “ERISA abounds with the language and terminology of trust law. ERISA’s legislative history confirms that the Act’s fiduciary responsibility provisions ‘codify and make applicable to ERISA fiduciaries certain principles developed in the evolution of the law of trusts.’” Firestone, 489 U.S. at 110. As the Fifth Circuit has stated, because ERISA is so analogous to trust law, this is “an area within the exclusive jurisdiction of the courts of equity,” and thus “ERISA claims do not entitle a plaintiff to a jury trial.” Borst, 36 F.3d at 1324. Courts have used this language to conclude that there is no right to a jury trial without considering the other prongs of the Seventh Amendment analysis.

See also:

McDougall v. Pioneer Ranch Ltd. P’ship, 494 F.3d 571, 576 (7th Cir. 2007). *The Seventh Circuit reiterated, in an MPPAA case, that “[t]he general rule in ERISA cases is that there is no right to a jury trial because ‘ERISA’s antecedents are equitable, not legal.’” (internal citation omitted).*

Patton v. MFS/SON Life Fin. Distributions Inc., 480 F.3d 478, 484 (7th Cir. 2007). *In a case under § 502(a)(1)(b), the court stated “in ERISA cases . . . the plaintiff has no right to a jury trial.”*

Wilkins v. Baptist Healthcare Sys., Inc., 150 F.3d 609, 616 (6th Cir. 1998). *The Sixth Circuit concluded that, because the plaintiff “has no cause of action for which money damages are a recognized remedy,” “his appeal [was of] the denial of benefits” and “the district court properly denied his motion for a jury trial.”*

Mathews v. Sears Pension Plan, 144 F.3d 461, 468 (7th Cir. 1998). *“[T]here is no right to a jury trial in an ERISA case.”*

Stewart v. KHD Deutz of Am. Corp., 75 F.3d 1522, 1527 (11th Cir. 1996). *In a case under § 502(a)(1)(b) and (a)(3) the court stated “no Seventh Amendment right to a jury trial exists in actions brought pursuant to ERISA.”*

Houghton v. SIPCO, Inc., 38 F.3d 953, 957 (8th Cir. 1994). *“[T]here is no right to money damages or to a jury trial under ERISA.”*

The right to a jury trial depends on the nature of action and the relief sought. Considering that ERISA § 502(a) provides different remedies and causes of action for (a)(1)(B), (a)(2), and (a)(3) claims, the result of Seventh Amendment analysis may depend on what provision of § 502(a) is used. The next sections examine the jury trial right under § 502(a)(1)(B), (a)(2), and (a)(3).

1. Availability of a jury trial under ERISA §502(a)(1)(B)

Most circuits hold that there is no jury trial right in actions for benefits brought under ERISA § 502(a)(1)(B) because these claims are equitable rather than legal and thus the Seventh Amendment to the United States Constitution does not guarantee the right to a jury trial. See, e.g., Graham v. Hartford Life & Acc. Ins. Co., 589 F.3d 1345, 1356 (10th Cir. 2009) (“the proper common law analogue for a § 1132(a)(1)(B) claim for benefits is” an action to enforce a trust” “which at common law was an equitable action”) (citation omitted); O’Hara v. Nat’l Union Fire Ins. Co. of Pittsburgh, 642 F.3d 110, 116 (2d Cir. 2011) (“[T]here is no right to a jury trial in a suit brought to recover ERISA benefits[.]”); Adams v. Cyprus Amax Minerals Co., 149 F.3d 1156, 1162 (10th Cir. 1998) (describing ERISA’s remedies as primarily equitable, so that there is no right to jury trial under 7th Amendment); Tischmann v. ITT/Sheraton Corp., 145 F.3d 561, 568 (2d Cir. 1998) (labeling claims for ERISA benefits inherently equitable in nature, not contractual, and denying right to jury trial); Hunt v. Hawthorne Assocs., Inc., 119 F.3d 888, 907 (11th Cir. 1997); see also Muller v. First UNUM Life Ins. Co., 341 F.3d 119, 124 (2d Cir. 2003); Thomas v. Or. Fruit Prods. Co., 228 F.3d 991, 996-97 (9th Cir. 2000) (because remedies available to participants or beneficiaries are equitable, there is no Seventh Amendment right to a jury).

A few district courts, however, have suggested that the Supreme Court’s opinion in Firestone implies a result contrary to the majority position. See, e.g., Lamberty v. Premier Millwork & Lumber Co., 329 F. Supp. 2d 737, 744-45 (E.D. Va. 2004) (finding action to recover benefits essentially was action to recover legal entitlement); Hulcher v. United Behavioral Sys., 919 F. Supp. 879, 885 (E.D. Va. 1995) (stating “action[s] to recover [ERISA] benefits under the subject plan are legal in nature” and plan beneficiaries are “constitutionally entitled to trial by jury on any claim raised under [§ 502](a)(1)(B)”); Vaughn v. Owen Steel Co., 871 F. Supp. 247, 250 (D.S.C. 1994) (finding that § 502 claims are most analogous to state law contract claims and consequently must be tried before jury). But courts, including the court that authored it, have found Lamberty to be distinguishable and not persuasive. See, e.g., Perez v. Silva, 185 F. Supp. 3d 698, 705 n. 13 (D. Md. 2016); Jetseck v. Prudential Ins. Co. of Am., No. 07-cv-3753, 2007 WL 3449031, at *2 n. 1 (N.D. Ill. Nov. 15, 2007); Termini v. Life Ins. Co. of N. Am., 474 F. Supp. 2d 775, 777 (E.D. Va. 2007).

Some courts have found a right to a jury trial by concluding that certain benefits claims have both legal and equitable elements. See Weems v. Jefferson-Pilot Life Ins. Co., 663 So. 2d 905, 913-14 (Ala. 1995) (holding that right to recover compensation and punitive damages leads inexorably to right to jury trial); Blue Cross & Blue Shield of Ala. v. Lewis, 753 F. Supp. 345, 347-48 (N.D. Ala. 1990).

In addition, hybrid claims brought under other federal statutes or state law and joined with ERISA action for benefits may be tried before a jury. See, e.g., Stewart v. KHD Deutz of Am. Corp., 75 F.3d 1522, 1528 (11th Cir. 1996) (finding claimant entitled to jury trial in hybrid action under Labor Management Relations Act (“LMRA”) and ERISA); Leannah v. Alliant Energy Corp., 2008 WL 4830140 (E.D. Wis. Oct. 28, 2008) (same). If a case requires bifurcation of jury and non-jury claims, the jury’s

resolution of factual issues in common with the non-jury ERISA claims will have a binding effect on the non-jury claims. Menovcik v. BASF Corp., No. 09-cv-12096, 2011 WL 4945764, at *7 (E.D. Mich. Oct. 18, 2011); see also Brown v. Sandimo Materials, 250 F.3d 120, 127-28 (2d Cir. 2001) (district court must heed any factual determination made by the jury and determine if any equitable remedy is available as they are only available if the legal remedies are inadequate). In Golden v. Kelsey-Hayes Co., however, the Sixth Circuit denied a jury trial in a hybrid action brought under the LMRA and ERISA on the ground that the LMRA claim was an equitable one and thus not triable by jury. 73 F.3d 648, 662-63 (6th Cir. 1996).

2. Availability of a jury trial under ERISA § 502(a)(2)

The overwhelming majority of courts have held that no jury trial right exists for ERISA § 502(a)(2) claims because such actions are equitable in nature. For example, the Second Circuit has ruled that no right to a jury trial exists in ERISA claims seeking the equitable remedy of restitution. Sullivan v. LTV Aero. & Def. Co., 82 F.3d 1251, 1258 (2d Cir. 1996). As one lower court noted, ERISA § 502(a)(2) actions are “restitutional in nature,” and therefore no right to a jury trial exists. Raff v. Travelers Ins. Co., No. 90-cv-7673, 1996 WL 154171 (S.D.N.Y. Apr. 3, 1996).

See also:

Perez v. Silva, 185 F. Supp. 3d 698, 705 (D. Md. 2016) *An action under § 502(a)(2) “is not subject to the Seventh Amendment’s jury guarantee.”*

Bell v. Pension Comm. of ATH Holding Co., LLC, No. 115-cv-02062, 2016 WL 4088737, at *2 (S.D. Ind. Aug. 1, 2016). *The court concluded that “following well-established Seventh Circuit precedent,” “the Plaintiffs are not entitled to jury demand under ERISA Section 502(a)(2).”*

Kenney v. State St. Corp., No. 09-cv-10750, 2011 U.S. Dist. LEXIS 104716, at *69-70 (D. Mass. May 18, 2011). *The court held claims under § 502(a)(2) were equitable; thus plaintiff was not entitled to a jury trial.*

In re YRC Worldwide ERISA Litig., No. 09-cv-2593, 2010 WL 4920919, *4, *6 (D. Kan. Nov. 29, 2010). *(Striking a plaintiff’s jury demand in a § 502(a)(2) case).*

In re First Am. Corp. ERISA Litig., No. 07-cv-01357, 2009 WL 536254, *1-*3 (C.D. Cal. Feb. 9, 2009) *The court struck the plaintiffs’ jury demand in a § 502(a)(2) case because, inter alia, “controlling Ninth Circuit authority holds that there is no right to a jury trial for fiduciary breach claims brought under ERISA § 502.”*

George v. Kraft Foods Global, Inc., Nos. 07-cv-1713, 07-cv-1954, 2008 WL 780629, at *5 (N.D. Ill. Mar. 20, 2008). *The court held that a “claim under § 502(a)(2) was an equitable [claim] for which there is no constitutional right to a jury trial.”*

White v. Martin, No. 99-cv-1447, 2002 WL 598432, at *3-*4 (D. Minn. Apr. 12, 2002). The district court found no right to a jury trial under § 502(a)(2) because the plaintiff's action sought the equitable relief of restitution that did not fit into definition of "legal" under Knudson.

Broadnax Mills, Inc. v. Blue Cross & Blue Shield of Va., 876 F. Supp. 809, 816 (E.D. Va. 1995). The court held that § 502(a)(2) is equitable in nature despite the availability of damages, and thus denied the right to a jury trial.

While most courts have denied a jury trial in ERISA § 502(a)(2) cases, a few courts applying Knudson have found a jury trial right under § 502(a)(2). A federal district court ruled that after Knudson, plaintiffs who seek money damages in § 502(a)(2) claims are seeking a legal remedy and are therefore entitled to a jury trial. Bona, 2003 WL 1395932, at *34-35. In Bona, the court stated that because the plaintiffs were suing on behalf of the plan under § 502(a)(2), they could seek either damages or equitable relief. Id. at *34.

After noting that the Second Circuit has repeatedly held that no jury trial is available when plaintiffs seek equitable relief, the district court in Bona stated that the plaintiffs sought monetary damages. Id. at *35. Following Bona, the Second Circuit in Pereira v. Farace relied on Knudson and emphasized the fact that the defendants "never possessed the funds in question and thus were not unjustly enriched" to conclude that "the remedy sought against them cannot be considered equitable." 413 F.3d 330 at 339 (2d Cir. 2005).

See also:

Hellman v. Catalado, No. 12-cv-02177, 2013 WL 4482889, at *5 (E.D. Mo. Aug. 20, 2013) The court concluded that "under the reasoning of [Knudson]," "the relief sought is not equitable, but a claim for restitution at law entitling Plaintiff to a jury trial on his ERISA claim imposing personal liability for breach of fiduciary duty under 29 U.S.C. § 1132(a)(2)."

Healthcare Strategies, Inc. v. ING Life Ins. & Annuity Co., No. 11-cv-282, 2012 WL 162361, at *6 (D. Conn. Jan. 19, 2012). A claim for the defendant to "restore to the Plans the losses they have suffered as a result of [the defenadnt's] use of plan assets to generate revenue sharing payments" did not call for equitable restitution—the return of "specifically identifiable property in the hands of the defendant"—and thus "it [was] inappropriate to strike [the plaintiff's] demand for a jury trial as to [that] count."

Chao v. Meixner GPTA, No. 07-cv-0595, 2007 WL 4225069, at *5 (N.D. Ga. Nov. 27, 2007). The court found a right to a jury trial in § 502(a)(2) case after applying the Seventh Amendment's two-prong test. The court found that the plaintiff sought a legal remedy and the action arose in part at law.

Kirse v. McCullough, No. 04-cv-1067, 2005 U.S. Dist. LEXIS 17023, at *8-9 (W.D. Mo. May 12, 2005). The court granted a right to jury trial in § 502(a)(2) claim after applying the Seventh Amendment's two-prong test.

The analysis in Pereira appears to represent a minority view, and though it followed Pereira, a court in the Southern District of New York recently suggested that “[t]he Pereira court may have over-read [Knudson] in applying its dictum to the issue of the right to a trial by jury under the Seventh Amendment.” Cunningham v. Cornell Univ., No. 16-cv-6525, 2018 WL 4279466, at *4 (S.D.N.Y. Sept. 6, 2018).

Similarly, district courts applying the Supreme Court's decision in Montanile v. Bd. of Trustees of Nat. Elevator Indus. Health Benefit Plan, 136 S. Ct. 651, 658 (2016), an ERISA § 502(a)(3) case in which the Court stated that recovery against a defendant's general assets rather than “particular funds or property in the defendant's possession” is “a legal remedy, not an equitable one,” decline to conclude that it creates a right to a jury trial in § 502(a)(2) cases. See, e.g., Ramos v. Banner Health, No. 15-cv-2556, 2019 WL 1558069, at *3 (D. Colo. Apr. 10, 2019); Tracey v. Massachusetts Inst. of Tech., No. 16-cv-11620, 2019 WL 1005488, at *3 (D. Mass. Feb. 28, 2019); Gernandt v. SandRidge Energy Inc., No. 15-cv-1001-D, 2017 WL 3219490, at *12 (W.D. Okla. July 28, 2017); Bell v. Pension Comm. of ATH Holding Co., LLC, No. 15-cv-02062, 2016 WL 4088737, at *2 (S.D. Ind. Aug. 1, 2016).

3. Availability of a jury trial under ERISA § 502(a)(3)

Suits under ERISA § 502(a)(3) are consistent with the well-settled doctrine that limits the right to a jury trial to legal, and not equitable, causes of action. Because Congress limited the relief for suits under §502(a)(3) to “other appropriate equitable relief,” a jury trial is inappropriate in such causes of action. See De Pace v. Matsushita Elec. Corp., 257 F. Supp. 2d 543, 573-74 (E.D.N.Y. 2003); see also George, 2008 WL 780629, at *6 (“The Seventh Circuit has recognized that congressional silence on the right to a jury trial in ERISA reflects an intent that claims brought under the statute be equitable in nature”) (citing Brown v. Retirement Comm. of the Briggs & Stratton Retirement Plan, 797 F.2d 521, 527 (7th Cir. 1986)). Accordingly, no right to a jury trial exists because § 502(a)(3) provides only equitable relief. Sullivan v. LTV Aerospace and Def. Co., 82 F.3d 1251, 1258 (2d Cir. 1996) (noting distinction between §§ 502(a)(1) and 502(a)(3) and finding no jury trial right under the latter because it provides only for equitable relief); McDonough v. Horizon Blue Cross Blue Shield of N.J., Inc., No. 09-cv-571 (SRC), 2011 WL 4455994, at *11 (D.N.J. Sept. 23, 2011) (“[T]here is no right to a jury trial in an action brought under ERISA § 502(a)(3).”); Bona, 2003 WL 1395932, at *33 (holding no right to a jury trial on § 503(a)(3) claims); Gieger v. UNUM Life Ins. Co. of Am., 213 F. Supp. 2d 813, 818 (N.D. Ohio 2002) (same).

When faced with a constitutional challenge to this position, courts have found that the Seventh Amendment is limited to “suits at common law,” and therefore does not come into play in suits under § 502(a)(3) which are based in equity. Cox v. Keystone Carbon Co., 861 F.2d 390, 393 (3d Cir. 1988). The Supreme Court's recent ruling in Montanile does not change this result. 136 S. Ct. at 655. While that case

involved a § 502(a)(3) claim, it was brought by a plan fiduciary against a participant for reimbursement of funds that the participant also recovered from a third party, and the Court concluded that “the fiduciary cannot bring [such a] suit under § 502(a)(3) because [it] is not one ‘for appropriate equitable relief.’” *Id.* Thus, it is well-settled that there is no right to a jury trial for suits under § 502(a)(3).

B. RULE 23 AND ERISA CLASS ACTION LITIGATION

A class action, if available, may be an individual plaintiff’s best legal recourse in ERISA litigation. This is especially true for benefits claims, because the amount any single plaintiff may be able to recover is relatively low. In addition, because ERISA’s attorneys’ fees award provision is generally discretionary, the provision does not provide a great incentive for attorneys to represent single plaintiffs. See ERISA § 502(g)(1), codified as 29 U.S.C. § 1132 (g)(1); ALAN M. SANDALS, ERISA CLASS ACTIONS AND STRATEGIC ISSUES: THE PLAINTIFF’S PERSPECTIVE, American Bar Association Center for Continuing Legal Education, N99ELI ABA-LGLED K-1, 10 (1999).

Considering the representative nature of an ERISA § 502(a)(2) claim, class actions are a useful tool to protect the interests a plan participant may represent. Congress considered requiring class actions for claims brought under ERISA § 502(a)(2) but so far it has remained silent on the issue. Coan v. Kaufman, 457 F.3d 250, 259-61 (2d Cir. 2006). Claims brought under § 502(a)(2) still must be brought on a “representative capacity on behalf of the plan” and, by following the class action requirements, courts will likely perceive them to be acting in a representative capacity of the plan that satisfies § 502(a)(2). *Id.* (quoting Mass. Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 142 n.9 (1985)).

Because ERISA preempts state law in most situations, ERISA class action litigation must comply with the Federal Rules of Civil Procedure. The requirements for class certification under Federal Rule of Civil Procedure 23 and ERISA’s dynamics can create unique considerations for both sides of a potential class action suit.

1. Procedural considerations

a) Considerations under Rule 23

To gain class certification, the prospective class must satisfy the four requirements of Rule 23(a) and one of three requirements under Rule 23(b). The four requirements of a putative class under Rule 23(a) are (1) numerosity; (2) commonality; (3) typicality; and (4) adequacy of representation. The three grounds for certification under Rule 23(b) are (1) risk of inconsistent and binding decisions; (2) defendant subject to injunctive or declaratory relief; or (3) common questions predominate and a class action is a superior method of adjudication. Fed. R. Civ. P. 23.

Plaintiffs must establish that the proposed class satisfies the requirements of Rule 23(a) and (b). See Walker v. Asea Brown Boveri, Inc., 214 F.R.D. 58, 63-64 (D. Conn. 2003) (citing E. Texas Motor Freight Sys., Inc. v. Rodriguez, 431 U.S. 395, 407 (1977)). A court deciding whether to certify a class does not accept the plaintiff’s theory

of the case at face value but instead engages in a rigorous analysis that often entails some analysis of the case's merits. Wit v. United Behavioral Health, 317 F.R.D. 106, 119 (N.D. Cal. 2016) (citing Rodman v. Safeway, Inc., No. 11-cv-3003, 2014 WL 988992, at *6 (N.D. Cal. Mar. 10, 2014); Wal-Mart Stores, Inc. v. Dukes, 564 U.S. 338, 351 (2011); see also Sanft v. Winnebago Indus., Inc., 214 F.R.D. 514, 519 (N.D. Iowa 2003) (citing Gen. Tel. Co. v. Falcon, 457 U.S. 147, 161 (1982)). It has broad discretion to certify a class. Wit, 317 F.R.D. at 119 (citing Zinser v. Accufix Research Inst., Inc., 253 F.3d 1180, 1186 (9th Cir. 2001)). “[W]hile a court should not determine the merits of a claim at the class certification stage, it is appropriate to ‘consider the merits of the case to the degree necessary to determine whether the requirements of Rule 23 will be satisfied.’” Heffner v. Blue Cross & Blue Shield of Ala., Inc., 443 F.3d 1330, 1337 (11th Cir. 2006) (quoting Valley Drug Co. v. Geneva Pharm., Inc., 350 F.3d 1181, 1188 n.15 (11th Cir. 2003)).

Rule 23(c) requires a court to make a determination on class certification “at an early practicable time.” Fed. R. Civ. P. 23(c)(1). Courts can, however, revisit the class certification question at any time. Also, if individual issues become too numerous or complex, a class action can be limited to one particular issue or a class may be divided into subclasses in accordance with Rule 23(c)(4).

Generally, “the preferred approach is to err on the side of certification.” SANDALS, supra, at 2. When examining class certification, it should be remembered that the underlying principle of the federal civil rules is the “just, speedy, and inexpensive determination of every action.” FED. R. CIV. P. 1. Thus, judicial economy will often trump other concerns when examining class certification. See Pipefitters Local 636 Ins. Fund v. Blue Cross Blue Shield of Michigan, 654 F.3d 618, 630 (6th Cir. 2011) (“Given the huge amount of judicial resources expended by class actions, particular care in their issuance is required.”); Bradford v. AGCO Corp., 187 F.R.D. 600, 605 (W.D. Mo. 1999)).

b) Considerations under ERISA

There is great interplay among the requirements of Rule 23 and an attempt to shape a class to satisfy one prong may affect other prongs. For example, although advancing a broad class definition may help satisfy the numerosity requirement, the other requirements of Rule 23 may become more difficult to satisfy if the added number of plaintiffs presents more individual circumstances that frustrate a common strategy.

In addition, fundamental ERISA litigation decisions, such as whether a plaintiff is suing on behalf of the plan under ERISA § 502(a)(2) or for individual relief under § 502(a)(3), can drastically change the way the class is defined and, in turn, the potential certification of the class. For example, if a claim is based on breach of fiduciary duty and plan-relief is sought under ERISA § 409(a), a single plaintiff under § 502(a)(2) could suffice and could avoid class certification problems. Steuart H. Thomsen, ERISA CLASS ACTIONS, American Bar Association, 28-Sum Brief 36 (1999). But see Coan, 457 F.3d at 260 (requiring procedural safeguards to protect other interested parties be taken by a plan participant who brings a suit on behalf of the plan).

The type of plan will also affect whether a plaintiff can satisfy Rule 23's requirements. A plaintiff may have difficulty in certifying a class when the alleged violation happened under a defined-contribution plan as opposed to a defined-benefit plan. See Spano v. The Boeing Co., 633 F.3d 574, 591 (7th Cir. 2011). In deciding whether to certify a class, a court must distinguish between "an injury to one person's retirement account that affects only one person and an injury to one account that qualifies as a plan injury." Id. at 581. In the defined-contribution context, a plaintiff may have a difficult time establishing a "plan injury" because participants make individual investment decisions. In this situation, a plaintiff will have a difficult time defining an appropriate class and avoiding intra-class conflicts. Id. at 591. As discussed below, these issues may prevent a plaintiff from meeting the requirements of Rule 23.

2. Requirements of Rule 23(a) in ERISA class actions

Plaintiffs seeking class certification must at a minimum prove that the putative class meets all four of the requirements under Rule 23(a).

a) Numerosity

Rule 23(a)(1) permits class certification only where "the class is so numerous that joinder of all members is impracticable." Fed. R. Civ. P. 23(a)(1). Courts have consistently ruled that "impracticability" does not mean "impossible," and that courts should consider several factors beyond mere numbers when examining the difficulty and inconvenience of joinder. Sanft, 214 F.R.D. at 520-21 (providing in-depth analysis of numerosity factors). These factors include the geographic location of class members, the amount and nature of the claims, the difficulty of identifying class members, the impact on judicial economy, the "inconvenience of trying individual suits, and any other factor relevant to the practicality of joinder." Krueger v. Ameriprise Fin., Inc., 304 F.R.D. 559, 569 (D. Minn. 2014) (internal quotation marks omitted) (quoting Paxton v. Union Nat'l Bank, 688 F.2d 552, 559 (8th Cir. 1982)).

Consideration of these other factors is particularly important "[w]here a class is not very numerous." Escalante v. California Physicians' Serv., 309 F.R.D. 612, 618 (C.D. Cal. 2015) (citing Jordan v. Los Angeles Cnty., 669 F.2d 1311, 1319 (9th Cir.), *vacated on other grounds*, 459 U.S. 810 (1982)).

See:

Sanft v. Winnebago Indus., Inc., 214 F.R.D. 514, 526 (N.D. Iowa 2003). Class of 51 current and former employees alleging improper reduction of benefits did not satisfy numerosity requirement where most of class resided in Northern Iowa and where each member of the putative class was known, thus making joinder more practical.

Plaintiffs do not need to specify the exact number of potential class members, but should clearly identify the class and provide an estimate based on good faith and common sense. Bhattacharya v. Capgemini North America, Inc., 324 F.R.D. 353, 361 (N.D. Ill. 2018); Assif v. Titleserv, Inc., 288 F.R.D. 18, 23 (E.D.N.Y. 2012).

Although no bright-line rule exists, a class of forty members has repeatedly been cited as a rule-of-thumb for presuming that joinder would be impractical. Daniel F. v. Blue Shield of California, 305 F.R.D. 115, 126 (N.D. Cal. 2014) (citing Celano v. Marriott Int'l, Inc., 242 F.R.D. 544, 549 (N.D. Cal. 2007)); Leber v. Citigroup 401(k) Plan Inv. Comm., 323 F.R.D. 145, 159 (S.D.N.Y. 2017) (“In this Circuit, numerosity is ‘presumed at a level of 40 members.’”) (quoting Consol. Rail Corp. v. Town of Hyde Park, 47 F.3d 473, 483 (2d Cir. 1995)); Coffin v. Bowater Inc., 228 F.R.D. 397, 402 (D. Me. 2005); La Flamme v. Carpenters Local # 370 Pension Plan, 212 F.R.D. 448, 452 (N.D.N.Y. 2003); Grunewald v. Kasperbauer, 235 F.R.D. 599, 604 (E.D. Pa. 2006); see also Cuthie v. Fleet Reserve Ass’n, 743 F. Supp. 2d 486, 498 (D. Md. 2010) (“A class consisting of as few as 25 to 30 members raises the presumption that joinder would be impractical.”) (quoting Dameron v. Sinai Hosp. of Balt., Inc., 595 F. Supp. 1404, 1407-08 (D. Md. 1984)). When the action is brought on behalf of the plan, individual members of the plan can be counted in the class even though the action is on behalf of the plan. In re Beacon Assocs. Litig., 282 F.R.D. 315, 338 (S.D.N.Y. 2012); In re CMS Energy ERISA Litig., 225 F.R.D. 539, 543 (E.D. Mich. 2004).

In the ERISA context, numerosity—as well as other Rule 23(a) requirements such as commonality—can be satisfied where the class is defined by an employer’s general practice or, for example, a plan change affecting all employees’ benefits. For example, in Bittinger v. Tecumseh Products Co., a class of 1,100 retirees alleged that their former employer denied them fully-funded insurance benefits where the employer terminated their benefits at the expiration of a collective bargaining agreement and offered them new partially-funded benefits upon signing a release of claims against employer. 123 F.3d 877, 884 (6th Cir. 1997). The retirees, seeking relief under ERISA § 502(a)(1)(B) for benefits due, satisfied numerosity despite the employer’s claims that retirees failed to address numerosity. Id. The court held that where 1,100 retirees based their claim on the common question of the original bargaining agreement, numerosity was “obvious.” Id. Indeed, in many ERISA cases where class certification is at issue, numerosity is rarely disputed when the other Rule 23 requirements are satisfied.

See:

George v. Duke Energy Ret. Cash Balance Plan, 259 F.R.D. 225, 237 (D.S.C. 2009). The court concluded that Rule 23(a)’s requirements were satisfied as to a class defined by participants in a plan during years that the defendant applied an incorrect interest crediting rate to all participant account balances, but not as to the participants’ fiduciary breach claim.

Bradford v. AGCO Corp., 187 F.R.D. 600, 604-05 (W.D. Mo. 1999). Retirees claiming breach of fiduciary duty where benefits under collective bargaining agreement were allegedly denied satisfied numerosity, commonality, and typicality requirements despite the potential existence of individual reliance issues. Because they met commonality and typicality, the class also satisfied numerosity where the class consisted of only

twenty to sixty-five members and the court was concerned about judicial resources that would be expended in individual trials.

See also:

Wiseman v. First Citizens Bank & Trust Co., 212 F.R.D. 482, 485-488 (W.D.N.C. 2003), reaffirmed on reconsideration, 215 F.R.D. 507 (W.D.N.C. 2003). Class of 3,580 participants of a 401(k) pension plan claiming breach of fiduciary duty for alleged misleading related to a fund available under the 401(k) satisfied numerosity but did not satisfy typicality or commonality where there were issues of independent control of accounts.

Mueller v. CBS, Inc., 200 F.R.D. 227, 235-37 (W.D. Pa. 2001). Class of 3,300 former employees claiming interference with benefits where employees were fired before retirement satisfied numerosity but did not satisfy the commonality and typicality requirements because the class was overly broad.

Generally, when injunctive relief is sought, some courts have held that the numerosity requirement should not be applied rigorously. See Jones v. Am. Gen. Life & Accident Ins. Co., 213 F.R.D. 689, 694 (S.D. Ga. 2002). An injunction is one of the remedies available under ERISA § 502(a)(3)'s "appropriate equitable relief" language . 29 U.S.C. § 1132(a)(3). Courts hold that if the issue of an ERISA class action is whether benefits or reimbursement for benefits will be paid, injunctive relief requiring specific performance can lead to a result similar to monetary damages. See Blue Cross & Blue Shield of Ala. v. Sanders, 138 F.3d 1347, 1353 (11th Cir. 1998) (ruling that injunction requiring specific performance of reimbursement by participants to claims administrator was equitable relief).

See:

In re Unisys Corp. Retiree Med. Benefit ERISA Litig., 57 F.3d 1255, 1268-69 (3d Cir. 1995). Class of retirees claiming breach of fiduciary duty based on employer/plan administrator's alleged representations that benefits were for life was not entitled to monetary damages but was entitled to an injunction ordering specific performance of the assurances made by employer. Court ruled that the award of those assurances was restitutionary in nature and thus equitable.

Escalante v. California Physicians' Serv., 309 F.R.D. 612, 618 (C.D. Cal. 2015). Numerosity requirement satisfied even if the class numbered as small as 19 members because primary relief plaintiffs sought is injunctive and declaratory, and therefore, allowing a class action would be in the interests of judicial economy.

Bublitz v. E.I. du Pont de Nemours & Co., 202 F.R.D. 251, 256 (S.D. Iowa 2001). A class of seventeen was sufficient where the plaintiffs were primarily seeking injunctive and declaratory relief.

McHenry v. Bell Atl. Corp., No. 97-cv-6556, 1998 WL 512942, at *3, *8 (E.D. Pa. Aug. 19, 1998). *Class of employees who accepted employment at subsidiary of parent company was certified to seek injunction for restoration of their retirement and savings plan benefits that they alleged were reduced under the subsidiary, and the possibility of the reduction was not shared with employees.*

b) Commonality

The requirements of commonality and typicality “tend to merge.” Gen. Tel. Co. v. Falcon, 457 U.S. 147, 157 n.13 (1982). However, the difference between the two requirements can implicate other prongs of Rule 23 and determine class certification. See Walker, 214 F.R.D. at 63-64 (finding commonality satisfied but not typicality). Typicality considers the sufficiency of the named plaintiffs, and commonality considers the sufficiency of the class itself. Mueller v. CBS, Inc., 200 F.R.D. 227, 237 (W.D. Pa. 2001) (citing Hassine v. Jeffes, 846 F.2d 169, 176 n.4 (3d Cir. 1998)). Although courts tend to rule consistently on the requirements of typicality and commonality, this Handbook examines the two requirements separately. Any case citations, however, will acknowledge both typicality and commonality where the requirements were decided on the same grounds. See also Section XIII.B.2.c discussing typicality, below.

Rule 23(a)(2), often referred to as the “commonality” element, requires that there be “questions of law or fact common to the class.” FED. R. CIV. P. 23(a)(2). Courts historically read this requirement liberally and did not require that all questions raised be common or that class members be situated identically. See Califano v. Yamasaki, 442 U.S. 682, 701 (1979). Normally, one common question can suffice if it is related to the resolution of the case. Id.; Fallick v. Nationwide Mut. Ins. Co., 162 F.3d 410, 424 (6th Cir. 1998); Bradford v. AGCO Corp., 187 F.R.D. 600, 603 (W.D. Mo. 1999).

The Supreme Court, however, in Wal-Mart Stores, Inc. v. Dukes, appeared to tighten the necessary showing a plaintiff must make to satisfy commonality under Rule 23. 131 S. Ct. 2541 (2011). The Court held that commonality requires “a common contention . . . that is capable of classwide resolution – which means that determination of its truth or falsity will resolve an issue that is central to the validity of each one of the claims in one stroke.” Id. at 2551. Essentially, a plaintiff must show class members have suffered the same injury, which requires more similarity than simply suffering a violation of the same provision of law. Id. A court, when analyzing commonality, will frequently need to analyze the merits of a plaintiff’s underlying claims. Id.

See:

Bond v. Marriott Int’l, Inc., 296 F.R.D. 403, 408 (D. Md. 2014). *Proposed class definition of participants in plan that defendant allegedly improperly exempted from ERISA requirements does not satisfy commonality requirement, as the allegation was that the proposed class members suffered a violation of the same provision of law.*

Groussman v. Motorola, Inc., No. 10-cv-911, 2011 WL 5554030, at *4 (N.D. Ill. Nov. 15, 2011). *The plaintiff failed to establish commonality under Dukes when plaintiff only established class members were participants in the plan and invested in a company's stock.*

Class actions for injunctive or declaratory relief, regularly sought under ERISA § 502(a)(3) claims, often present common questions by their nature. Furthermore, because an act affecting many plan participants or beneficiaries often triggers ERISA claims, the commonality requirement is readily satisfied in many ERISA class actions. *See Bittinger*, 123 F.3d at 884 (finding commonality satisfied where each class member's claim was based on collective bargaining agreement that employer altered).

Courts have even found that plaintiffs covered by different plans can satisfy the commonality requirement where a sole triggering event is at issue. For example, in *Forbush v. J.C. Penney Co.*, a class of retired employees satisfied commonality and typicality requirements despite being covered under four different plans because the common question related to the employer's method of calculating social security benefits. 994 F.2d 1101, 1006 (5th Cir. 1993).

See:

Fallick v. Nationwide Mut. Ins. Co., 162 F.3d 410, 422 (6th Cir. 1998). *A beneficiary in "one ERISA benefit plan can represent a class of participants in numerous plans other than his own, if the gravamen of the plaintiff's challenge is to the general practices which affect all of the plans."*

ERISA plaintiffs often encounter commonality and typicality problems where representations to participants or employees about potential plan changes were not uniform. Where a court must examine different representations to individual plaintiffs, especially where the ERISA claims allege breach of fiduciary duty through misrepresentations or corresponding issues of reliance, commonality and typicality are more difficult to satisfy. Some circuits allow class actions to proceed to determine whether there was a fiduciary breach based on common representations, while reserving questions of reliance and individual harm based on any diverse representations for later hearings or subclass treatment. *See In re Sears Retiree Grp. Life Ins. Litig.*, 198 F.R.D. 487, 492-93 (N.D. Ill. 2000) (discussing different approaches of circuits on this issue). In evaluating whether different communications will defeat commonality and typicality the degree of variation in the representations is an important inquiry. *Id.*

See:

Fotta v. Trs. of the United Mine Workers of Am., 319 F.3d 612, 618-19 (3d Cir. 2003). *Commonality requirement not satisfied when plaintiffs had to prove the distinct benefits that were wrongfully withheld or delayed for each plaintiff.*

Sprague v. Gen. Motors Corp., 133 F.3d 388, 397-98 (6th Cir. 1998). *Retirees seeking lifetime health care coverage at no cost and making ERISA claims based on theories of bilateral contract and estoppel did not satisfy commonality and typicality requirements where the claims depended on which documents each retiree signed and what representations were made to each retiree. Thus, the individualized interactions with each retiree, the subjective understanding of each retiree, and their respective reliance on those understandings were too varied for certification.*

Hudson v. Delta Air Lines, Inc., 90 F.3d 451, 457-58 (11th Cir. 1996). *Retirees claiming breach of contract, interference through misleading statements, and breach of fiduciary duty did not satisfy commonality requirement where employer made different oral and written communications about impending changes in the benefits plan. The court held that even if plaintiffs could have shown that employer disseminated a uniform message to all putative class members, individual reliance issues would remain.*

Owen v. Regence Bluecross Blueshield of Utah, 388 F. Supp. 2d 1335, 1341 (D. Utah 2005). *Breach of fiduciary duty claim based on a material omission required individualized determination of causation or detrimental reliance, thus defeating commonality and typicality.*

In re Sears Retiree Grp. Life Ins. Litig., 198 F.R.D. 487, 492-93 (N.D. Ill. 2000). *Retirees seeking certification after employer amended group life insurance plan by reducing benefits for some employees did not satisfy commonality and typicality requirements for claims of breach of fiduciary duty and estoppel where allegations of misrepresentation relied on a variety of oral and written communications. Plaintiffs attempted to remedy their claims based on two documents received by all putative class members, but the court rejected this attempt, holding that communications must be looked at within the “total mix” of information that was available to plaintiffs.*

But see:

Bacon v. Stiefel Labs., 275 F.R.D. 681, 692 (S.D. Fla. 2011). *While plaintiffs could not meet typicality requirement where their claims required individual proof of detrimental reliance, the commonality requirement was satisfied.*

In re First Am. Corp. ERISA Litig., 258 F.R.D. 610, 618 (C.D. Cal. 2009). *The issue of “[w]hether the First American Defendants breached their fiduciary duties by failing to provide complete and accurate information to Plan participants regarding investment in First American stock and First American’s business improprieties” was sufficient to satisfy commonality.*

Richards v. Fleet Boston Fin. Corp., 238 F.R.D. 345, 349 (D. Conn. 2006). Employees claimed the employer breached its fiduciary duties in drafting plan descriptions, benefit statements, and employee reference guide. Employees satisfied the commonality requirement because the documents suggested a presumption of “likely prejudice” common to all members of the class. The court held that it did not need to look at individual assessments of the information in the documents drafted by the employer.

In re Aquila ERISA Litig., 237 F.R.D. 202, 207-08 (W.D. Mo. 2006). Questions such as “whether Defendants’ communications to the Plan and Plan participants provided complete and accurate information concerning the risks of investing in” the allegedly imprudent stock and “whether Defendants provided false and misleading information, or failed to disclose material information, to the Plan and Plan participants concerning the financial health of the Company” satisfied the commonality requirement.

Bradford v. AGCO Corp., 187 F.R.D. 600, 604-05 (W.D. Mo. 1999). Retirees claiming breach of fiduciary duty where benefits under collective bargaining agreement were allegedly changed or denied satisfied commonality and typicality requirements despite the potential existence of individual reliance issues. The similarities of the class members and the fact that the terms of the contract and retirement plan would govern the outcome of case “trumped” reliance issues.

Differing representations not only pose commonality and typicality problems but can affect virtually every element of Rules 23(a) and (b). See Frahm v. Equitable Life Assurance Soc’y of U.S., 137 F.3d 955, 957 (7th Cir. 1998) (finding class satisfied commonality but not Rule 23(b)(3)); see also Section XIII.B.3.c discussing Common Questions, below.

Although not explicit in Rule 23, courts considering motions for class certification generally require that a proposed class be “sufficiently identifiable without being overly broad.” Sanneman v. Chrysler Corp., 191 F.R.D. 441, 445-46 (E.D. Pa. 2000) (discussing requirements of class definition and relevant circuit court decisions). This “definiteness” element implicates various Rule 23 requirements, but is most often examined in conjunction with the commonality and typicality requirements.

In a class action involving a defined-contribution plan, a plaintiff may have difficulty appropriately defining a class because plan participants make individual investment decisions. See Spano, 633 F.3d at 586. A plaintiff must limit his proposed class to other individuals that also made similar investment decisions. Id. But in defining a class of individuals harmed by an investment decision, a plaintiff cannot “build[] into the class definitions assumptions about the complicated and unsettled issues of loss and causation.” George v. Kraft Foods Global, Inc., No. 08-cv-3799, 2011 WL 5118815, at *8 (N.D. Ill. Oct. 25, 2011). In Kraft, the plaintiff attempted to define the class sufficiently by limiting the class to only beneficiaries harmed by the fiduciaries’ imprudent investment option. Id. The court rejected this definition because the plaintiff

used class certification as a backdoor way of resolving the contested issue of loss and causation. Id.

See:

Spano v. The Boeing Co., 633 F.3d 574, 586 (7th Cir. 2011). The class did not satisfy the typicality requirement because it was too broad. The class was not limited to only plan members who invested in imprudent investment option.

Mueller v. CBS, Inc., 200 F.R.D. 227, 233-34 (W.D. Pa. 2001). Putative class of employees claiming interference with benefits where employees were fired before retirement did not satisfy the commonality and typicality requirements due to “indefiniteness.” The class was “overly broad, unacceptably vague, and arbitrary” because some in the class were employed in foreign countries and not subject to ERISA, and plaintiffs provided no temporal limitation for those who would be included in the class.

Because the commonality requirement also overlaps with all three of the alternative requirements of Rule 23(b), the commonality requirement may actually be a “superfluous provision, or at least partially redundant, since the existence of common questions can be viewed as an essential ingredient of a finding that the class will satisfy one of the 23(b) requirements.” C. WRIGHT, A. MILLER & M. KANE, FEDERAL PRACTICE AND PROCEDURE 2D. § 1763 at 227; see also In re LifeUSA Holding Inc., 242 F.3d 136, 144 (3d Cir. 2001) (describing that Rule 23(b)(3) is the more demanding inquiry of commonality). The Supreme Court’s decision in Dukes, however, may lead courts to more rigorously analyze whether a plaintiff satisfies commonality.

c) Typicality

Rule 23(a)(3) requires that the claims or defenses of the class representative be typical of the class. FED. R. CIV. P. 23(a)(3). In other words, the typicality requirement assures that the claims of the representative are similar enough to the claims of the class that the representative can adequately represent the class. Falcon, 457 U.S. at 157 n.13. In this way, the typicality requirement also buttresses the adequacy of representation in Rule 23(a)(4) requirement. While the two requirements are related, some courts read the typicality requirement independently and require plaintiffs to demonstrate that other class members have the same or similar grievances. See Donaldson v. Pillsbury Co., 554 F.2d 825, 830 (8th Cir. 1977) (listing courts adopting this interpretation).

In ERISA cases, lack of typicality is most commonly the cause for denial of certification where there are the types of varied representations that also cause problems for the commonality requirement. See Groussman v. Motorola, Inc., No. 10-cv-911, 2011 WL 5554030, at *5 (N.D. Ill. Nov. 15, 2011) (plaintiff failed to establish typicality because varied investment strategies would cause class members to argue for

different dates upon which an investment became imprudent); In re Sears Retiree Grp. Life Ins. Litig., 198 F.R.D. 487, 492-93 (N.D. Ill. 2000) (discussing circuits' differing approaches on issue of non-uniform communications to class members); see also Retired Chicago Police Ass'n v. City of Chicago, 7 F.3d 584, 597 (7th Cir. 1993) (finding typicality not met where representations regarding health care plan varied among class members). Although factual distinctions may exist between the circumstances of class representatives and members of the class, claims based on different interests or different interactions with employer are less likely to satisfy typicality. See Thomsen, supra, at 39. Such differences most often occur when potential plan changes are communicated to different groups of participants.

See:

Bittinger v. Tecumseh Prods. Co., 123 F.3d 877, 884-85 (6th Cir. 1997). Retirees claiming denial of benefits after a collective bargaining agreement terminated benefits and a new offer required a release of claims against employer meet requirements of typicality and commonality. The common issue was that the original agreement guaranteed lifetime benefits, and the plaintiffs were typical in that they followed a "pattern," despite not receiving uniform communications and despite the fact that only some retirees had signed the releases. Instead of denying class certification, the court held that any individualized issues of estoppel could be remedied in other ways, such as the creation of subclasses.

Forbush v. J.C. Penney, Co., 994 F.2d 1101, 1105-06 (5th Cir. 1993). Despite class members' participation in different pension plans, the employer's general practice of overestimating social security benefits allowed plaintiffs to satisfy typicality and commonality.

Jones v. NovaStar Fin., Inc., 257 F.R.D. 181, 190-91 (W.D. Mo. 2009). A plaintiff who alleged that defendants failed to disclose alleged mismanagement of the company and made affirmative misrepresentations regarding the company sought to certify a class consisting of others who invested in the company's stock. The defendants argued that the putative class failed the typicality requirement because the named plaintiff could not establish she relied on any communication to decide to invest and admitted she "could not recall whether she had reviewed documents discussing NovaStar business practices or its SEC filings." The court found that the typicality element was satisfied, however. It determined that individual reliance was not required "[b]ecause ERISA § 502(a)(2) focuses on plans, rather than individuals" and, regardless of the named plaintiff's ability to prove individual reliance, her claims were "sufficiently typical of those of the class."

Kohl v. Ass'n of Trial Lawyers, 183 F.R.D. 475, 484 (D. Md. 1998). Pension plan participants claiming denial of accrued benefits satisfied

typicality and commonality requirements because they suffered the same harm where plan administrator failed to include cost of living adjustments.

But see:

Sprague v. Gen. Motors Corp., 133 F.3d 388, 399 (6th Cir. 1998). Retirees seeking lifetime health care coverage at no cost and making ERISA claims based on theories of bilateral contract and estoppel did not satisfy typicality and commonality requirements where there were different representations to different retirees. The typicality premise, “as goes the claim of the named plaintiff, so goes the claims of the class,” was not satisfied.

*Carr v. Int’l Game Tech., No. 3:09-cv-00584, 2012 WL 909437, at *6 (D. Nev. Mar. 16, 2012), on reconsideration, No. 3:09-cv-00584, 2013 WL 638834 (D. Nev. Feb. 20, 2013). Named plaintiffs who testified that they did not rely on the alleged misrepresentations that formed the basis of the action failed to satisfy typicality requirement.*

Bacon v. Stiefel Labs., 275 F.R.D. 681, 698-99 (S.D. Fla. 2011). Class certification was denied on the grounds that the plaintiffs failed to establish typicality because “individual determinations made in reliance upon Defendants’ omissions and misrepresentations likely varied with each individual’s needs.” Plaintiffs also were not entitled to a presumption of detrimental reliance because “[i]nvesting decisions, particularly in a volatile market as existed at the end of 2008 and during difficult corporate conditions as may have existed with [the Company], are personal and cannot be presumed.”

Walker v. Asea Brown Boveri, Inc., 214 F.R.D. 58, 64 (D. Conn. 2003). Retirees alleging interference with accrued benefits where pension plan issued lump sum payments less than statutory minimum and where retirees had signed releases against employers satisfied commonality but did not satisfy typicality. The commonality requirement was satisfied where the issues were related to the calculation and distribution of lump sum payments. The typicality requirement was not satisfied because the class representatives were potentially subject to unique defenses because they signed releases that other class members did not and the validity of each waiver was at question.

Gesell v. Commonwealth Edison, 216 F.R.D. 616, 624 (C.D. Ill. 2003). There could be no typicality where conduct involved different meetings with different employees and employees individually based decisions on different reasons or on different statements by employer.

In re Sears Retiree Grp. Life Ins. Litig., 198 F.R.D. 487, 491-93 (N.D. Ill. 2000). Retirees seeking certification after employer amended group life

insurance plan by reducing benefits for some employees did not satisfy typicality and commonality requirements for claims of breach of fiduciary duty and estoppel because allegations of misrepresentations pertained to a variety of oral and written communications. Plaintiffs attempted to remedy their claims by relying on only two documents received by all putative class members, but the court rejected this attempt, holding that communications must be looked at within the “total mix” of information that was available to plaintiffs. The court also held that the communications were too varied for class certification because the communications differed “from region to region, time to time, retirement seminar to retirement seminar, individual injury to individual injury.”

Likewise, if the class representative is subject to particular defenses due to unique circumstances, typicality will be more difficult to satisfy. Under this “unique defenses” doctrine, for example, if the class representative signed a waiver and other members have not, the validity of the waiver is likely to become a focus of the litigation and affect the class representative’s ability fairly and adequately to represent the class. Walker, 214 F.R.D. at 64-65. A unique defense becomes a factor in considering the class representative’s adequacy and may bar the representative’s ability to represent the class. See generally Scott v. N.Y. City Dist. Council of Carpenters Pension Plan, 224 F.R.D. 353 (S.D.N.Y. 2004). The mere fact that the named plaintiffs could be subject to such defenses may render their claims atypical of other class members. See In re Indep. Energy Holdings PLC, Sec. Litig., 210 F.R.D. 476, 481 (S.D.N.Y. 2002) (stating “a unique defense need not be proven in order to defeat class certification”). The Fifth Circuit has stated that “the key typicality inquiry is whether a class representative would be required to devote considerable time to rebut Defendant’s claim.” Feder v. Elec. Data Sys. Corp., 429 F.3d 125, 138 (5th Cir. 2005) (quoting Lehocky v. Tidel Techs., Inc., 220 F.R.D. 491, 501-02 (S.D. Tex. 2004)); see also Langbecker v. Elec. Data Sys. Corp., 476 F.3d 299, 314 (5th Cir. 2007).

In Langbecker, a class of participants of a 401(k) defined contribution plan claimed the company breached its fiduciary duty by continuing to allow participants to purchase the company’s own stock when the plan fiduciaries allegedly knew that it was not a prudent investment. 476 F.3d at 303-04. One of the named plaintiffs continued to trade in the company stock after the disclosures that led to the decrease in the stock price. Id. at 314. The plan fiduciaries argued that this action prevented him from being a typical member of the class. Id. The Fifth Circuit disagreed. While acknowledging that it might create an intraclass conflict and he might be subject to some unique defenses, the court found the plaintiff’s act did not mean that he could not be typical of the whole class. Id. The Fifth Circuit found that the named plaintiff’s personal investing strategy is different from the fiduciary’s breach of duty. Id. Therefore, the named plaintiff was a typical class member. Id.

In Wiseman v. First Citizens Bank & Trust Co., a 401(k) pension plan participant class alleged a breach of fiduciary duty for alleged misleading statements relating to a fund available under the 401(k) plan. 212 F.R.D. 482 (W.D.N.C. 2003). Under the 401(k), class members had independent control of the accounts and the

named plaintiffs, as experienced bankers and investors, were likely to face a different defense strategy than typical class members would. *Id.* at 488. Thus, the class satisfied numerosity but could not satisfy typicality or commonality.

See also:

In re Schering Plough Corp. ERISA Litig., 589 F.3d 585, 599-600 (3d Cir. 2009). *Because plaintiff signed a release that gave rise to a possible defense that was unique to her, class certification was vacated*

Baffa v. Donaldson, Lufkin & Jenrette Sec. Corp., 222 F.3d 52, 59 (2d Cir. 2000). *The court affirmed a denial of class certification because the typicality requirement could not be met and “class certification is inappropriate [if] a putative class representative is subject to a unique defense that threatens to become the focus of the litigation.”*

Carr v. Int’l Game Tech., No. 3:09-cv-00584, 2012 WL 909437, at *6 (D. Nev. Mar. 16, 2012), on reconsideration, No. 3:09-cv-00584, 2013 WL 638834 (D. Nev. Feb. 20, 2013). *Named plaintiffs’ execution of release subjected them to unique defenses that threatened to become the focus of the litigation.*

d) Adequacy of representation

Rule 23(a)(4) requires that the “representative parties will fairly and adequately protect the interests of the class.” FED. R. CIV. P. 23(a)(4). Courts have read this rule to entail two main inquiries: one, whether the class representative’s interests are antagonistic to any of the proposed class members; and, two, whether the class representative’s attorneys are qualified. *See Bradford v. AGCO Corp.*, 187 F.R.D. 600, 605 (W.D. Mo. 1999) (citing *Amchem Prods., Inc. v. Windsor*, 521 U.S. 591, 625 n.20 (1997)).

Also, courts have used “a ‘generic standard’ for the adequacy requirement, noting that ‘the class representatives [must] possess a sufficient level of knowledge and understanding to be capable of ‘controlling’ or ‘prosecuting’ the litigation.’” *Feder*, 429 F.3d at 130 (quoting *Berger v. Compaq Computer Corp.*, 257 F.3d 475, 482-83 (5th Cir. 2001)). Some courts have stated that the class representative may rely on legal counsel to obtain some of that knowledge, but the class representative may not rely completely on counsel. *Id.* at 131, 132 n.4.

Under the first inquiry, antagonism has been defined as a “conflict that goes to the very subject matter of the litigation.” *Mueller v. CBS, Inc.*, 200 F.R.D. 227, 237 (W.D. Pa. 2001) (citing *Ga. State Conference of Branches of NAACP v. Georgia*, 99 F.R.D. 16, 34 (S.D. Ga. 1983)). For example, in *Doe v. Guardian Life Insurance Co. of America*, the lead plaintiff was a partner of a law firm suing on behalf of the beneficiaries and participants of an employee health insurance plan used by his firm. 145 F.R.D. 466 (N.D. Ill. 1992). The plaintiff claimed insurers breached fiduciary duties and violated disclosure requirements by denying claims for treatment of bipolar disorder. *Id.* at 474.

The court found no antagonism where the lead plaintiff potentially had a fiduciary duty and conflict due to his firm's use of the plan. Id. The court held that defendants did not provide evidence to rebut the lead plaintiff's personal stake in the litigation, and any defenses unique to the plaintiff did not affect plaintiff's general interest in reimbursement for treatment of bipolar disorder. Id.

Some courts, however, will find a plaintiff inadequate if the potential for intra-class conflict exists. See Spano, 633 F.3d at 586; George, 2011 WL 5554030, at *4. For example, in Spano, the lead plaintiff sued, on behalf of plan participants, the plan's fiduciaries for imprudent investments. 633 F.3d at 586. The court held the plaintiff did not adequately represent the class because some plaintiffs could be harmed by relief granted to the class. Id. The court reasoned that whether a participant was harmed or benefited from the alleged imprudent investment depended on dates the participant first invested and later sold the investment. Id. The court refused to potentially bind absent class members to a harmful decision. Id.

See also:

In re Schering Plough Corp. ERISA Litig., 589 F.3d 585, 602 (3d Cir. 2009). The fact that a named plaintiff had executed a release and covenant not to sue the Company as part of her severance package also rendered her an inadequate class representative.

Langbecker v. Elec. Data Sys. Corp., 476 F.3d 299, 314-15 (5th Cir. 2007). The court held that there might be too many intraclass conflicts to satisfy the adequacy of representation requirement. The multiple conflicts included that some members of the class signed releases; many members had continued to purchase the company's stock; the price drop affected class members in different ways; and plaintiffs were seeking an injunction that could be contrary to the interests of some class members. The court remanded the case to the district court to consider these conflicts to determine if a class could be certified and if there was a need for subclasses within the overall class.

*Groussman v. Motorola, Inc., No. 10-cv-911, 2011 WL 5554030, at *5 (N.D. Ill. Nov. 15, 2011). The plaintiff failed to establish adequacy and typicality because the plaintiff and other class members had different incentives in defining when an investment option became imprudent.*

*Mathews v. Sears Pension Plan, No. 95-cv-1988, 1996 WL 199746, at *4 (N.D. Ill. Apr. 23, 1996). The district court disqualified a named plaintiff who signed a release as not only atypical but also an inadequate representative because he would have interests adverse to rest of class. As one who signed a potentially valid release, he would have a stronger incentive to settle and maximize his own self-interest, rather than vigorously press the claims of absent class members.*

Under the second inquiry, courts assume adequacy of counsel upon a showing of basic experience and qualifications by the plaintiff unless defendants challenge the adequacy of counsel. See Mueller, 200 F.R.D. at 238-39. Due to ERISA's complexity, plaintiff's counsel for a class action would presumably need experience with ERISA and class actions to satisfy this adequacy requirement. See Kohl v. Ass'n of Trial Lawyers, 183 F.R.D. 475, 485 (D. Md. 1998) (citing Sosna v. Iowa, 419 U.S. 393, 403 (1975)). A representative plaintiff, however, need only have a basic understanding of the claims and issues to serve as a representative. Mueller, 200 F.R.D. at 238 (citing Surowitz v. Hilton Hotels Corp., 383 U.S. 363, 366 (1966)).

The adequacy of representation requirement also overlaps with the other requirements of Rule 23(a). For example, commonality and typicality directly affect the adequacy of representation requirement because if a putative class representative had varied experiences as to circumstances related to a common issue, the interests of the representative and the rest of the class could diverge and become antagonistic. Conversely, where commonality and typicality are met, the adequacy of representation requirement is rarely problematic for plaintiffs.

See:

Chesmore v. All. Holdings, Inc., 276 F.R.D. 506, 513 (W.D. Wis. 2011). The fact that plaintiffs and other class members might be subject to laches defenses "is hardly unique grounds for finding plaintiffs are inadequate representatives of the larger class, especially in light of the fact that nothing suggests these affirmative defenses will swallow the case."

Kohl v. Ass'n of Trial Lawyers, 183 F.R.D. 475, 484-85 (D. Md. 1998). Retirees claiming denial of accrued benefits were not antagonistic to their class. Whether they were antagonistic to current employees who could potentially lose benefits if suit were successful was not relevant to certification of class that consisted solely of retirees/former employees focusing on the common issue of failure to provide cost of living adjustments.

But see:

*Groussman v. Motorola, Inc., No. 10-cv-911, 2011 WL 5554030, at *5 (N.D. Ill. Nov. 15, 2011). Plaintiff's failure to establish typicality due to an intra-class conflict between class members also meant Plaintiff failed to establish adequacy for the same reasons.*

3. Requirements of Rule 23(b) in ERISA class actions

Besides the four requirements of Rule 23(a), a putative plaintiff class must satisfy one of the three alternative requirements of Rule 23(b). A plaintiff can plead that the class fits under more than one Rule 23(b) section, and the relief sought under ERISA will often determine which of the requirements may be applicable. Furthermore, as under Rule 23(a), if a class does not meet any requirement of Rule 23(b), the suit

can be limited in scope or the class can be divided into subclasses that better satisfy the requirements. See Fed. R. Civ. P. 23(c)(4).

a) Risk of inconsistent or varying decisions

Rule 23(b)(1) allows class certification if the prosecution of separate actions would create a risk of inconsistent adjudications with respect to individual members of a class that would either (A) establish incompatible standards of conduct for defendants; or (B) as a practical matter, be dispositive to the interests of other members not a party to the adjudications. FED. R. CIV. P. 23(b)(1); see generally *Ortiz v. Fibreboard Corp.*, 527 U.S. 815, 830-36 (1999) (discussing history of Rule 23(b)). Also, notice is not required for a class under Rule 23(b)(1), but notice may be directed by the court. Fed. R. Civ. P. 23(c)(2)(A); *UAW v. Gen. Motors Corp.*, 497 F.3d 615, 630 (6th Cir. 2007).

The Rule 23(b)(1) requirement, through its two possibilities, is “the most easily satisfied prong of 23(b) in ERISA cases.” SANDALS, supra, at 3. For example, if participants of a plan were to sue individually against a plan administrator who owed the same duty to all participants, the defendant could face incompatible rulings on standards of conduct, thus triggering Rule 23(b)(1)(A). Similarly, with respect to Rule 23(b)(1)(B), the potential costs to individual defendants, as well as the *stare decisis* effect of different cases, could impair other plan members’ ability to sue and recover. Id.

See:

In re Beacon Assocs. Litig., 282 F.R.D. 315, 342 (S.D.N.Y. 2012). *The court concluded that “[a] breach of fiduciary duty claim brought by one member of a retirement plan necessarily affects the rights of the rest of the plan members to assert that claim, as the plan member seeks recovery on behalf of the plan as an entity,” and that “the prosecution of separate actions would risk prejudice to putative class members.”*

Adams v. Anheuser-Busch Co., 2012 WL 1058961, at * 11 (S.D. Ohio March 28, 2012). *The court found a risk of “individual actions [producing] inconsistent adjudications concerning the meaning of [the relevant plan provision]” and thus of “result[ing] in incompatible standards of conduct for the Plan administrator.”*

Chesemore v. Alliance Holdings, Inc., 276 F.R.D. 506, 517 (W.D. Wis. 2011). *The court noted that the “plaintiffs [were] asserting claims against the trustees for breach of fiduciary duty” and that “[s]uits by individual class members could create inconsistent results for the fiduciaries.”*

Humphrey v. United Way of Texas Gulf Coast, No. 05-cv-0758, 2007 WL 2330933, at * 10 (S.D. Tex. Aug. 14, 2007). *“Individual suits might lead to conflicting orders on the interpretation of the [plan] and the resulting calculation of the . . . benefits.”*

Kohl v. Ass'n of Trial Lawyers, 183 F.R.D. 475 (D. Md. 1998). *Retirees claiming denial of accrued benefits satisfied both Rules 23(b)(1) and 23(b)(2) where calculation of the cost of living adjustments in separate litigations would create inconsistencies and where it appeared that plan administrator acted in consistent manner toward the class members.*

But see:

Spano v. The Boeing Co., 633 F.3d 574, 586 (7th Cir. 2011). *Cautioning that courts should not apply 23(b)(1) too liberally, the court stated "a claim of imprudent management . . . is not common if the alleged conduct harmed some participants and helped others."*

b) Defendant is subject to injunctive or declaratory relief

Rule 23(b)(2) allows for class certification where the party opposing the class has acted on grounds generally applicable to the class, thus making injunctive or declaratory relief appropriate. In the ERISA context, if the relief sought is for an entire plan, this section is almost "automatically" applicable. McHenry v. Bell Atlantic Corp., No. 97-cv-6556, 1998 WL 512942, at *7 (E.D. Pa. Aug. 18, 1998) (citing Baby Neal for and by Kanter v. Casey, 43 F.3d 48, 57-58 (3d Cir. 1994)). In addition, because relief will likely have the same effect on all class members under Rule 23(b)(2), notice to class members of the suit or the option to opt out is not required. In re Allstate Ins. Co., 400 F.3d 505, 506-07 (7th Cir. 2005); see also UAW, 497 F.3d at 630. "But when . . . the effect of the declaration on individual class members will vary with their particular circumstances, they should be given notice of the class action so that they can decide whether they would be better off proceeding individually." In re Allstate Ins. Co., 400 F.3d at 508 (citing In re Monumental Life Ins. Co., 365 F.3d 408, 417 (5th Cir. 2004)).

Rule 23(b)(2) is difficult to satisfy if individual reliance must be shown because a class representative's success will not establish on its own relief for other class members. Heffner, 443 F.3d at 1344-45; see also Langbecker, 476 F.3d at 317 (denying certification under Rule 23(b)(2) where individual damage calculations will be required). Therefore, if individual reliance is an issue, certification under Rule 23(b)(2) is unlikely.

Rule 23(b)(2) is also difficult to satisfy if plaintiffs seek monetary relief. In Wal-Mart v. Dukes, the Supreme Court held a plaintiff can only recover monetary relief under this prong if the monetary relief is incidental to the injunctive or declaratory relief. 131 S. Ct. at 2557. In doing so, the Court rejected the previous test used by many circuits: determining whether monetary relief predominated over a claim for injunctive relief. Id. at 2559. In its decision, the Court referenced a Fifth Circuit decision that defined incidental monetary relief as "damages that flow directly from liability to the class as a whole on the claims forming the basis of the injunctive or declaratory relief." Id. at 2560. A class cannot be certified under 23(b)(2) if monetary relief requires individual determinations as to the amount or availability of damages. Id. at 2560-61.

See:

Nationwide Life Ins. Co. v. Haddock, 460 Fed.Appx. 26, 29 (2d Cir. 2012). Plaintiffs alleged plan violated ERISA by accepting payments from mutual funds the plan offered as investment options and sought declaratory relief and individualized money damages. The court concluded a class could not be certified under Rule 23(b)(2) because the monetary relief was not incidental to the declaratory judgment.

But see:

Mezyk v. U.S. Bank Pension Plan, No. 3:09-cv-384, No. 3:10-cv-696, 2011 WL 6729570, at *2 (S.D. Ill. Dec. 21, 2011). The court certified a class under Rule 23(b)(2) even though an ultimate decision in favor of plaintiffs would require defendant to make individual benefit determinations and monetary awards. The court concluded that recalculating benefit payments was incidental to declaratory relief.

c) Common questions predominate and a class action is superior

Rule 23(b)(3) allows for class certification where the questions of law or fact common to the class predominate over questions affecting individual class members, and where a class action is superior to other methods of adjudication. Factors relevant to this requirement include: (A) the individual interests of members of class in controlling prosecution or defense of separate actions; (B) any litigation concerning the controversy already commenced by or against class members; (C) the desirability of concentrating litigation in a particular forum; and (D) any difficulties likely in managing the class. Fed. R. Civ. P. 23(b)(3). Unlike Rule 23(b)(1) and (b)(2), stringent notice requirements must be met for a class to be certified under Rule 23(b)(3). *UAW*, 497 F.3d at 630; Fed. R. Civ. P. 23(c)(2)(B).

Although this requirement is often read together with the Rule 23(a)(2) commonality requirement, the Rule 23(b)(3) commonality component is more demanding, and courts must take a “close look at whether common questions predominate over individual ones.” *Comcast Corp. v. Behrend*, 569 U.S. 27, 34 (2013) (citing *Amchem Prods., Inc. v. Windsor*, 521 U.S. 591, 623-24 (1997)) (internal quotation marks omitted). Whereas the Rule 23(a)(2) commonality requirement looks at whether the common issues apply to all class members, Rule 23(b)(3) looks at whether the proposed class action is practical for all class members. *Burke v. Local 710 Pension Plan*, No. 98-cv-3723, 2000 WL 336518, at *6 (N.D. Ill. Mar. 28, 2000) (quoting *Doe v. Guardian Life Ins. Co. of Am.*, 145 F.R.D. 466, 475 (N.D. Ill. 1992)).

Similar to the commonality prong, defining a class by a general issue such as breach of fiduciary duty instead of individualized issues such as reliance can be the key for ERISA plaintiffs. Whether common questions predominate over individual questions is a matter of “degree.” *SANDALS*, *supra*, at 5. Individual circumstances, even

reliance, are not problematic unless they are so voluminous or complex that they bog down examination of common questions. Frahm v. Equitable Life Assurance Soc’y of U.S., 137 F.3d 955, 957 (7th Cir. 1998).

See:

Burke v. Local 710 Pension Plan, No. 98-cv3723, 2000 WL 336518, at *5 (N.D. Ill. Mar. 28, 2000). *Plaintiffs sued pension plan, claiming plan failed to properly give beneficiaries credit for contributions to their retirement accounts. While the court found plaintiffs met the commonality requirement, the court held plaintiffs “failed to demonstrate that these questions predominate over the class members rather than being an individual question which is unique to individual members.”*

Doe v. Guardian Life Ins. Co. of Am., 145 F.R.D. 466, 476-77 (N.D. Ill. 1992). *Beneficiaries and participants of employee health insurance plan who claimed insurers breached fiduciary duties and violated disclosure requirements by denying claims for treatment of bipolar disorder satisfied commonality requirement and typicality requirements. Common questions, however, did not predominate where individual issues of diagnosis, non-coverage, and estoppel could potentially require numerous and lengthy mini-trials.*

In ERISA cases, the cause of injury and the nature of damages are often common questions that do not require individual inquiries. Furthermore, because the common bond for ERISA plaintiffs is often an employer or plan, the Rule 23(b)(3) factors are usually not problematic for class certification as any ERISA suit would likely be known to the other potential class members and will often be initiated in the same forum.

See:

Ries v. Humana Health Plan, Inc., No. 94-cv-6180, 1997 WL 158337, at *10 (N.D. Ill. Mar. 31, 1997). *Participants of healthcare plan claiming breach of fiduciary duty and seeking reimbursement for alleged discounted payments to health care providers satisfied Rule 23(b)(3). The court found that management of the class, despite uncertainty of the number of class members and despite various plans involved, did not pose a problem to the management of the class where the various plans likely contained similar language.*

4. Procedural requirements to sue on behalf of a plan under § 502(a)(2) & Rule 23

As an alternative to class certification, a plaintiff can sue defendants in a “representative capacity on behalf of the plan” under § 502(a)(2). Coan, 457 F.3d at 259-61 (2d Cir. 2006). To proceed on the plan’s behalf, a plaintiff must employ robust procedural safeguards that will protect other plan members. Id. at 259. Courts have not

conclusively defined the procedural safeguards a plaintiff must employ before he or she is able to proceed on behalf of a plan but instead evaluate the safeguards on a case by case basis. See id. at 260; In re AEP ERISA Litig., No. 03-cv-67, 2009 WL 3854943, at *4 (S.D. Ohio Nov. 17, 2009).

Plaintiffs can ensure they have provided sufficient procedural safeguards by satisfying the requirements of Rule 23; however, most courts do not expressly require plaintiffs to satisfy Rule 23 to proceed on behalf of a plan. See, e.g., George, 2011 WL 5118815, at *10 (rejecting defendant's argument that plaintiff must satisfy Rule 23 requirements to proceed on behalf of plan); Fish v. Greatbanc Trust Co., 667 F. Supp. 2d 949, 951 (N.D. Ill. 2009) (same). But see Buckmaster v. Wyman, No. 05-cv-0166, 2006 WL 1785845, at *5 (E.D. Wis. June 23, 2006) (holding "a participant in an ERISA plan may assert a claim against the plan fiduciaries under § 502(a)(2), but he must do so either as a representative of the plan in a derivative action or as representative of the beneficiaries in a class action").

If a plaintiff tries but fails to certify a class under Rule 23, a court may bar the plaintiff from proceeding as a plan representative. See, e.g., Abbott v. Lockheed Martin Corp., No. 06-cv-0701, 2010 WL 547172, at *3-4 (S.D. Ill. Feb. 10, 2010) (denying class certification because court found an intra-class conflict that effectively foreclosed any possible procedural safeguards to protect absent class members); Matassarin v. Lynch, No. 96-cv-0482, 1997 U.S. Dist. LEXIS 24203, at *20 (W.D. Tex. Nov. 10, 1997) (concluding sufficient procedural safeguards were impossible once court determined plaintiff was an inadequate class representative). But see In re Diebold ERISA Litig., No. 5:06-cv-0170, 2009 U.S. Dist. LEXIS 116856, at *19 (N.D. Ohio Mar. 11, 2009) (denying class certification and stating that "Plaintiffs are not precluded from proceeding with this action individually to recover losses to the Plan as a whole").

XIV. CLAIMS BASED ON THE FEDERAL COMMON LAW OF ERISA

This chapter addresses the scope of the federal courts' power to develop federal common law under ERISA, with a special emphasis on remedies and the elements of currently recognized federal common law claims. Justice Stevens observed that “[t]he six carefully integrated civil enforcement provisions found in § 502(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.” Mass. Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 146 (1985). While ERISA is described as a “comprehensive and reticulated statute,” Nachman Corp. v. PBGC, 446 U.S. 359, 361 (1980), the Supreme Court later concluded (in a Justice Brennan opinion) “that courts are to develop a ‘federal common law of rights and obligations under ERISA-regulated plans.’” Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 110 (1989) (quoting Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 56 (1987) (holding that ERISA does not apply), holding limited in part by Ky. Ass’n of Health Plans, Inc. v. Miller, 538 U.S. 329 (2003)) (citations omitted).

A. THE COURTS’ POWER TO DEVELOP ERISA FEDERAL COMMON LAW

1. Justifications for the courts’ power to develop federal common law

The courts’ power to fashion a federal common law remedy under ERISA begins with § 514(a), which states that ERISA preempts state laws “insofar as they may . . . relate to” an employee benefit plan. 29 U.S.C. § 1144(a). Focusing on this language, the Supreme Court has concluded that “[t]he deliberate care with which ERISA’s civil enforcement remedies were drafted and the balancing of policies embodied in its choice of remedies argue strongly for the conclusion that ERISA’s civil enforcement remedies were intended to be exclusive” of traditional state law claims. Pilot Life, 481 U.S. at 54. Furthermore, turning to the legislative history, the Court has maintained that “in light of the Act’s virtually unique pre-emption provision, ‘a body of Federal substantive law will be developed by the courts to deal with issues involving rights and obligations under private welfare and pension plans.’” Franchise Tax Bd. v. Constr. Laborers Vacation Trust, 463 U.S. 1, 25 n.26 (1983) (quoting remarks of ERISA’s sponsor) (citations omitted), superseded by statute on other grounds, 28 U.S.C. § 1441(e).

Because “the pre-emptive force of § 502(a) was modeled after § 301 of the LMRA [Labor-Management Relations Act of 1974],” Pilot Life, 481 U.S. at 54, and “ERISA abounds with the language and terminology of trust law,” Firestone, 489 U.S. at 110, the Court later in 1989 concluded that, as with the LMRA, Congress intended for the courts to develop a federal common law “guided by principles of trust law.” Id. at 111. In accepting this role, courts often insist that federal common law merely fills gaps in ERISA. In some cases, courts have stated that this “gap-filling” power is limited to the ability to address questions of statute interpretation and plan construction that

ERISA's text leaves unanswered. In other cases, courts find that "gap-filling" includes creating remedies that ERISA specifically does not recognize.

See:

Fotta v. Trs. of the UMW Health & Ret. Fund of 1974, 165 F.3d 209, 211-12, 214 (3d Cir. 1998). A "beneficiary of an ERISA plan may bring an action for interest on delayed benefits payments under section 502(a)(3)(B)" notwithstanding the lack of an express provision in ERISA. The court based this right on its power to develop common law to "effectuate the statutory pattern enacted . . . by Congress."

UIU Severance Pay Trust Fund v. Local Union No. 18-U, United Steelworkers of Am., 998 F.2d 509, 512 (7th Cir. 1993). The court affirmed the right of a non-fiduciary employer to claim restitution for erroneous contributions to a plan, even though the employer would have no standing under ERISA's six authorized causes of action. The court noted, "[w]e have . . . been extremely reluctant to find that ERISA creates certain causes of action . . . in addition to those enumerated in the statute itself. The Union, however, does not ask us to imply a 'new' cause of action under ERISA but simply urges us to fill in ERISA's interstices with federal common law" (citations omitted).

Jamail, Inc. v. Carpenters Dist. Council of Houston Pension & Welfare Trusts, 954 F.2d 299, 303 (5th Cir. 1992). The court found a common law right to restitution for non-fiduciary employers stating "[w]henver Congress enacts complex and comprehensive legislation, such as ERISA, minor gaps in the legislation are unavoidable. Congress cannot be expected to perceive in advance all the ramifications of its legislation. It is the judiciary's role, therefore, to fill in these gaps."

2. Scope of the power to develop federal common law

As noted above, some courts have used federal common law to fashion remedies not found among ERISA's "exclusive" list of statutory remedies. However, much of the federal common law development under ERISA relates purely to interpretation of the Act's explicit provisions. Jeffrey A. Brauch, *The Federal Common Law of ERISA*, 21 HARV. J.L. & PUB. POL'Y 541, 556 (1998). Courts interpreting ERISA have been guided by trust law principles. For example, courts have used trust principles in their interpretation of ERISA fiduciary duties. See, e.g., Varsity Corp. v. Howe, 516 U.S. 489, 502-03 (1996) (relying on common law of trusts to hold that employer acted as fiduciary in informing employees about benefit plan). Similarly, courts apply the common law of agency to determine whether an individual was an "employee" within ERISA's definition.

See:

Kujanek v. Hous. Poly Bag I, Ltd., 658 F.3d 483, 487 (5th Cir. 2011). In applying common law trust principles to an ERISA plan, the court stated that “ERISA does not expressly enumerate the particular duties of a fiduciary, but rather relies on the common law of trusts to define the general scope of a fiduciary’s responsibilities.”

Sipma v. Mass. Cas. Ins. Co., 256 F.3d 1006, 1011 (10th Cir. 2001). Based on common law agency principles, the plaintiff was an employee for ERISA purposes.

Dykes v. Depuy, Inc., 140 F.3d 31, 39 (1st Cir. 1998). Whether the plaintiff was a protected employee under ERISA was determined under common law agency principles.

Additionally, in Firestone, the Supreme Court invoked its power to create federal common law to establish a standard of review for plan administrator decisions under ERISA. Firestone, 489 U.S. at 115. It held that “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.” Id. The circuit courts have further elaborated on this standard.

See:

Gross v. Sun Life Assurance Co. of Canada, 734 F.3d 1, 16 (1st Cir. 2013). Ambiguous language in a plan, such as the requirement that a plan beneficiary provide evidence of disability “satisfactory to us” as plan administrators, does not prevent *de novo* review.

Geddes v. United Staffing Alliance Emp. Med. Plan, 469 F.3d 919, 925 (10th Cir. 2006). Pursuant to the principles of trust law, courts still must apply a deferential standard of review when a fiduciary delegates his discretionary decision making power to a non-fiduciary.

Diaz v. Prudential Ins. Co. of Am., 424 F.3d 635, 637 (7th Cir. 2005). After Firestone, “[i]f a plan wishes to insulate its decision to deny benefits from plenary review, the surest way to do so . . . is by including language” articulating the plan administrator’s discretion.

Kinstler v. First Reliance Standard Life Ins. Co., 181 F.3d 243, 250 (2d Cir. 1999). Following the logic of Firestone, the *de novo* standard applied to all issues concerning a denial of benefits claim in the absence of discretionary decision making authority.

The courts of appeal have also held, as a matter of federal common law, that while ERISA requires that pension benefits vest upon retirement, the parties to a welfare benefit plan are free to determine contractually when and if those benefits will

vest or be terminated. See, e.g., Schonholz v. Long Island Jewish Med. Ctr., 87 F.3d 72, 77 (2d Cir. 1996).

See:

Neuma, Inc. v. AMP, Inc., 259 F.3d 864, 873 (7th Cir. 2001). *Sponsors are free to subject welfare benefit plans to vesting requirements not required by ERISA through a plan's documents.*

Finally, courts have fashioned a federal common law to address issues of plan interpretation. ERISA does not provide any principles for interpreting the plans it covers. Brauch, supra, at 572-73. In response, the courts have turned to common law doctrines to fashion a federal common law of ERISA plan interpretation. For instance, several courts have applied common law principles of contract interpretation in construing the terms of ERISA plans. See, e.g., Grun v. Pneumo Abex Corp., 163 F.3d 411, 419 (7th Cir. 1999).

See also:

Miller v. Monumental Life Ins. Co., 502 F.3d 1245, 1253-54 (10th Cir. 2007). *To interpret an ambiguous plan, the court applied the federal common law doctrine of contra proferentem, construing ambiguities against the plan's drafters.*

Citizens Ins. Co. of Am. v. MidMichigan Health ConnectCare Network Plan, 449 F.3d 688, 693-94 (6th Cir. 2006). *After finding a plan provision ambiguous, the court employed traditional common law principles of contract interpretation to resolve the ambiguity, such as reviewing extrinsic evidence and drawing inferences.*

Neuma, Inc. v. AMP, Inc., 259 F.3d 864, 873-77 (7th Cir. 2001). *Following federal common law rules of contract interpretation, the court held a provision of a plan to be unambiguous and refused to consider extrinsic evidence.*

Bellino v. Schlumberger Techs., Inc., 944 F.2d 26, 29 (1st Cir. 1991) *"The federal common law of rights and obligations, while still in formation, must embody common-sense canons of contract interpretation" (quotations and alterations omitted).*

3. Principles that guide the development of ERISA common law

Although Pilot Life invited federal courts to develop federal common law under ERISA, more recent Supreme Court decisions have placed limits upon its development. For example, Mertens v. Hewitt Associates extended Russell and made clear that legal relief is unavailable under ERISA § 502(a)(3), which limits individual claims to "appropriate equitable relief." 508 U.S. 248, 255 (1993). Guided by trust law principles, the Court found that only "those categories of relief that were *typically*

available in equity (such as injunction, mandamus, and restitution, but not compensatory damages)” could be obtained. *Id.* at 256; see also supra Section IV.B (discussing statutory remedies). While the Court’s Mertens decision recognized restitution as an equitable remedy, more recently the Court has distinguished between restitution “at law,” in which the plaintiff “could not assert title or right to possession of particular property” and restitution “*in equity*, ordinarily in the form of a constructive trust or an equitable lien, where money or property identified as belonging in good conscience to the plaintiff could clearly be traced to particular funds or property in the defendant’s possession.” Great-West Life & Annuity Ins. Co. v. Knudson, 534 U.S. 204, 213 (2002). The court held that only restitution in equity is appropriate under ERISA § 502(a)(3).

While the Court has never addressed a claim for relief based solely on federal common law, such as in UIU Severance Pay Trust Fund or Jamail, these same principles of equitable relief would likely apply to how the Court would address the legitimacy of any federal common law claim. Beyond this, the Court has offered only limited guidance to courts crafting federal common law. Essentially, courts developing a federal common law are guided by ERISA’s language, structure and purpose.

See:

Hughes Aircraft Co. v. Jacobson, 525 U.S. 432, 447 (1999). *Refusing to apply a common-law theory of wasting trust to terminate a plan, the court unanimously held that “[ERISA] should not be supplemented by extratextual remedies, such as the common-law doctrines advocated by respondents. . . . Application of the wasting trust doctrine in this context would appear to be inconsistent with the language of ERISA’s termination provisions.”*

Varity Corp. v. Howe, 516 U.S. 489, 497 (1996). *Applying the fiduciary duties traditionally recognized under trust law to ERISA plans, the Court noted “we believe that the law of trusts often will inform, but will not necessarily determine the outcome of, an effort to interpret ERISA’s fiduciary duties.” While trust law may be a starting point, courts also consider “the language of the statute, its structure, or its . . . purposes, such as Congress’s desire to offer employees enhanced protection for their benefits, on the one hand, and, on the other, 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.”*

Mertens v. Hewitt Assoc., 508 U.S. 248, 259 (1993). *The Court rejected employees’ complaint seeking money damages against a non-fiduciary for knowingly participating in the breach of a fiduciary, noting that “[t]he authority of courts to develop a ‘federal common law’ under ERISA is not the authority to revise the text of the statute (citations omitted).”*

Guidry v. Sheet Metal Workers Nat'l Pension Fund, 493 U.S. 365, 376 (1990). In rejecting the application of a constructive trust to a plan—for embezzlement of company funds—as contrary to ERISA’s express proscription against alienation or assignment of pension benefits, the Court stated “[a]s a general matter, courts should be loath to announce equitable exceptions to legislative requirements or prohibitions that are unqualified by the statutory text.”

Consistent with the Court’s language in these cases, circuit courts limit the federal common law’s development by deferring to ERISA’s policies, purposes and specific provisions. In particular, courts state that they create federal common law only insofar as ERISA’s provisions are silent on an issue; only to the extent that such law is consistent with ERISA’s policies; and may rely upon state law only to the extent that it is not *inconsistent* with those policies.

See:

Zurich Am. Ins. Co. v. O’Hara, 604 F.3d 1232, 1237 (11th Cir. 2010). *Federal common law is inapplicable where the plan expressly addresses the issue before the court.*

Coop. Benefit Adm’rs, Inc. v. Ogden, 367 F.3d 323, 329-330 (5th Cir. 2004). “[F]ederal common law may be applied to fill ‘minor gaps’ in ERISA’s text, as long as the federal common law rule created is ‘compatible with ERISA’s policies.’ . . . [W]e [have] cautioned that the power of the judiciary ‘to develop federal common law pursuant to ERISA does not give carte blanche power to rewrite the legislation to satisfy our proclivities.’ Thus, federal courts do not have authority under ERISA to create federal common law when that statute ‘specifically and clearly addresses the issue before the [c]ourt.’ This is so because, in such instances, the legislative scheme does not contain a ‘gap’ that requires ‘filling’ by application of federal common law. Thus, a court’s general opinion as to what remedies might further ERISA’s underlying policies will not be sufficient ‘to overcome the words of its text regarding the specific issue under consideration.’”

Metro. Life Ins. Co. v. Johnson, 297 F.3d 558, 567 (7th Cir. 2002). “The Supreme Court has recognized, in situations where ERISA preempts state law but is silent on a topic, that courts would have to develop a body of federal common law, where appropriate, based on principles of state law.”

United McGill Corp. v. Stinnett, 154 F.3d 168, 171 (4th Cir. 1998). “Courts should only fashion federal common law when necessary to effectuate the purposes of ERISA.”

However, several courts warn that the authority to create new federal common law remedies is “far more circumscribed” than is the power to fashion

substantive rules based on the laws of contracts and trusts. In particular, courts have consistently rejected attempts to expand ERISA federal common law to include claims for purely legal remedies. N. Am. Coal Corp. Ret. v. Roth, 395 F.3d 916, 917 (8th Cir. 2005) (reversing district court's finding that fiduciary must pay restitution under § 1132(a)(3) because restitution was a legal remedy); Pappas v. Buck Consultants, Inc., 923 F.2d 531, 541 (7th Cir. 1991) (refusing to find cause of action for misrepresentation against non-fiduciaries).

See also:

Travelers Cas. & Sur. Co. of Am. v. IADA Servs., Inc., 497 F.3d 862, 866 (8th Cir. 2007). There was no right of contribution under ERISA because, in the court's view, "[g]iven the comprehensive nature of the overall statutory scheme, . . . the statute's failure to include certain remedies should not be construed as an oversight."

Reich v. Compton, 57 F.3d 270, 284 (3d Cir. 1995). The plaintiff could not "sue a nonfiduciary under section 502(a)(5) for knowingly participating in a fiduciary breach" and the court could not create a cause of action through its authority under federal common law.

Buckley Dement, Inc. v. Travelers Plan Admin. of Ill., Inc., 39 F.3d 784, 789 (7th Cir. 1994). The court would not recognize a federal common law claim by a plan administrator for compensatory damages against a non-fiduciary for failure to process claims in a timely fashion, saying "[t]he statute's 'six carefully integrated civil enforcement provisions' to remedy ERISA violations, found at 29 U.S.C. § 1132(a), demonstrate the evident care with which the remedial aspects of the statute were crafted. This consideration counsels against our concluding that Congress intended the federal courts to fashion any other remedies."

The Supreme Court also has advised that while federal courts may "develop a federal common law . . . under ERISA . . . the scope of permissible judicial innovation is narrower in areas where other federal actors are engaged." Black & Decker Disability Plan v. Nord, 538 U.S. 822, 831 (2003) (internal citations omitted) (rejecting courts' ability to impose treating physician rule absent authorization of Congress or Secretary of Labor).

B. RECOGNIZED FEDERAL COMMON LAW ERISA CLAIMS

When circuit courts recognize federal common law claims not otherwise available under ERISA, they adhere closely to ERISA's connections with trust law that the Supreme Court recognized in Firestone and to traditional contract law elements. Thus, courts consistently reject relief claims that they characterize as purely legal in nature. See, e.g., Ogden, 367 F.3d at 332-33 (rejecting federal common law claim for unjust enrichment after characterizing it as legal in nature); UNUM Life Ins. Co. of Am. v. Grouke, 406 F. Supp. 2d 524, 533 (M.D. Pa. 2005) (same); Costigan & Co., P.C. v.

Costigan, No. 00-cv-6143, 2000 WL 1693544, at *4 (S.D.N.Y. Nov. 13, 2000) (refusing to find ERISA federal common law claim for conversion, noting remedy was legal and not equitable in nature); Ferry v. Mut. Life Ins. Co., 868 F. Supp. 764, 773-77 (W.D. Pa. 1994) (rejecting federal common law claims for tortious breach of contract, conversion, and breach of fiduciary duty). Parties may not refashion their claims under federal common law where ERISA already expressly provides for such relief. See Rego v. Westvaco Corp., 319 F.3d 140, 148-49 (4th Cir. 2003) (rejecting plaintiff's attempt to refashion claims for negligent misrepresentation and breach of fiduciary duty under federal common law where plaintiff essentially was seeking damages for denial of benefits and breach of fiduciary duty, two actions for which ERISA already provides remedies).

Unless otherwise noted, the elements of the claims that courts recognize, such as the elements for a restitution claim, appear to be identical to what they would be in other contexts where these claims might be sought.

1. **Federal common law theories of liability used by plaintiffs who are participants or beneficiaries against an ERISA plan**
 - a) **Restitution**

Courts not only recognize a claim for restitution under ERISA § 502(a)(3)—as one form of the “other appropriate equitable relief” available to parties that have standing as participants, beneficiaries and fiduciaries—but, as noted at the beginning of this section, nearly every circuit also recognizes the right of non-fiduciary employers to seek restitution for amounts mistakenly contributed to ERISA plans. See Young Am., Inc. v. Union Cent. Life. Ins. Co., 101 F.3d 546, 548 (8th Cir. 1996). While ERISA’s anti-inurement principle declares that “the assets of a plan shall never inure to the benefit of any employer,” it contains an exception allowing pension plans to reimburse employers when an excess contribution results from a “mistake of fact or law.” 29 U.S.C. § 1103(c)(1)-(2)(A). However, as the Seventh Circuit noted in UIU Severance Pay Trust Fund, “ERISA *permits* plan trustees to return to employers payments made to a plan which are the result of a mistake of law or fact[.] . . . [I]t does not establish a cause of action by which employers may seek to *compel* such a refund. Absent a judicially-crafted cause of action, employers are left to the mercy of plan trustees who have no financial incentive to return mistaken payments.” 998 F.2d at 512-13 (citation omitted). Acknowledging this fact, every circuit except the Second and Eleventh Circuits recognize an employer’s general right to seek restitution for mistaken plan contributions. Significantly, though not surprisingly, each of these courts has cautioned that they will apply these equity principles to determine whether or not restitution should be awarded.

See:

Laborers Pension Tr. Fund-Detroit & Vicinity v. Interior Exterior Specialists Constr. Grp., Inc., 394 F. App'x 285, 294 (6th Cir. 2010). *The Sixth Circuit*

recognizes a limited cause of action for restitution under federal common law.

State St. Bank & Tr. Co. v. Denman Tire Corp., 240 F.3d 83, 89-90 (1st Cir. 2001). *An action under federal common law exists when one plan mistakenly transfers funds to another plan, though a court must still analyze the equities of each case.*

Kwatcher v. Mass. Serv. Emps. Pension Fund, 879 F.2d 957, 967 (1st Cir. 1989), *overruled in part on other grounds by Raymond B. Yates, M.D., P.C. Profit Sharing Plan v. Hendon*, 541 U.S. 1 (2004). *“Such an anodyne makes the playing field level for employers and employees; reduces the risk of draconian treatment for those who overpay; and is fully consonant with ERISA’s underlying policies as expressed in 29 U.S.C. § 1103(c)(2)(A). Rather than undermining ERISA’s remedial scheme, equity supplements it by providing a tool for courts to use when one party ‘has been unjustly enriched at the expense of another.’ . . . Recoupment will not follow automatically upon a mere showing that a plaintiff has tendered more than required, but only ‘when the equities favor it.’”*

Plucinski v. I.A.M. Nat’l Pension Fund, 875 F.2d 1052, 1057-58 (3d Cir. 1989). *“Of course, general equitable principles govern and when it would be inequitable to so order, for example, when restitution would result in the underfunding of the plan, the court should in its sound discretion deny recovery. We believe that creating such a cause of action will fill in the interstices of ERISA and further the purposes of ERISA. We do not believe that by enacting [§ 1103] of ERISA, which simply permits funds to refund mistaken contributions, Congress intended to foreclose the courts from investing employers with a remedy” (citations omitted).*

But see:

Dime Coal Co. v. Combs, 796 F.2d 394, 398-400 (11th Cir. 1986). *The court rejected a federal common law claim for restitution by non-fiduciary employers and noted, “[r]egardless of whether we focus on the refund provision as originally enacted or on the 1980 amendment that authorizes the return of the mistaken contributions at issue in this case, we find no indication in the language of the statute or in its legislative history that Congress intended or would approve of the implication of the remedy [of restitution]. . . . We are thus confident that the trustees could have refunded the mistaken contributions that are at issue in this case without exposing themselves to the fiduciary liability they fear. But we hold that, as a matter of federal law, a contributing employer may not require multiemployer employee benefit plan trustees to return such contributions if the trustees choose not to do so. Whether such an action might be entertained in the future is a decision that must be left solely in the capable hands of the Congress.”*

Trs. of the Operating Eng'rs Pension Tr. v. Tab Contractors, 224 F. Supp. 2d 1272, 1283 (D. Nev. 2002). In denying defendant's unjust enrichment claim, the court noted that the Ninth Circuit has declined to recognize a federal common law action for restitution in favor of employers.

For its part, the Second Circuit recognizes a more circumscribed restitution right by an employer for erroneous contributions. In addition to demonstrating that the case's equities favor restitution, one seeking reimbursement must show that the plan's refund policy is "arbitrary or capricious." Dumac Forestry Servs. Inc. v. Int'l Bhd. of Elec. Workers, 814 F.2d 79, 82 (2d Cir. 1987); see also Frank L. Ciminelli Constr. Co. v. Buffalo Lab. Supp. Unemployment Benefit Fund, 976 F.2d 834, 835 (2d Cir. 1992) (applying arbitrary or capricious standard in restitution case); Heffernan v. iCare Mgmt., LLC, 356 F. Supp. 2d 141, 156-57 (D. Conn. 2005) (dismissing claim for recovery of overpayments after employer failed to allege plan's refund policy was arbitrary and capricious). The Second Circuit also has applied the arbitrary and capricious standard to cases where employers seek to have their erroneous contributions set off against required future payments. See Brown v. Health Care & Ret. Corp. of Am., 25 F.3d 90, 94 (2d Cir. 1994) ("[W]e extend the requirements of Dumac and Ciminelli to an employer asserting a setoff."); Durso v. Cappy's Food Emporium, Ltd., No. 05-cv-3498, 2006 WL 3725546, at *3 (E.D.N.Y. Dec. 14, 2006) (granting summary judgment against setoff claim because defendant did not create issue of fact as to whether refund policy was arbitrary and capricious and whether equities favored setoff).

The Seventh Circuit has offered a non-exclusive list of factors courts should consider in weighing the equity of ordering restitution in a given case. These include the following: (1) whether the erroneous contributions are the sort of mistaken payments that equity demands be refunded; (2) whether the plaintiff delayed in bringing suit, so that laches, or some other equitable defense bars recovery; (3) whether the plaintiff ratified the payments by failing to question them over a period of years; and (4) whether defendant would be unjustly enriched if recovery were denied. See Trustmark Life Ins. Co. v. Univ. of Chi. Hosps., 207 F.3d 876, 883 (7th Cir. 2000). Moreover, the Seventh Circuit has observed that courts may deny restitutionary relief where overriding and explicit contractual provisions in the plan addressed erroneous contributions. See Admin. Comm. of the Wal-Mart Stores, Inc. Assocs.' Health & Welfare Plan v. Varco, 338 F.3d 680, 691-92 (7th Cir. 2003).

The Supreme Court's 2002 decision in Knudson has somewhat changed ERISA's landscape for restitutionary claims. As noted above, *equitable* restitution under ERISA § 502(a)(3) requires the plaintiff to identify a particular asset set that rightly belong to the plaintiff. 534 U.S. at 214. It is likely that this same limitation would apply to federal common law restitution claims. Otherwise, allowing what the Supreme Court called restitution "at law" under the federal common law would render equitable relief under § 1132(a)(3) less favorable than the relief available under federal common law, clearly defying what the Court identified as congressional intent in Knudson.

See:

Coop. Benefit Adm'rs, Inc. v. Ogden, 367 F.3d 323, 335 (5th Cir. 2004). “ERISA plan fiduciaries do not have a federal common law right to sue a beneficiary for legal (as distinct from equitable) relief on a theory of unjust enrichment or restitution.”

Rego v. Westvaco Corp., 319 F.3d 140, 145-46 (4th Cir. 2003). Applying *Knudson*, the court declined to consider a monetary claim for denied benefits “equitable relief” when the assets could not be particularly identified. The court found that “[i]n this case, defendants possess no particular fund or property that can be clearly identified as belonging in good conscience to the plaintiff. The ‘particular fund[] or property’ that is the basis of Rego’s claim was simply his share of the Savings Plan. And that share has long since been transferred to Rego; it is no longer in defendants’ possession.”

But see:

Empire Koshier Poultry, Inc. v. United Food & Commercial Workers Health & Welfare Fund of N.E. Pa., 285 F. Supp. 2d 573, 581-82 (M.D. Pa. 2003). Distinguishing *Knudson* as a statutory claim, making it inapplicable to federal common law claims, the court held that a federal common law cause of action for equitable restitution is cognizable in the context of ERISA plans.

UNUM Life Ins. Co. of Am. v. Long, 227 F. Supp. 2d 609, 614 (N.D. Tex. 2002). The court granted summary judgment in favor of a restitutionary claim for overpayment of disability benefits and distinguished *Knudson* as a statutory claim under § 1132(a)(3) in saying that “[n]othing in [*Knudson*], which involved only statutory claims brought under section 502(a)(3) of ERISA, precludes an insurer from enforcing its rights through traditional common law remedies. Because UNUM has alleged a claim for unjust enrichment under federal common law, jurisdiction is proper under 28 U.S.C. § 1331.”

b) Rescission

Several courts have determined that federal common law allows for the so-called equitable rescission of an ERISA-governed plan if the plan reflects the sponsor’s material misstatements or omissions. See, e.g., Shipley v. Ark. Blue Cross & Blue Shield, 333 F.3d 898, 903 (8th Cir. 2003) (holding that “misrepresentation as to a material matter made knowingly in an application for an ERISA-governed insurance policy is sufficient to rescind the policy”); Sec. Life Ins. Co. of Am. v. Meyling, 146 F.3d 1184, 1191 (9th Cir. 1998) (finding that “ERISA must provide a rescission remedy when an insured makes material false representations regarding his health”); Hauser v. Life Gen. Sec. Ins. Co., 56 F.3d 1330, 1333-35 (11th Cir. 1995) (assuming that right of rescission exists under ERISA-created federal common law).

The Fourth Circuit also has concluded that rescission is a remedy available in connection with an ERISA plan.

See:

Griggs v. E.I. DuPont de Nemours & Co., 385 F.3d 440, 446-49 (4th Cir. 2004) (*Griggs II*). *Employee who took early retirement brought action against employer claiming that employer negligently misrepresented the tax consequences of his election to take early retirement. The Fourth Circuit found that the plaintiff could not unilaterally “unretire” by returning his benefits and returning to work, so his action to amend his benefit election to select a monthly annuity rather than a lump sum payment clearly involved equitable rescission. The court held, as a matter of federal common law, rescission may be granted as “appropriate equitable relief” under ERISA, even if a full restoration of benefits conferred in the transaction cannot be accomplished.*

c) Indemnification and contribution

ERISA Section 409(a) imposes personal liability upon fiduciaries for any and all fiduciary duty breaches. In response to this personal liability, fiduciaries have sought indemnification or contribution from co-fiduciaries to the extent they are also responsible for breach of fiduciary duties contributing to the loss to the plan. See Brauch, supra, at 585-86. ERISA’s text does not specifically address the availability of indemnification or contribution from co-fiduciaries, however. Nonetheless, the Second Circuit has addressed claims for indemnification or contribution and has concluded that these remedies are available in connection with ERISA plans directly as a result of federal common law. The Seventh Circuit has concluded indemnification is available as a remedy but has left open the question of whether contribution is available as a remedy. See Summers v. State St. Bank & Tr. Co., 453 F.3d 404, 413 (7th Cir. 2006).

See:

Chemung Canal Tr. Co. v. Sovran Bank/Md., 939 F.2d 12, 16 (2d Cir. 1991). *The court found a federal common law right to contribution. It concluded “that the traditional trust law right to contribution must also be recognized as a part of ERISA. By so concluding, we are not creating a right from whole cloth. We are simply following the legislative directive to fashion, where Congress has not spoken, a federal common law for ERISA by incorporating what has long been embedded in traditional trust law and equity jurisprudence.”*

Free v. Briody, 732 F.2d 1331, 1337-38 (7th Cir. 1984). *In holding that § 1109 includes an implied right to indemnification, the Seventh Circuit stated that the issue is “whether the indemnity [Defendant] seeks is within the appropriate equitable relief he may seek under section 1109.” After finding ERISA grants the courts the power to shape an award so as to*

make the injured plan whole and apportion the damages equitably between the wrongdoers, it concluded “[an] award of indemnification within the limited circumstances of this case appears . . . properly within the court’s equitable powers.” Because the legislative history of ERISA “demonstrates that Congress intended to codify the principles of trust law with whatever alterations were needed to fit the needs of employee benefit plans. General principles of trust law provide for indemnification under the appropriate circumstances” (citations omitted).

The Ninth Circuit Court of Appeals, however, has taken a contrary position. See Kim v. Fujikawa, 871 F.2d 1427, 1432 (9th Cir. 1989) (citations omitted) (“As the Supreme Court noted in [Russell], section 409 of ERISA only establishes remedies for the benefit of the *plan*. Therefore, this section cannot be read as providing for an equitable remedy of contribution in favor of a *breaching fiduciary*.”). In 2007, the Eighth Circuit Court of Appeals agreed with the Ninth Circuit and held that the right of contribution was not available. Travelers Cas. & Sur. Co. of Am. v. IADA Servs., Inc., 497 F.3d 862, 866-67 (8th Cir. 2007).

In the absence of guidance from the courts of appeals, various district courts in other circuits have decided the cases without uniformity.

See:

Green v. William Mason & Co., 976 F. Supp. 298, 300-01 (D.N.J. 1997). *The court upheld a counterclaim for contribution or indemnity against a co-fiduciary, observing that “[a] number of other courts have agreed with Chemung’s analysis, and likewise have permitted claims of contribution or indemnity among co-fiduciaries.” The court further reasoned that courts rejecting such claims had wrongly “construed Congress’s failure to expressly provide for contribution among fiduciaries despite of its knowledge of traditional trust law principles as a rejection of a scheme of contribution and indemnification.”*

Petrilli v. Gow, 957 F. Supp. 366, 375 (D. Conn. 1997). *The Court upheld the right to contribution against co-fiduciaries under Chemung but rejected a contribution claim against non-fiduciaries, reasoning that “[s]ince non-fiduciaries cannot be sued directly by plaintiffs, a right of contribution and indemnification in this context would be very unlike Chemung. In Chemung, contribution and indemnification were allowed as a matter of apportionment among fiduciaries, each of whom could have been sued by plaintiffs. Given the Mertens holding, there can be no such right of contribution or indemnification.”*

But see:

Roberts v. Taussig, 39 F. Supp. 2d 1010, 1012 (N.D. Ohio 1999). *“Having reviewed the existing law within the circuits, as well as the reasoning in*

several district court cases, it is the opinion of this Court that there is no right to contribution or indemnification under ERISA.”

In a suit for contribution, the party seeking contribution must (1) have been found liable for a breach; (2) establish the party from which it seeks contribution breached its fiduciary duties; and (3) show the breach caused a loss to the plan. First, a request for contribution is predicated on a finding that the fiduciary was liable. See, e.g., Urological Surgery Prof'l Ass'n v. William Mann Co., 764 F. Supp. 2d 311, 324-25 (D.N.H. 2011) (holding that party seeking contribution must first be found liable for breach); United Labs., Inc. v. Savaiano, No. 06 C 1442, 2007 WL 4162808, at *8 (N.D. Ill. Nov. 19, 2007) (holding that majority of defendants could not assert a claim for contribution among co-fiduciaries because defendants were not subject to liability as fiduciaries to the ESOP). Second, the party seeking contribution must show that the conduct of the party from which it seeks contribution is sufficient to support a breach of fiduciary duty claim. See, e.g., Jadom Furniture Co. v. Oct. Grp. Int'l, L.L.C., No. 05-cv-6077, 2007 WL 2359767, at *3-*4 (N.D. Ill. Aug. 14, 2007) (holding that indemnification claim could not go forward where party seeking indemnification could not support argument that party they sought indemnify from breached any fiduciary duty). The party seeking contribution must also show the other fiduciary's breach caused a loss to the plan. See, e.g., Via Christi Reg'l Med. Ctr., Inc. v. Blue Cross & Blue Shield of Kan., Inc., No. 04-cv-1253, 2006 WL 3469544, at *18 (D. Kan. Nov. 30, 2006) (stating that BCBS could establish IMA was a co-fiduciary whose breach of duty caused in whole or in part the loss to the plan, then BCBS might be entitled to contribution).

A fiduciary may seek contribution from another fiduciary even if the fiduciaries were not fiduciaries at the exact same time or were not fiduciaries with the same functions. See, e.g., In re State St. Bank & Trust Co. Fixed Income Funds Inv. Litig., 772 F. Supp. 2d 519, 551-52 (S.D.N.Y. 2011) (finding fiduciary sufficiently pleaded a claim for contribution against a fiduciary with different duties because fiduciaries had potentially overlapping duties). Generally, however, a fiduciary charged with a breach of fiduciary duty may not assert a cause of action for contribution against a non-fiduciary. See, e.g., Petrilli v. Gow, 957 F. Supp. 366, 375 (D. Conn. 1997) (finding no right of contribution by breaching fiduciaries against participating nonfiduciaries). But a fiduciary found liable for violating ERISA may be able to seek contribution from a party that knowingly participated in the fiduciary's breach but was not itself a fiduciary or a party in interest. See Daniels v. Bursey, No. 03-cv-1550, 2004 WL 1977402, at *4 (N.D. Ill. Aug. 10, 2004) (stating that “the [c]ourt sees no good reason why a knowing participant in a breach should be treated more favorably than a co-fiduciary”).

d) Estoppel

Several cases have addressed estoppel claims where participants sought to enforce benefits allegedly promised, though usually not included within the plan's terms itself. ERISA Section 502(a)(1)(B) allows participants to sue for benefits only under the plan itself. In addition, the Supreme Court in Varity found that ERISA § 502(a)(3) may also allow participants to enforce benefits promised under the plan, but only against a fiduciary. 516 U.S. at 515. As a result, plaintiffs have sought to use

estoppel claims to enforce benefits promised, in one form or another, but not included within the written plan's terms. While most courts recognize some form of estoppel, there is some conflicting authority among the circuits as to the extent of the availability of this claim as well as the elements necessary to establish it. See Blum v. Spectrum Rest. Grp., 261 F. Supp. 2d 697, 715 n.11 (E.D. Tex. 2003) (noting circuit split regarding estoppel claims).

The Eleventh Circuit has held, for example, that estoppel is only available as a matter of federal common law, (1) where the party seeks only to apply a written representation at issue, (2) to ambiguous plan terms. Jones v. Am. Gen. Life & Accident Ins. Co., 370 F.3d 1065, 1069-71 (11th Cir. 2004). This holding was a gloss on an earlier ruling which rejected an estoppel claim where the claim would have modified a written plan. See Nachwalter v. Christie, 805 F.2d 956, 960 (11th Cir. 1986) (holding that oral agreements or representations could not modify plans because of requirement under ERISA § 1102(a)(1) that plan be "established and maintained pursuant to a written instrument").

See also:

Callery v. U.S. Life Ins. Co., 392 F.3d 401, 407-08 (10th Cir. 2004). *The court stated the Tenth Circuit has not recognized a claim for equitable estoppel but has left open the possibility that estoppel may be applied in "egregious" cases.*

White v. Provident Life & Accident Ins. Co., 114 F.3d 26, 29 (4th Cir. 1997). *"As we recently noted . . . ERISA simply does not recognize the validity of oral or non-conforming written modifications to ERISA plans."*

Miller v. Coastal Corp., 978 F.2d 622, 624-25 (10th Cir. 1992). *"An employee benefit plan cannot be modified, however, by informal communications, regardless of whether those communications are oral or written. ERISA requires all modifications to an employee benefit plan to be written, and to conform to the formal amendment procedures. The facts of this case do not provide us the opportunity to address whether an estoppel claim exists in limited, extraordinary circumstances" (citations omitted).*

While nearly every court has adopted the Eleventh Circuit's logic as to oral modifications, a few circuits also follow a limited exception by distinguishing between modification and interpretation of ambiguous plan terms.

See:

Katz v. Comprehensive Plan of Grp. Ins., 197 F.3d 1084, 1090 (11th Cir. 1999). *"This circuit has created a very narrow common law doctrine under ERISA for equitable estoppel. It is only available when (1) the provisions of the plan at issue are ambiguous, and (2) representations are made which constitute an oral interpretation of the ambiguity" (citations omitted).*

Watkins v. Westinghouse Hanford Co., 12 F.3d 1517, 1527 (9th Cir. 1993). “[W]e have limited the circumstances in which an ERISA claimant may assert an equitable estoppel claim. . . . [A]n estoppel claim will not lie against a trust fund where recovery on the claim would contradict written plan provisions. . . . [Moreover,] a federal common law claim of equitable estoppel will be available only where (a) the provisions of the plan at issue are ambiguous such that reasonable persons could disagree as to their meaning or effect, and (b) representations are made to the employee involving an oral interpretation of the plan” (citations omitted).

Meanwhile, other circuits allow estoppel claims to be applied only to ambiguous plan terms or in “extraordinary circumstances.” Poore v. Simpson Paper Co., 566 F.3d 922, 928 (9th Cir. 2009); Pell v. E.I. DuPont de Nemours & Co., 539 F.3d 292, 300, 303-04 (3d Cir. 2008); Schonholz v. Long Island Jewish Med. Ctr., 87 F.3d 72, 78 (2d Cir. 1996); see also Bonovich v. Knights of Columbus, 963 F. Supp. 143, 148 (D. Conn. 1997) (citation omitted) (“The elements of a promissory estoppel claim in an ERISA action are: (1) a promise; (2) reliance on the promise; (3) injury caused by the reliance; and (4) an injustice if the promise is not enforced. Further, for purposes of ERISA, a plaintiff must demonstrate a promise that the defendant reasonably should have expected to induce action or forbearance on the plaintiff’s part.”).

The Sixth Circuit holds that while issues of actuarial soundness usually preclude applying estoppel to pension benefit plans, such considerations do not preclude the application of estoppel principles to welfare benefits plans. Armistead v. Vernitron Corp., 944 F.2d 1287, 1300 (6th Cir. 1991) (“If the effective terms of the plan may be altered by transactions between officers of the plan and individual plan participants or discrete groups of them, the rights and legitimate expectations of third parties to retirement income may be prejudiced. This is not necessarily the case with insurance benefit plans.”), *abrogated on other grounds by* M&G Polymers USA, LLC v. Tackett, 135 S. Ct. 926 (2015). The Sixth Circuit holds, however, that estoppel does apply to pension benefit plans when “the representation was made in writing and where the plaintiff can demonstrate extraordinary circumstances.” Bloemker v. Laborers’ Local 265 Pension Fund, 605 F.3d 436, 440 (6th Cir. 2010).

But see:

Coleman v. Nationwide Life Ins. Co., 969 F.2d 54, 59 (4th Cir. 1992). “We do not think, however, that the statutory emphasis on adherence to the written terms of ERISA plans leaves room for this distinction between pension and welfare benefit plans. Section 1102 requires that ‘every employee benefit plan shall be established and maintained pursuant to a written instrument,’ and the requirement that formal amendment procedures be included in the written document similarly applies to ‘every employee benefit plan.’ According to ERISA’s definition, the term ‘employee benefit plan’ includes both welfare benefit and pension plans” (citations omitted).

Finally, the Seventh Circuit has developed its own, somewhat unique, estoppel doctrine. Although it holds that “estoppel principles generally apply to all legal actions,” the court has distinguished, like the Sixth Circuit, between pension plans and welfare plans. Black v. TIC Inv. Corp., 900 F.2d 112, 114-15 (7th Cir. 1990). Additionally, the court distinguishes between multi-employer welfare benefit plans and “unfunded single-employer welfare benefit plans” by applying estoppel only to the single employer plans. Pearson v. Voith Paper Rolls, Inc., 656 F.3d 504, 508 n.2 (7th Cir. 2011). Moreover, the court has consistently declined to extend this limited application. See id. (citing multiple Seventh Circuit precedents). In 1999, the court rejected all distinctions between “estoppel” and “equitable estoppel” in enunciating a new test to apply the general doctrine in the ERISA context. Coker v. TWA, Inc., 165 F.3d 579, 585 (7th Cir. 1999) (“The cause of action has four elements: (1) a knowing misrepresentation; (2) made in writing; (3) with reasonable reliance on that misrepresentation by the plaintiff; (4) to her detriment.”). Interestingly, it would appear that only the Seventh Circuit requires that the representation (a) be in writing and (b) be a knowing misrepresentation. Some cases in the Seventh Circuit appear to have also required the plaintiff to establish “extraordinary circumstances” for an estoppel claim. See, e.g., Bowerman v. Wal-Mart Stores, Inc., 226 F.3d 574, 583, 591 (7th Cir. 2000).

e) Prejudgment interest

ERISA does not expressly provide for prejudgment interest. As a matter of federal common law, however, courts hold that such an award is “available, but not obligatory.” Janeiro v. Urological Surgery Prof'l Ass'n, 457 F.3d 130, 145 (1st Cir. 2006). Prior to Knudson, several courts held that prejudgment interest was available for a denial of pension benefits. However, some courts have concluded this rule applies only in the benefit context, and not to employer restitutionary claims for erroneous contributions, due to ERISA’s anti-inurement rule. See, e.g., Airco Indus. Gases, Inc. v. Teamsters Health & Welfare Pension Fund, 850 F.2d 1028, 1037 (3d Cir. 1988) (“We agree with the district court that the anti-inurement policy of ERISA bars an award of interest on any refund, regardless of the fund’s financial stability.”).

See:

Skretvedt v. E.I. DuPont De Nemours, 372 F.3d 193, 208 (3d Cir. 2004).
“We . . . reverse the Magistrate Judge’s denial of prejudgment interest with respect to the delayed payment of [the plaintiff’s] incapability benefits so that the [district court] may exercise its discretion in the first instance in determining whether prejudgment interest is appropriate.”

Anthuis v. Colt Indus. Operating Corp., 971 F.2d 999, 1010 (3d Cir. 1992).
“As a general rule, prejudgment interest is to be awarded when the amount of the underlying liability [may be reasonably ascertained] and the relief granted would otherwise fall short of making the claimant whole because he or she has been denied the use of the money which was legally due.”

Sweet v. Consol. Aluminum Corp., 913 F.2d 268, 270 (6th Cir. 1990). “ERISA requires that a retirement plan be operated for the exclusive benefit of the employees and beneficiaries. . . . Even assuming arguendo that the Trustee was acting prudently in withholding the pension funds[,] . . . it cannot be said that this did not confer a benefit on the trustee. Any additional time one gains, rightfully or wrongfully, in not having to submit payment of a sum of money owed another is without doubt a benefit.”

Short v. Cent. States, Se. & Sw. Areas Pension Fund, 729 F.2d 567, 576 (8th Cir. 1984) abrogation on other grounds recognized in Baxter ex rel. Baxter v. Lynn, 886 F.2d 182, 187 (8th Cir. 1989). “Essentially, the Fund has retained money which rightfully belongs to [the beneficiary]. To allow the Fund to retain the interest it earned on funds wrongfully withheld would be to approve of unjust enrichment.”

The circuits appear split as to whether pension beneficiaries are entitled to interest for denial of benefits where the benefits were later restored without resort to litigation.

Compare:

Parke v. First Reliance Standard Life Ins. Co., 368 F.3d 999, 1007 (8th Cir. 2004). The court allowed a beneficiary’s claim for interest on denied benefits where the benefits were voluntarily restored, so there was no underlying judgment upon which the court could make an award of “prejudgment interest.” The court found that, if interest was an appropriate remedy “to avoid unjust enrichment of a plan provider who wrongfully delays the payment of benefits, the award is appropriate whether a judgment is obtained or not.”

Fotta v. Trs. of the UMW Health & Ret. Fund of 1974, 165 F.3d 209, 212 (3d Cir. 1998). The court allowed a beneficiary’s claim for interest on denied benefits where the benefits were eventually restored without litigation, stating “[t]he principles justifying prejudgment interest also justify an award of interest where benefits are delayed but paid without the beneficiary’s having obtained judgment. The concerns . . . [about] making the claimant whole and preventing unjust enrichment[] are not diminished merely because the plan has paid the overdue benefits without the claimant having resorted to litigation to secure payment. A late payment of benefits effectively deprives the beneficiary of the time value of his or her money whether or not the beneficiary secured the overdue benefits through a judgment as the result of ERISA litigation.”

With:

Clair v. Harris Tr. & Sav. Bank, 190 F.3d 495, 497 (7th Cir. 1999). In denying a claim for interest on restored benefits where it was not necessary to resort to litigation, the court said “[t]hese plaintiffs . . . do not seek unpaid benefits. Their complaint is that their benefits were not paid in a timely fashion and as a result they lost the time value of the money. They want the interest they could have earned had they been paid the money in a timely fashion and invested it, but interest is not a benefit specified anywhere in the plan, and only benefits specified in the plan can be recovered in a suit under section 502(a)(1)(B).”

Finally, it appears that an interest award on wrongfully delayed benefits remains permissible after Knudson as a remedy for a breach of fiduciary duty to a beneficiary. See generally Skretvedt, 372 F.3d at 208-09; Parke, 368 F.3d at 1006-07.

Courts generally provide that the decision whether to grant prejudgment interest is a matter for the district court to decide based on the circumstances of the case. The circuits have also adopted different standards to determine whether to award prejudgment interest. The Third, Seventh, Eighth and D.C. Circuits hold that prejudgment interest is presumptively available when benefits have been delayed. See Masters v. UHS of Del., Inc., 631 F.3d 464, 475 (8th Cir. 2011); Moore v. CapitalCare, Inc., 461 F.3d 1, 12 (D.C. Cir. 2006); Fritcher v. Health Care Serv. Corp., 301 F.3d 811, 820 (7th Cir. 2002); Fotta, 165 F.3d at 213-14. The presumption in favor of prejudgment interest is overcome only in unusual cases that involve the bad faith or good will of the parties. See Trustmark Life Ins. Co. v. Univ. of Chi. Hosps., 207 F.3d 876, 885 (7th Cir. 2000).

Other circuits hold the decision to award prejudgment interest is in the district court’s discretion. See Weber v. GE Grp. Life Assurance Co., 541 F.3d 1002, 1016 (10th Cir. 2008); Benesowitz v. Metro. Life Ins. Co., 514 F.3d 174, 176 (2d Cir. 2007); Blankenship v. Liberty Life Assurance Co. of Bos., 486 F.3d 620, 627 (9th Cir. 2007); Cottrill v. Sparrow, Johnson & Ursillo, Inc., 100 F.3d 220, 223 (1st Cir. 1996), abrogated on other grounds by Hardt v. Reliance Standard Life Ins. Co., 560 U.S. 242 (2010). The Second Circuit uses four factors to guide a district court’s discretion: “(i) the need to fully compensate the wronged party for actual damages suffered, (ii) considerations of fairness and the relative equities of the award, (iii) the remedial purpose of the statute involved, and/or (iv) such other general principles as are deemed relevant by the court.” Slupinski v. First UNUM Life Ins. Co., 554 F.3d 38, 55 (2d Cir. 2009).

The circuit courts also differ on the rate district courts should use to calculate prejudgment interest. Many circuit courts allow district courts discretion to determine the proper interest rate. See Allison v. Bank One - Denver, 289 F.3d 1223, 1244 (10th Cir. 2002); Ford v. Uniroyal Pension Plan, 154 F.3d 613, 618-19 (6th Cir. 1998); Cottrill, 100 F.3d at 223. This discretion has created a lack of uniformity among district courts. Compare Radford Tr. v. First UNUM Life Ins. Co. of Am., 321 F. Supp. 2d 226, 259 (D. Mass. 2004) (stating that 12% Massachusetts statutory rate would “better serve[] ERISA’s goals of making claimants whole”), rev’d in part on other grounds,

491 F.3d 21 (1st Cir. 2007) with Cottrill, 100 F.3d at 224-25 (recognizing ERISA's goals of uniformity and applying federal post-judgment rate); and Vickers v. Principal Mut. Life Ins. Co., 993 F. Supp. 19, 21 (D. Mass. 1998) (applying federal interest rate for calculating prejudgment interest to promote uniformity in ERISA cases). A court may calculate the prejudgment interest rate using the statutory post-judgment framework set forth in 28 U.S.C. § 1961(a), which sets the rate at a rate equal to the weekly average 1-year constant maturity Treasury yield. See Ford, 154 F.3d at 619 (stating that "the statutory postjudgment framework set forth in 28 U.S.C. § 1961 is a reasonable method for calculating prejudgment interest awards"). The Ninth Circuit requires a district court to use 28 U.S.C. § 1961 to determine the interest rate unless "the trial judge finds, on substantial evidence, that the equities of that particular case require a different rate." Blankenship, 486 F.3d at 628.

Seventh Circuit courts generally use the prime rate as the default rate for prejudgment interest. See, e.g., First Nat'l Bank of Chi. v. Standard Bank & Tr., 172 F.3d 472, 480 (7th Cir. 1999). The Seventh Circuit uses the prime rate over the federal interest rate because the prime rate is "necessary to compensate plaintiffs not only for the loss of the use of their money but also for the risk of default." Gorenstein Enters., Inc. v. Quality Care-USA, Inc., 874 F.2d 431, 436 (7th Cir. 1989). According to Gorenstein, simply using the lower federal rate undercompensates a plaintiff by not taking into account the risk of default. Id. at 436-37.

2. Federal common law defenses

a) Unconscionability

While finding that it did not have opportunity to decide the issue under the facts presented, one court has raised the possibility that under federal common law unconscionability could be a defense against enforcement of a benefit plan's terms.

See:

Operating Eng'rs Local 139 Health Benefit Fund v. Gustafson Constr. Corp., 258 F.3d 645, 655 (7th Cir. 2001). "The federal common law of ERISA may include a concept of unconscionability that would entitle an employer to complain if a fund's trustees used the power delegated to it by the plan to establish a completely exorbitant interest rate on delinquent contributions. No case says that, but it may be encompassed by the principle that the trustees are not to act in an arbitrary and capricious manner. However that may be, 1.5 percent a month (or 18 percent a year) is not unconscionable—or at least the defendant made no effort to show that it was so exorbitant as to be unconscionable in the circumstances, and it is too late now for it to attempt to do so. Indeed, it doesn't even call it 'unconscionable,' but merely 'oppressive,' which has no legal standing."

b) Waiver

Courts remain somewhat undecided as to the contours of federal common law regarding whether an insurer can be found to waive a defense in an ERISA plan. Courts have left open the larger question of whether waiver might apply in the ERISA context, while constraining their findings to the facts of their specific cases. See *Lauder v. First UNUM Life Ins. Co.*, 284 F.3d 375, 382 (2d Cir. 2002) (“[We] conclude that principles of waiver are appropriately applied in this case. Because we do not consider this the appropriate set of facts on which to create a federal common law doctrine of waiver in the ERISA context, we limit our holding to the circumstances of this particular claim.”); *Glass v. United of Omaha Life Ins. Co.*, 33 F.3d 1341, 1348 (11th Cir. 1994) (“[W]e leave open whether in other circumstances waiver principles might apply under the federal common law in the ERISA context. However, we reject plaintiff’s waiver argument under the circumstances of this case.”); *Thomason v. Aetna Life Ins. Co.*, 9 F.3d 645, 650 (7th Cir. 1993) (“While it might be appropriate to apply certain waiver principles to ERISA claims, the waiver principles upon which plaintiff relies are not among them.”). The Fifth Circuit has definitively held that waiver is a viable argument under ERISA. See *High v. E-Systems, Inc.*, 459 F.3d 573, 581-82 (5th Cir. 2006); *Pitts v. Am. Sec. Life Ins. Co.*, 931 F.2d 351, 356-57 (5th Cir. 1991). The Fourth Circuit has reached the opposite conclusion, holding that “the federal common law under ERISA . . . does not incorporate the principles of waiver.” *White v. Provident Life & Accident Ins. Co.*, 114 F.3d 26, 29 (4th Cir. 1997).

XV. SPECIFIC ISSUES IN ERISA LITIGATION

A. ERISA § 510, 29 U.S.C. § 1140: ACTIONS FOR INTERFERENCE WITH RIGHTS PROVIDED UNDER ERISA

ERISA's anti-retaliation provision, § 510, codified at 29 U.S.C. § 1140, makes it unlawful for "any person" to "discharge, fine, suspend, expel, discipline, or discriminate against a participant or beneficiary" if the action is taken for any of the following reasons:

- (1) Because the person exercised any right to which the participant or beneficiary is entitled under an employee benefit plan;
- (2) To "interfer[e] with the attainment of any right to which [a] participant may become entitled under [an employee welfare benefit] plan"; or
- (3) Because the person has given information or is about to testify in a proceeding or inquiry related to the plan.

The Supreme Court has interpreted "plan" to include all employee benefit plans, including those providing vested benefits. Inter-Modal Rail Emps. Ass'n v. Atchison, Topeka & Santa Fe Ry. Co., 520 U.S. 510, 514 (1997). This interpretation means that although employers can modify or terminate unvested benefits, they may not act with the intention to prevent employees from enjoying the benefits the plan provides. See Coomer v. Bethesda Hosp. Inc., 370 F.3d 499, 510 (6th Cir. 2004).

See:

Inter-Modal Rail Emps. Ass'n v. Atchison, Topeka & Santa Fe R.R. Co., 520 U.S. 510, 514-16 (1997). A plan sponsor may retain the "unfettered right to alter its promises, but to do so it must follow the formal procedures set forth in the plan." Without § 510, the formal amendment process would be undermined and program sponsors could informally amend a plan, one beneficiary at a time.

Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 143 (1990). Section 510 counterbalances the flexibility provided to plan sponsors to amend or terminate a welfare benefit plan by requiring that they do not "circumvent the provision of promised benefits."

Because § 510 claims are tried in a manner similar to disparate treatment employment discrimination claims brought under other federal statutes, it is important to review the general framework for employment claims where the employer's motivation is at issue.

1. General framework of employment discrimination litigation

In both § 510 cases and disparate treatment employment discrimination cases, the primary issue is whether the employer's actions were motivated by a bias against a protected trait, such as race, age or gender, or in response to a protected activity, such as the exercising of an employee's rights or an employee's participation in an investigation of the employer. Courts rely on one of two methods to determine whether the defendant was motivated by an illegal factor: the direct evidence framework and the indirect evidence, or McDonnell Douglas, framework.

a) Direct evidence framework

Some plaintiffs may be able to present evidence that clearly indicates the defendant intended to discriminate and "can be interpreted as an acknowledgment of discriminatory intent." Troupe v. May Dep't Stores Co., 20 F.3d 734, 737 (7th Cir. 1994); Baines v. Walgreen Co., 863 F.3d 656, 661 (7th Cir. 2017). Such so-called "direct evidence" includes racial slurs uttered by the employers' authorized agents, the admission of a decision maker that she acted against a plaintiff due to a protected characteristic, or an employer policy aimed expressly at race, age or religion. See HAROLD S. LEWIS, JR. & ELIZABETH H. NORMAN, LITIGATING EMPLOYMENT DISCRIMINATION AND CIVIL RIGHTS CASES: ANALYSIS § 6.2, at 406 (3d ed. 2002). Courts have defined direct evidence as "evidence that, if believed, would prove the existence of the fact without inferences or presumption." Id.

In actual practice, however, this method is rarely applied, because as one court has stated, "employers are rarely so cooperative as to include a notation in a personnel file that the firing is for reasons expressly forbidden by law." See Tappe v. Alliance Capital Mgmt., L.P., 198 F. Supp. 2d 368, 373 (S.D.N.Y. 2001) (quoting Bickertsaff v. Vassar College, 196 F.3d 435, 448 (2d Cir. 1999)). Moreover, employers have "taught their supervisory employees not to put discriminatory beliefs or attitudes into words oral or written." Troupe v. May Dep't Stores Co., 20 F.3d 734, 736 (7th Cir. 1994). As a result, the direct evidence framework is of limited usefulness because it is only used in cases where it is obvious that the defendant's agents acted illegally. Moreover, as courts are not mind readers, it is difficult to determine reliably what a person is thinking based on anything short of a clear statement as to motivation. Even seemingly "clear" or "direct" statements by a supervisor may still require a court to make an inferential leap.

Determining whether evidence is "direct" may appear important to courts because the plaintiff is considered to have a lighter burden under such a framework. See Tappe, 198 F. Supp. 2d at 374. Any plaintiff in a direct evidence case will likely attempt to strengthen a claim, however, by presenting additional evidence that allows a jury to infer that there was discrimination. Thus, even direct evidence cases will often involve the same forms of evidence that are used in the McDonnell Douglas framework as described below. See LEWIS & NORMAN, supra, at 407-08. Because full consideration of the direct evidence framework in discrimination litigation is beyond the

scope of this Handbook, see LEWIS & NORMAN, supra, at 406 for a more detailed discussion of the topic.

b) Indirect or McDonnell Douglas framework

While a lack of evidence makes proving unlawful intent through direct evidence difficult, proving intent through circumstantial means often is difficult due to the volume of facts the fact-finder considers. In cases proved through circumstantial evidence, a fact-finder must consider the parties' actions and then infer from those acts and circumstances what the parties intended. As it would be impossible to hold complete trials for every such fact-intensive claim, the Supreme Court developed a framework, beginning with McDonnell Douglas Corp. v. Green, 411 U.S. 792 (1973), to allow courts to deal with such cases through summary judgment.

First, the plaintiff must make a prima facie case of discrimination. The prima facie case typically requires plaintiff to show that (1) plaintiff was part of a protected class, (2) sought or wished to maintain a position or benefit, (3) was qualified for the job, and (4) suffered some adverse employment decision, such as termination. See Reeves v. Sanderson Plumbing Prods., Inc., 530 U.S. 133, 142 (2000), superseded by statute on other grounds as stated in Penton v. Thaler, 2013 WL 2483244 (S.D. Tex. June 10, 2013). Courts modify the basic prima facie elements to cover the range of employment situations and there is no rigid set of facts plaintiffs must prove to meet the prima facie case. Also, the burden is intended to be a minimal one. The prima facie case raises a presumption of discrimination because it eliminates the most common non-discriminatory reasons for adverse employment actions—a lack of qualifications and lack of available positions. See LEWIS & NORMAN, supra, § 6.10, at 421.

Once the plaintiff establishes the prima facie case, the defendant must respond by presenting evidence that the plaintiff was rejected or another was preferred due to a “legitimate, nondiscriminatory reason.” Reeves, 530 U.S. at 142. Because the defendant merely faces a burden of producing a reason that is legitimate and non-discriminatory, and not a burden of proving it, there is no weighing of credibility at this stage. Id. Once a defendant presents a legitimate reason, any presumptions in the case, and the McDonnell Douglas framework itself, fall away. Id. The only issue that remains was whether there was discrimination or not. Id. In other words, a fact finder must decide based on the evidence produced, whether the plaintiff has shown that the defendant discriminated based on a protected trait.

In most cases, plaintiffs present evidence to convince the fact-finder that the reason the defendant has presented is pretextual. A plaintiff's showing that the employer's reason was pretextual does not compel a finding for the plaintiff. St. Mary's Honor Ctr. v. Hicks, 509 U.S. 502, 511 (1993). Rather, a plaintiff proves a discrimination claim by proving discrimination, and not merely by proving the employer's reason cannot be believed. Id. Some circuits interpreted St. Mary's to mean that no reasonable fact-finder could find the defendant liable for intentional discrimination when the plaintiff only presented a prima facie case and evidence sufficient to reject the defendant's proffered explanation. See Reeves, 530 U.S. at 140 (citing Fisher v. Vassar

College, 114 F.3d 1332 (2d Cir. 1997)). These circuits granted summary judgment for the defendant unless the plaintiff gave some additional evidence of discrimination. In Reeves, the Court rejected this so-called “pretext-plus” approach. 530 U.S. at 147. It reiterated the holding of St. Mary’s by stating that defeating the employer’s proffered explanation does not compel a finding for the plaintiff, but such a showing, along with the prima facie case, *might* be sufficient to support a verdict that there was illegal discrimination. See 530 U.S. at 147 (citing St. Mary’s Honor Ctr., 509 U.S. at 511). In Reeves, the evidence the plaintiff presented to demonstrate that the employer’s proffered reason was false did not also have to establish discriminatory intent. The plaintiff could reach a jury based on the prima facie case and the evidence of pretext.

While the McDonnell Douglas framework is frequently called a “burden shifting framework,” the ultimate burden of persuading the trier of fact that the defendant intentionally discriminated against the plaintiff remains at all times on the plaintiff. Tex. Dep’t of Cmty. Affairs v. Burdine, 450 U.S. 248, 253 (1981); Lewis v. City of Union City, Ga., 918 F.3d 1213, 1220-21 (11th Cir. 2019). Throughout the trial, whether in the plaintiff’s case-in-chief or in cross-examining the defendant’s witnesses, the plaintiff attempts to establish facts that would allow the finder of fact to conclude by a preponderance of the evidence that the defendant acted with an illegal intent. Likewise, the defendant attempts to present all evidence that would prevent such a finding by the fact finder.

The “burden shifting” approach is analytical only and does not establish an order of proof at trial. See Coates v. Johnson & Johnson Corp., 756 F.2d 524, 531 n.5 (7th Cir. 1985). A plaintiff will not present just enough evidence to establish the prima facie case and then go no further until the defendant presents a nondiscriminatory explanation. Instead, McDonnell Douglas provides a framework that reviewing courts (or a trial court hearing motions for a judgment as a matter of law) use to determine whether to give the case to the trier of fact to resolve the factual dispute that lies at the heart of the case: whether the defendant or its agents acted with an unlawful intent.

2. Procedural prerequisites to an action under ERISA § 510, 29 U.S.C. § 1140

a) Preemption

According to the Supreme Court, ERISA contains numerous safeguards “to completely secure the rights and expectations [of employees and their beneficiaries].” Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 137 (1990). The most prominent of these are § 514(a), 29 U.S.C. § 1144(a), ERISA’s preemption provision; § 502(a), 29 U.S.C. § 1132(a), the Act’s “carefully integrated civil enforcement scheme”; and § 510, which prohibits interference with ERISA-protected rights. Id. In combination, these provisions will likely preempt state causes of action where the plaintiff alleges that the employer interfered with the plaintiff’s right to benefits under the plan.

In Ingersoll-Rand, the Court decided that state causes of action for wrongful termination were preempted because such claims were the “prototypical [claim] Congress intended to cover under § 510.” 498 U.S. at 143. Protection against termination intended to prevent the vesting of pension rights is a “crucial part of ERISA because, without it, employers would be able to circumvent the provision of promised benefits.” Id. While the existence of an enforcement scheme does not dictate preemption of state law remedies, preemption in this case was warranted because Congress intended that § 502(a) be the exclusive remedy for the rights ERISA guarantees. Id. at 143-44 (quoting Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 54 (1987) (holding that ERISA does not apply), overruled in part on other grounds by Ky. Ass’n of Health Plans, Inc. v. Miller, 538 U.S. 329 (2003)). The state law cause of action in Ingersoll-Rand clearly provided a remedy for rights expressly guaranteed by § 510 and exclusively enforced by § 502(a). As a result, “due regard for federal enactments require that state jurisdiction [in matters that § 510 protects] must yield.” Id. at 144. Section 510 has preempted a variety of state claims that seek to recover damages for an employer’s actions that have interfered with benefits.

See:

McLain v. Andersen Corp., 567 F.3d 956, 964-66 (8th Cir. 2009). *Plaintiff’s age discrimination claim, brought under the Minnesota Human Rights Act, that his employer discriminated against him to interfere with the his pension benefits was preempted by § 510.*

McGowin v. ManPower Intern., Inc., 363 F.3d 556, 558-59 (5th Cir. 2004). *Plaintiff’s state claims of fraud and conspiracy to commit fraud were completely preempted by ERISA § 502(a).*

Wood v. Prudential Ins. Co. of Am., 207 F.3d 674, 677-79 (3d Cir. 2000). *Claims of discrimination under state statute and constitution that were essentially § 510 claims were preempted even though the state claims provided remedies that § 510’s enforcement provision, § 502, did not.*

St. Arnaud v. Chapdelaine Truck Ctr., Inc., 836 F. Supp. 41, 43 (D. Mass. 1993). *State claim for wrongful termination based on breach of an implied covenant of good faith and fair dealing was preempted because § 510 protection was similar to the state claim and superseded it.*

Varela v. Barnum Fin. Grp., No. 13-cv-3332, 2015 WL 12964717, at *3 (S.D.N.Y. Aug. 11, 2015), *aff’d*, 644 F. App’x 30 (2d Cir. 2016). *State law claims of negligence, negligent misrepresentation, and breach of fiduciary duty “relate[d] to” a benefit plan covered by ERISA and therefore ERISA preempted them.*

But see:

Thurkill v. Menninger Clinic, Inc., 72 F. Supp. 2d 1232, 1235-36 (D. Kan. 1999). *State wrongful termination claim was not preempted due to*

emerging view that where the plaintiff's suit merely impacts an ERISA plan but the suit's factual basis is independent of the rights and duties under the plan, there is no preemption.

Almont Ambulatory Surgery Ctr., LLC v. UnitedHealth Grp., Inc., 121 F. Supp. 3d 950, 969-70 (C.D. Cal. 2015). ERISA did not preempt insurer's California Unfair Competition Law claim, relating to ERISA plan administrator's allegedly fraudulent practices designed to manipulate insurer to pay for unnecessary medical services, because the claim did not directly implicate an ERISA-regulated relationship. The court said the claim pertained to the actions taken by out-of-network providers in relation to an ERISA administrator, and implicated duties derived from state law that were outside the duties imposed by ERISA.

Nat'l Sec. Sys., Inc. v. Iola, 700 F.3d 65, 85 (3d Cir. 2012). The plaintiff's state law claims were not preempted to the extent that the claims rested on alleged misrepresentations made about an ERISA plan before that plan's existence, as the claims were therefore not premised on a challenge to the actual administration of the plan.

b) Appropriate parties

Determining the proper parties in a § 510 action depends partially upon whether the court considers § 510 to apply beyond the employment relationship. Many courts interpret § 510's language to provide a cause of action for a retaliatory act that affects the *employment relationship* in response to an employee asserting rights under the employee welfare benefits plan. See generally West v. Butler, 621 F.2d 240, 245 (6th Cir. 1980). Although the term "discriminate" could be broadly interpreted to refer to any time "any person" makes distinctions between persons, most courts have declined to use a broad interpretation. Becker v. Mack Trucks, Inc., 281 F.3d 372, 382 (3d Cir. 2002). Rather, they have limited "discriminate" to refer to actions affecting the employer-employee relationship. Id.

See:

Becker v. Mack Trucks, Inc., 281 F.3d 372, 382 (3d Cir. 2002). Employer did not discriminate under § 510 by refusing to rehire former non-vested employees. A employer-employee relationship does not exist until the employee has been hired.

Haberern v. Kaupp Vascular Surgeons Ltd. Defined Benefit Pension Plan, 24 F.3d 1491, 1503 (3d Cir. 1994). Employer did not "discriminate" under § 510 by decreasing benefits of plaintiff even though she was the only employee affected by the change. The reduction did not affect the employment relationship and was not a sufficient action to violate § 510.

McGath v. Auto-Body N. Shore, Inc., 7 F.3d 665, 669 (7th Cir. 1993). Section 510 would include actions like demotion or discharge, but not a

discriminatory apportionment of benefits or a plan change that affects only one employee.

Gross v. St. Agnes Health Care, Inc., No. 12-cv-2990, 2013 WL 4925374, at *18 (D. Md. Sept. 12, 2013). Plaintiff could not maintain ERISA claims against organizations that were not her employer. Plaintiff also failed to state a claim under § 510 because she did not show that employer engaged in conduct affecting the employment relationship.

But see:

Mattei v. Mattei, 126 F.3d 794, 806 (6th Cir. 1997). The court decided that § 510 applied beyond the employment relationship because while Congress described the prohibited conduct in terms of words used in labor law, the definition it used for “person” was broader than the employment relationship. To effectuate Congress’s intent, the court resolved the inconsistency by allowing the provision to apply to any defendant who discriminates against a person for enjoying ERISA rights. The defendants in § 510 actions are most commonly employers who take negative employment actions against employees to circumvent ERISA’s protections. See, e.g., *Lindemann v. Mobil Oil Corp.*, 141 F.3d 290, 292 (7th Cir. 1998) (“Lindemann II”); *Shahid v. Ford Motor Co.*, 76 F.3d 1404, 1407 (6th Cir. 1996). The text of § 510, however, makes it illegal for “any person” to “discharge, fine, suspend, expel, discipline, or discriminate against a participant or beneficiary.” 29 U.S.C. § 1140. ERISA defines a “person” as “an individual, partnership, joint venture, corporation, mutual company, joint-stock company, trust, estate, unincorporated organization, association or employee organization.” 29 U.S.C. § 1002(9). Courts have used this broad language to conclude that Congress did not intend to limit the range of possible defendants to only employers. *Maez v. Mountain States Telephone & Telegraph, Inc.*, 54 F.3d 1488, 1501 n.8 (10th Cir. 1995); *Teamsters Local Union No. 705 v. Burlington N. Santa Fe, LLC*, 741 F.3d 819, 827 (7th Cir. 2014). Thus, even where ERISA § 510 actions involve only the employment relationship, possible defendants are not limited only to employers.

See:

Mattei v. Mattei, 126 F.3d 794, 806 (6th Cir. 1997). After determining that § 510 prohibits actions beyond employee-employer relationship, the court determined that plaintiff could properly sue estate that prevented her from obtaining ERISA benefits.

Inter-Modal Rail Emps. Ass’n v. Atchison, Topeka & Santa Fe R.R. Co., 80 F.3d 348, 350 n.5 (9th Cir. 1996), *rev’d on other grounds*, 520 U.S. 510 (1997). Successor who was not the plaintiffs’ employer can be liable under § 510 where it allegedly engaged in conspiracy with employer to interfere with ERISA-protected rights.

Tingey v. Pixley-Richards W., Inc., 953 F.2d 1124, 1132 n.4 (9th Cir. 1992). *Action for interference with benefits was proper against both employer and insurer that allegedly coerced employer to fire plaintiff.*

Straus v. Prudential Emp. Sav. Plan, 253 F. Supp. 2d 438, 447-48 (E.D.N.Y. 2003). *Former employees and beneficiaries are entitled to bring claims under § 510.*

Warner v. Buck Creek Nursery, Inc., 149 F. Supp. 2d 246, 257-58 (W.D. Va. 2001). *Due to broad definitions for “person” and “discriminate,” corporate directors can be sued individually even if they were acting in their corporate capacity.*

Choi v. Mass. Gen. Physicians Org., Inc., 66 F. Supp. 2d 251, 254 (D. Mass. 1999). *Accepting that § 510 prohibits actions beyond the employee-employer relationship, the court allowed suit against a defendant who was a former employer at the time of the alleged interference.*

Custer v. Pan American Life Ins. Co., 12 F.3d 410, 421 (4th Cir. 1993). *The court determined that ERISA § 510 is not limited to employers and could be extended to the administrator and underwriter of a group health and life policy, which was an ERISA-governed employee welfare benefit plan.*

Teamsters Local Union No. 705 v. Burlington N. Sante Fe, LLC, 741 F.3d 819, 827 (7th Cir. 2014). *Although the court dismissed the plaintiff’s § 510 claim because it rested entirely on the kind of unlawful discharge allegations that require that the defendants have an employer relationship with the plaintiffs, the court stated that § 510, in general, does not condition liability on the existence of an employment relationship, and that non-employers, such as unions, can engage in some of the acts prohibited by §510, including discrimination.*

Manuel v. Turner Indus. Grp., LLC, 905 F.3d 859, 871 (5th Cir. 2018), reh’g denied (Nov. 2, 2018). *Dismissal of § 510 claims on the basis that the plaintiff was not an employee was reversed and remanded because the court concluded that § 510 claims may be maintained against non-employers.*

But see:

Byrd v. MacPapers, Inc., 961 F.2d 157, 161 (11th Cir. 1992). *Insurer could not be a defendant in § 510 action because § 510 is addressed only at employment relationship and unscrupulous employers.*

To have standing, the plaintiff in an ERISA § 510 action must show that he is eligible for the benefits which he claims triggered the discriminatory reaction. Ameritech Benefit Plan Comm. v. Commc’n Workers, 220 F.3d 814, 824 (7th Cir. 2000).

This requirement for standing applies even if the plaintiff became ineligible for the benefits by the very discriminatory provision of the plan that he or she is challenging. Id. Such plaintiffs cannot challenge discrimination under § 510 because ERISA itself does not proscribe discrimination in the provision of employee benefits. Id. at 825 (citing Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 91 (1983)). Where a group of individuals seek to establish individualized damages under a § 510 action, each person must be a plaintiff, or there must be a representative for the certified class. Inter-Modal Rail Emps. Ass'n, 80 F.3d at 350 n.5 (holding that railway association lacks standing to bring suit on plaintiffs' behalf), rev'd on other grounds, 520 U.S. 510 (1997).

c) Applicable statute of limitations

Neither § 510 of ERISA nor its civil enforcement provision, § 502(a), provides a statute of limitations for actions alleging an interference with benefits. Muldoon v. C.J. Muldoon & Sons, 278 F.3d 31, 32 (1st Cir. 2002); Musick v. Goodyear Tire & Rubber Co., 81 F.3d 136, 137 (11th Cir. 1996). Because neither section falls under 28 U.S.C. § 1658 (see below), and because Congress did not establish a time limitation for a federal cause of action arising under §§ 502 or 510, courts will adopt an applicable state law limitation as federal law if it is not inconsistent with federal law or policy to do so. See Wilson v. Garcia, 471 U.S. 261, 266-67 (1985) superseded on other grounds by statute, 28 U.S.C. § 1658; Muldoon, 278 F.3d at 32. When determining which state statute of limitations should apply, courts frequently consider the language of the statute creating the cause of action and select statutes whose language more specifically and narrowly contemplates the conduct § 510 addresses. Musick, 81 F.3d at 139.

Several courts have considered what the statute of limitations for § 510 claims should be, and they usually apply the relevant state law statute for wrongful termination or retaliatory discharge. Muldoon, 278 F.3d at 32. The First Circuit in Muldoon, for example, decided that Massachusetts's wrongful termination action more closely mirrored a § 510 action than a breach of contract action and ruled that the plaintiff's action was time barred. See id. Because state causes of action vary, however, the applicable statutes of limitations vary by state as well.

See:

Sandberg v. KPMG Peat Marwick, L.L.P., 111 F.3d 331, 335-36 (2d Cir. 1997). In New York, § 510 actions are governed by a two-year statute of limitations because New York's workers' compensation law provides the closest analog to § 510 .

Musick v. Goodyear Tire & Rubber Co., 81 F.3d 136, 137 (11th Cir. 1996). In Alabama, the two-year statute of limitations for the recovery of wages is applied because the statute creating that cause of action more closely tracks the language of § 510 than the general language of the state's cause of action governing contract disputes which has a six-year statute of limitations.

Teumer v. Gen. Motors Corp., 34 F.3d 542, 549-50 (7th Cir. 1994). In Illinois, § 510 actions are governed by a five-year statute of limitations because § 510 is most similar to Illinois' retaliatory discharge tort.

Byrd v. MacPapers, Inc., 961 F.2d 157, 159-60 (11th Cir. 1992). Because in Florida wrongful discharge actions more closely resemble actions founded on statutory rights than actions for lost wages, § 510 actions in that state are governed by a four-year statute of limitations instead of the two-year statute of limitations for actions based on contracts.

Clark v. Coats & Clark, Inc., 865 F.2d 1237, 1242 (11th Cir. 1989). In Georgia, suits for front and back pay are governed by the state's two-year statute of limitations for recovery of wages, but actions for reinstatement are governed by the twenty-year statute of limitations for equitable actions to enforce statutory rights.

Colitas v. Aventis Cropscience USA Holding II Inc., No. 02-cv-932, 2002 WL 1877928, at *2-3 (E.D. Pa. Aug 12, 2002). The Third Circuit has held the most analogous Pennsylvania cause of action to a § 510 claim is an employment discrimination claim. Under Pennsylvania law, employment discrimination claims are subject to the two-year statute of limitations for tortious conduct.

Christopher v. Mobil Oil Corp., 149 F.R.D. 549, 551 (E.D. Tex. 1993). In Texas, § 510 claims are governed by the statute of limitations for the state's wrongful discharge and employment discrimination statutes.

Karamsetty v. Wells Fargo & Co., 967 F. Supp. 2d 1305, 1321 (N.D. Cal. 2013). The court explained that because § 510 does not contain its own statute of limitations, courts must apply the most analogous state law statute of limitations period. Here, the court applied the two-year statute of limitations from the California Code of Civil Procedure's wrongful termination provisions to the plaintiff's discrimination claim.

Regardless which statute of limitations applies, courts agree that the statutory period begins to run when the alleged interference occurred and was communicated to the plaintiff. See *Berger v. AXA Network LLC*, 459 F.3d 804, 815 (7th Cir. 2006) (holding period begins when plaintiffs discovered unlawful policy and not when employer applied policy to them); see also *Muldoon*, 278 F.3d at 32.

Federal causes of action "aris[ing] under an Act of Congress enacted" after December 1, 1990, which do not establish a time limitation, are governed by the general federal four-year statute of limitations. 28 U.S.C. § 1658; *Jones v. R.R. Donnelley & Sons Co.*, 541 U.S. 369, 381-83 (2004). Section 1658's four-year statute of limitations will not apply to ERISA actions such as those under § 510 because ERISA was enacted in 1974. *Syed v. Hercules Inc.*, 214 F.3d 155, 159 (3d Cir. 2000); *Hidy v. TIAA Grp. Long Term Disability Benefits Ins. Policy*, No. Civ.A.01-450-SLR, 2002 WL

450084, at *2 (D. Del. Mar. 19, 2002), aff'd, 57 F. App'x 124 (3d Cir. 2003). However, § 1658 does apply to a cause of action based on a post-1990 amendment to a pre-existing statute, as long as that amendment can be said to create a new right of action. Jones, 541 U.S. at 381-83. Thus, it is conceivable that a subsequent amendment to ERISA that creates a new cause of action but does not provide a time limitation would be governed by § 1658's four-year statute of limitations.

3. Elements of an action under ERISA § 510, 29 U.S.C. § 1140

The purpose of § 510 is to “prevent unscrupulous employers from discharging or harassing their employees in order to keep them from obtaining their vested pension rights.” Majewski v. Automatic Data Processing, Inc., 274 F.3d 1106, 1113 (6th Cir. 2001). To prove a violation of § 510, a plaintiff must show more than mere loss of benefits and must demonstrate that the defendant had a specific intent to violate the statute. Id.; Lindemann II, 141 F.3d at 295. At the least, the defendant's desire to prevent the plaintiff's enjoyment of benefits must have been a motivating factor. Carter v. Pathfinder Energy Servs., Inc., 662 F.3d 1134, 1151-52 (10th Cir. 2011); see also Branham v. Delta Airlines, 184 F. Supp. 3d 1299, 1309-10 (D. Utah 2016), aff'd, 678 F. app'x 702 (10th Cir. 2017). The purpose prong, however, requires only a showing that the change in benefit status was the predominant motivation to the change in employment, not the sole motivation. Id.

a) Prohibited conduct

Section 510 actions most commonly involve claims that an employer terminated an employee or took some negative action against an employee to interfere with the employee's ability to enjoy ERISA benefits. See, e.g., DiFederico v. Rolm Co., 201 F.3d 200, 204 (3d Cir. 2000); Lindemann II, 141 F.3d at 292. In what the Supreme Court has called the “prototypical” § 510 claim, an employee alleged his employer terminated him four months before his pension would have been vested because the company wished to avoid contributing to his pension fund. See Ingersoll-Rand, 498 U.S. at 136. A plaintiff can still state a claim under § 510 even if the employer paid the plaintiff's benefits before the termination. Kowalski v. L & F Prods., 82 F.3d 1283, 1288 (3d Cir. 1996). Because no limiting language in § 510 suggests that only future benefits should be protected, a termination in retaliation for enjoying past benefits violates § 510. Id. at 1287.

Several courts have held that an employer does not violate § 510 when it modifies a benefit plan's terms that provides unvested benefits, even with the specific intent to prevent employees from gaining those benefits. See Coomer v. Bethesda Hosp., Inc., 370 F.3d 499, 510 (6th Cir. 2004); Teumer v. Gen. Motors Corp., 34 F.3d 542, 545 (7th Cir. 1994); Haberern, 24 F.3d at 1502-03; see also McGann v. H & H Music Co., 946 F.2d 401, 404-05 (5th Cir. 1991). In these cases, courts have held that § 510 addresses the employment relationship that gives rise to the benefits and does not exist to protect the benefits themselves. See Teumer, 34 F.3d at 545. Even if the plan is modified to prevent a single employee from gaining benefits, at least one court has refused to allow a § 510 action if there is also no change in employment status.

See Haberern, 24 F.3d at 1504 (noting actions for discriminatory modifications to plans are properly brought under 29 U.S.C. § 1054(g)). But see Aronson v. Servus Rubber, Div. of Chromalloy, 730 F.2d 12, 16 (1st Cir. 1984) (arguing that changes made to pension plan itself, rather than actions taken within employment relationship to affect pension rights, may constitute discrimination under § 510); Vogel v. Independence Fed. Sav. Bank, 728 F. Supp. 1210, 1225 (D. Md. 1990) (finding plan change improper because it affected only plaintiff).

The Sixth Circuit took an expansive view of prohibited conduct under § 510 in Mattei v. Mattei, where the court found that § 510 applied beyond the employment relationship. See 126 F.3d 794, 806 (6th Cir. 1997). After reviewing the language of § 510 and its legislative history, the court determined that the verbs § 510 uses, such as “discharge, fine, suspend,” were drawn primarily from the employment relationship. Id. The definitions the Act uses for “person,” “participant” and “beneficiary,” however, extend beyond that relationship. Id. at 803. The Sixth Circuit reconciled this inconsistency by reading the scope of § 510 broadly to encompass interference beyond the employment relationship so as to realize the full intent of Congress in creating § 510. Id. Thus, in Mattei, the court found that an estate would violate § 510 if, as alleged, it stopped payments to the deceased’s widow because she accepted benefits from her husband’s ERISA plan. Id. at 804. The estate “discriminated against” the plaintiff because she was treated differently from other beneficiaries of the estate based on her acceptance ERISA benefits. See id.; see also Heimann v. Nat’l Elevator Indus. Pension Fund, 187 F.3d 493, 507 (5th Cir. 1999) (arguing that § 510 covers retired employees as well as current employees), overruled in part on other grounds by Arana v. Ochsner Health Plan, 338 F.3d 433 (5th Cir. 2003); Straus v. Prudential Emp. Sav. Plan, 253 F. Supp. 2d 438, 448 (E.D.N.Y. 2003) (arguing that § 510 covers former employees and beneficiaries as well as current employees); but see Becker v. Mack Trucks, 281 F.3d 372, 383 n.10 (3d Cir. 2002) (rejecting the 5th and 6th Circuits’ expansive interpretation of § 510).

In addition to these situations, courts have found other conduct violates § 510 because it interferes with the attainment or enjoyment of the rights ERISA provides.

See:

Lessard v. Applied Risk Mgmt., 307 F.3d 1020, 1025-27 (9th Cir. 2002). Plaintiff awarded judgment under § 510 based on allegations that, following sale of employer’s assets and automatic transfer of almost all employees to corporate successor, the benefits of a select group of employees were terminated because those employees were on medical leave, on the condition that their benefits would be reinstated only if they returned to work.

Garratt v. Walker, 164 F.3d 1249, 1256 (10th Cir. 1998). An employer can discriminate within the meaning of § 510 if the employer made conditions so difficult so as to create a constructive discharge.

Ahne v. Allis Chalmers Corp., 640 F. Supp. 912, 919-20 (E.D. Wis. 1986). Allegations that an employer lowered employees' salary just prior to termination so as to pay a lower termination benefit state a claim under § 510.

Soto v. Int'l Paper Co., No. 18-cv-3836, 2018 WL 5921350, at *5 (C.D. Cal. Nov. 13, 2018). Plaintiff pleaded sufficient facts to establish a § 510 claim that defendant intended to interfere with plaintiff's attainment of early retirement benefits by terminating plaintiff when he was a month away from his fifty-fifth birthday.

But see:

Becker v. Mack Trucks, Inc., 281 F.3d 372, 379, 382-83 (3d Cir. 2002). An employer's refusal to rehire former employees does not violate § 510 even if that refusal was based upon the employer's desire to avoid creating future pension liability disproportionately greater than that which would be incurred if it hired new employees without past service or pension credit.

Teumer v. Gen. Motors Corp., 34 F.3d 542, 545 (7th Cir. 1994). An intentional mischaracterization of the cause of layoffs so that fewer benefits would be paid would not violate § 510 because the mischaracterization itself caused no change in the employment status of the employees.

Edes v. Verizon Comm'ns, Inc., 288 F. Supp. 2d 55, 59 (D. Mass. 2003). An employer may hire employees under terms that render them ineligible to receive benefits given to other employees without violating § 510.

b) Proving conduct was based on prohibited motivation

As in employment discrimination cases, § 510's most important element, and most difficult to prove, is that the defendant's conduct was based on a prohibited motivation, specifically a desire to interfere with ERISA rights. It is conceivable that a plaintiff could establish this specific intent through direct evidence. Like employment discrimination cases, however, such direct evidence of animus is rarely available and seldom presented to courts. See Dister v. Cont'l Grp., Inc., 859 F.2d 1108, 1111 (2d Cir. 1988) (noting that "direct evidence of discriminatory intent is . . . scarce or nonexistent"); Phelps v. Field Real Estate Co., 793 F. Supp. 1535, 1542 (D. Colo. 1991) (same).

Absent direct evidence, courts rely on the McDonnell Douglas framework to determine intent based on circumstantial evidence. See, e.g., Manning v. Am. Republic Ins. Co., 604 F.3d 1030, 1042 (8th Cir. 2010); DiFederico, 201 F.3d at 205. In § 510 actions, the plaintiff must first establish a prima facie case in which the plaintiff shows he or she (1) belongs to the protected class; (2) met his or her employer's legitimate job expectations; (3) suffered an adverse employment action and (4) similarly situated employees outside of the protected class received more favorable treatment. Morgan v. SVT, LLC, 724 F.3d 990, 996 (7th Cir. 2013); Lindemann II, 141 F.3d at 296.

Another common formulation of the prima facie case requires the plaintiff to establish “(1) prohibited employer conduct (2) taken for the purpose of interfering (3) with the attainment of any right to which the employee may become entitled.” Majewski, 274 F.3d at 1114; DiFederico, 201 F.3d at 205. A plaintiff’s burden in establishing a prima facie case is not intended to be an onerous one. Majewski, 274 F.3d at 1114. Some courts may allow the bare minimum of proof to establish the prima facie case if the facts also indicate the negative action occurred near the scheduled vesting of the benefits because that proximity creates an inference of prohibited activity. Pennington v. Western Atlas, Inc., 202 F.3d 902, 908 (6th Cir. 2000); see also Eichorn v. AT&T Corp., 248 F.3d 131, 150 (3d Cir. 2001) (holding that plaintiff presented sufficient circumstantial evidence of intent to survive summary judgment where employer entered into eight-month re-employment no-hire agreement that extended just beyond vesting period for plaintiff’s pension benefits). They may also presume the prima facie case is established if it is certain that the plaintiff’s case is ultimately doomed because the plaintiff cannot present evidence of pretext in the third stage of McDonnell Douglas.

Under the McDonnell Douglas framework, the defendant must present evidence of a legitimate, nondiscriminatory reason for its action against the plaintiff. See, e.g., Reeves, 530 U.S. at 142-43; DiFederico, 201 F.3d at 205; Lindemann II, 141 F.3d at 296. If the defendant cannot present a legitimate non-discriminatory reason for its actions, the plaintiff is entitled to judgment in his or her favor. At this point, however, the defendant’s burden is one of production, not persuasion – the defendant need merely present a reason that would be legitimate, and the truthfulness of its proffered explanation will be assumed. Winkel v. Kennecott Holdings Corp., 3 F. App’x 697, 707 (10th Cir. 2001) (noting defendant’s burden at this stage is only one of production and truthfulness assumed); Dister, 859 F.2d at 1112 (noting defendant need not persuade). If the defendant presents a legitimate reason, the presumptions of the McDonnell Douglas framework, along with the framework itself fall away. See Reeves, 530 U.S. at 142. A variety of legitimate non-discriminatory reasons have been accepted by courts in § 510 cases. See Brockett v. Reed, 78 F. App’x 148, 151 (2d Cir. 2003) (accepting as reason plaintiff’s unsatisfactory job performance); DiFederico v. Rolm Co., 201 F.3d 200, 205-06 (3d Cir. 2000) (accepting as reason plaintiff’s failure to return to work even after employer attempted to accommodate her health problems); Lindemann II, 141 F.3d at 296 (accepting as reason excessive absenteeism and tardiness even where absences were due to illness); Shahid, 76 F.3d at 1414 (accepting as reason plaintiff’s misconduct in accepting kickbacks); Humphreys v. Bellaire Corp., 966 F.2d 1037, 1044 (6th Cir. 1992) (accepting as reason evidence that plaintiff was “out for himself” and sale of mine he managed).

As in any case under the McDonnell Douglas approach, the plaintiff then may produce evidence that the proffered legitimate reason is pretext. Shahid, 76 F.3d at 1413. Although some courts state that at this point the “burden shifts back to the plaintiff,” id., the Supreme Court has noted that at this point all presumptions have fallen away and the issue is whether there was discrimination or not. See Reeves, 530 U.S. at 142-43; DiFederico, 201 F.3d at 206. The plaintiff has the burden to prove whether the legitimate reason is unworthy of credence or that the interference with benefits was a motivating factor in the defendant’s actions. Shahid, 76 F.3d at 1413. This is

precisely the issue that the plaintiff must prove from the very start of a § 510 claim and the plaintiff has had this burden throughout the entire case.

When proving pretext, a plaintiff might present evidence that (1) the proffered reason has no basis in fact, (2) the reason did not in fact motivate the defendant or (3) the reason was insufficient to motivate the discharge. See Imwalle v. Reliance Med. Prod., Inc., 515 F.3d 531, 545 (6th Cir. 2008) (citing Manzer v. Diamond Shamrock Chems. Co., 29 F.3d 1078, 1084 (6th Cir. 1994)); Mumm v. Charter Twp. of Superior, 727 F. App'x 110, 113 (6th Cir. 2018). Evidence sufficient to establish the prima facie case may be insufficient to establish pretext. In Humphreys, the termination's proximity to the upcoming benefit vesting allowed for an inference of discrimination that established the prima facie case but was insufficient to prevent the court from granting the employer summary judgment. 966 F.2d at 1044; see Hamilton v. Starcom Mediavest Grp., Inc., 522 F.3d 623, 630 (6th Cir. 2008) (granting employer summary judgment even though employee established prima facie case). Although the negative employment action also occurred on or about the time of the proffered legitimate reason, it was insufficient to show pretext merely because of its proximity to the vesting date. Humphreys, 966 F.2d at 1044-45; see also Petrus v. Lucent Techs., Inc., 102 F. App'x 969, 971-72 (6th Cir. 2004) (holding that plaintiff could not make prima facie case of ERISA discrimination by pointing to two year gap between employer's action and vesting date without additional, highly probative facts that suggest intentional discrimination).

Also, courts have rejected claims that statements to the effect that the employer cannot "afford" the plaintiff demonstrate pretext. Merely citing financial considerations alone does not indicate pretext because then "any actions by an employer that result in savings would be suspect." See Conkwright v. Westinghouse Elec. Corp., 933 F.2d 231, 239 (4th Cir. 1991); see also Morabito v. Master Builders, Inc., 127 F.3d 1102 (table), No. 96-3898, 1997 WL 668955, at *2 (6th Cir. 1997). Determining pretext is highly dependent upon the facts of the case and subject to evidence presented by the parties.

See:

Hamilton v. Starcom Mediavest Grp., Inc., 522 F.3d 623, 630 (6th Cir. 2008)-_Evidence that employer only terminated plaintiff among those who had similar job duties and was hiring in other positions did not establish pretext. Employer terminated plaintiff because she had the least amount of experience and, despite hiring in some areas, was still laying off employees in other areas.

Smith v. Hinkle Mfg., Inc., 36 F. App'x 825, 830 (6th Cir. 2002). Pretext was established where (1) complaints about plaintiff's performance all were documented in two-week period between informing employer of son's health problem and her discharge and (2) her recent pay raise suggested employer was not actually dissatisfied with her performance.

Dister v. Cont'l Grp., Inc., 859 F.2d 1108, 1116-17 (2d Cir. 1988). Evidence that plaintiff's position had been made unnecessary and plaintiff frequently had nothing to do at work prevented plaintiff from showing termination to reduce costs was pretextual.

Humes v. McDonnell Douglas Corp., 922 F. Supp. 229, 235 (E.D. Mo. 1996). By failing to show her low competency score was undeserved and because her termination came five years before her benefits were to vest, plaintiff failed to show her termination for poor performance was pretextual.

As stated earlier in this section, evidence that the legitimate reason presented was not the true reason for the employer's action does not compel a finding for the plaintiff because, as the Supreme Court notes, establishing that the employer acted for a non-legitimate or even illegal reason does not necessarily mean the defendant acted with an ERISA-prohibited intent. See *St. Mary's Honor Ctr.*, 509 U.S. at 511. For example, under § 510, a defendant is liable if it specifically intended to interfere with ERISA benefits. If it terminated an employee based on race, but claimed the termination was due to absenteeism, merely proving that evidence of absenteeism was pretextual would not establish a violation because race-based animus does not violate § 510.

The Court has expressly noted, however, that after establishing prima facie case and providing evidence of pretext, a reviewing court should not require a plaintiff to provide additional proof of prohibited intent before sending the case to the fact-finder. *Reeves*, 530 U.S. at 147. So long as a reasonable fact finder could find that the proffered explanation was false and could find evidence sufficient to establish prohibited intent, a court must let the fact-finder have the case if the court is considering a motion for summary judgment. See *id.* at 148-49. Similarly, the court must accept the fact-finder's verdict if the court is hearing a motion for judgment as a matter of law. *Id.*

4. Remedies available in an action under ERISA § 510, 29 U.S.C. § 1140

Interference with rights protected under § 510 is remedied exclusively by § 502(a). 29 U.S.C. § 1132(a). It preempts state remedies, even if the remedies under ERISA are not as complete as those available under state law. See *Ingersoll-Rand*, 498 U.S. at 144-45; *Tolton v. Am. Biodyne, Inc.*, 48 F.3d 937, 942 (6th Cir. 1995); *Humphrey v. Paul Revere Life Ins. Co.*, No. 11-cv-11298, 2012 WL 928432, at *2 (D. Mass. Mar. 15, 2015).

Because actions under § 510 are brought through the civil enforcement provision, § 502(a), a plaintiff's remedies are limited to those in other ERISA actions. If the plaintiff was terminated wrongfully and was owed benefits under the plan, the plaintiff may seek the payment of those benefits. See *Zimmerman v. Sloss Equip., Inc.*, 72 F.3d 822, 827 (10th Cir. 1995). Plaintiffs also may seek equitable relief such as back pay and front pay or reinstatement. See *Schwartz v. Gregori*, 45 F.3d 1017, 1021-22

(6th Cir. 1995). While some defendants have argued that equitable relief does not include front or back pay, courts have provided those remedies. Id. at 1022-23 (finding that back pay was appropriate equitable relief because it made plaintiff whole and front pay was appropriate substitute for reinstatement which was not feasible). Attorneys' fees are also allowed under ERISA § 502(g). 29 U.S.C. § 1132(g); Filipowicz v. Am. Stores Benefit Plans Comm., 56 F.3d 807, 816 (7th Cir. 1995) (stating five factor test that guides court's discretion in determining whether to award attorney's fees).

Other remedies are not available in § 510 actions, however, because they are not available in other ERISA actions. For example, most courts continue to hold that no extra-contractual damages, such as compensatory or punitive damages, are allowed in ERISA actions. See, e.g., Montanile v. Board of Trustees of Nat. Elevator Industry Health Benefit Plan, 136 S. Ct. 651 (2016); Senese v. Chicago Area I.B. of T. Pension Fund, 237 F.3d 819, 825 (7th Cir. 2001); McLeod v. Oregon Lithoprint Inc., 102 F.3d 376, 378 n.2 (9th Cir. 1996). But see Blue Cross & Blue Shield of Alabama v. Lewis, 753 F. Supp. 345, 347 (N.D. Ala. 1990) (holding Ingersoll-Rand gave federal courts "green light" to fashion extra-contractual remedies including punitive damages). Similarly, § 510 plaintiffs cannot recover compensatory damages. Zimmerman, 72 F.3d at 827-29; Warner v. Buck Creek Nursery, Inc., 149 F. Supp. 2d 246, 255 (W.D. Va. 2001) (noting compensatory damages are not equitable); Teutscher v. Woodson, 835 F.3d 936, 946 (9th Cir. 2016). Also, there can be no damages for mental anguish. Nero v. Indus. Molding Corp., 167 F.3d 921, 932 (5th Cir. 1999).

Because the remedies allowed in § 510 cases are only equitable, there is no right to a jury trial. See, e.g., Langlie v. Onan Corp., 192 F.3d 1137, 1141 (8th Cir. 1999); Spinelli v. Gaughan, 12 F.3d 853, 857-58 (9th Cir. 1993); Evanoff v. Banner Mattress Co., Inc., 550 F. Supp. 2d 697, 701 (N.D. Ohio 2008); Morgan v. Ameritech, 26 F. Supp. 2d 1087, 1090 (C.D. Ill. 1998); Thomas v. Allen-Stone Boxes, Inc., 925 F. Supp. 1316, 1321 (W.D. Tenn. 1995); Jarmakani v. Bank of Am. Nat'l Ass'n, No. 17-cv-2037, 2018 WL 6267341, at *9 (C.D. Cal. Mar. 27, 2018) ("the law is clear that jury trials are unavailable under ERISA"). But see Lewis, 753 F. Supp. at 347 (interpreting Ingersoll-Rand to allow extra-contractual remedies and by extension right to jury).

5. Relationship between ERISA's anti-retaliation provision and other federal discrimination statutes

In addition to ERISA, there are numerous other federal statutes that protect employees and apply to benefit plans. Chief among these are the Age Discrimination in Employment Act (ADEA), codified at 29 U.S.C. §§ 621-634 (2002), and the Americans with Disabilities Act (ADA), codified at 42 U.S.C. § 12101-12213 (2002). For a more detailed discussion of how these acts impact employee benefit plans, see Employee Benefits Guide, §§ 10.01, 10.03 (Matthew Bender 2001). This section focuses on the increasing overlap between these statutes and the protections ERISA § 510 affords and the possible dual liability that employers may face under the statutes.

a) Age Discrimination in Employment Act

The ADEA prohibits discrimination against employees forty and older and makes it unlawful for an employer to “limit, segregate, or classify . . . employees in any way that would deprive . . . any individual of employment opportunities . . . because of such individual’s age.” 29 U.S.C. §§ 623(a)(2), 631(a). Claims involving both the ADEA and ERISA § 510 can be established using the McDonnell Douglas framework, although the Supreme Court has not squarely confirmed that the framework is applicable to ADEA claims. See Reeves, 530 U.S. at 142 (assuming McDonnell Douglas applies because parties did not dispute it).

Hazen Paper Co. v. Biggins illustrates one intersection of ERISA § 510 and the ADEA. 507 U.S. 604, 612 (1993). There, the employer terminated an employee a few weeks before his benefits would have vested. Id. at 607. In addition to claiming that the termination violated § 510, the plaintiff claimed that his pension status was a proxy for age and that the termination indicated that the employer fired him because of his age. Id. The question on appeal was whether the evidence that the employer interfered with the vesting of the pension could support the finding of age discrimination. Id.

The Supreme Court vacated the lower court’s ruling and held that interference with the vesting of pension benefits alone does not establish a violation of the ADEA. Id. at 613. Although previous circuit court decisions held that the years of service could be a proxy for age, the Court held that the two were “analytically distinct” and that the two factors were not equivalent. Id. at 611, 613. While the termination clearly violated § 510, that violation did not also violate the ADEA because the employee was not terminated because of age. Id. at 612. A violation of the ADEA only occurs where an employer wrongly acts based on age, not where it wrongly terminates an older employee for any illegal reason. As discussed above, this is the principle St. Mary’s Honor Center established: plaintiffs suing under federal employment statutes must prove a specific intent to violate the statute, not that the employer wrongly terminated an employee.

The Court noted, however, that an employer could have dual liability if in fact it terminated the employee both because it wanted to avoid paying a pension and to get rid of older workers. Id. at 613. Moreover, in cases where the pension status was actually based on age rather than years of service, an employer who terminates an employee to prevent vesting may violate the ADEA. Id. On remand, the First Circuit initially found that there was sufficient evidence to find an ADEA violation even without considering the evidence to the ERISA claim. See Biggins v. Hazen Paper Co., No. 91-1591, 1993 WL 406515, at *5 (1st Cir. Oct. 18, 1993). This decision was subsequently vacated and withdrawn by the First Circuit *en banc* out of concerns that the jury’s factual findings were so contaminated by the ERISA § 510 claim that a new trial was needed on the ADEA count. Biggins v. Hazen Paper Co., No. 91-1591, 1994 WL 398013, at *1 (1st Cir. June 27, 1994) (*en banc*).

See also:

Kentucky Ret. Sys. v. EEOC, 554 U.S. 135, 143 (2008). In interpreting the application of the ADEA to a pension plan, the Supreme Court reiterated that as a “matter of pure logic,” age and pension status are analytically distinct. Even if age is used as a factor and the employer distinguishes among employees based on pension status, a plaintiff in an ADEA suit must show that the differential treatment was “actually motivated” by age.

Nw. Airlines, Inc. v. Phillips, 675 F.3d 1126, 1132–33, (8th Cir. 2012). The employer was entitled to summary judgment because the plan did not violate the ADEA or ERISA. While the “stovepipe model” plan used to calculate benefits used age as one of its factors, any reductions to the benefits of older workers were due to pension status, not “because of age.”

Szczesny v. Gen. Elec. Co., 66 F. App’x 388 (3d Cir. 2003). Employer’s alleged “totem poling” scheme in which older workers were systematically replaced with younger workers, violated neither ERISA nor the ADEA where there was no evidence that employer’s specific intent was to harvest employee’s pension funds and no evidence to support employee’s claim of age discrimination.

Carson v. Lake Cty., Ind., 865 F.3d 526, 535 (7th Cir. 2017): County did not violate ADEA where employees’ age was not the but-for cause of the county’s decision to fire them, and where the employees failed to make out a prima facie case for age discrimination or establish ADEA claims under a disparate impact theory. The plaintiff employees had accepted incentive packages to retire which included supplemental health insurance and then were later rehired, and they were all age 65 or older when they were subsequently fired. However, they were terminated because they were impermissibly enrolled in the retiree-only supplement while also working part-time, and other employees of a similar age who were not enrolled in the supplement were not fired.

Another potential intersection between § 510 claims and ADEA claims relates to the procedural requirements of ADEA claims and the ability of plaintiffs to relate ADEA claims back to timely ERISA § 510 actions under Federal Rule of Civil Procedure 15(c). See Louis Maslow II, Comment, *Dual Liability: The Growing Overlap of the Age Discrimination in Employment Act and Section 510 of the Employee Retirement Income Security Act*, 58 ALB. L. REV. 509, 520 (1994). To bring an ADEA claim, a plaintiff must file a complaint with the EEOC within 180 days of the occurrence or, in some cases, 300 days. 29 U.S.C. § 626(d)(1)-(2). As discussed above, the statute of limitations for an ERISA § 510 claim is significantly longer. Rule 15(c) allows a party to add additional claims after the statute of limitations has run where the defendant had notice of the possible other claims and the new claims “arose out of the conduct, transaction or occurrence [as the] . . . original pleading.” Fed. Rule Civ. P. 15(c). Some have theorized that a plaintiff that failed to file an ADEA claim in the time allotted could amend a timely ERISA claim by adding an ADEA count under Rule 15(c)

because the claims originate from the same conduct or occurrence and a defendant would have likely had notice that an age claim could arise. See Maslow, supra, at 527.

The United States District Court for the Northern District of California allowed a time-barred ADEA claim to continue in Tusting v. Bay View Fed. Sav. & Loan Ass'n, 762 F. Supp. 1381, 1382 (N.D. Cal. 1991). Stating the EEOC deadline was “not a jurisdictional prerequisite to suit,” the court determined that the claim could be added. Id. Because the factual basis of the claim was the same as the timely-filed ERISA claim and was brought to the defendant’s attention in the original pleading, the new claim would not prejudice the defendant. Id. (citing 6A C. WRIGHT, A. MILLER & M. KANE, FEDERAL PRACTICE AND PROCEDURE § 1497, at 94-95). This case is consistent with other employment discrimination cases where plaintiffs were able to add new claims that arose out of the same transaction or occurrence. See Maslow, supra, at 527. But see Fairchild v. Forma Scientific, Inc., 147 F.3d 567, 575 (7th Cir. 1998) (noting that ADA charge cannot relate back to ADEA charge where factual allegations for original claim could not also support ADA claim). While few other cases have involved this intersection of § 510 and the ADEA, employers should be wary that plaintiffs could use § 510 to resurrect stale ADEA claims that otherwise may have been lost as untimely.

b) Americans with Disabilities Act

The ADA generally provides that “no [employer, employment agency or labor organization] shall discriminate against a qualified individual with a disability because of the disability . . . in . . . hiring, advancement or discharge, employee compensation, [or] other terms, conditions, and privileges of employment.” 42 U.S.C. § 12112(a). Self-funded ERISA plans are “covered entities” under the ADA. Heather J. Blum, Annotation, *The Propriety Under ERISA and the Americans With Disabilities Act of Capping HIV-Related Claims*, 131 A.L.R. FED. 191, 203 (1996). Moreover, the Act provides that no employer may target a disabled person by reducing that person’s benefits to avoid the cost of insuring that person. See Interpretive Guidance to Title I of the Americans with Disabilities Act, 29 C.F.R. § 1630.5 App. (2002); Employee Benefits Guide, § 10.03. An employer would not violate the Act, however, if it were to reduce benefits for all employees out of concern for the cost of the whole even if disabled employees are more likely to be disadvantaged by the change. 29 C.F.R. § 1630.5 App.

As stated above, ERISA § 510 decisions arising before the ADA held that an employer did not violate § 510 by intentionally changing the benefits it provided even if it did so only to avoid paying the higher cost of treating a single disabled employee. See McGann v. H & H Music Co., 946 F.2d 401, 404-05 (5th Cir. 1991). The most notable of these cases is McGann v. H & H Music Co., where the Fifth Circuit held that an employer did not violate § 510 by capping its AIDS-related insurance benefit at \$5,000 when it found out that one of its employees had AIDS but placed no cap on other catastrophic illnesses. Id. at 403. The court determined the limit was set for all employees who might be afflicted with AIDS and no evidence indicated the change was targeted at the plaintiff even though he was the only employee known to have had AIDS. Id. at 404. Moreover, the court stated that the employer reserved the right to modify the benefits at anytime, so the plaintiff was not entitled to the benefits he sought.

Id. at 405. Although not addressed in McGann, other courts have held that a plaintiff cannot bring suit for changes in an unvested benefits plan under § 510 because the change does not affect the employment relationship as a termination or demotion would. See Teumer, 34 F.3d at 545; Haberern, 24 F.3d at 1502-03.

The question in suits arising under the ADA is whether an employer violates federal law if it reduces the benefits of all out of concern for the cost of insuring the whole but does so only because the expected cost of insuring a single disabled employee will raise the cost for the entire pool of workers. Such a reduction would not violate § 510 because, as noted, changes in the benefits plans do not affect the employment relationship and also would affect employees other than the worker who sought the benefits. See Teumer, 34 F.3d at 545; McGann, 946 F.2d at 404.

An employer, however, may be liable under the ADA if a court determines that the reduction was in fact due to “subterfuge,” which the EEOC defines as a disability-based distinction that is not justified by business or insurance costs. See Blum, 131 A.L.R. FED. at 200. In such a case, the employer must prove that the distinction is a bona fide insurance plan and that the change was justified by legitimate actuarial data or actual experience. Id. Most cases on this issue have settled, however. See id. at 205.

B. ERISA LIABILITY OF EMPLOYERS UNDER MANAGED CARE AND EMPLOYER-SPONSORED HEALTH PLANS

Although the percentage of Americans who receive health benefits through employers has decreased in recent decades, a majority of Americans are still covered by employer-based health insurance. Compare Health Insurance Coverage in the United States: 2017, U.S. CENSUS BUREAU, 1, 3 (2018), available at <https://www.census.gov/content/dam/Census/library/publications/2018/demo/p60-264.pdf> (reporting that 56% of Americans were covered by employer-based health insurance in 2017), with Health Insurance Coverage: 2001, U.S. CENSUS BUREAU, 13 (2002), available at <https://www2.census.gov/library/publications/2002/demo/p60-220.pdf> (finding 63% received employer-based health insurance in 2001). Although many ERISA provisions are concerned with pension plans, ERISA also governs these group health plans. Nancy R. Mansfield et al., *Evolving Tension Between HMO Liability Precedent and Legislation*, 36 TORT & INS. L.J. 949, 950 (Summer 2001). When a beneficiary is dissatisfied with his or her benefits and sues under ERISA, the question often arises as to the liabilities of the employer-sponsor.

This section of the Handbook provides an introduction to basic aspects of managed care and considers under what circumstances an employer-sponsor of a managed-care plan has obligations under ERISA and possible grounds for employer liability based on the negligence or malpractice of the administrator of the plan it sponsors.

1. Introduction to basic aspects of managed care

Because healthcare costs have dramatically increased in recent decades, many employers have turned to managed care products to more effectively control their health care costs. MATTHEW BENDER, *EMPLOYEE BENEFITS GUIDE* § 11.01 (2001). A variety of managed care programs have become commonplace for today's employers. One of the most common types is the health maintenance organization ("HMO"). HMOs generally involve a group of care providers who work for a single company or as part of a organization that controls both the cost of healthcare and the quantity of healthcare services. Another type of managed care program is a preferred provider organization ("PPO"). PPOs are usually a network of independent care providers who have agreed to perform services at a certain amount which is below what they would charge their fee-for-service customers. Employees are provided incentives to choose providers within the PPO network, or, perhaps more accurately, disincentives in the form of lower reimbursements if they choose providers outside the network.

In both PPO and HMO plans, costs are in part controlled by a process called "utilization review" ("UR"). It is this aspect of managed care that frequently leads to litigation over whether the plan improperly denied the beneficiary's claim of benefits. The UR process consists of several techniques that attempt to eliminate unnecessary or inappropriate procedures. For example, many plans require "pre-certification" which requires a pre-admission review of the case to determine whether the physician's order of elective hospitalization is medically warranted. A beneficiary who fails to comply with a plan's pre-certification procedure may be charged a penalty. See Nazay v. Miller, 949 F.2d 1323, 1331 (3d Cir. 1991) (finding employer who assessed penalty did not breach any fiduciary duty).

PPOs and HMOs both offer certain advantages to the employer as opposed to traditional benefit plans or fee-for-service arrangements. HMOs, for example, provide a comprehensive benefit package with little out of pocket expense and stress "wellness" and preventative care that may reduce the need for more serious treatment in the future. See EMPLOYEE BENEFITS GUIDE, § 11.08. PPOs offer a wider array of services and a wider choice of providers that allow employees to select their primary physicians. See id. at § 11.12. Both plans offer reduced paperwork and usually do not require employees to pay for services first and then wait for reimbursement. See id. at §§ 11.08, 11.12.

Many managed care plans have been criticized, however, because they limit access to care or contain economic incentives to not provide some forms of treatment. In an effort to lower costs, managed care programs may also reduce the quality of care by relying on less experienced doctors or doctors who are willing to lower their costs to comply with the plan. Another criticism of managed care is that by limiting employees' ability to choose their own doctor, it prevents the development of a close physician-patient relationship. Id. at § 11.08

2. Determining the scope of the employer-sponsor's liability

Generally, the employer who merely sponsors an ERISA-governed health care plan will owe no fiduciary duty to the plan beneficiaries under ERISA. Layes v. Mead Corp., 132 F.3d 1246, 1249 (8th Cir. 1998); Lifecare Mgmt. Servs. LLC v. Onz. Mgmt. Adm'rs Inc., 703 F.3d 835, 845 (5th Cir. 2013). One court considering the issue noted that the law clearly establishes that a beneficiary may not recover from his employer, provided the employer is only a plan sponsor. Wyluda v. Fleet Fin. Grp., 112 F. Supp. 2d 827, 830 (E.D. Wis. 2000). The Wyluda court concluded that "ERISA permits suits to recover benefits only against the Plan as an entity . . ." Id. (citing Jass v. Prudential Health Care Plan, Inc., 88 F.3d 1482 (7th Cir. 1996)). An employer that does not control the administration of the plan is not a proper party in an ERISA suit. Layes, 132 F.3d at 1249.

See:

Crowley ex rel. Corning, Inc., Inv. Plan v. Corning, Inc., 234 F. Supp. 2d 222, 228 (W.D.N.Y. 2002). Where sponsor does not control investment decisions and is not a fiduciary of the plan, the employer-sponsor cannot be a defendant in a suit alleging that the defendant breached duties by materially misleading beneficiaries. If a committee of the sponsor is the designated administrator or fiduciary, the sponsor cannot be held liable for the committee's alleged mismanagement under a respondeat superior theory.

Smith v. Commonwealth Gen. Corp., 589 F. App'x 738, 744 (6th Cir. 2014). Former employer was not a proper defendant in an action brought by a retired employee challenging the reduction of his monthly benefits under an early retirement program, because ERISA governed the program and neither the employer nor its successor corporation controlled the program's administration.

Once an employer chooses to wear "two hats," however, and acts as both the employer and in a fiduciary capacity as a plan administrator, fiduciary duties under ERISA attach. Varity Corp. v. Howe, 516 U.S. 489, 498 (1996); Hamilton v. Allen-Bradley Co., Inc., 244 F.3d 819, 824 (11th Cir. 2001); Law v. Ernst & Young, 956 F.2d 364, 372-73 (1st Cir. 1992). ERISA defines the administrator of a plan as "person specifically so designated by the terms of . . . the plan . . ." 29 U.S.C. § 1002(16)(A)(i). If no administrator is designated, however, the plan sponsor will be the administrator. Id. The plan sponsor is the employer if the benefit plan was established or maintained by a single employer. 29 U.S.C. § 1002(16)(B). Thus, the primary way to determine if an employer-sponsor has fiduciary duties is look to the terms of the plan, because even if the employer is not designated as the administrator, it may be the administrator anyway if no administrator is named. Ibson v. United Healthcare Servs., Inc., 877 F.3d 384, 391 (8th Cir. 2017).

Even if not formally the administrator, however, employer-sponsors may be liable as fiduciaries if they “exercise[] any discretionary authority or discretionary control respecting management . . . [or] administration of [the] plan.” 29 U.S.C. § 1002(21). Courts have allowed a plan participant to recover benefits from an employer based on the employer’s “discretionary decision-making authority over the plan’s benefits.” Witowski v. Tetra Tech., Inc., 38 F. Supp. 2d 640, 644 (N.D. Ill. 1998). In these cases, however, employer-sponsors become liable only for acts they commit while functioning as plan administrator and not for acts committed while they are conducting business not regulated by ERISA. Holdeman v. Devine, 572 F.3d 1190, 1193 (10th Cir. 2009).

In Varity, for example, an employer was both the sponsor and the designated plan administrator, and it represented to its employees that an impending corporate restructuring would not affect their benefits. 516 U.S. at 498-99. The corporation knew this was false. Id. at 494. The Court found that while Varity’s misrepresentations related to the financial health of the company, Varity was not acting as an employer making business decisions. Id. at 505. Because those statements were intentionally connected to the statements it made about the security of the employees’ benefits, it was exercising “discretionary authority” respecting the plan’s “management” or “administration,” within the meaning of ERISA § 3(21)(A). Id. Communications respecting the future of plan benefits are aspects of plan administration and by failing to communicate truthful information, the employer did not act “solely in the interest of the participants and beneficiaries.” Id. at 505-06. Thus, the defendants violated the fiduciary obligations for plan administrators because “lying is inconsistent with the duty owed by all fiduciaries and codified in section 404(a)(1).” Id. at 506.

See also:

Bannistor v. Ullman, 287 F.3d 394, 405-07 (5th Cir. 2002). Officers of bankrupt employer corporation were ERISA “fiduciaries” for the purpose of employees’ action alleging a breach of fiduciary duty through the improper disposal of employee benefit plan assets; the officers had exercised control over plan assets by using cash advances from employer’s lien or to pay accounts other than employee benefit plans, and qualified as ERISA “plan administrators” and “employers” because they acted indirectly in employer’s interest regarding the plan in part by approving a new health plan in their capacity as board members and had check-signing authority for employer.

Hamilton v. Allen-Bradley Co., Inc., 244 F.3d 819, 824 (11th Cir. 2001). The employer is a plan administrator because the employer exercises sufficient control over the plan. Under the plan, employees must process claims through the employer’s human resource department.

Law v. Ernst & Young, 956 F.2d 364, 372-73 (1st Cir. 1992). Although plan documents made a committee within the employer-sponsor the

administrator, evidence established that employer itself exercised sufficient control over plan to make it a proper defendant in ERISA suit.

Ibson v. United Healthcare Servs., Inc., 877 F.3d 384, 390-91 (8th Cir. 2017). The insurer that issued the policy that funded an employer-sponsor's group health plan was not a "plan administrator" for ERISA civil penalty purposes, but the employer-sponsor was, because another plan administrator had not been explicitly designated.

Mehling v. New York Life Ins. Co., 163 F. Supp. 2d 502, 510 (E.D. Pa. 2001). The employer-sponsor was a fiduciary because the employer retained the power to appoint, retain, and monitor the named fiduciaries.

Kodes v. Warren Corp., 24 F. Supp. 2d 93, 101 (D. Mass. 1998). Third-party administrator was not a fiduciary because plan documents clearly provided that the employer-sponsor retained "final authority and responsibility for the Plan and its operation."

Harrison v. PNC Fin. Servs. Grp., 928 F. Supp. 2d 934, 941-43 (S.D. Ohio 2013). A former employee sufficiently pled that his former employer had exercised administrative control over its management of a severance plan, as required to establish that the employer was the appropriate defendant in the employee's ERISA action. The employee's allegations and the employer's denial letter indicated that the employer made the initial determination that the employee was not eligible for severance benefits under the plan and then referred the employee to the plan administrator.

But see:

In re Luna, 406 F.3d 1192, 1202-1208 (10th Cir. 2005). Employers, whose company owed unpaid monthly employer contributions to ERISA-covered employee benefit funds pursuant to collective bargaining agreement were not fiduciaries under ERISA because they did not exercise authority or control respecting management or disposition of plan assets. Under the collective bargaining agreement, employers had no duty other than to make monthly contributions and no discretion other than to fail to make those contributions.

Crocco v. Xerox Corp., 137 F.3d 105, 107 (2d Cir. 1998). The court rejected the argument that an employer can become a de facto administrator and stated that "if a plan specifically designates a plan administrator, then that individual or entity is the plan administrator for the purposes of ERISA."

*Arnold v. F.A. Richard & Assocs., Inc., No. Civ.A. 99-2135, 2000 WL 1693659, at *3 (E.D. La. Nov. 8, 2000). The court found no evidence that employer had necessary discretion to be considered a fiduciary even though employer was designated as the plan administrator.*

Witowski v. Tetra Tech, 38 F. Supp. 2d 640, 644 (N.D. Ill. 1998). Although employer was nominal plan administrator, plaintiffs admitted that the service provider exercised “final discretionary authority to determine all questions of eligibility . . . and to interpret and construe the terms of [the policies].” The court refused to allow the suit to continue because the employer did not maintain sufficient discretionary authority over the administration of the plan and the provision of benefits.

Levi v. McGladrey LLP, No. 12-cv-8787, 2016 WL 1322442, at *4 (S.D.N.Y. Mar. 31, 2016). The plaintiff’s ERISA claim failed because, “[u]nder long-standing Second Circuit precedent,” a party who is not a plan administrator cannot be held liable for a violation of 29 U.S.C. § 1132(a)(1), “even if it were a de facto co-administrator.”

3. Duties and responsibilities of the employer-sponsor if it is the administrator

In addition to potential liabilities for breach of fiduciary duty, ERISA imposes other obligations on employer-sponsors who act as plan administrators. Among the most relevant are the obligations dealing with reporting and disclosures to plan participants.

a) Disclosure obligations under ERISA

ERISA requires that every employee benefit plan “provide adequate notice in writing to any participant or beneficiary whose claim 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.” 29 U.S.C. § 1133(1). If terminating coverage, the employer has a duty to notify the beneficiary. If a participant does not receive adequate notice, the action cannot be barred by the statute of limitations.

In *Kodes v. Warren Corp.*, a former employee and his wife were covered by his employer’s ERISA-governed insurance plan. 24 F. Supp. 2d 93, 102 (D. Mass. 1998). Although claims were initially reviewed by a third party administrator, the employer-sponsor was a fiduciary and proper defendant because it retained final authority to review and deny claims. *Id.* at 101. When the employee suffered a work related injury, he was told that he and his wife would both be covered as long as he continued to make weekly payments. *Id.* at 97. When the employee later sought coverage for medical procedures for his wife, the coverage was denied because the employer said he failed to make the required payments. *Id.* The plaintiffs challenged this decision after the three-year limitations period elapsed, and the defendant argued the claim should be barred. *Id.* at 102. The court found that the employer could not prove that the employee and his wife actually received formal notification that their participation in the plan was terminated and could have reasonably assumed that they were still covered under the plan despite their failure to make the required contribution. *Id.* Thus, the employer-sponsor’s motion for summary judgment was denied. *Id.*

See also:

Miller v. Am. Airlines, Inc., 632 F.3d 837, 852-53 (3d Cir. 2011). A plan's termination letter was legally insufficient because the letter did not provide specific reasons for the termination written in language a participant could understand and did not advise the plaintiff how he can perfect his claim in detail.

Epright v. Env'tl. Res. Mgmt., Inc. Health & Welfare Plan, 81 F.3d 335, 342 (3d Cir. 1996). "When a letter terminating or denying Plan benefits does not explain the proper steps for pursuing review of the termination or denial, the Plan's time bar for such a review is not triggered."

White v. Jacobs Eng'g Grp. Long Term Disability Benefit Plan, 896 F.2d 344, 350 (9th Cir. 1989). "When a benefits termination notice fails to explain the proper steps for appeal, the plan's time bar is not triggered."

Santana-Diaz v. Metro. Life Ins. Co., 816 F.3d 172, 182 (1st Cir. 2016). The benefits denial letter sent by a plan administrator to an employee was defective because it failed to include the limitations period for filing suit, and thus was per se prejudicial.

Several circuit courts also have considered whether ERISA imposes upon a company that acts as administrator of its employee benefit program a duty to truthfully disclose, upon inquiry from plan participants or beneficiaries, whether it is considering amending the benefit plan. The majority view is that a duty of accurate disclosure begins when "(1) a specific proposal (2) is being discussed for purposes of implementation (3) by senior management with the authority to implement the change." *Beach v. Commonwealth Edison Co.*, 382 F.3d 656, 659 (7th Cir. 2004) (quoting *Fischer v. Phila. Elec. Co.*, 96 F.3d 1533, 1539 (3d Cir. 1996)); see also *Mathews v. Chevron Corp.*, 362 F.3d 1172, 1180-82 (9th Cir. 2004); *McAuley v. IBM Corp.*, 165 F.3d 1038, 1043-45 (6th Cir. 1999); *Vartanian v. Monsanto Co.*, 131 F.3d 264, 268 (1st Cir. 1997); *Hockett v. Sun Co.*, 109 F.3d 1515, 1522 (10th Cir. 1997); *Fischer v. Phila. Elec. Co.*, 96 F.3d 1533, 1538-44 (3d Cir. 1996); *Wilson v. Sw. Bell Tel. Co.*, 55 F.3d 399, 405 (8th Cir. 1995); *Barnes*, 927 F.2d at 544. Two circuits have concluded that the duty of disclosure arises sometime before the change is under "serious consideration" – although these circuits have had difficulty determining just what information must be disclosed, and when. *Beach*, 382 F.3d at 660; see *Martinez v. Schlumberger, Ltd.*, 338 F.3d 407, 425 (5th Cir. 2003); *Ballone v. Eastman Kodak Co.*, 109 F.3d 117, 122-26 (2d Cir. 1997).

See also:

Barrs v. Lockheed Martin Corp., 287 F.3d 202, 207-08 (1st Cir. 2002). Employer did not have a fiduciary duty under ERISA to inform former employee's ex-wife that the former employee had substituted a new optional life insurance policy for the optional life insurance policy of which she was the irrevocable beneficiary pursuant to a divorce decree.

Soland v. George Washington Univ., 60 F. Supp. 3d 60, 66 (D.D.C. 2014). A professor brought an ERISA action against a university, alleging that the university breached its fiduciary duty by failing to inform him of a department-wide retirement plan that was purportedly being developed at the time he was negotiating his retirement. The court found that the university had no duty to disclose the potential new plan under the “serious consideration” test. The university did not have any specific plan, and, at most, engaged in preliminary activities such as gathering information, developing strategies, and analyzing options. The court also found that the university did not have a duty to disclose under the “materiality” test, which incorporates the “serious consideration” test as a factor, because the “materiality” test applies only to misrepresentations and does not create a general obligation to disclose future potential plan changes.

b) Disclosure obligations related to COBRA benefits

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) mandates that plan sponsors give former employees the opportunity to continue coverage under the employer’s group health plan if a qualifying event occurs. 29 U.S.C. § 1161(a). Termination of employment is a qualifying event and requires that the employer-sponsor to notify the administrator of the group health plan within 30 days of the termination. 29 U.S.C. §§ 1163(2), 1166(a)(1). The plan administrator must then notify the discharged employee and other qualified beneficiaries of the COBRA rights within fourteen days. 29 U.S.C. § 1166. When an employer is also a plan administrator, this further obligation to inform falls to it. Regulations from the Department of Labor indicate an employer-sponsor who is also the administrator has forty-four days to notify the employee. See Roberts v. Nat’l Health Corp., 963 F. Supp. 512, 515 (D.S.C. 1997). But see Hamilton v. Mecca, Inc., 930 F. Supp. 1540, 1553 (S.D. Ga. 1996) (requiring notice within fourteen days).

In Bowerman v. Wal-Mart Stores, Inc., the court held that under relevant provisions of ERISA and COBRA, health benefit plan participants had to be informed of their plan’s requirements through a summary plan description (SPD) that was understandable by the average plan participant and reasonably apprised participants of plan rights and obligations. 226 F.3d 574, 588-89 (7th Cir. 2000) (citing 29 U.S.C. § 1022(a)). In that case, the SPDs were inadequate because they contained inadequate disclosures about the relationship between COBRA coverage, effective dates of rehiring, and susceptibility to preexisting condition limitations that materially misled the employee. Id. Because the employee had reasonably relied on the employer’s misrepresentations and omissions when deciding not to pay her COBRA premium, the company was estopped from denying the employee’s COBRA coverage election. Id. at 586-87. Notably, this case was decided before HIPAA became effective.

See also:

Emilien v. Stull Techs. Corp., No. 02-1422, 2003 WL 21675343, at *5 (3d Cir. July 18, 2003). Employer's notice to employee regarding her right to continued medical coverage under COBRA was inadequate and did not fulfill employer's statutory obligation to give accurate and understandable information on conversion; notice was contained in letter that referred to the term "Qualifying Event" without any explanation of the term and it was highly unlikely that a lay person would understand the meaning of such a term without further explanation.

Underwood v. Fluor Daniel, Inc., 106 F.3d 394 (table), No. 95-3036, 1997 WL 33123, at *4 (4th Cir. Jan. 28, 1997). The defendant was required to notify terminated employee's wife that she was also eligible for COBRA benefits after husband's termination.

Honey v. Dignity Health, 27 F. Supp. 3d 1113 (D. Nev. 2014). An employer's 168-day delay in sending an employee and her qualifying beneficiaries notice of their right to continue health plans was not a good-faith attempt to comply with a reasonable interpretation of COBRA's notice provisions, even absent a showing of prejudice or bad faith that would establish an ERISA violation, because the employee had repeatedly informed the employer of its failure to provide notice.

But see:

Chesnut v. Montgomery, 307 F.3d 698, 702 (8th Cir. 2002). Employer satisfied notice requirements by providing former employee with sufficient oral notice of her right to elect COBRA continuation coverage; there is no authority indicating that the notice required by § 1166 must be in writing.

Degruipe v. Sprint Corp., 279 F.3d 333, 337 (5th Cir. 2002). The law requires only that the employer make a good faith attempt to comply with notification provisions. Good faith can be demonstrated by an attempt to hand deliver a letter to an individual or by first class mail and even if the company later learns that the letter was returned as undeliverable, the company has fulfilled its responsibility.

Chiari v. New York Racing Ass'n Inc., 972 F. Supp. 2d 346, 365-36 (E.D.N.Y. 2013). An employer's duty to provide a terminated employee with COBRA information upon his termination was discharged once it sent a COBRA package to the former employee's sister's address, because that was the employee's address of record. The court found that the employer was not required to track down the former employee to make sure he received the COBRA forms, and the former employee could not state a COBRA claim by merely claiming that he did not receive the letter.

c) More stringent review of decisions by employer-sponsors who are also administrators

Where the employer is both the plan administrator and the sponsor, it also risks being subject to a more stringent review of its decisions, even under the abuse of discretion standard of review. See Winters v. Costco Wholesale Corp., 49 F.3d 550, 553 (9th Cir. 1995). Due to the potential conflict of interest that arises when the employer that pays for the service also has the power to decide whether it is performed, courts may conduct a more searching review to determine if the employer breached its fiduciary obligations under the plan. Id.

4. Employer-sponsor's liability related to managed care plans when it is not the administrator

Although no reported cases have so held, many lawyers and employers continue to be concerned that employers could be held liable for the negligent or wrongful denials of benefits committed by the plan administrators the employers choose. Some cases have held that *HMOs* and *plan administrators* can be liable for the malpractice of doctors in their provider network and for the results of a failure to provide quality benefits. See Rice v. Panchal, 65 F.3d 637, 642, 646 (7th Cir. 1995) (remanding to state court medical malpractice suit against plan administrator of employer's plan because case did not require interpretation of ERISA plan); Crum v. Health Alliance-Midwest, Inc., 47 F. Supp. 2d 1013, 1019-20 (C.D. Ill. 1999) (allowing wrongful death suit against HMO where provider's negligence prevented patient from receiving care); Wigdahl v. Fox Valley Family Physicians S.C. by & through Hazel, No. 18-cv-3513, 2018 WL 4520380, at *3 (N.D. Ill. Sept. 21, 2018) (finding that negligence claims against in-network provider were not preempted by ERISA). But see Tolton v. Am. Biodyne, Inc., 48 F.3d 937, 942 (6th Cir. 1995) (holding state law wrongful death claims against administrator and health provider related to denial of benefits were preempted because they dealt with decision to provide ERISA benefits). When it comes to whether the employer-sponsor should be liable for the negligence of the managed care provider it chose, however, there have been no cases to address the matter.

Commentators suggest, however, that a plaintiff could potentially allege that an employer failed to exercise due care in selecting a managed care provider and therefore would be liable for injuries the plaintiff received in the course of treatment. See EMPLOYEE BENEFITS GUIDE, § 11.11. To best protect itself against any possible liability, employers should be certain to investigate fully any program they choose, including the organization's management, the criteria the organization uses in selecting its staff and facilities and qualifications and licenses of the providers. See id. at § 11.13.

In Pegram v. Herdrich, 530 U.S. 211 (2000), the Supreme Court held that HMOs cannot be sued in federal court under ERISA for a treatment decision. In response to that case, numerous states adopted statutes that subject HMOs to liability to some degree. See Mansfield, et al., supra, at 957. Most states that have passed these statutes, which include Texas, California, Ohio, Missouri and Georgia, require HMOs to meet the standard of ordinary care in treatment decisions they make. See id.

at 968 (comparing state standards). Interestingly, only half of these states included a provision that made the employer-sponsor exempt from suit. See id. Legislatures in Arizona, California, Georgia, Maine, Ohio, Oklahoma and Washington established that employers are not liable for the actions of the plans in which they chose to enroll. See id. These provisions are consistent with the Supreme Court's opinion in Pegram because there the Court held that employers are not liable for selecting plans which include financial incentives because in choosing such a plan they are not acting as a fiduciary, but as a settlor of the plan. See id. at 972. Similarly, choosing a certain HMO would not be the act of a fiduciary.

Even if a plaintiff alleged that an employer was liable for the actions of a managed care plan it chose, the employer may still have protection from state law claims due to ERISA's broad preemption provision. See, e.g., Tolton, 48 F.3d at 942; see also Danca v. Private Health Care Sys., 185 F.3d 1, 5-6 (1st Cir. 1999); Kuhl v. Lincoln Nat'l Health Plan of Kansas City, 999 F.2d 298, 303 (8th Cir. 1993); Hogan v. Jacobson, 823 F.3d 872, 881 (6th Cir. 2016). In cases where the injuries to the plaintiff were the result of an HMO's decision to deny benefits under an ERISA plan, courts have held that ERISA preempts the state law claims. See Kuhl, 999 F.2d at 302-03. Whether the HMO should be liable for its decision to deny benefits "relates to" an ERISA plan and therefore preempts the state law remedies, even if ERISA does not provide remedies that would replace those provided by state law. Tolton, 48 F.3d at 943. Because courts accept that Congress carefully considered ERISA's regulatory scheme and decided to allow only a limited set of remedies, they ordinarily will not permit additional remedies Congress did not establish. Id. (citing Pilot Life, 481 U.S. at 54.).

Similarly, it is likely that courts would extend this holding to preempt state law claims against employers that are based on decisions under an ERISA plan. In those cases, a court would not allow a state wrongful death or negligence claim against an employer where the injury resulted from a decision to deny ERISA benefits because to do otherwise would allow a recovery that ERISA does not provide in a case that "relates to" an ERISA plan. See DiFelice v. Aetna U.S. Healthcare, 346 F.3d 442, 452 (3d Cir. 2003); Tolton, 48 F.3d at 942; Kuhl, 999 F.2d at 303. But see Rice, 65 F.3d at 642, 646 (suggesting state law claims against employer may be allowed where injuries occurred due to malpractice and not denial of benefits).

C. LITIGATION INVOLVING CASH BALANCE CONVERSION

Federal law, including ERISA, the ADEA, and the Internal Revenue Code (IRC), provide certain protections for the employee benefits of participants in private sector pension and health benefit plans. One way these laws affect benefit plans is through the restrictions they place on plan changes, including amendments that convert a traditional pension plan formula to a so-called cash balance plan formula.

For example, a plan amendment cannot reduce benefits that participants have already earned. Advance notification to plan participants is required if, as a result of an amendment, the rate that plan participants may earn benefits in the future is reduced significantly. Additionally, other legal requirements must be satisfied, including

prohibitions against age discrimination. See Fact Sheet: Cash Balance Pension Plans, UNITED STATES DEPARTMENT OF LABOR, EMPLOYEE BENEFITS SECURITY ADMINISTRATION (November 2011), available at <https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/cash-balance-pension-plans>. This section examines the benefits and risks of conversion to cash balance plans and litigation related to the issue.

1. Characteristics of cash balance plans

By way of background, there are three basic types of pension plans employers provide: defined benefit plans, defined contribution plans, and cash balance plans. Before considering the characteristics of cash balance plans, it is important to understand the other types of plans.

a) Traditional forms of benefit plans

A defined benefit plan is a retirement plan that provides a specific benefit at retirement for each eligible employee. Hughes Aircraft Co. v. Jacobson, 525 U.S. 432, 439 (1999) (citing Comm'r v. Keystone Consol. Indus., Inc., 508 U.S. 152, 154 (1993)). Employers usually fund defined benefit plans on an actuarial basis, which ensures that the plan will have adequate funds to pay promised benefits to plan participants when they retire. To determine participants' benefits, the pension plan establishes a formula that often considers years of services and salary. Because a defined benefit plan "consists of a general pool of assets rather than individual dedicated accounts," the employer "typically bears the entire investment risk and . . . must cover any underfunding . . . that may occur from the plan's investments." Eaton v. Onan Corp., 117 F. Supp. 2d 812, 816 (S.D. Ind. 2000) (quoting Hughes Aircraft, 525 U.S. at 439).

Historically, the benefit formulas in defined benefit plans typically were based on a percentage of the participant's salary over the last year or several years before retirement, multiplied by the participant's years of service with the employer. Id. Because this design assumes the typical employee's compensation is highest near the end of that person's career, an employee usually earns the largest share of a retirement benefit near the end of his or her career. Id. Thus, such a plan rewards long-term employment and loyalty. Some pension practitioners refer to this as a "backloaded" accrual of benefits. Id.

A second common form of benefit plan, the defined contribution plan, establishes an individual account for each participant. ERISA defines defined contribution plans as those that "provide-[] for an individual account for each participant and for benefits based solely upon the amount contributed to the participant's account." 29 U.S.C. § 1002(34). The employee may make voluntary contributions to an individual plan account, which can be supplemented by periodic contributions by the employer. Eaton, 117 F. Supp. 2d at 817. The participant's retirement benefit is determined by the balance in the individual account, which will depend on the contributions plus net investment earnings on the contributions. Id. While employees bear the investment risk

because the benefit is not a fixed amount, they may also enjoy higher market-based returns. Because benefits in defined contribution plans are based on contributions and investment earnings over an entire career and not just the last year or last few years of employment, defined contribution plans generally do not have the “backloading” feature found in many defined benefit plans. Id.

b) Definition of cash balance plans

The first cash balance pension plan was established in 1986. See Jerry Geisel, *IRS, Treasury OK Cash Balance Design*, BUSINESS INSURANCE, Dec. 15, 2002, at 22. The IRS has described cash balance plans as follows:

In general terms, a cash balance plan is a defined benefit pension plan that defines benefits for each employee by reference to the amount of the employee’s hypothetical account balance. An employee’s hypothetical account balance is credited with hypothetical allocations and hypothetical earnings determined under a formula selected by the employer and set forth in the plan. These hypothetical allocations and hypothetical earnings are designed to mimic the allocations of actual contributions and actual earnings to an employee’s account that would occur under a defined contribution plan. Cash balance plans often specify that hypothetical earnings [or “interest credits”] are determined using an interest rate or rate of return under a variable outside index (e.g., the annual yield on one-year Treasury securities).

IRS NOTICE 96-8, 1996-1 C.B. 359, 1996 WL 17901 (Feb. 5, 1996).

By legal definition, a cash balance pension plan is a defined benefit plan because the individual accounts cash balance plans establish are merely fictional and do not actually exist. See *Esden v. Bank of Boston*, 229 F.3d 154, 158-59 & n. 6 (2d Cir. 2000). From an economic standpoint, however, a cash balance pension plan resembles a hybrid arrangement where a defined benefit plan functions as a defined contribution plan. See *Eaton*, 117 F. Supp. 2d at 817.

Because cash balance plans provide that an individual’s account will receive interest credits that are outside the control of the employer, the employer bears the risk that the plan’s investment return may fall below the interest credit rate guaranteed by the plan. Id. Similarly, the employer benefits if the plan’s net investment return is above the rate guaranteed by the plan. Id. Because the employer bears the risk with these investments, cash balance plans, like defined benefit plans, are subject to a number of statutory requirements that do not apply to defined contribution plans. Id.

A cash balance plan must comply with the same requirements as defined benefit plans under ERISA. Most of these requirements were written between 1974 and 1984, before cash balance plans were developed and began to be widely adopted. Id. Because the rules for defined benefit plans were not developed to address the features of cash balance plans, litigation has resulted from employers and employees trying to apply ERISA and other laws that regulate defined benefit plans to cash balance plans. See Esden, 229 F.3d at 159; Eaton, 117 F. Supp. 2d at 817-18.

c) Benefits for employers who switch to cash balance plans

Cash balance plans have become increasingly popular among employers in recent years because employers believe that cash balance pension plans are more attractive to younger workers than traditional defined benefit plans that tend to provide the greatest benefits to long-term career employees. Id. at 1818. Cash balance plans provide greater mobility of benefits from one job to another over the course of a career. See Esden, 229 F.3d at 158 n. 5; Lyons v. Georgia-Pacific Corp. Salaried Emps. Ret. Plan, 221 F.3d 1235, 1248 (11th Cir. 2000) (Lyons I) (noting that “one arguable benefit of [cash balance] plans is that they allow younger workers to take a larger benefit with them when changing jobs”); Eaton, 117 F. Supp. 2d at 818. Employers also benefit in that the contributions are actually made to a single fund and they enjoy continued flexibility in funding so long as solvency is maintained. Esden, 229 F.3d at 158 n.5. Moreover, employers may retain any amount of investment income that exceeds the value of the promised benefits. Id.

Employees also benefit from the cash balance plans because they are easier to understand and the benefits accrue more evenly over time. Id. Also, because the benefits are more portable, they are better suited to the modern labor market where there is greater job-mobility than in the past. Id.

d) Drawbacks associated with cash balance plans

Despite these benefits, many older workers have challenged attempts to convert their pension plans to cash balance plans. Eaton, 117 F. Supp. 2d at 818. Most challenges arise because conversion “can affect adversely the expectations of a generation of employees who were too young to derive much benefit from the traditional ‘final average pay’ design, but who are too old to have gotten an early start in their careers on the benefits of a cash balance plan.” Id. Some commentators have observed that through conversions, this generation has received essentially the worst of both worlds. See generally Hope Viner Samborn, *Now You See It, Now You Don’t, Older Workers Watch Pensions Erode as Employers Turn to Cash-Balance Plans*, 85 A.B.A.J. 34 (Nov. 1999) (noting conversions “have spurred groups of older workers to file class action lawsuits alleging age discrimination and other violations of the law” and discussing lawsuits filed by dissatisfied workers).

2. Risks associated with conversion to cash balance plans

a) Conversion to cash balance plans spark age discrimination claims

In Eaton v. Onan Corp., the United States District Court for the Southern District of Indiana rejected the plaintiffs' allegations that because the rate of benefit accrual in the plan declined with an employee's age the design of a cash balance plan was age discriminatory as a matter of law. 117 F. Supp. 2d at 826. Employers who switch from a defined benefit plan to a cash balance plan frequently become targets of lawsuits alleging age discrimination. Younger employees will usually do better than they would have under a defined contribution or benefit plan because the accrual pattern under a cash balance plan will provide them with a larger benefit if they leave their current employer. Older workers with more experience who have been working towards their defined benefit plan usually protest the switch to a cash balance plan because the accrual rate they receive leaves them with less at retirement than the original percentage of their salary they expected to receive as their pension.

When these older workers think the new plan reduces their older plan's earnings they turn to federal law because parallel provisions of ERISA and the ADEA prohibit discrimination under the plan when, "the rate of an employee's benefit accrual is reduced, because of the attainment of any age." 29 U.S.C. § 1054(b)(1)(H)(i); see also 29 U.S.C. § 623(i)(1)(A). Whether a violation of these provisions occurred does not depend upon intent. Eaton, 117 F. Supp. 2d at 823.

Plaintiffs have argued that the rate of benefit accrual must be measured only in terms of an annuity payable at normal retirement age—in effect age 65. Id. In Eaton, the court considered a hypothetical situation in which two employees, one age 25 and the other 45, began employment at the same time with the same pay and their employer credits the same amount to each of their hypothetical cash balance accounts. Id. at 823. If this credit is projected forward using an identical interest rate to when each employee turns 65, the annuity that would be payable to the younger worker obviously would be larger than that paid to the older worker because a given amount of money will be worth more by accruing interest for 40 years than it would be after 20.

If, as the plaintiffs argued, rate of benefit accrual were measured by the value of the annuity paid at retirement age, the employer in the hypothetical situation would violate the law because a younger worker would receive a greater benefit for an equal amount of work. Id. The Eaton court concluded that while ERISA and the ADEA may permit this standard, they do not require it. Id. at 834. Measuring the rate of accrual in terms of the current cash balance of the participant's account is equally, if not more, appropriate, and there is no violation of the law so long as the employees' accounts are credited by amounts that are based on factors other than age. Id.

See:

Campbell v. BankBoston, N.A., 206 F. Supp. 2d 70, 74, 75, 79 (D. Mass. 2002). Where no accrued benefits were reduced by the conversion to a cash balance system and the plaintiff was credited with what he had accrued up to the date of the conversion, there was no intentional age discrimination by the defendant. Moreover, unvested welfare benefits may be altered or terminated at any time. Thus, the conversion violated no federal statute.

Eaton v. Onan Corp., 117 F. Supp. 2d 812, 826 (S.D. Ind. 2000). The plan's cash balance design did not violate the age discrimination provisions of the ADEA or ERISA because the rate of benefit accrual in the defendant's plan did not decline based on changes in an employee's age.

In December 2002, the IRS and the Treasury Department proposed regulations to confirm that cash balance plans that provide a larger annuity to younger workers would not violate anti-discrimination laws. See Geisel, *supra*, at 22. The regulations allowed employers to either convert accrued benefits to an opening cash balance or maintain the old accrued benefit in a separate account and start a new cash balance plan with a zero balance. *Id.* While these regulations sought to fill a regulatory void and reduce the number of age discrimination suits brought against employers, legislation in Congress slowed the adoption of these regulations. See Jerry Geisel, *Bill Would Block Treasury Rules on Cash Balance*, BUSINESS INSURANCE, Sept. 14, 2003, at 1.

In 2006, the Seventh Circuit became the first Circuit Court to address the legality of a cash-balance plan under ERISA's anti-discrimination provision for defined benefit plans, § 1054(b)(1)(H)(i). See *Cooper v. IBM Pers. Pension Plan*, 457 F.3d 636, 638 (7th Cir. 2006). The court compared § 1054(b)(1)(H)(i) with § 1054(b)(2)(A), the anti-discrimination provision that applies to defined contribution plans. It concluded that both sections were identical except that the former was prohibitive while the latter was permissive. *Id.* Accordingly, an employer was prohibited from denying "allocations" to an employee's account as well as changing the rate at which benefits accrued because of the employee's age. *Id.* The court held that "benefit accrual" in § 1054(b)(1)(H)(i) was not synonymous with "accrued benefit." *Id.* at 639. Rather, the term "benefit accrual," like "allocations" in the rule applicable to defined contribution plans, referred to an employer's inputs while "'accrued benefits' refers to outputs after compounding." *Id.* Because every employee under the IBM plan received the same 5% pay credit and the same interest credit per year, the court held that the plan did not discriminate against older employees. *Id.* at 640.

Further, the court found support for its holding in the proposed Treasury regulations, which treated the rate of "benefit accrual" as the contributions to a beneficiary's hypothetical account for the year rather than the output from the plan at normal retirement age. *Id.* at 639. The court rejected the plaintiffs' argument that a cash balance plan was discriminatory because a younger worker would have a greater opportunity to earn interest than an older worker. *Id.* In the court's view, "[t]reating the time value of money as a form of age discrimination is not sensible." *Id.*; see also *Drutis*

v. Rand McNally & Co., 499 F.3d 608, 615 (6th Cir. 2007) (adopting Cooper's reasoning to hold that "benefit accrual" as used in § 1054(b)(1)(H)(i) refers to an employer's inputs to the defined benefit plan); George v. Duke Energy Ret. Cash Balance Plan, 560 F. Supp. 2d 444, 454-459 (D.S.C. 2008) (relying on Cooper and Drutis to grant the defendant's motion for judgment on the pleadings concerning plaintiffs' ERISA age discrimination claim); Sunder v. U.S. Bank Pension Plan, No. 4:05CV01153, 2007 WL 541595, at *8-10 (E.D. Mo. Feb 16, 2007) (relying on Cooper to conclude that cash balance plans do not violate ERISA's prohibition on age discrimination).

In Register v. PNC Financial Service Group, Inc., the Third Circuit followed Cooper's lead and said that cash balance plans do not violate ERISA's anti age-discrimination provision for three reasons. 477 F.3d 56, 70 (3rd Cir. 2007). First, the court stated that "benefit accrual" must relate to an individual's hypothetical account balance rather than an age-65 annuity payable at normal retirement age. Id. at 68. A contrary reading would simply overlook the difference between a cash balance plan from a traditional defined benefit plan. Id. Second, the court adopted Cooper's rationale, and read § 1054(b)(1)(H)(i) and § 1054(b)(2)(A) *in pari materia* to conclude that the provisions are nearly the same and proscribe the same sort of conduct. Id. Because the defendant's plan did not reduce the rate of "allocations" under § 1054(b)(2)(A) due to age, it did not reduce the rate of "benefit accrual" due to age either. Id. at 69. The court rejected the appellants' argument that § 1054(b)(1)(H)(i) and § 1054(b)(2)(A) should be read differently, and noted that applying a different test for discrimination to each would lead to an absurd result. Id. Third, the court agreed with the Seventh Circuit's decision in Cooper that "benefit accrual" referred to an employer's input into the hypothetical account rather than to the compounded output after normal retirement age. Id. Thus, the employer's plan satisfied the requirements of § 1054(b)(1)(H)(i) because contributions in the shape of either earnings or interest credits were not reduced due to an employee's age. Id. at 70.

In 2008, the Second Circuit also held that cash balance plans do not violate § 1054(b)(1)(H)(i). See Hirt v. Equitable Ret. Plan for Emps., Managers & Agents, 533 F.3d 102, 110 (2d Cir. 2008). The court overruled the district court's rulings, which equated the term "accrued benefit" with "benefit accrual," citing § 204(b)(1)(G), in which Congress outlawed reductions in a beneficiary's "accrued benefit" due to age. Id. at 108. The Second Circuit observed that Congress knew how to use the term "accrued benefit" as it had done so in § 204-(b)(1)(G), but intentionally left out the same term in § 1054(b)(1)(H)(i). Id. Thus, the rate of "benefit accrual" could not be interpreted as the age-65 annuity that can be purchased with the account balance. Id. The court also relied on § 1054(b)(1)(H)'s legislative history to conclude that the rate of "benefit accrual" referred to an employer's contributions rather than the total benefit to be gained at retirement age. Id. at 109. In enacting § 1054(b)(1)(H), Congress chose to prohibit plans from reducing an employee's benefits after the normal retirement age of 65. Id. Thus, because § 1054(b)(1)(H) prohibited reductions after normal retirement age, "it makes little sense to look to the accrued benefit – i.e., the annual benefit commencing at normal retirement age – as a reference point in evaluating whether there has been a reduction in the rate of benefit of accrual." Id.; see also Tomlinson v. El Paso Corp., 653 F.3d 1281, 1287-88 (10th Cir. 2011) (agreeing with the Second, Sixth and Seventh

Circuits that cash balance plans do not violate § 1054(b)(1)(H)'s prohibition on age discrimination); Hurlic v. S. Cal. Gas Co., 539 F.3d 1024, 1028-29 (9th Cir. 2008) (agreeing with Second, Third, Sixth and Seventh Circuits that cash balance plans do not violate § 1054(b)(1)(H)'s prohibition on age-discrimination).

b) Wearaway issue (no accrual)

Wearaway occurs when a defined benefit plan based on final average salary is converted to a cash balance plan, and, at the time of conversion, the initial value of a participant's cash balance account is less than the value of benefits accrued under the previous plan. Kenneth R. Elliott & James H. Moore, Jr., *Cash Balance Pension Plans: The New Wave*, COMPENSATION AND WORKING CONDITIONS, Summer 2000, at 7. Until pay and interest credits under the new plan bring their cash account balance up to the value previously earned under the old plan, some workers will have a period during which they do not accrue additional benefits. Id. Employers are obligated to notify plan participants of amendments that will result in a significant reduction in the rate of future benefit accruals. Id. Although many participants argue that the wearaway period during a conversion should be explained, and the lost potential benefits should be rewarded to each worker, employers are not required to provide individual notices for each plan participant. Id.

See:

Jensen v. Solvay Chems., Inc., 625 F.3d 641, 655-57 (10th Cir. 2010). *An employer provided adequate notice of wearaway period by giving employees a table containing 14 examples of changes in monthly benefits.*

Congress amended ERISA in 2002 to provide that a plan may not be amended to provide for a significant reduction in the rate of future benefit accrual unless the plan administrator provides a notice that is "written in a manner calculated to be understood by the average plan participant and shall provide sufficient information . . . to allow applicable individuals to understand the effect of the plan amendment." 29 U.S.C. § 1054(h)(2).

Plaintiffs have also argued that "wearaway" followed by a continuation of benefits once the cash balance account surpasses the frozen pre-conversion formula benefits violates ERISA's anti-backloading provisions. Section 1054(b)(1)(B) is one of several anti-backloading provisions that disallows a plan from increasing the rate at which benefits accrue in a given year by more than 133 1/3% of the benefit accrued in any previous year. 29 U.S.C. § 1054(b)(1)(B). Congress designed the anti-backloading provisions to protect short-term workers from plans that concentrate the allocation of benefits in the later years of an employee's service. Hurlic, 539 F.3d at 1033. In Hurlic, the plaintiffs asserted that, because benefits do not accrue at all during the "wearaway" period, the benefits that resume once the cash balance account exceeds the frozen pre-conversion formula benefits violate the 133 1/3% rule. Id. The Ninth Circuit opined that, under § 1054(b)(1)(B)(i), a plan amendment is treated as in effect for all previous years. Id. at 1035. Thus, only the new cash balance plan is relevant to determining whether

the defendants violated the anti-backloading provisions. Id. The plaintiffs' pre-conversion formula benefits are deemed as if they never existed. Id. The court also observed that problems associated with the conversion to cash balance plans are not pertinent to the objectives of the anti-backloading requirements, which are designed to protect short-term and/or younger employees. Id.; accord Tomlinson, 653 F.3d at 1290-91; Register, 477 F.3d at 70-72; George, 560 F. Supp. 2d at 470-72; Wheeler v. Pension Value Plan for Emps. of Boeing Co., No. 06-cv-500, 2007 WL 2608875, at *16 (S.D. Ill. Sept. 6, 2007); Richards v. FleetBoston Fin. Corp., No. 04-cv-1638, 2006 WL 2092086, at *3 (D. Conn. July 24, 2006).

c) Lump-sum whipsaw payment problems

Numerous ERISA and IRC provisions and regulations place requirements on defined benefit plans but do not apply to defined contribution plans. Under ERISA, "accrued benefit" for defined benefit plans refers to the benefit determined under the plan and expressed in the form of an annual benefit commencing at normal retirement age, while for defined contribution plans, accrued benefit refers only to "the balance of the individual's account." 29 U.S.C. § 1002(23). Second, only defined benefit plans are subject to ERISA and IRC provisions which limit backloading and establish valuation rules. See Esden, 229 F.3d at 159. Moreover, these rules envision that distributions from a defined benefit plan be in the form of a single-life annuity payable at retirement age. Id. Any optional form distribution may be no less than the actuarial equivalent of the annuity. Id.

In 1984, Congress added § 203(e), 29 U.S.C. § 1053(e), to ERISA and the essentially identical § 417(e), 26 U.S.C. § 417(e), to the IRC. Lyons I, 221 F.3d at 1242. These new provisions made the rate of the Pension Benefit Guaranty Corporation ("PBGC") the maximum rate an employer could use to discount a normal retirement benefit to present value. Id. Treasury Department regulations that interpret both the IRC and ERISA provisions require that, in distributing optional forms of an accrued benefit, the present value of any optional form of benefit cannot be less than the present value of the normal retirement benefit. See id. at 1244 (citing Treas. Reg. §§ 1.411(a) - 11(d), 1.417(e) - 1(d)). By establishing the maximum discount rate by statute, Congress is able to protect employee benefits, because, mathematically, the higher the rate used to discount a benefit to present value, the lower the present value of the benefit. See Esden, 229 F.3d at 164. If employers could chose a higher rate than the one Congress imposed, the present value of the employee's accrued benefit would be lower. Id. The regulations under § 417 impose interest rate and mortality assumptions that employers must use when they convert the normal retirement benefit—i.e. a single-life annuity—to a lump-sum payment option. See id. at 165; see also Elayne Robertson Demby, *Cash Balance Whipsaw*, PLANSPONSOR, May 1, 1999, available at www.plansponsor.com.

The unsettled question was whether cash balance plans, which are technically and legally defined benefit plans but function like defined contribution plans, should be subject to these regulations on defined benefit plans. In 1996, the IRS issued IRS Notice 96-8 which stated, "that, when calculating a lump-sum distribution, a cash

balance plan must project the current balance of the hypothetical account forward to normal retirement age and then discount that benefit to present value and pay out the present value amount. See Esden, 229 F.3d at 165. The Notice required that the benefit be discounted to present value using the rules in Treasury Regulations §§ 1.411(a)-11(d) and 1.417(e)-1(d)(1). Id. If the plan credit interest rate (used to project the account to normal retirement age) exceeded the applicable rate under the regulations (used to discount the benefit back to present value), the result will be a lump-sum whose value is greater than the employee's cash balance account balance. Id.

The Notice stated that if a plan paid out only the current value of the account balance, it must have committed either one of two different violations. Id. at 166. On one hand, the plan would have violated § 417(e) and ERISA § 205(g) because paying out only the current value of the account balance means the plan used a discount rate equal to the plan's credit rate and in excess of the applicable discount rate § 417(e) required. Id. Alternatively, it would have violated § 411(a)(2) and ERISA § 203(a)(2) because paying out only the current value of the account balance means the plan projected the current balance forward at a rate less than the plan's credit rate and worked a forfeiture under the plan's terms. Id. Cash balance plan proponents commonly refer to these IRS standards as the "whipsaw" calculation and argue that they unfairly require employers to provide employees with an unwarranted windfall.

d) Litigation related to the whipsaw issue

Several cases have illustrated the potential pitfalls facing employers in the area of conversion to cash balance plans due to the whipsaw issue. In Lyons v. Georgia-Pacific Corp. Salaried Employees Retirement Plan, 221 F.3d 1235, 1252 (11th Cir. 2000) (Lyons I), the Eleventh Circuit held that benefits under a cash balance plan must be determined by projecting the account balance to age 65 and then discounting back to the employee's actual age to determine the amount of the employee's lump sum distribution. In doing so, the court ruled that employers must comply with the position of the IRS as stated in Notice 96-8. Id. at 1245.

In Lyons I, an employee elected to receive a lump sum payout under the cash balance plan. Id. at 1239. The employer paid the nominal current value of the employee's personal account. In his suit against the employer, the plaintiff alleged that under the Treasury regulations, the employer should have determined the value of the annuity the plaintiff would have received at age 65 and discounted that amount to its present value using the PBGC rate. Id. Under this approach, the plaintiff personally would have received approximately \$13,000 more but the class as a whole stood to gain \$20 million in benefits. Id. at 1239 & n. 7.

The interest rate used to credit the employee's account was greater than the PBGC's discount rate. Id. at 1241. Accordingly, if the employer projected the account's value out to age 65 with the interest credit rate and then discounted to present value with the PBGC rate, there would be more in the account than when the calculations began. Id. Had the plan's interest credit rate been pegged to the PBGC

rate, there would have been no dispute in Lyons I because the same rate used to project the value at age 65 would have been the same rate used to reduce the benefit to present value and that amount would equal the value of the payment the employer made. Id. There was no dispute that the employer failed to comply with the regulations, so it argued that the regulations were invalid. Id. at 1244.

The Eleventh Circuit held that the regulations were valid and could be applied in cases such as Lyons I, where the distribution was consensual. Id. at 1249. At best, ERISA § 203(e) was ambiguous on the issue, and there was no reason to not defer to the agency's interpretation that was not contrary to Congress' will. Id. at 1246. Thus, under the Regulations, the employer was obligated to discount to present value using the PBGC rate. Because the interest credit rate exceeded the PBGC rate, merely paying the hypothetical balance was not enough because that amount was less than the present value of the normal retirement benefit. Id. at 1252.

The Retirement Act of 1994 substantially altered the language of ERISA § 203(e), however. On remand from the Lyons I decision, the Northern District of Georgia found that, as a result of the amendment, the statute's language was no longer ambiguous and could not support the Treasury's interpretation. Lyons v. Georgia-Pacific Corp. Salaried Emps. Ret. Plan, 196 F. Supp. 2d 1260, 1272-73 (N.D. Ga. 2002) (Lyons II). Therefore, for employees who receive their lump sum distribution payment after 1994, the Treasury Regulations that restrict the defined benefit plan's ability to distribute a portion of the participant's accrued benefit without complying with specified valuation rules did not apply because they improperly expanded ERISA's scope. Id. at 1273. In that case, the employee will not receive the more favorable lump sum calculation under ERISA § 203(e). 29 U.S.C. § 1053(e); 26 C.F.R. § 1.411(a)-11; Lyons II, 196 F. Supp. 2d at 1273.

In Esden v. Bank of Boston, the United States Court of Appeals for the Second Circuit also considered a cash balance plan that was somewhat different from Lyons I. In Esden, the court held that the Bank of Boston's cash balance plan violated ERISA and the IRC by failing to use IRS rules to calculate a participant's lump sum distribution. 229 F.3d at 157. The Second Circuit determined that a plan may not project a balance using a rate lower than the rate guaranteed by the employer's plan. Id. at 167-68.

In Esden, the employer's cash balance plan guaranteed a minimum return of 5.5% and a maximum return of 10%. Id. at 160-61. Applying the Treasury regulations, her minimum accrued benefit discounted to present value was at least \$61.54 more than what her employer actually paid her. Id. The plaintiffs alleged that the employer worked an illegal forfeiture under ERISA § 203(e) by using a rate of 4% to project the value of the benefit at normal retirement age, rather than the Plan's minimum rate of 5.5%. Id. Other members of the plaintiff's class had similar allegations. Esden sued under ERISA § 502(a)(1)(B) and (a)(3) to recover the benefits and for injunctive relief and attorney's fees under 502(g). Id. at 162 & n. 11.

The Second Circuit noted that ERISA and IRC provisions and regulations stated that the present value of any optional benefit—i.e., a lump sum—must be actuarially equivalent and cannot be less than the the normal retirement benefit's present value. Id. at 165 (citing Treas. Reg. § 1.417(e)-1(d)(1) as in effect in 1991). Next, the court accepted the IRS interpretation in Notice 96-8 that required the benefit's value to be projected to normal retirement age and then discounted to present value as § 417(e) requires. Id. While acknowledging the whipsaw problem, the Notice provides two additional requirements for plans whose interest credit rates are tied to a variable outside index. Id. at 166. First, a plan must prescribe a method to determine which rates will be used to project the benefit to normal retirement age and this method cannot allow an employer discretion to determine this rate. Id. The plan in Esden complied with this rule. Second, however, the Notice states that a forfeiture occurs if the projection results in a value below that promised by the plan. Id. at 167. The plan failed this portion of the Notice because it projected the benefit using a rate 1.5% below the promised rate and thus worked a forfeiture. The court also rejected the employer's argument that the regulations were invalid and unreasonable. Id. at 168.

Lyons I and Esden suggest two rules. First, an employer who provides a cash balance plan must project the value of the normal retirement benefit using a projection rate that is at least equal to the plan's interest credit rate. See Esden, 229 F.3d at 167. Second, at least for employees who received benefits before 1994, the applicable discount rate used to determine the present value of that normal retirement benefit must be no greater than the prescribed PBGC rate. See Lyons I, 221 F.3d at 1252. If an employer uses a credit rate that is greater than the PBGC rate, an employee is likely to enjoy a windfall because the present value of the payout will be greater than the balance of the cash account. Employers can avoid this windfall, however if their plans' credit rate equals the PBGC rate. See Lyons I, 221 F.3d at 1241.

Some courts have directly addressed the issue of lump sum disbursements following employees' early termination of their interests in ERISA plans. In Berger v. Xerox Corp. Retirement Income Guarantee Plan, the court held that the employer's method of determining lump sum distributions made to participants prior to normal retirement age violated ERISA, which "requires that any lump-sum substitute for an accrued pension benefit be the actuarial equivalent of that benefit." 338 F.3d 755, 759 (7th Cir. 2003). To determine the lump sum to which an employee is entitled under ERISA, "the plan must add the [future interest] credits to the employee's cash balance account. . . discounted at the prescribed discount rate back to the date on which the employee left Xerox's employ." Id. at 760. However, the plan's own description specified a lump-sum entitlement that was not the prescribed actuarial equivalent of the pension benefit that employees would be entitled to at normal retirement age. Id. As such, the plan conditioned the employee's right to future interest credits on the form of the distribution that he elected to take – his pension at age 65 rather than a lump sum at the time of early termination – which was precisely what the law forbids. Id. at 763.

In another case in the Sixth Circuit, an employer argued that under Treas. Reg. §1.411(a)-7(a)(1)(ii), it was entitled to use the statutory rate to project forward the age-65 annuity as well as to discount the annuity back to present value. West v. AK

Steel Corp., 484 F.3d 395, 409 (6th Cir. 2007). There, AK Steel posited that Treas. Reg. §1.411(a)-7(a)(1)(i), which defined an “accrued benefit” as an annual distribution that started at “normal retirement age,” was inapplicable because the plan itself defined an “accrued benefit” as an annual distribution equal to the “accrued benefit” under the plan. Id. The Sixth Circuit rejected that argument because § 1.2 of the plan referred to an “accrued benefit” as a single life annuity that started at “normal retirement age.” Id. The Court read other provisions of the plan that conflicted with § 1.2 against AK Steel, and rejected AK Steel’s position that the plaintiffs were only entitled to the value of their hypothetical accounts. Id. Further, the court noted that the plan’s terms violated ERISA because AK Steel did not take the plaintiffs’ future interest credits into account to calculate the actual amount of the lump-sum payment. Id. In short, the Sixth Circuit affirmed the district court’s ruling as well as its reasoning regarding the whipsaw calculation. Id. at 412.

In addition, AK Steel argued that the plaintiffs should not be entitled to money damages because any award would be a “distribution” under the Pension Protection Act of 2006 (“PPA”). Id. at 411. The PPA amended ERISA § 203 to validate any plan that distributes a lump sum payment equal to the balance of an individual’s hypothetical account. PPA § 701(a)(2). Under PPA § 701(e)(2), the amendments to ERISA apply to any “distributions” made after the date of the statute’s enactment. PPA § 701(e)(2). The PPA, however, only “appl[ies] to periods beginning on or after June 29, 2005.” PPA § 701(e)(1). Accordingly, AK Steel argued that any money damages paid to the plaintiffs after the PPA went into effect would constitute as an impermissible “distribution” under the PPA. West, 484 F.3d at 411. The Sixth Circuit stated that § 701(d)(2) of the PPA in conjunction with the legislative history of the Act indicated that there would be no retroactive application of the amendments. Id. at 412. The plaintiffs, who had been deprived of the whipsaw calculation, received their lump sum benefits before the PPA went into effect. Id. Therefore, the PPA posed no bar to claims for monetary relief for prior harms. Id.

In Sunder v. U.S. Bank Pension Plan, the defendants calculated the plan participants’ lump sum distributions upon conversion to a cash balance plan using a variety of factors such as a mortality rate, a discount rate and retirement subsidies. No. 4:05CV01153, 2007 WL 2811078, at *5-7 (E.D. Mo. Sept. 24, 2007). A lump sum amount of the “accrued benefits” under the old plan was discounted to present value at an 8% rate as opposed to the 30-year Treasury rate, which was 6.07% at the time. Id. at *8. The district court ruled that by using the 8% rate, the defendants did not protect the value of the plaintiffs’ “accrued benefits” because § 417(c)(3) provided that an “accrued benefit” must be the “actuarial equivalent” of benefits that start at “normal retirement age.” Id. Thus, the plaintiffs had a right to a higher opening balance of their “accrued benefits” that would have resulted from applying the lower Treasury rate. Id. However, on appeal, the Eighth Circuit reversed. Sunder v. U.S. Bancorp Pension Plan, 586 F.3d 593, 600-01 (8th Cir. 2009). The Eighth Circuit held that the plan did not err in calculating the opening cash balances using the 8% discount rate because using that rate did not decrease any benefits that had already accrued. Id. at 600. Because the plan’s method for calculating the opening balance did not reduce any accrued benefit, the Eighth Circuit ruled that plaintiffs were not entitled to any damages. Id. at 603.

See also:

George v. Duke Energy Ret. Cash Balance Plan, 560 F. Supp. 2d 444, 466-467 (D.S.C. 2008). *Plaintiffs stated sufficient facts to withstand a motion for judgment on the pleadings because factual and expert testimony was required to determine the precise terms of the plan. Plaintiffs alleged that, under the plan, they were entitled to a whipsaw calculation that employed a discount rate equal to the lesser of 4% or the statutory rate prescribed by the treasury.*

Laurent v. PriceWaterhouseCoopers LLP, 448 F. Supp. 2d 537, 547-551 (S.D.N.Y. 2006). *The plan must project the cash balance forward to normal retirement age even if a plan is not required by ERISA to set a minimum threshold for how interest is credited to the beneficiaries' hypothetical accounts. ERISA does not require that benefits under a cash balance plan project the value of account balances beyond normal retirement age if the employee has terminated his employment before he reaches normal retirement age.*

Parry v. SBC Commc'ns, Inc., 375 F. Supp. 2d 31, 49-51 (D. Conn. 2005). *Defendants' handout of a lump sum amount that was based upon a whipsaw calculation complied with ERISA even though it was less than an "enhanced annuity benefit" under other provisions of the plan.*

Courts have also differed on what constitutes "normal retirement age" for purposes of the whipsaw calculation. In *Fry v. Exelon Corporate Cash Balance Pension Plan*, the Seventh Circuit noted that "ERISA does not require the 'normal retirement age' to be the same for every employee." 571 F.3d 644, 647-48 (7th Cir. 2009). But, the court explained, the employer's discretion to set a normal retirement age was confined by ERISA's language. *Id.* The court held that the plan's definition of "normal retirement age" as the participant's age when beginning work plus five years was valid under ERISA. *Id.* Similarly, in *McCorkle v. Bank of America Corp.*, the Fourth Circuit found that "normal retirement age" can be defined by a plan by reference to a participant's years of service. 688 F.3d 164, 171 (4th Cir. 2012).

In *Laurent v. PriceWaterhouseCoopers LLP*, however, the Second Circuit rejected the Seventh Circuit's reasoning in *Fry* and the Fourth Circuit's reasoning in *McCorkle*. 794 F.3d 272, 284-85 & n. 17 (2d Cir. 2015) The court in *Laurent* held that a plan that defined "normal retirement age" by reference to an employee's age after five years of service was invalid under ERISA, because five years of service is not an "age." *Id.* at 285.

D. ERISA ISSUES RELATED TO EMPLOYER STOCK

In recent years, there has been significant ERISA litigation related to plan investments in, or plan decisions to allow participants to invest in, employer stock. Often plaintiffs will argue that the plan's fiduciaries breached their duties under ERISA

by continuing to either invest in, or offer as an investment option, the employers' stock because they claim that the stock was an imprudent investment. This section provides a background on Employee Stock Ownership Plans ("ESOPs"), discusses trends in ERISA litigation related to employer stock, and also the issue of "adequate consideration" with respect to employer stock under 29 U.S.C. § 1106. See also Chapter XX, infra.

1. Background on ESOPs and investments in employer stock

To promote employee ownership of companies, Congress adopted the ESOP provisions of ERISA. E.g., 29 U.S.C. § 1107; Kuper v. Iovenko, 66 F.3d 1447, 1458 (6th Cir. 1995) ("In drafting the ESOP provisions of ERISA, Congress intended to encourage employees' ownership of their employer company."), abrogated on other grounds by Dudenhoeffer, 573 U.S. 409 (2014). An ESOP has been defined as "a plan that primarily invests in the shares of stock of the employer that creates the plan." Chao v. Hall Holding Co., 285 F.3d 415, 425 (6th Cir. 2002) (citing Kuper, 66 F.3d at 1457), cert. denied, 537 U.S. 1168 (2003).

ESOP fiduciaries are generally "subject to the same fiduciary standards as any other [ERISA] fiduciary except to the extent that the standards require diversification of investments." Eaves v. Penn., 587 F.2d 453, 460 (10th Cir. 1978). In describing these duties, some courts have stated that ERISA fiduciaries "must act for the exclusive benefit of plan beneficiaries" and that those duties in performing plan functions are "the highest known to the law." E.g., Howard v. Shay, 100 F.3d 1484, 1488 (9th Cir. 1996) (quoting Donovan v. Bierwirth, 680 F.2d 263, 272 n.8 (2d Cir. 1982)). Another court noted that the "fiduciary standard applicable to ESOP trustees, set out in ERISA § 404, is indisputably rigorous." Horn v. McQueen, 215 F. Supp. 2d 867, 874 (W.D. Ky. 2002). In particular, when deciding whether to invest plan assets in employer securities, ESOP fiduciaries "are governed by the 'solely in the interest' and 'prudence' tests of §§ 404(a)(1)(A) and (B)." Eaves, 587 F.2d at 459.

2. Litigation related to employer stock

In recent years, so-called "stock drop" suits have been the most common form of ERISA litigation involving employer stock. These suits are brought by participants in plans, most commonly a 401(k) or ESOP, that are authorized to invest in employer securities. In a typical case, plan participants who held the employer's stock file suit after a decrease in the stock's trading price, i.e., a "stock drop." They allege that the fiduciaries breached their fiduciary duties by allowing participants to continue to invest in the employers' stock when it was not proper to do so.

ERISA generally places upon plan fiduciaries the duty to diversify investments "so as to minimize the risk of large losses." 29 U.S.C. § 1104(a)(1)(C). Because large losses are easier to avoid if the investments of the plan are diversified, prudence would normally dictate that a fiduciary diversify the assets of the plan. Craig C. Martin, Matthew J. Renaud, & Omar R. Akbar, What's Up On Stock Drops? Moench Revisited, 39 J. Marshall L. Rev. 605, 609 (2006). However, fiduciaries of plans that are

authorized to invest in employer securities — called “Eligible Individual Account Plans” (“EIAPs”) — are exempted from this duty insofar as it relates to investments in employer stock. 29 U.S.C. § 1104(a)(2); Fifth Third Bancorp v. Dudenhoeffer, 573 U.S. 409, 419 (2014). They are also exempted from ERISA’s bar on investing more than ten percent of plan assets in employer stock. 29 U.S.C. § 1107(b)(1).

EIAP fiduciaries are not, however, exempted from other duties ERISA may impose on them: the duty of loyalty, ERISA § 404(a)(1)(A), the duty of prudence, ERISA § 404(a)(1)(B), and the duty to act in accordance with the plan’s governing documents, ERISA § 404(a)(1)(D). The duty of prudence, in particular, may place EIAP fiduciaries in a difficult position when the price of employer stock drops, because despite the policy established in favor of investments in employer stock and plan documents which provide for such investments, they may need to decide whether it would be imprudent to continue investing in employer stock.

This section discusses how courts have dealt with the claims made in stock drop suits, which often allege breaches of all duties incumbent upon fiduciaries.

a) Duty of loyalty

ERISA § 404(a)(1)(A) obligates fiduciaries to act “for the exclusive purpose of (1) providing benefits to participants and their beneficiaries” This duty thus encompasses situations where conflicts of interest or self-dealing arise. See Craig C. Martin et al., supra, at 608. The potential for disloyal self-dealing is “inherently great” in situations where investments are undiversified. Martin v. Feilen, 965 F.2d 660, 670-71 (8th Cir. 1992). Typical indicators of a breach of the duty of loyalty include that high-ranking company officials sold company stock while the plan purchased shares or that the plan was being used to prop up the stock price in the market. DiFelice v. U.S. Airways, Inc., 497 F.3d 410, 422 (4th Cir. 2007) (DiFelice II).

It is not necessarily a breach of the duty of loyalty, however, for a fiduciary to have financial interests adverse to plan beneficiaries. DiFelice II, 497 F.3d at 421. There is also no *per se* breach if an “officer, employee, agent or other representative” of the plan sponsor also serves as a plan fiduciary, even if that fiduciary purchases company securities on behalf of that plan. Id. Plaintiffs also need to allege more than the fact that an ERISA fiduciary’s compensation was linked to the company’s stock to make a claim for conflict of interest that violates the duty of loyalty. In re Citigroup ERISA Litig., 662 F.3d 128, 146 (2d Cir. 2011). ERISA does not prohibit a fiduciary from acting solely in his own interests when he is not acting in a fiduciary capacity. Friend v. Sanwa Bank Cal., 35 F.3d 466, 469 (9th Cir. 1994). It is not enough to state a claim for a breach of the duty of loyalty to “simply recast purported breaches of the duty of prudence as disloyal acts.” Sacerdote v. New York Univ., No. 16-cv-6284 (KBF), 2017 WL 3701482, at *14 (S.D.N.Y. Aug. 25, 2017).

In stock drop litigation, the duty of loyalty is primarily implicated by fiduciaries’ obligations to investigate and to communicate truthfully with plan participants, which are discussed below in detail.

b) Duty of prudence

Section 404(a)(1)(B) obligates fiduciaries to act “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” This general standard of prudence applies to all ERISA fiduciaries, including those responsible for plans that hold employer stock. Dudenhoeffer, 573 U.S. at 418-19. Whether a fiduciary acted prudently is judged not in comparison to the actions a layperson would take, but the actions of a person “familiar” with ERISA matters. Katsaros v. Cody, 744 F.2d 270, 279 (2d Cir. 1984). Prudence generally focuses on the process that a fiduciary undertakes in reaching a decision, rather than results or the performance of the investment. See In re Unisys Sav. Plan Litig., 74 F.3d 420, 434 (3d Cir. 1996); DiFelice v. Fiduciary Counselors, Inc. (DiFelice I), 398 F. Supp. 2d 453, 467 (E.D. Va. 2005) (“[T]he general fiduciary obligation of § 404(a) does not require prescience of fiduciaries, but instead measures a fiduciary’s performance based on the facts then at their disposal.”).

Historically, some courts held that ERISA fiduciaries should not be liable for offering employer stock to plan participants when the plan document required them to do so. However, in Dudenhoeffer, the Supreme Court held that ERISA’s duty of prudence does not “var[y] depending upon the specific nonpecuniary goal set out in an ERISA plan.” Dudenhoeffer, 573 U.S. at 420-21. To the contrary, plan fiduciaries should follow plan documents only to the extent they are consistent with the duties of prudence and loyalty in ERISA. *Id.*

i. **Some courts reject duty of prudence claims under ERISA § 404(a)(2) when the claims are no more than “failure to diversify” claims**

As a general matter, ERISA imposes a duty on the fiduciaries of most plans to “diversify[] the investments of the plan so as to minimize the risk of large losses.” 29 U.S.C. § 1104(a)(1)(C). For EIAPs, however, which include 401(k) plans and ESOPs, ERISA states at § 404(a)(2) that the duty to diversify and the duty of prudence (to the extent that it requires diversification) are not violated by the acquisition or holding of qualifying employer stock. 29 U.S.C. § 1104(a)(2). In Fifth Third Bancorp v. Dudenhoeffer, the Supreme Court confirmed that “ESOP fiduciaries . . . need not diversify the fund’s assets.”

A limited number of courts have also rejected duty of prudence claims by determining that, despite the label plaintiffs attach to their claim, they really seek to hold the defendants liable for failing to diversify the plan’s holdings away from employer stock. Based on ERISA’s terms in § 404(a)(2), those courts held that plaintiffs cannot state a claim for breach of the duty of prudence by alleging that the defendants failed to diversify an EIAP by reducing its holdings of employer stock. See, e.g., Lanfear v. Home Depot Inc., 718 F. Supp. 2d 1364, 1378-79 (N.D. Ga. 2010) (granting motion to dismiss); In re Beazer Homes USA, Inc. ERISA Litig., No. 1:07-cv-0952, 2010 WL 1416150, at *6-7 (N.D. Ga. Apr. 2, 2010); Pedraza v. Coca-Cola Co., 456 F. Supp. 2d

1262, 1270 (N.D. Ga. 2006). For example, in Lanfear, the plaintiffs did not directly allege a failure to diversify, but the court determined the core of their claim was that the defendants violated ERISA by failing to take any meaningful steps to prevent losses as a result of the plan's investment in employer stock by eliminating the employer stock fund as an option. 718 F. Supp. 2d at 1378. The court concluded that "in other words, [plaintiffs claimed] that Defendants should have diversified the Plan's investments," a claim that § 404(a)(2) mandated must be dismissed. Id. These cases appear to have been abrogated. When the plaintiffs appealed the district court's decision in Lanfear, the Eleventh Circuit rejected the district court's holding under § 404(a)(2). Lanfear v. Home Depot, Inc., 679 F.3d 1267, 1276-77 (11th Cir. 2012). It held that plaintiffs' claims that the employer stock was overpriced and not a prudent investment were distinct from a claim that the fiduciaries failed to diversify the plan. Id. Accordingly, the claim did not fall within the exemption under § 404(a)(2). Id. at 1277.

ii. No presumption of prudence by fiduciaries of EIAPs with respect to investments in company stock

Before 2014, numerous courts applied a rebuttable presumption of prudence to an EIAP fiduciary's decision to invest in employer stock. See, e.g., In re Citigroup ERISA Litig., 662 F.3d 128, 138 (2d Cir. 2011); Quan v. Computer Scis. Corp., 623 F.3d 870, 881 (9th Cir. 2010); Kirschbaum v. Reliant Energy, Inc., 526 F.3d 243, 254 (5th Cir. 2008); Kuper v. Iovenko, 66 F.3d 1447, 1459 (6th Cir. 1995); Moench v. Robertson, 62 F.3d 553, 571 (3d Cir. 1995); Smith v. Aon Corp., No. 04 C 6875, 2006 WL 1006052, at *5-*6 (N.D. Ill. Apr. 12, 2006); see also LaLonde v. Textron, Inc., 369 F.3d 1, 6 (1st Cir. 2004). This presumption was known as the Moench presumption, based on the first case to apply it, Moench v. Robertson, 62 F.3d 553 (3d Cir. 1995).

The Supreme Court rejected the Moench presumption in Fifth Third Bancorp v. Dudenhoefter, 573 U.S. 409 (2014), holding that "because ESOP fiduciaries are ERISA fiduciaries and because § 1104(a)(1)(B)'s duty of prudence applies to all ERISA fiduciaries, ESOP fiduciaries are subject to the duty of prudence just as other ERISA fiduciaries are." Id. at 418-19.

iii. The showing required to establish a breach of the duty of prudence after Dudenhoefter

In Dudenhoefter, the Supreme Court laid out pleading standards for duty of prudence claims against ESOP fiduciaries. Dudenhoefter, 573 U.S. at 426-28. In general, Dudenhoefter made it more difficult to state a claim against ESOP fiduciaries at public companies. In re BP, P.L.C. Sec. Litig., 2017 WL 914995, at *3 n. 7 (S.D. Tex. Mar. 8, 2017) (describing Dudenhoefter standard as "virtually insurmountable"). The Court established different standards for cases basing a duty of prudence claim on publicly available information and those basing a prudence claim on nonpublic information available to the fiduciary. Id.

Under Dudenhoeffer, “where a stock is publicly traded, allegations that a fiduciary should have recognized from publicly available information alone that the market was over- or undervaluing the stock are implausible as a general rule, at least in the absence of special circumstances.” Id. at 426. Underlying this rule was the idea that “a fiduciary usually is not imprudent to assume that a major stock market . . . provides the best estimate of the value of the stocks traded on it that is available to him.” Id. at 427 (internal quotation marks omitted). The Court did not define what might constitute a “special circumstance, e.g., id. (“We do not here consider whether a plaintiff could nonetheless plausibly allege imprudence on the basis of publicly available information by pointing to a special circumstance affecting the reliability of the market price as an unbiased assessment of the security’s value.”), and although several lower courts have addressed the issue, no clear rules have emerged.

By contrast, ESOP fiduciaries at privately held companies are generally not entitled to the same heightened pleading standard. Allen v. GreatBanc Tr. Co., 835 F.3d 670, 679 (7th Cir. 2016). Where fiduciaries cannot point to an unbiased public-market assessment, “[a]ll the plaintiff must do is to plead the breach of a fiduciary duty, such as prudence, and to explain how this was accomplished.” Id.

See:

Kopp v. Klein, 894 F.3d 214, 220 (5th Cir. 2018). The plaintiff alleged that the defendants were imprudent to rely on the market price because “their own fraudulent activities had caused the public markets to overvalue [the] stock,” and argued that defendants’ fraud was a “special circumstance” under Dudenhoeffer. The Fifth Circuit disagreed, holding fraud was “not the type of special circumstance contemplated by the Supreme Court” because it was “by definition not public information” and “would [not] affect the reliability of the market price.”

Coburn v. Evercore Trust Co., N.A., 844 F.3d 965, 969-70 (D.C. Cir. 2016). The D.C. Circuit suggested that evidence “demonstrate[ing] that illicit forces (such as fraud, improper accounting, illegal conduct, etc.) were influencing the market” or that “otherwise suggest[s] that the market was not efficient” would constitute a “special circumstance” because it would “suggest that the public market price did not reflect the true value of the shares.”

To state a claim for breach of the duty of prudence on the basis of nonpublic information, on the other hand, “a plaintiff must plausibly allege an alternative action that the defendant could have taken that would have been consistent with the securities laws and that a prudent fiduciary in the same circumstances would not have viewed as more likely to harm the fund than to help it.” Dudenhoeffer, 573 U.S. at 427-28. In addition, the Supreme Court stated that courts should consider: (1) that “the duty of prudence . . . does not require a fiduciary to break the law,” (2) “the extent to which an ERISA-based obligation to either to refrain on the basis of inside information from making planned trade or to disclose inside information to the public could conflict with

the complex insider trade and corporate disclosure requirements imposed by the federal securities laws or with the objectives of these laws,” and (3) “whether the complaint has plausibly alleged that a prudent fiduciary in the defendant’s position could not have concluded that stopping purchases . . . or publicly disclosing negative information would do more harm than good to the fund.” Id. at 428-30. This standard applies equally to risk-based claims and value-based claims. Coburn, 844 F.3d at 971; Rinehart v. Lehman Bros. Holdings Inc., 817 F.3d 56, 66 (2d Cir. 2016).

However, exactly what is required under this standard remains an open question. Although the Supreme Court revisited this issue in Amgen Inc. v. Harris, 136 S.Ct. 758 (2016), it declined to further define what must be plead under Dudenhoeffer to plausibly allege a duty of prudence claim based on nonpublic information. The Ninth Circuit had held that the complaint satisfied Dudenhoeffer because “when the federal securities laws require disclosure of material information, it is quite plausible that removing the [employer] Common Stock Fund from the list of investment options would not cause undue harm to plan participants.” 136 S. Ct. at 759-60. The Court held that the Ninth Circuit failed to “properly evaluate the complaint.” Id. at 759. The Court held that while it “may be true” that “removing the [employer] Common Stock Fund from the list of investment options was an alternative action that could plausibly have satisfied [Dudenhoeffer]’s standards,” there were no facts and allegations supporting that proposition in the stockholders’ complaint. Id. at 760.

The Supreme Court more recently declined to resolve “what it takes to plausibly allege an alternative action ‘that a prudent fiduciary in the same circumstances would not have viewed as more likely to harm the fund than to help it.’” Ret. Plans Comm. of IBM v. Jander, 140 S. Ct. 592, 594 (2020) (quoting Dudenhoeffer, 573 U.S. at 428.) The plaintiffs alleged breach of fiduciary duty for failing to disclose nonpublic information that one of IBM’s corporate divisions was overvalued. 140 S. Ct. 592. The plaintiffs argued that IBM should have issued a disclosure statement before the fraud was discovered and caused the stock to drop. Instead of resolving the issue, the Supreme Court remanded the case with instructions for the Second Circuit to consider the interaction between ERISA and securities laws.

See also:

DiFelice v. U.S. Airways, Inc., 497 F.3d 410, 418-20 (4th Cir. 2007). The Fourth Circuit affirmed judgment for defendants and held that whether fiduciaries exercised prudence in selecting and retaining the investment options depended on the “totality of the circumstances, including, but not limited to: the plan structure and aims, the disclosures made to participants regarding the general and specific risks associated with investment in company stock, and the nature and extent of challenges facing the company that would have an effect on stock price and viability.” In considering the circumstances, the court found that “the trustees, at the time they engaged in the challenged transactions, employed the appropriate methods to investigate the merits of the investment and to structure the investment.”

Summers v. State St. Bank & Trust Co., 453 F.3d 404, 408-10 (7th Cir. 2006). The court affirmed the summary judgment for the defendants and held that defendant had no duty to diversify the ESOP by selling employer stock. The court stated that, under the theory that the market was efficient, the market price of the employers' stock was the best indicator of its value at every point in its decline. A fiduciary has no obligation to act on the theory that the market is overvaluing the employer's stock.

In re Huntington Bancshares ERISA Litig., 620 F. Supp. 2d 842, 851-53 (S.D. Ohio 2009). The plaintiffs failed to state ERISA claims based on a stock drop that resulted when the real estate bubble burst in 2007. Plaintiffs alleged the defendants should not have continued to offer the company's stock as an investment option in light of the company's \$1.5 billion exposure in the subprime market. Although the company stock had "experienced a significant drop" in its price, the drop was similar to that of other companies in the industry and the court held that the plaintiffs failed to show plausible imprudence claims, i.e., they failed to present factual allegations showing a precipitous decline in stock price accompanied by red flags suggesting corporate malfeasance or impending collapse. The court dismissed the claim because the complaint "merely set[] out the 'formulaic recitation of the elements' of [a] breach of fiduciary duty" claim.

Courts have suggested that fiduciaries might have a duty to divest an EIAP of employer securities in several situations. For example, the Seventh Circuit has suggested that the duty might exist where a company was acquired in a stock-for-stock deal that would convert the target company's stock into the acquirer's stock and the acquirer had a higher debt to equity ratio that made its stock more risky. *Steinman v. Hicks*, 352 F.3d 1101, 1106 (7th Cir. 2003) (suggesting employer's complete investment in its own stock during corporate transaction with high bankruptcy risk may have been breach, but declining to address that issue because plaintiffs had not raised that argument). The Ninth Circuit has stated the duty would exist "where a company's financial situation is seriously deteriorating and there is a genuine risk of insider self-dealing." *Wright*, 360 F.3d at 1098. The Ninth Circuit has also suggested that fiduciaries might be liable where a company's stock "was artificially inflated during that time by an illegal scheme about which the fiduciaries knew or should have known, and then suddenly declined when the scheme was exposed." *Syncor*, 516 F.3d at 1102.

See:

In re Syncor ERISA Litig., 516 F.3d 1095, 1102-03 (9th Cir. 2008). Defendant Syncor was the fiduciary of its own ESOP plan. Syncor's stock lost almost half its value when it was discovered that Syncor's board of directors had made illegal bribes in Taiwan. In reversing the district court's summary judgment in favor of the defendants, the court stated "[a] violation may occur where a company's stock did not trend downward over time, but was artificially inflated during that time by an illegal scheme

about which the fiduciaries knew or should have known, and then suddenly declined when the scheme was exposed.”

Harzewski v. Guidant Corp., 489 F.3d 799, 807-08 (7th Cir. 2007). The Seventh Circuit reversed a dismissal based on lack of standing. It suggested that on remand the plaintiffs might be able to establish a claim by showing that the fiduciaries could have avoided imposing “excessive risk” on plan participants by selling the plan’s employer stock based on plaintiffs’ allegation that the employer “knew that the price of its stock was overvalued but took no measures to protect the participants in the pension plan, as it could have done by selling [its] stock held by the plan before the overvaluation was discovered by the market and its price plummeted.” The court stated however that the plaintiffs might have difficulty showing an injury.

LaLonde v. Textron, Inc., 369 F.3d 1, 2, 6 (1st Cir. 2004). The court held that plaintiffs had stated a claim by alleging that Textron had artificially inflated its stock price by concealing “the disparate problems throughout Textron’s segments and their adverse effect on Textron which are the subject of a federal securities lawsuit.” The securities suit alleged that Textron concealed “internal problems” that led to a 70% decline in earnings per share and termination of 10% of Textron’s workforce.

In re Fremont Gen. Corp. Litig., 564 F. Supp. 2d 1156, 1159 (C.D. Cal. 2008). The court held that the plaintiffs stated a claim where the complaint contained “detailed and specific allegations that Fremont General was in dire financial circumstances and subject to serious mismanagement, all of which circumstances were, or should have been, known to Defendants. The Complaint further alleges that the fiduciaries failed to investigate the prudence of investing in Fremont General stock, resulting in harm to the plaintiffs.”

Shirk v. Fifth Third Bancorp, No. 05-cv-49, 2007 WL 1100429, at *10 (S.D. Ohio Apr. 10, 2007). On a motion to dismiss, the court found that the plaintiffs had alleged sufficient facts to rebut a presumption of reasonableness. “In particular, Plaintiffs allege that Defendants knew or should have known that Fifth Third was engaged in numerous practices . . . that put Fifth Third stock at risk, that they failed to take into account whether the stock was inflated in value, that they created or maintained public misconceptions concerning the true financial health of the Company, and despite the availability of other investment options, continued to invest and allow investment of the Plan’s assets in Fifth Third stock even as Fifth Third’s questionable practices came to public light.”

Smith v. Aon Corp., No. 04 C 6875, 2006 WL 1006052, at *5-*6 (N.D. Ill. Apr. 12, 2006). The court held that plaintiffs had adequately pled a breach of the duty of prudence by alleging that defendants (1) had offered Aon

stock as an investment option, (2) purchased Aon stock while Aon was involved in numerous improper business practices which had resulted in a complaint filed by the New York Attorney General, among other improprieties.

c) “Duty to investigate”

In considering the duty of prudence, some courts have referred to the duty to investigate. ERISA does not expressly identify this as a separate duty. Rather, it is related to the duty of prudence. *See, e.g., Yates v. Nichols*, 286 F. Supp. 3d 854, 862 (N.D. Ohio 2017) (“[A]bsent an investment that is . . . imprudent . . . there can be no recovery for a failure to investigate.”). It can arise in two separate scenarios. First, fiduciaries may need to investigate when they hold positions within the corporation through which they know or should know of affairs affecting the company stock’s value. Second, they may need to investigate when plan fiduciaries are making decisions regarding where to invest plan assets.

i. Duty to investigate company affairs potentially affecting stock value

In *Hill v. Tribune Co.*, plaintiffs brought suit after it was revealed that certain employees had reported artificially high circulation figures for its newspapers, resulting in allegedly artificially inflated advertising revenues. No. 05 C 2602, 2006 WL 2861016, at *15 (N.D. Ill. Sept. 29, 2006). The plaintiffs alleged that “internal controls for circulation were so obviously deficient that defendants would have known the circulation figures could not be relied upon.” *Id.* The court surveyed the case law and stated that “conclusory allegations that all defendants should have known pertinent facts about the corporation generally have not been found to be sufficient unless it is, at a minimum, alleged that each particular defendant was in a position to know or learn the information.” *Id.* “Thus, allegations a defendant was a director or officer of the corporation, or an employee in a particular position, will generally suffice to support that the defendant should have known certain related information transacted at Board level; but alleging that a defendant was a member of a plan’s investment committee, without more, is generally insufficient to take as true that the defendant should have known specific information about the operations of the corporation that sponsors the plan.” *Id.* (affirmed by Pugh, 521 F.3d at 701).

See:

Rinehart v. Lehman Bros. Holdings Inc., 817 F.3d 56, 67-68 (2d Cir. 2016). *The Second Circuit affirmed dismissal of the complaint, finding plaintiffs had not stated a claim for breach of fiduciary duty based on a failure to investigate nonpublic information about the company. “The [complaint] in this case includes no specific allegations about what lines of inquiry would have revealed this information or who, if pressed, in fact would have disclosed it to the Plan Committee defendants.”*

In re Westar Energy, Inc. ERISA Litig., No. 03-4032-JAR, 2005 WL 2403832, at *22, *25 (D. Kan. Sept. 29, 2005). The court rejected the theory that plan fiduciaries were required “to conduct an independent investigation into and/or monitor the merits of investing the Plan’s assets in [company] stock.” The court stated that “[p]lan fiduciaries would not generally be expected to investigate, ascertain or monitor the Company and its officers with respect to matters that Plan administrators are not properly privy to.” The court went on to state, however, that Plan fiduciaries cannot turn a “blind eye” to what they might know in their corporate capacity.

Howell v. Motorola Inc., 337 F. Supp. 2d 1079, 1090-92 (N.D. Ill. 2004). Plaintiffs brought suit alleging that members of Motorola’s 401(k) committee should have known the riskiness of investing in Telsim, a Turkish telecommunications company. The court dismissed the claim, stating that the plaintiffs had “not alleged that Committee Defendants knew any facts regarding the Telsim transaction” and had not identified the corporate positions of the committee members who were alleged to have been Motorola employees.

ii. Duty to investigate investment decisions

Several cases have focused on the need for fiduciaries to investigate in the context of investment decisions, as opposed to internal corporate affairs. In this context, a fiduciary satisfies his duty of prudence if he “[h]as given appropriate consideration to those facts and circumstances that, given the scope of such fiduciary’s investment duties, the fiduciary knows or should know are relevant to the particular investment” 29 C.F.R. § 2550.404a-1(b)(1)(i). The fact that this regulation makes fiduciaries responsible for facts they “should know” gives rise to a duty to investigate.

A fiduciary is not necessarily required to undertake a formal investigation of the plan’s investment options. In *Nelson v. IPALCO, Enters., Inc.*, 480 F. Supp. 2d 1061, 1099 (S.D. Ind. 2007), the court rejected this contention, holding that although there was “no evidence that the Pension Committee formally considered [continuing investments in company stock] or that it asked any outside adviser to provide an opinion on this question,” the Pension Committee was “thoroughly familiar” with the investment and formal investigation would not have led them to change their decision.

The duty to investigate investment decisions was discussed extensively in *DiFelice II*, 497 F.3d at 420-21. In this case, the U.S. Airways plan offered participants thirteen different funds, one of which contained company stock. *Id.* at 415. Participants could readily transfer their money between funds. *Id.* U.S. Airways was an embattled company, especially in the wake of the September 11, 2001 terrorist attacks, and its stock fell from \$4.48 per share in October 2001 to \$3.72 per share in June 2002, the class period covered by the suit. *Id.* at 416. The plaintiffs alleged that the fiduciaries failed to give sufficient attention to the company’s precarious financial position. *Id.* at 420.

After reviewing the plan committee's actions, the court concluded that the defendants had satisfactorily discharged their obligations with respect to the performance of the company fund. Id. at 420-21. The plan committee met formally four times to consider whether to continue to offer the fund. Id. at 421. On at least two occasions, the committee sought outside legal opinions regarding the fund. Id. The court noted that the fact that the committee had twice sought independent advice distinguished the case from Armstrong v. LaSalle Bank N.A., 446 F.3d 728, 734 (7th Cir. 2006), where the court questioned whether the fiduciaries ever considered other options. DiFelice II, 497 F.3d at 421.

The court qualified the importance of independent advice, however, by stating that while independent advice provides "evidence of a thorough investigation," id. (citing Howard v. Shay, 100 F.3d 1484, 1489 (9th Cir. 1996)), defendants cannot use it as a "whitewash," id. (citing Donovan v. Bierwith, 680 F.2d 263, 272 (2d Cir. 1982)). See also Chesemore v. Alliance Holdings, Inc., 886 F. Supp. 2d 1007, 1042 (W.D. Wis. 2012) ("Employing a financial advisor is evidence of adequate investigation, but reliance on experts is not a shield—it is 'but a single factor to be weighed in determining whether a fiduciary has breached her duty. The fiduciary must still evaluate the advice given and exercise his own judgment about the transaction.'" (internal citations and quotation marks omitted)).

d) Duty to monitor appointed fiduciaries

The duty to monitor is another fiduciary duty that is derived from the duty of prudence. Courts have found that ERISA imposes on fiduciaries a duty to monitor those they appoint to make decisions about the plan. Howell, 633 F.3d at 572–73; Coyne & Delany Co. v. Selman, 98 F.3d 1457, 1465 (4th Cir. 1996); Martin v. Feilen, 965 F.2d 660, 669-70 (8th Cir. 1992); Leigh v. Engle, 727 F.2d 113, 135 (7th Cir. 1984); In re Enron, 284 F. Supp. 2d 511, 553 (S.D. Tex. 2003); see In re Target Corp. Sec. Litig., 275 F. Supp. 3d 103, 1093 (D. Minn. 2017) ("[A]ppointing fiduciaries must review the performance of trustees and other fiduciaries 'in such manner as may be reasonably expected to ensure that their performance has been in compliance with the terms of the plan and statutory standards.'"); In re Bausch & Lomb, 2008 WL 5234281, at *10 ("Under ERISA, fiduciaries who have appointed other fiduciaries have a continuing duty to monitor the actions of the appointed fiduciaries."); In re Xerox Corp. ERISA Litig., 483 F. Supp. 2d 206, 215 (D. Conn. 2007).

In defining this duty, courts have followed the reasoning in a DOL Interpretative Bulletin: "At reasonable intervals the performance of trustees and other fiduciaries should be reviewed by the appointing fiduciary in such manner as may be reasonably expected to ensure that their performance has been in compliance with the terms of the plan and statutory standards, and satisfies the needs of the plan." Howell, 633 F.3d at 573 (citing 29 C.F.R. § 2509.75-8); In re Elec. Data Sys. Corp., ERISA Litig., 305 F. Supp. 2d 658, 671 (E.D. Tex. 2004) (citing same).

While acknowledging the duty to monitor, courts have stated that the duty is a limited one. Howell, 633 F.3d at 573; In re Elec. Data Sys. Corp., ERISA Litig., 305

F. Supp. 2d at 671; Acosta v. Chimes D.C., Inc., No. 15-cv-3315, 2019 WL 931710, at *18 (D. Md. Feb. 26, 2019). Accordingly, a monitoring fiduciary need only “review the performance of its appointees at reasonable intervals in such a manner as may be reasonably expected to ensure compliance with the terms of the plan and statutory standards.” In re Calpine Corp. ERISA Litig., No. C-03-1685, 2005 WL 1431506, at *6 (N.D. Cal. Mar. 31, 2005); see also Howell, 633 F.3d at 573; Shirk v. Fifth Third Bancorp., No. 05-cv-049, 2009 WL 692124, at *19 (S.D. Ohio Jan. 29, 2009). Moreover, a monitoring fiduciary who delegates to an appointee is “not required to monitor the prudence of the individual investments offered under the Plan.” E.g., Lingis v. Motorola, Inc., 649 F. Supp. 2d 861, 892 (N.D. Ill. 2009). However, “even if appropriate monitoring procedures are in place[,] an appointing fiduciary may be subject to liability.” Perez v. WPN Corp., No. 14-1494, 2017 WL 2461452, at *14 (W.D. Penn. June 7, 2017).

See:

Howell v. Motorola, Inc., 633 F.3d 552, 572–73 (7th Cir. 2011). The court held that a standard requiring fiduciaries to review all business decisions of Plan administrators “would defeat the purpose of having trustees appointed to run a benefits plan in the first place.”

Coyne & Delany Co. v. Selman, 98 F.3d 1457, 1466 n.10 (4th Cir. 1996). “[C]ourts have properly taken a restrictive view of the scope of this duty and its attendant potential for liability.”

Vellali v. Yale Univ., 308 F. Supp. 3d 673, 691-92 (D. Conn. 2018). The plaintiff stated a claim for failure to monitor by alleging defendants “failed to monitor the [Plan] Committee to ensure that its members complied with their fiduciary duties to select reasonable investment options; negotiate reasonable recordkeeping and investment management fees; and continually monitor investment performance, recordkeeping fees and investment management fees.” Additionally, plaintiff “alleged facts sufficient to state claims for breach of the duty of prudence . . . identified two fiduciaries . . . who were responsible for monitoring the performance of members of the Committee and had authority to discipline or remove Committee members.”

Neil v. Zell, 677 F. Supp. 2d 1010, 1023-24 (N.D. Ill. 2009). The district court dismissed plaintiffs’ claim that corporate officers and directors breached a duty to monitor an ESOP’s independent trustee. The plaintiffs’ general allegations were insufficient because they did not allege how the defendants failed to monitor their appointee.

*In re Calpine Corp., No. C-031685, 2005 WL 1431506, at *6 (N.D. Cal. Mar. 31, 2005). “The duty of an ERISA fiduciary to review the performance of its appointees is a limited one.”*

In re Excel Energy, Inc., Sec., Derivatives, & ERISA Litig., 312 F. Supp. 2d 1165, 1176 (D. Minn. 2004). “The scope of the duty to monitor appointees is relatively narrow.”

Liss v. Smith, 991 F. Supp. 278, 311 (S.D.N.Y. 1998). “The ‘limited’ fiduciary obligations imposed on one who appoints trustees thus includes the obligation to ensure that the appointees are performing their fiduciary obligations.”

See also:

In re Westar Energy, Inc., ERISA Litig., No. 03-4032-JAR, 2005 WL 2403832, at *24 (D. Kan. Sept. 29, 2005). “[The defendant’s] limited fiduciary duty to appoint and remove Committee members included a duty to monitor and evaluate their competence and performance, for purposes of exercising his duty to appoint and remove them.”

While courts are continuing to define the scope of the duty to monitor, see *Tibble v. Edison Intern.*, 135 S.Ct. 1823, 1829 (2015) (“We express no view on the scope of respondents’ fiduciary duty in this case.”), some courts have articulated conduct the duty to monitor includes. For example, it includes the duty to take action when the appointed fiduciaries are not performing their duties properly. See *In re Bausch & Lomb*, 2008 WL 5234281, at *10; *Liss*, 991 F. Supp. at 311. Other courts have stated that it includes the duty to disclose information about the employers’ stock as to which the appointing fiduciary had actual knowledge. *Hill*, 2006 WL 2861016, at *21. Because the “scope of the duty to monitor is often unclear, many courts have declined to dismiss a duty to monitor claim on a motion to dismiss” because of the intensive fact analysis required to determine the scope of the duty. *In re Syncor ERISA Litig.*, 351 F. Supp. 2d 970, 986 (C.D. Cal. 2004).

See:

DeFazio v. Hollister, Inc., No. 2:04-cv-1358, 2012 WL 1158870, at *25 (E.D. Cal. Apr. 6, 2012). “The continual use of a preset sales price and lack of any document or discussion suggesting that the Trustees had performed an investigation to determine the fair market value of the Plan’s shares should have served as a red flag...” and therefore, the board members breached their duty to adequately monitor the Trustees.

In re Elec. Data Sys. Corp., ERISA Litig., 305 F. Supp. 2d 658, 671 (E.D. Tex. 2004). “[A]t this stage of the proceedings the Court will not endeavor to define the duty to monitor’s outer edges with no factual record to indicate how far this may or may not push those edges.”

In re Sprint Corp., ERISA Litig., 388 F. Supp. 2d 1207, 1228 (D. Kan. 2004). “The court [found] it unnecessary to precisely define the contours of the duty to monitor at this early phase of litigation.”

In re ADC Telecomm., Inc., ERISA Litig., No. 03-2989, 2004 WL 1683144, at * 7 (D. Minn. July 26, 2004). “Though Plaintiffs make broad allegations under the rubric of the ill-defined and limited duty to monitor, courts have been unwilling to delineate and probe the scope of the defendant’s monitoring duties on the motion to dismiss.”

But see:

Pedraza v. Coca-Cola Co., 456 F. Supp. 2d 1262, 1278 (N.D. Ga. 2006) abrogated on other grounds, *Lanfear v. Home Depot, Inc.*, 679 F.3d 1267 (11th Cir. 2012). “The [c]ourt [did] not need to determine the scope of the monitoring duty or whether such duty includes a duty to inform in order to rule on the motion to dismiss.” However, the claim was dismissed because there was no breach of fiduciary duty by the appointed fiduciary.

The duty to monitor claim is often considered a derivative claim because it usually succeeds or fails based upon whether the plaintiffs’ main claim succeeds. In cases where the court finds that continued investment in employer stock was prudent, the courts have routinely dismissed claims for breaches of the duty to monitor as well. E.g., Citigroup, 662 F.3d at 145; Brown, 628 F.3d at 461; Pugh, 521 F.3d at 702; In re Dell, 563 F. Supp. 2d at 695; White v. Chevron Corp., No. 16-cv-0793, 2016 WL 4502808, at *19 (N.D. Cal. Aug. 29, 2016); In re Bausch & Lomb, 2008 WL 5234281, at *10.

e) Duty to disclose information and avoid misrepresentations

In addition to claims for breaches of the duty of prudence and to monitor, plaintiffs in stock drop cases will also allege that the company or its officers and directors breached fiduciary duties under ERISA by making inaccurate statements about the financial health of the company or the value of investments in the employer’s stock in public filings and press releases. Plaintiffs assert that they were damaged because they relied on these allegedly misleading statements and continued to invest in the employers’ stock and that when the “truth” about the employer’s financial condition was revealed, the stock’s price fell.

Courts have held that fiduciaries have a duty to disclose complete and accurate information about plan benefits to plan beneficiaries, generally as an obligation arising from the general nature of the fiduciary’s role. See In re Unisys, 74 F.3d at 441; In re Dell, 563 F. Supp. 2d at 694-95; In re Dynegey, Inc. ERISA Litig., 309 F. Supp. 2d 861, 881 (S.D. Tex. 2004); In re Duke Energy, 281 F. Supp. 2d at 791. In addition to specific disclosure requirements under 29 U.S.C. §§ 1021-31; 29 C.F.R. §§ 2520.101-2520.107-1, ERISA prohibits fiduciaries from knowingly providing false information to plan participants regarding the plan or benefits and requires that when they speak about the plan they do so truthfully. In re WorldCom, Inc., 263 F. Supp. 2d 745, 766 (S.D.N.Y. 2003). But “[w]hile the duty of loyalty ERISA fiduciaries owe beneficiaries clearly encompasses a duty not to lie, the degree to which that duty imposes an affirmative

obligation to disclose material information is unclear.” Lingis, 649 F. Supp. 2d at 875–76 (citing Varity Corp., 516 U.S. at 506). See Boyd v. ConAgra Foods, Inc., 879 F.3d 314, 323 (8th Cir. 2018) (“Under ERISA, a fiduciary has a duty to inform when it knows that silence may be harmful, and cannot remain silent if it knows or should know that the beneficiary is laboring under a material misunderstanding of plan benefits.”); Soland v. George Washington Univ., 60 F. Supp. 3d 60, 64-65 (D.D.C. 2014) (“ERISA does not impose a duty to disclose . . . unless a beneficiary has made a specific inquiry or the fiduciary has made a statement about future plans that would be misleading absent further disclosure.”).

A breach of fiduciary duty claim arises if fiduciaries “mislead plan participants or misrepresent the terms or administration of a plan.” Vallone v. CNA Fin. Corp., 375 F.3d 623, 640 (7th Cir. 2004). To show a violation of this duty, courts generally require plaintiffs prove a material misrepresentation or omission, reliance, and causation of damages. In re Dell, 563 F. Supp. 2d at 695.

See:

Negron v. Cigna Health and Life Ins., 330 F. Supp. 3d 341, 360-61 (D. Conn. 2018): Plaintiff stated a claim for breach of the duty to disclose by alleging misrepresentation that actual practices did not differ from plan terms.

Soland v. George Washington Univ., 60 F. Supp. 3d 60, 64-68 (D.D.C. 2014). To establish a failure to disclose claim, a plaintiff “must ultimately prove (1) . . . defendants owed fiduciary duties to him under ERISA; (2) that they made a misstatement or misleadingly omitted information—thereby triggering a duty of disclosure; and (3) that any misstatement or omission was material to his decision to retire.” Here, the plaintiff had not identified “any explicit statement by [defendant] that was false or misleading . . . [or claimed] that he specifically asked [defendant]” about the plan, and thus had not stated a claim for duty to disclose. Merely “signaling his interest in learning what retirement options were available” was not enough to trigger a duty to disclose absent a specific inquiry.

Edgar v. Avaya, Inc., 503 F.3d 340, 347 n.12 (3d Cir. 2007), abrogated on other grounds, Fifth Third Bancorp v. Dudenhoeffer, 573 U.S. 409 (2014). The court held that plan documents warning participants of the risks of investing in the plan and notifying participants that they were responsible for investigating their investment options were sufficient to satisfy the fiduciaries’ obligations not to misinform participants. The court also stated that if the fiduciaries had themselves divested the plan of Avaya stock on the basis of non-public information, they potentially could have faced liability under federal securities laws.

In re Huntington Bancshares Inc. ERISA Litig., 620 F. Supp. 2d 842, 854, 856 (S.D. Ohio 2009). To establish a failure to disclose claim, a plaintiff

must establish “(1) defendant was acting as a fiduciary when it made the challenged statements; (2) the statements constituted material misrepresentations; and (3) plaintiff relied on them to his/her detriment.” There, the company’s SEC filings disclosed the company’s potential exposure. The court held that “Plaintiffs cannot satisfy their pleading burden by ignoring the content of the disclosures and conclusorily asserting that they were incomplete.” Moreover, the court held that “Plaintiffs must identify the additional information that they claim was required to be disclosed and provide a basis for that assertion.”

But see:

In re Dynegey, Inc. ERISA Litig., 309 F. Supp. 2d 861, 882 (S.D. Tex. 2004). *The court held that plaintiffs had stated a claim for a breach of the duty to investigate where they had alleged that “by virtue of their positions within the company and access to contradictory information” the plan fiduciaries should have known that its summary plan description distributed to participants contained material misrepresentations.*

A key issue in fiduciary breach claims is whether the defendant was acting as a fiduciary when he or she performed the act that the plaintiff is challenging. An ERISA breach of fiduciary duty claim requires that the defendant “was acting as a fiduciary (that is, was performing a fiduciary function) when taking the action subject to complaint.” *Pegram v. Herdrich*, 530 U.S. 211, 226 (2000); *In re R.H. Donnelley Corp. ERISA Litig.*, No. 09 C 7571, 2011 WL 86623, at *3 (N.D. Ill. Jan. 10, 2011). ERISA allows employers to wear “two hats” and recognizes that an individual or corporation may act in two separate capacities, both as a fiduciary and an employer. *See McGath v. Auto-Body N. Shore, Inc.*, 7 F.3d 665, 670-71 (7th Cir. 1993). Under this doctrine, when a defendant is merely conducting general business activities, ERISA’s fiduciary duties do not apply. As the Supreme court stated in *Varity Corp. v. Howe*, persons do not act as ERISA fiduciaries “simply because [they make] statements about [the company’s] expected financial condition or because an ordinary business decision turned out to have an adverse impact on the plan.” 516 U.S. 489, 505 (1996) (internal quotation marks omitted). Rather, communications are fiduciary in nature only if the statements are “intentionally connected” to benefits. *See id.*; *Citigroup*, 662 F.3d at 144.

Following *Varity*, courts have dismissed disclosure claims related to employer stock that are based on statements filed with the SEC, annual reports, press releases about an employer’s business, and other communications to shareholders, regulators, investors, and customers because those statements are made in a general corporate capacity and not an ERISA fiduciary capacity. *See In re Bausch & Lomb*, 2008 WL 5234281, at *7; *In re WorldCom, Inc.*, 263 F. Supp. 2d at 760. “Those who prepare and sign SEC filings do not become ERISA fiduciaries through those acts, and consequently, do not violate ERISA, if the filings contain misrepresentations.” *In re WorldCom, Inc.*, 263 F. Supp. 2d at 760 (ERISA’s “two hats” doctrine precluded plaintiffs from bringing an ERISA claim based on misrepresentations that were purportedly made in SEC filings incorporated into summary plan description).

Several courts have held that incorporating SEC filings into plan materials by reference does not make the SEC filings “intentionally connected” to plan benefits. See, e.g., Kirschbaum, 526 F.3d at 257; Wachovia, 2010 WL 3081359, at *16; Lingis v. Motorola, Inc., 649 F. Supp. 2d 861, 875-76 (N.D. Ill. 2009). But see Dudenhofer v. Fifth Third Bancorp., —692 F.3d 410, 423 (6th Cir. Sept. 5, 2012) (reversing district court’s dismissal of ERISA claim because plaintiffs plausibly alleged that defendants breached fiduciary duties by “intentionally incorporating” company SEC filings into Plan’s SPD which plaintiffs had alleged conveyed misleading information to participants), reversed on other grounds, 573 U.S. 409 (2014). As one district court has explained, “when Defendants incorporated the 10-Ks and 10-Qs into the Form S-8 that [the company] was required to file with the SEC on behalf of the Plan, [the company] was ‘discharging its corporate duties under the securities laws, and was not acting as an ERISA fiduciary.’” Lingis, 649 F. Supp. 2d at 875 (quoting Kirschbaum, 526 F.3d at 257); see also In re GlaxoSmithKline ERISA Litig., 494 F. App’x 172, 176 (“[T]he fact that Summary Plan Descriptions (“SPDs”) incorporate certain of GSK’s public SEC filings give rise to ERISA liability absent allegations supporting the inference that individual Plan administrators made ‘intentional or knowing misstatements . . . by incorporating SEC filings into the SPDs.’”). Shirk, 2009 WL 692124, at *16 (stating “preparation of SEC filings is not an ERISA fiduciary act ‘even if misleading and incorporated by reference in required ERISA disclosures’”); In re Bausch & Lomb, Inc. ERISA Litig., No. 06-cv-6297, 2008 WL 5234281, at *7 (W.D.N.Y. Dec. 12, 2008) (dismissing duty to disclose claim where challenged statements consisted of SEC filings and statements made to the market”).

Courts have also rejected attempts by plaintiffs to import a broader duty of disclosure into ERISA, holding that “[w]hen Congress and the Department of Labor have carefully prescribed a detailed list of matters that must be disclosed to plan participants and beneficiaries, it ill-behooves federal judges to add to that list.” Sprague v. Gen. Motors Corp., 133 F.3d 388, 405 n.15 (6th Cir. 1998) (en banc). Courts have also been wary to create new disclosure obligations under ERISA for concern of “disturbing the carefully delineated corporate disclosure laws.” Baker v. Kingsley, 387 F.3d 649, 662 (7th Cir. 2004). As one court has explained, “[it] is difficult to believe that Congress intended that ERISA – a statute governing employee-benefit plans – supplant the comprehensive and delicately balanced system of laws and regulations that define the information that a corporation must disclose to the investing public.” Wright v. Medtronic, Inc., No. 09-cv-0443, 2011 WL 31501, at *7 (D. Minn. Jan. 5, 2011). An expansive view of the duty to disclose also may expose fiduciaries to other risks. For example, “requiring disclosure of non-public information to plan beneficiaries when the information has not been provided to the market generally may run afoul of the insider trading laws The statutory text of ERISA itself counsels against a construction that would require fiduciaries to make otherwise impermissible disclosures.” Lingis, 649 F. Supp. 2d at 876.

In defining the disclosure obligations of fiduciaries, the Supreme Court has expressly declined to hold that ERISA imposes a duty on fiduciaries to disclose information on their own initiative, or in response to employee inquiries. See Varity Corp., 516 U.S. at 506. The fiduciary is also under no duty to “give investment advice”

or “opine on” the stock’s condition. Citigroup, 662 F.3d at 143, abrogated on other grounds, 573 U.S. 409 (2014); Edgar, 503 F.3d at 350 (citing Unisys, 74 F.3d at 443), abrogated on other grounds, 573 U.S. 409 (2014). Furthermore, “plan administrators are not required to inform all Plan participants and beneficiaries of every corporate event, especially contingent events, that might impact the value of a company’s common stock.” Sweeney v. Kroger Co., 773 F. Supp. 1266, 1269 (E.D. Mo. 1991); see also Bear Stearns, 763 F. Supp. 2d at 577 (dismissing disclosure claim and holding that any duties to disclose information related to plan benefits do not extend to the investment themselves because ERISA does not require disclosure of information about the employer finances); Wright, 2011 WL 31501, at *7 (rejecting “wide-ranging” duty of disclosure because “ERISA defines when a fiduciary must disclose plan- and benefit-specific information that is of interest to plan participants but not to investors generally”); In re Citigroup, 2009 WL 2762708, at *21 (holding that “ERISA provided a ‘comprehensive set of reporting and disclosure requirements’” and “plaintiffs can point to no ERISA provision requiring that fiduciaries disclose information bearing on an employer’s financial condition”); Shirk v. Fifth Third Bancorp, No. 05-cv-049, 2009 WL 692124, at *18 (S.D. Ohio Jan. 29, 2009) (holding there is no “general duty of disclosure beyond what is specifically required under ERISA”).

See also:

Herrington v. Household Int’l, Inc., No. 02 C 8257, 2004 WL 719355, at **7-8 (N.D. Ill. Mar. 31, 2004). *The court held that ERISA did not impose a general duty to disclose any non-public information potentially related to the value of an employer’s stock because such a standard “is too broad as it would require defendants to continuously gather and disclose nonpublic information bearing some relation to the plan sponsor’s financial condition” and would “extend[] the statutory language beyond their plain meaning.”*

Additional discussion of the duty to disclose information and avoid misrepresentations can be found in Section V.B of this Handbook.

f) ERISA § 404(c) defense to stock drop litigation

ERISA § 404(c) provides that:

In the case of a pension plan which provides for individual accounts and permits a participant or beneficiary to exercise control over the assets in his account, if a participant or beneficiary exercises control over the assets in his account . . . no person who is otherwise a fiduciary shall be liable under this part for any loss, or by reason of any breach, which results from such participant’s or beneficiary’s exercise of control

29 U.S.C. § 1104(c).

Stock drop lawsuits commonly involve individual account plans which allow participants to select their own investment options. Fiduciaries often point to this control and argue that under § 404(c) plaintiffs' claims should fail because due to the participants' control over their investments, the fiduciaries cannot be liable for losses that may have resulted from the participants' decisions to invest in employer stock.

However, several courts have rejected the argument that the § 404(c) defense applies where plaintiffs are challenging the fiduciaries' decisions as to which investment options, including employer stock, to offer under the plan. See, e.g., In re Suntrust Banks, Inc. ERISA Litig., 2015 WL 12734077, at *1 (N.D. Ga. Oct. 8, 2015) (collecting cases). These courts have held that the prudence of the fiduciaries' action is evaluated not based on the full array of plan options provided to participants. Rather, "the relevant 'portfolio' that must be prudent is *each* available Fund considered on its own, including the Company Fund, not the full menu of Plan funds." DiFelice II, 497 F.3d at 423-24; Brieger v. Tellabs, Inc., 245 F.R.D. 345, 351 (N.D. Ill. 2007); In re Unisys Sav. Plan Litig., 74 F.3d 420, 438-41 (3d Cir. 1996) . "[A] fiduciary cannot free himself from his duty to act as a prudent man simply by arguing that other funds, which individuals may *or may not* elect to combine with a company stock fund, could theoretically, in combination, create a prudent portfolio." DiFelice II, 497 F.3d at 423.

Not all courts accept this view, however. In an opinion on class certification, the Fifth Circuit considered ERISA § 404(c) where the plan permitted participants to choose their own investments. Langbecker v. Elec. Data Sys. Corp., 476 F.3d 299, 313 (5th Cir. 2007). Contrary to decisions in other jurisdictions, the Fifth Circuit held that § 404(c) applied to the fiduciaries' selection of investment options. Id. at 313. Langbecker rejected the plaintiffs' argument that the defense was inapplicable to suits brought on behalf of the plan under § 502(a)(2). Id. at 310. Plaintiffs based their argument largely on a footnote to a DOL regulation which stated that designating investment options is a fiduciary function that is not a result of any participant's decision. See Final Regulations Regarding Particular Directed Individual Account Plans (ERISA § 404(c) plans), 57 Fed. Reg. 46906, 46924-225, n.27. The majority found that this footnote was an unreasonable interpretation of ERISA § 404(c) because it would render the statute superfluous: "The DOL footnote would render the § 404(c) defense applicable only where plan managers breached no fiduciary duty, and thus only where it is unnecessary." Langbecker, 476 F.3d at 311.

The majority also rejected the dissent's contention that its holding meant that "no duty of prudence will attach to the selection and monitoring of plan investment choices." Id. at 312. Rather, the court suggested that fiduciaries may be liable for these choices, but such liability would depend on whether, in fact, a participants' losses were the result of the choices presented or the participants' investment decisions. Id. at 312. "Section 404(c) contemplates an individual, transactional defense" when plan fiduciaries have violated their duties in selecting and monitoring plan investments. Id. Thus, Langbecker requires an inquiry into which event — the fiduciary's breach or the participant's investment decisions — caused the loss.

After Langbecker, the Seventh Circuit in Hecker v. Deere & Co. considered § 404(c) in a case where the plaintiffs alleged that the fiduciaries allowed the plan and its participants to pay excessive administrative fees based on the investment options that were included in the plan. 556 F.3d 575, 589 (7th Cir. 2009). The court affirmed the dismissal of the case on a motion to dismiss because “[e]ven if [ERISA § 404(c)] does not always shield a fiduciary from an imprudent selection of funds under every circumstance that can be imagined, it does protect a fiduciary that satisfies the criteria of [§ 404(c)] and includes a sufficient range of options so that the participants have control over the risk of loss.” Id. (citing Langbecker, 476 F.3d at 310-11 and In re Unisys, 74 F.3d at 445). The court found that the fiduciaries provided plan participants with a sufficient variety of investment options. Id. at 590. In a subsequent opinion, however, the Seventh Circuit clarified that its decision was based solely on the allegations in that case and that it did not necessarily decide that fiduciaries could insulate themselves from liability in all situations merely by providing participants a large number of investment options. Hecker v. Deere & Co., 569 F.3d 708, 711 (7th Cir. 2009).

See also:

Pfeil v. State St. Bank & Trust Co., 671 F.3d 585, 599 (6th Cir. 2012), abrogated on other grounds, 573 U.S. 409 (2014). The Sixth Circuit held that the district court erred when it relied on § 404(c) at the motion to dismiss stage because the plaintiff had not addressed the affirmative defense in its complaint. The defendants also did not “assert or prove that it had complied with the requirements of the regulation to qualify for the safe harbor.” The lower court’s decision was reversed and case remanded for further proceedings.

*Stanford v. Foamex L.P., No. 07-4225, 2011 WL 4528365, at *23(E.D. Pa. Sept. 30, 2011). The party asserting a § 404(c) defense bears the burden of demonstrating that the requirements have been met. When defendants do not address the requirements set forth in the Department of Labor regulations’ requirements, that burden cannot be satisfied.*

*In re YRC Worldwide, Inc. ERISA Litig., No. 09-2593-JWL, 2011 WL 1457288, at *2–4 (D. Kan. Apr. 15, 2011). The court agreed with other courts that § 404(c)’s safe harbor provision is not available in connection with claims challenging the selection of plan investment options and the decision to continue offering a particular investment. The court struck defendant’s § 404(c) defense.*

*In re Washington Mutual, Inc. Sec., Derivative & ERISA Litig., No. C07-1874 MJP, 2009 WL 3246994, *7-*8 (W.D. Wash. Oct. 5, 2009). While noting that the case was similar to Hecker in that plaintiffs included a response to a potential § 404(c) defense in the complaint and that participants had access to a variety of investment options, the court declined to dismiss the case on a motion to dismiss. A critical distinction*

to the court was that “Plaintiffs here challenge the decision to preserve investment alternatives, not the administrative fees associated with any particular alternative” as in Hecker.

Tullis v. UMB Bank, N.A., 640 F. Supp. 2d 974, 979-80 (N.D. Ohio 2009), aff’d by 423 F. App’x 567, 571 (6th Cir. 2011). The court granted summary judgment for defendants because it found that the safe harbor defense was applicable to the participants’ claims. Plaintiffs sought to recover losses from an investment advisor’s fraudulent activities about which the trustee allegedly knew, but the court found that the participants exercised complete control over their accounts and related assets and they were provided a broad range of investment alternatives.

Lingis v. Motorola, Inc., 649 F. Supp. 2d 861, 870 (N.D. Ill. 2009). The court granted summary judgment for the defendants and found that the ERISA § 404(c) defense applied. It determined that the participants were given sufficient information about their investment alternatives and that they had independent control over their investment decisions. In addition, the court found that by offering 8 investment options in addition to the employer stock fund, the defendants provided participants with “a broad range of investment alternatives” as required by Hecker.

3. Adequate consideration must be given when plan acquires employer stock

Aside from stock drop cases, another important area of litigation related to employer stock involves ERISA’s prohibited transactions provisions, particularly ERISA § 406, 29 U.S.C. § 1106. Section 406(a) prohibits certain types of transactions between a plan and a party in interest, which includes a fiduciary of the plan. Hall Holding, 285 F.3d at 424. One of the prohibited transactions is the acquisition of employer securities by a plan. 29 U.S.C. § 1106(a)(1)(E). However, under ERISA § 408(e), 29 U.S.C. § 1108(e), “§ 406 does not apply to the acquisition or sale by a plan of the employer’s securities as long as the acquisition or sale is for ‘adequate consideration.’” Hall Holding, 285 F.3d at 425 (citing 29 U.S.C. § 1108(e)(1)).

Adequate consideration does not require “a premium above market.” Thompson, 2002 WL 246407, at *3 (rejecting claim “that adequate consideration requires a premium above market”). ERISA provides two definitions for adequate consideration, depending on if the stock is publicly-traded. 29 U.S.C. § 1002(18). ERISA provides that:

“adequate consideration” . . . means

- (A) in the case of a security for which there is a generally recognized market, either

- (i) the price of the security prevailing on a national securities exchange which is registered under section 78f of Title 15, or
 - (ii) if the security is not traded on such a national securities exchange, a price not less favorable to the plan than the offering price for the security as established by the current bid and asked prices quoted by persons independent of the issuer and of any party in interest; and
- (B) in the case of an asset other than a security for which there is a generally recognized market, the fair market value of the asset as determined in good faith by the trustee or named fiduciary pursuant to the terms of the plan and in accordance with regulations promulgated by the Secretary.

29 U.S.C. § 1002(18).

For cases involving a publicly-traded stock, the inquiry is rather straightforward. If the plan acquires the stock at a price at or below the publicly-traded price, adequate consideration is provided, and there is no prohibited transaction because the § 408(e) exemption applies. See, e.g., In re Radioshack Corp. ERISA Litig., 547 F. Supp. 2d 606, 617 (N.D. Tex. 2008); In re Coca-Cola Enters. Inc. ERISA Litig., No. 060953, 2007 WL 1810211, at *17 (N.D. Ga. 2007).

To determine whether adequate consideration was provided if the stock is not publicly-traded, courts consider not only the fair market value of the employer securities, but also analyze “the process that led to the determination of fair market value in light of § 404’s fiduciary duties.” Hall Holding, 285 F.3d at 437. See also Brundle v. Wilmington Trust, N.A., 919 F.3d 763, 780 (4th Cir. 2019) (“[C]ourts look to the *conduct* of the trustee and whether it met its fiduciary obligations, not to whether the trustee arrived at a ‘fair’ value.”); Perez v. Bruister, 823 F.3d 250, 263 (5th Cir. 2015) (“[T]he ERISA § 408(e) adequate consideration exemption ‘is expressly focused upon the *conduct* of the fiduciaries’ and is ‘read in light of the overriding duties’ in ERISA § 404, particularly the duty of care.”). Courts have stated that analyzing the process is necessary because “the definition of ‘adequate consideration’ has two distinct parts. First, there is the ‘fair market value’ part, then there is the ‘as determined in good faith by the trustee’ part.” Id. at 436. “[I]n practice, the ‘fair market value’ inquiry overlaps considerably with the ‘good faith’ inquiry; both are ‘expressly focused upon the *conduct* of the fiduciaries.” Henry v. Champlain Ent., Inc., 445 F.3d 610, 619 (2d Cir. 2006) (Sotomayor, J.). “The role of courts in reviewing the adequacy of consideration in an ERISA case is to determine whether the fiduciary can show that the price paid represented a good faith determination of the fair market value of the asset at the time the challenged transaction was consummated, not to redetermine the appropriate

amount for itself de novo.” Hugler v. First Bankers Trust Servs., Inc., No. 12-cv-8649, 2017 WL 1194692, at *10 (S.D.N.Y. Mar. 30, 2017) (internal quotations omitted).

In Herman v. Mercantile Bank N.A., the Eighth Circuit held that if a prudent trustee would have purchased the employer stock at the price defendant paid for it, then no ERISA violation occurred “regardless of whether defendant made a good faith effort to determine the fair market value of the stock.” 143 F.3d 419, 421 (8th Cir. 1998). In Hall Holding, the Sixth Circuit expressly rejected Herman. Instead, the court emphasized the importance of both fair market value and good faith of the fiduciary. Hall Holding, 285 F.3d at 436.

The Hall Holding court also distinguished the Sixth Circuit’s decision in Kuper by stating that Kuper “only addressed violations of § 404 [failure to diversify plan assets], not § 406 [prohibited transactions due to lack of adequate consideration].” Id. at 438. Due to this difference, the Hall Holding court found that “the price paid by a hypothetical reasonable fiduciary is irrelevant in determining whether defendants violated § 406(a)(1).” Id. at 437. Moreover, in Hall Holding the court declined “to read a ‘causation’ element into a violation of § 406,” which would require “a casual link between the failure to investigate and the resultant harm” to the plan. Id. at 438-39; see also Horn v. McQueen, 215 F. Supp. 2d 867, 876 (W.D. Ky. 2002) (stating that “claims under § 406, therefore, operate under a different analytical framework than those under § 404, as § 406 lacks the causation element and places the burden on the defendants to show that adequate consideration was paid”).

In Horn, the plaintiffs alleged that the ESOP trustees caused the ESOP to pay more than adequate consideration for the employer securities. 215 F. Supp. 2d at 873. There, the district court applied the “prudent person” standard of care to the trustees’ actions. Id. The court distinguished the case before it from Moench and Kuper, in which the court adopted the arbitrary and capricious standard of review, by noting that those cases involved allegations of breach of fiduciary duties for failure to diversify ESOP holdings. Id. at 875. The court acknowledged that:

although dicta in these cases supports extending such reasoning to the case of an ESOP fiduciary accused of overpaying for employer securities, Cunningham confronts this issue head on and applies the prudent person standard. Because Cunningham is more factually and legally on point, it is better precedent, and we will follow it by applying the more rigorous standard of review to defendants’ actions in this case.

Id.

Thus, the court held that “a prohibited transaction under § 406 may be found even when, coincidentally, the ESOP paid no more than fair market value for employer securities, if the trustees failed to conduct a prudent investigation into the price of the stock under the circumstances then prevailing.” Id. at 874. The defendant-

fiduciary has the burden to demonstrate that it undertook a prudent investigation prior to the ESOP's stock purchase. *Id.* at 881. See also Brundle, 919 F.3d at 770 ("This burden is a heavy one.").

Furthermore, the court held that "overpayment by the ESOP for employer securities constitutes a loss to the plan, measured by the difference between purchase price paid and the fair market value of the stock at the time of the transaction." Horn, 215 F. Supp. 2d at 874. The Horn court found that even though "defendants were involved in varying degrees in an investigation into the value of the stock," the trustees were not acting on behalf of the ESOP. *Id.* at 890 (quoting Reich v. Hall Holding Co., 990 F. Supp. 955, 963 (N.D. Ohio 1998)). In other words, the failure to act "solely in the interest of plan participants and beneficiaries" was "sufficient to show a breach of ERISA § 406 and a prohibited transaction." *Id.*

See also:

Brundle v. Wilmington Trust, N.A., 919 F.3d 763, 779-81 (4th Cir. 2019). *The Fourth Circuit affirmed the district court's entry of judgment in favor of the defendant after a bench trial and held that, even assuming arguendo that a transaction was for "fair market value," the district court did not err in concluding that the transaction price was not "the product of a determination made by the fiduciary in good faith," and therefore, that adequate consideration had not been provided.*

Keach v. U.S. Trust Co., 419 F.3d 626, 638-40 (7th Cir. 2005). *The Seventh Circuit affirmed the district court's entry of judgment in favor of the defendants after a bench trial and held that a transaction was for "adequate consideration" where the defendants secured a fairness opinion within a reasonable time of the transaction approving the price and their reliance on the fairness opinion was reasonable.*

Summers v. State St. Bank & Trust Co., 104 F.3d 105, 106-08 (7th Cir. 1997). *ESOP participants challenged a transaction under ERISA § 406's prohibition of transactions between a fiduciary and a party-in-interest for a sale of employer securities. Judge Posner held that a "price . . . based on market value" would be considered reasonable even though there was no market in the new preferred stock because there was a market in the employer's common stock. The bank used the price of the common stock and made an adjustment for the preferred status of the stock that was sold, and the court affirmed dismissal of the prohibited transaction claim.*

Innis v. Bankers Trust Co. of South Dakota, No. 4:16-cv-00650, 2017 WL 4876240, at * (S.D. Iowa Oct. 13, 2017). *The district court denied defendant's motion to dismiss because it "[could] not determine on the record before it whether [defendant] determined fair market value in good faith while acting with prudence under § 1104 during the Transaction." Although defendant "provided documents demonstrating it utilized [an*

expert] to evaluate the sale, . . . [a]n independent appraisal is not a magic wand that fiduciaries may simply wave over a transaction to ensure that their responsibilities are fulfilled.” The court not at this point determine whether defendant’s reliance on the expert’s report was justified.

DeFazio v. Hollister, Inc., Nos. 2:04-cv-1358, 2:05-cv-0559, 2:05-cv-1726, 2012 WL 1158870, at *20 (E.D. Cal. Apr. 6, 2012). “[W]hile a prudent trustee may have determined that the significant cash need decreased the fair market value of HolliShare’s shares, the evidence shows that the Trustees never attempted to quantify how HolliShare’s cash needs affected the value of its stock.” The court held that the Trustees did not prove that the difference between the year-end book value and the month-end book value had any correlation to decrease of HolliShare’s stock because of their need for cash payments.

4. Remedies in Employer Stock Claims

Courts approach remedies in cases related to employer stock in much the same way they approach remedies in other ERISA claims. When a fiduciary is found to have violated the terms governing EIAP or ESOP plans, courts look to the nature of the breach and determine the appropriate remedy. See *Neil v. Zell*, 767 F. Supp. 2d 933, 940 (N.D. Ill. 2011) (ruling on remedies for breaches under § 404(a) and § 406(a)-(b)); *Graden v. Conextant Sys. Inc.*, 574 F. Supp. 2d 456, 464 (D.N.J. 2008) (finding sufficient facts were pled to bring claims for breach of the duty of prudence and failure to monitor). For a discussion of appropriate remedies that are generally available under ERISA cases, see Section IV of this outline.

In employer stock claims, the difficulty presented to courts is valuing the loss to the plan. For example, remedies sometimes depend on a determination of how much a plan would have gained if a fiduciary had invested prudently. Determining the remedy can be complicated when the plan is an ESOP or EIAP that required the fiduciary to invest in employer stock. In addition, complications arise when a plan has not paid in cash for the employer stock. In *Neil*, the defendant acquired employer stock on behalf of the plan through a loan from the employer. *Neil*, 767 F. Supp. 2d at 939. The ESOP financed the purchase with a promissory note for \$250 million, but had only paid back about \$15.3 million of the loan balance at the time of the suit. *Id.* The court rejected the defendant’s argument that recovery to the plan should be capped at the actual cash the ESOP had paid. *Id.* at 951. However, the court did not determine what the amount of damages should be and left the possibility of how to calculate damages open. *Id.* The plaintiffs presented the court three options for damage calculations: (1) the difference between the price paid and the price that should have been paid for the stock, *id.* at 944; (2) the difference between what the Plan actually earned and what the plan would have earned had the funds been available for other purposes, *id.* at 946; and (3) the difference between the amount paid for the stock and the current, fair-market value of the stock, *id.* at 947–48. All three possibilities were left open by the court. *Id.* at 944, 946, 948.

In ERISA cases generally, courts have discretion to craft remedies for a fiduciary breach. Neil, 767 F. Supp. 2d at 940. However, courts generally recognize that where there is no loss to the plan, there can be no recovery. King v. Nat'l Human Res. Comm., Inc., 218 F.3d 719, 724 (7th Cir. 2000). Windfall recoveries over and above the plan's losses are also unavailable under ERISA. Massachusetts Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 148 (1985).

E. LITIGATION AFFECTING EMPLOYEE WELFARE BENEFIT PLANS UNDER ERISA

ERISA governs two types of employee benefit plans: employee pension plans and employee welfare benefit plans. See 29 U.S.C. § 1002. A welfare plan requires “(1) a ‘plan, fund, or program’ (2) established or maintained (3) by an employer or by an employee organization, or by both, (4) for the purpose of providing medical, surgical, hospital care, sickness, accident, disability, death, unemployment or vacation benefits, apprenticeship or other training programs, day care centers, scholarship funds, or prepaid legal services or severance benefits (5) to participants or their beneficiaries.” Donovan v. Dillingham, 688 F.2d 1367, 1370-71 (11th Cir. 1982). A benefit is provided pursuant to a “welfare benefit plan” even if it is within a subsection of a pension plan. McBarron v. S & T Indus., Inc., 771 F.2d 94, 98 (6th Cir. 1985). Health, medical, disability, and life insurance benefits are considered employee welfare benefits. See 29 U.S.C. § 1002(1).

See also:

Neuma, Inc. v. AMP, Inc., 259 F.3d 864, 872 (7th Cir. 2001). A life insurance program is a welfare benefit plan as defined by ERISA.

Postma v. Paul Revere Life Ins. Co., 223 F.3d 533, 537-38 (7th Cir. 2000). Disability benefits are welfare benefits.

Owens v. Storehouse, Inc., 984 F.2d 394, 397-98 (11th Cir. 1993). Medical benefits fall within the definition of welfare benefits.

Williams v. Caterpillar, Inc., 944 F.2d 658, 667 (9th Cir. 1991). Health benefits are considered welfare benefits.

But see:

Massachusetts v. Morash, 490 U.S. 107, 116-17 (1989). Although vacation benefits are included in ERISA's list of possible welfare plan benefits, vacation pay which was paid out of the company's general assets did not form an ERISA-covered welfare plan to provide vacation benefits.

Raskin v. Cynet, Inc., 131 F. Supp. 2d 906, 908 n.2, 910 (S.D. Tex. 2001). Stock purchase option is not a welfare plan benefit. The test to see whether a plan qualifies as a welfare plan is: whether the plan (1) “exists”

(2) falls within a “safe harbor provision” (3) was established by the Department of Labor and (4) meets ERISA requirements of establishment or maintenance by an employer for the purposes of benefiting plan participants.

Further, the employer’s purchase of insurance for its employees can establish a welfare plan. See 29 U.S.C. § 1002(1); see also *Madonia v. Blue Cross & Blue Shield of Va.*, 11 F.3d 444, 447 (4th Cir. 1993).

Once a welfare benefit plan is established, it is subject to ERISA’s reporting and disclosure requirements. *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 82-84 (1995); see 29 U.S.C. §§ 1021-31. Additionally, ERISA’s fiduciary responsibility provisions are applicable to welfare benefit plans. *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 732 (1985) (stating that ERISA fiduciary obligations apply to welfare plans), *overruled in part on other grounds by Ky. Ass’n of Health Plans, Inc. v. Miller*, 538 U.S. 329 (2003); see 29 U.S.C. §§ 1101-1114.

1. Notable differences between welfare benefits and pension benefits

There are several differences between pension benefits and welfare benefits. Without question, however, the most significant difference between them is that ERISA provides many specific requirements for the substantive content of pension plans but the substantive content of welfare benefit plans is virtually unregulated. This difference is reflected mainly in how ERISA treats the two types of benefits in terms of vesting and minimum funding. See, e.g., *M&G Polymers USA, LLC v. Tackett*, 135 S. Ct. 926, 933 (2015) (“ERISA treats these two types of plans differently.”).

a) Vesting

Under ERISA, participants gain “vested” pension benefits when they gain a right or claim that is unconditional and legally enforceable against the plan. See 29 U.S.C. § 1002(19).

ERISA contains a number of vesting requirements for ERISA-covered pension plans. See 29 U.S.C. §§ 1051-61. Most critically, an ERISA-covered pension plan must provide that an employee’s pension benefits vest when the employee reaches normal retirement age. 29 U.S.C. § 1053(a)(1). Additionally, an ERISA-covered pension plan must provide that employees have non-forfeitable rights to any benefit that is derived from their own contributions. Id. Moreover, the plan also must provide employees a non-forfeitable right to benefits that are derived from the employer’s contributions after an employee completes certain years of service. For example, a plan satisfies ERISA if an employee who has completed five years of service has a non-forfeitable right to 100% of benefits that are derived from employer contributions. 29 U.S.C. § 1053(a)(2)(A-B). Along with these central requirements, ERISA imposes extensive additional requirements for vesting and accrual which are codified at 29 U.S.C. §§ 1051-61.

In contrast, welfare plans are not covered by ERISA's vesting requirements. 29 U.S.C. § 1051; M&G Polymers, 135 S. Ct. at 933. Courts have held that though vesting of welfare plans is not required under ERISA, it can be contracted for in welfare plans. See Inter-Modal Rail Emps. Ass'n v. Atchison, Topeka & Santa Fe Ry. Co., 520 U.S. 510, 515 (1997); Temme v. Bemis Co., 622 F.3d 730, 735 (7th Cir. 2010) (stating welfare benefits only vest if contract so provides). As discussed below, plaintiffs' attempts to obtain lifetime medical benefits have been a significant source of litigation over recent years and plaintiffs have had varying levels of success in asserting those claims. See, e.g., UAW, Local No. 1697 v. Skinner Engine Co., 188 F.3d 130, 139 (3d Cir. 1999).

b) Minimum funding requirements

ERISA-covered pension plans must comply with ERISA's complex system of minimum funding requirements. 29 U.S.C. §§ 1081-85. For example, ERISA's minimum funding system requires pension plans to calculate in accordance with Department of Treasury rules, the past, current, and projected future assets and liabilities of the pension plans. 29 U.S.C. § 10885(a)(c)(2). ERISA mandates that pension plans must have a minimum balance between plan assets and liabilities, such that assets cannot be less than liabilities by more than designated amounts at certain periods of time. Id. The requirements vary for different kinds of plans (e.g., single employer plans versus multiple employers plans), but all ERISA-covered pension plans must comply with some minimum funding requirements. See, e.g., 29 U.S.C. § 1083-84.

As with the vesting requirements, ERISA does not impose minimum funding requirements on welfare plans. 29 U.S.C. § 1081; M&G Polymers, 135 S. Ct. at 933; Curtiss-Wright Corp., 514 U.S. at 78. Because "ERISA does not create any substantive entitlement to employer-provided health benefits or any other kind of welfare benefits," there would be no reason to require employers that do provide welfare benefit plans to fund those plans to ensure that they will continue to provide benefits. See Curtiss-Wright Corp., 514 U.S. at 78. Courts have noted that the lack of minimum funding requirements reflects Congress's policy decision that administration of welfare benefit plans should remain flexible to encourage employers to provide them.

c) Alienability

Alienability refers to the right of an owner to transfer his property to another. In the context of pension and welfare benefits, alienability refers to the right of an owner to transfer some or all of those benefits to another, whether voluntarily or involuntarily. See, e.g., Tango Transp. v. Healthcare Fin. Servs. LLC, 322 F.3d 888-, 893 (5th Cir. 2003). While benefits that are completely alienable can be bought, sold, and taken by a court to satisfy a judgment, inalienable benefits cannot. Id. ERISA treats the alienability welfare benefits and ERISA-covered pension plan benefits quite differently. See 29 U.S.C. § 1056.

ERISA tightly restricts the alienation of pension plan benefits before they have been distributed. 29 U.S.C. § 1056(d)(1). ERISA pension benefits are not subject to garnishment or constructive trusts *before* the benefits have been distributed. Guidry v. Sheet Metal Workers Nat'l Pension Fund, 493 U.S. 365, 371-72 (1990). However, ERISA pension benefits are subject to garnishment and constructive trusts *after* the benefits have been distributed. Guidry v. Sheet Metal Workers Nat'l Pension Fund, 39 F.3d 1078, 1083 (10th Cir. 1994).

ERISA's anti-alienation provision expressly includes only pension benefits, not welfare benefits. 29 U.S.C. § 1056(d)(1). Although Congress had the choice to prohibit alienation of welfare benefits, it chose not to do so. See Mackey v. Lanier Collection Agency & Serv., Inc., 486 U.S. 825, 837 (1988) (finding that ERISA does not prevent garnishment of welfare benefits). Therefore, welfare benefits are presumably freely alienable. Id. at 837-38. ERISA also does not prevent the imposition of a constructive trust after the distribution of welfare benefits. Cent. States, Se. & Sw. Areas Pension Fund v. Howell, 227 F.3d 672, 679 (6th Cir. 2000).

Courts have not conclusively determined if ERISA permits a constructive trust on welfare benefits *before* their distribution, for reasons other than inalienability. The Sixth Circuit has held that a constructive trust before the distribution of welfare benefits is impermissible, reasoning that the plan administrator must distribute the benefits to the named beneficiary. See id. at 679, n.5. Conversely, the Ninth Circuit holds that ERISA permits a constructive trust on welfare benefits before or after their distribution, based on ERISA's express lack of an anti-alienation provision covering welfare plans. See Emard v. Hughes Aircraft Co., 153 F.3d 949, 954 (9th Cir. 1998), overruled in part on other grounds by Egelhoff v. Egelhoff, 532 U.S. 141 (2001).

The Fifth Circuit has held that ERISA welfare benefits are freely assignable. Tango Transp., 322 F.3d at 891-93. By the Fifth Circuit's rule, the right to sue, standing to sue, and the right to receive welfare benefits can all be freely assigned by the named ERISA beneficiary. Id.

2. Suits involving vesting of welfare benefits

ERISA specifically excludes welfare benefits from the minimum participation, vesting and minimum funding requirements applicable to pension benefits. 29 U.S.C. §§ 1051(1), 1053(a), 1081(a)(1); Curtiss-Wright Corp., 514 U.S. at 78. Courts have noted that "[t]o require the vesting of these ancillary benefits would seriously complicate the administration and increase the cost of plans whose primary function is to provide retirement income." Moore v. Metro. Life Ins. Co., 856 F.2d 488, 491 (2d Cir. 1988) (quoting H.R. Rep. No. 93-807).

Over the years, however, welfare benefits such as medical care have become important to many plan participants. This is especially true for retired employees who may have bargained for such benefits while they were employed at a relatively low cost to them. These benefits, however, can be very expensive to employers today. As a result, many employers have sought to modify or eliminate the

benefits or increase the premiums recipients pay for them. This has led to litigation in which the plaintiffs allege the defendants improperly modified their vested benefits in violation of ERISA.

Generally, ERISA does not regulate the substantive content of welfare benefit plans. Therefore, unless a plan sponsor contractually cedes its freedom, it is generally free under ERISA to adapt, modify or terminate welfare benefits at any time for any reason. Curtiss-Wright Corp., 514 U.S. at 78; Hackett v. Xerox Corp. Long-Term Disability Income Plan, 315 F.3d 771, 774 (7th Cir. 2003). However, a plan sponsor's promise of vested benefits is enforceable. See Am. Fed'n of Grain Millers v. Int'l Multifoods Corp., 116 F.3d 976, 980 (2d Cir. 1997); Wheeler v. Dynamic Eng'g, Inc., 62 F.3d 634, 637-38 (4th Cir. 1995). Vested for the purposes of ERISA means "nonforfeitable," which is further defined as "unconditional." 29 U.S.C. §§ 1002(19), 1002(25). Therefore, courts agree that the plan sponsor and employee may contract to maintain welfare benefits at a certain level that ERISA does not mandate. Schonholz v. Long Island Jewish Med. Ctr., 87 F.3d 72, 77 (2d Cir. 1996); Wise v. El Paso Natural Gas Co., 986 F.2d 929, 937 (5th Cir. 1993). Courts disagree, however, over what language is necessary for welfare benefits to vest.

See:

Schonholz v. Long Island Jewish Med. Ctr., 87 F.3d 72, 78 (2d Cir. 1996). An agreement to vest welfare benefits need only be as formal as the benefit plan itself.

Bidlack v. Wheelabrator Corp., 993 F.2d 603, 608 (7th Cir. 1993). When the agreement is ambiguous as to when and if the welfare benefits vest, extrinsic evidence may be used to show that the benefits were meant to be perpetual.

But see:

Wise v. El Paso Natural Gas Co., 986 F.2d 929, 937 (5th Cir. 1993). To create a contractual right to vested welfare benefits, the "commitments must be found in the plan documents and must be stated in clear and express language."

United Paperworkers Int'l Union v. Jefferson Smurfit Corp., 961 F.2d 1384, 1386 (8th Cir. 1992). The parties may bargain for welfare benefits to vest, but "the fruits of those bargains must be reduced to writing and incorporated . . . into the formal written ERISA plan provided to employees."

Anderson v. John Morrell & Co., 830 F.2d 872, 877 (8th Cir. 1987). For a contract to validly vest welfare benefits, "there must be a specific, if not written, expression of the employer's intent to be bound."

In determining the scope of vested rights, courts interpret the agreement at issue and apply principles of contract interpretation. Like welfare benefits for active employees, retiree welfare benefits only vest if and when a contract specifies, not upon the attainment of a certain status, such as retirement or disability.

See:

M&G Polymers USA, LLC v. Tackett, 135 S. Ct. 926, 933-36 (2015). *No inference of an intent to vest retirees with lifetime health care benefits should have been drawn from the context of labor negotiations.*

Curtiss-Wright Corp. v. Schoonejongen, 514 U.S. 73, 78 (1995). *Under a retirement health plan, “ERISA does not create any substantive entitlement to employer-provided health benefits or any other kind of welfare benefits.”*

Sullivan v. CUNA Mut. Ins. Soc’y, 649 F.3d 553, 557-58 (7th Cir. 2011). *The dismissal of Plaintiffs’ claim for medical benefits was affirmed because the benefits were not vested. The record showed that every version of the plan reserved the right to change or eliminate healthcare benefits. Even though certain documents given to participants did not expressly state that the employer had reserved a right to amend the plan, participants needed to show more than silence to establish vested rights to lifetime benefits. Citing to CIGNA Corp. v. Amara, 131 S. Ct. 1866 (2011), the court added that silence in a summary plan description about some feature of a benefit plan does not override language in the plan itself. In addition, the court stated that whether to reduce the plaintiff’s benefits was a business decision, not a legal question that could give rise to liability under ERISA.*

Temme v. Bemis Co., 622 F.3d 730, 735-37 (7th Cir. 2010). *The parties disputed whether an employer had agreed to provide vested lifetime medical benefits. The court looked to the terms of the last collective bargaining agreement and a “closing agreement” to determine the intent of the parties. After reviewing the terms of the documents, the court concluded that the agreement was negotiated to create enduring rights, had no termination date, and provided no method through which retiree benefits could end. As a result, the court found that the parties intended to provide lifetime benefits, and it reversed the lower court’s judgment for the employer.*

Grosz-Salomon v. Paul Revere Life Ins. Co., 237 F.3d 1154, 1160 (9th Cir. 2001). *Because the disability policy provided that the policy provider could change the policy upon written request without the beneficiaries’ consent, the plan’s provisions were not invoked in perpetuity when the employee was disabled. Rights to the disability benefit do not vest upon*

the occurrence of the disability but vest only when the contract so provides.

Chiles v. Ceridian Corp., 95 F.3d 1505, 1512-13 (10th Cir. 1996), overruled on other grounds, Tomlinson v. El Paso Corp., 653 F.3d 1281, 1295 (10th Cir. 2011). The language of the plan did not clearly indicate disability as the vesting trigger. Therefore, although the employee began to collect disability insurance, the employee did not have a vested right to the benefits.

Williams v. Caterpillar, Inc., 944 F.2d 658, 666-67 (9th Cir. 1991). “Retiree medical benefits do not become vested once an employee becomes eligible or retires.”

Moore v. Metro. Life Ins. Co., 856 F.2d 488, 491 (2d Cir. 1988). For a retirement welfare benefit plan, “[a]utomatic vesting does not occur in the case of welfare plans.”

In re White Farm Equip. Co., 788 F.2d 1186, 1193 (6th Cir. 1986). While a plan provider and an intended beneficiary may contract for vested retiree welfare benefits in the plan documents, retiree welfare benefits are not required to vest at retirement.

Coriale v. Xerox Corp., 775 F. Supp. 2d 583, 595 (W.D.N.Y. 2011). Plaintiffs could not rely on informal documents issued by their employer to establish that the employer agreed to provide free lifetime health benefits. The statements and guidebooks plaintiffs cited were not plan documents and in some cases pre-dated the actual plan, which included a reservation-of-rights clause that advised participants that Xerox could “terminate or change” the plan at any time, at its discretion.

But see:

*Merkner v. AK Steel Corp., No. 1:09-cv-423, 2010 WL 373998, at * 4 (S.D. Ohio Jan. 29, 2010). On a motion for a preliminary injunction to prohibit their former employer from further reducing benefits or imposing new charges for benefits prior to final judgment, the court held that retired employees presented evidence of a likelihood of success on the merits on their claim that they were entitled to vested medical benefits. A review of the applicable collective bargaining agreements supported a preliminary conclusion that the parties agreed that retiree benefits vested when plaintiffs retired. Because the language of agreements and summary plan descriptions reflected an intent for lifetime health benefits to vest at retirement, the court granted plaintiffs’ request for a preliminary injunction.*

Because welfare plans do not vest automatically under ERISA, the plan sponsor is free to amend the plan and apply the amendment retroactively, unless the benefit has contractually vested or has been paid. Member Servs. Life Ins. Co. v. Am.

Nat'l Bank & Tr. Co. of Sapulpa, 130 F.3d 950, 954 (10th Cir. 1997) (refusing to allow recoupment of benefits paid before amendment); Filipowicz v. Am. Stores Benefit Plans Comm., 56 F.3d 807, 815 (7th Cir. 1995). Although amendments may apply retroactively if the benefit has not vested, an ERISA welfare plan is not subject to an amendment based on informal communications between the employer and intended beneficiaries. Confer v. Custom Eng'g Co., 952 F.2d 41, 43 (3d Cir. 1991); Moore, 856 F.2d at 492. Instead, the plan sponsor must provide, in writing, a procedure for amending the plan and a procedure for identifying the persons who have authority to amend the plan. See 29 U.S.C. §§ 1102(a)(1), (b)(3); Curtiss-Wright Corp., 514 U.S. at 78-79. A plan beneficiary can bring an action against an employer when a plan is not amended according to the proper procedure. Id. at 83-84. Further, an employer may be liable if it uses the power to amend the welfare benefit plan to discriminate against an employee or to interfere with that employee's attainment of a right under the plan. See 29 U.S.C. § 1140; see also Section XV.A of this Handbook.

3. Disability benefit exemption

As part of its preemption rules, 29 U.S.C. § 1003(b)(3), exempts from ERISA coverage benefit plans maintained solely for the purpose of complying with applicable disability insurance. See 29 U.S.C. § 1003(b)(3). Section I of this Handbook also provides a detailed discussion of ERISA's preemption provisions.

4. The Consolidated Omnibus Budget Reconciliation Act

In some circumstances, employers must provide terminated employees an opportunity to continue to receive group health coverage that would otherwise be terminated. See 29 U.S.C. § 1161. Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), private employers who offer a group health plan must provide for continuation coverage of health benefits for laid-off employees at approximately the group rate. See 29 U.S.C. §§ 1161-67; see generally MICHAEL J. CANAN & WILLIAM D. MITCHELL, EMPLOYEE FRINGE & WELFARE BENEFIT PLANS § 10.3 (2002 ed.). COBRA requires "an employer who sponsors a group health plan to give the plan's 'qualified beneficiaries' the opportunity to elect 'continuation coverage' under the plan when the beneficiaries might otherwise lose coverage upon the occurrence of certain 'qualifying events.'" Geissal v. Moore Med. Corp., 524 U.S. 74, 80 (1998). A full discussion of COBRA is beyond the scope of this Handbook, but a few topics will be discussed here.

a) COBRA excludes disability benefits

COBRA defines "group health plan" as an employee welfare benefit plan that provides medical care to beneficiaries. See 29 U.S.C. § 1167(1). Several federal courts have interpreted the term "medical care" to exclude disability benefits.

See:

Austell v. Raymond James & Assocs., Inc., 120 F.3d 32, 33-34 (4th Cir. 1997). *Disability benefits designed to replace lost wages do not fall within*

COBRA's definition of health benefits because disability insurance is not "an amount paid to modify or alleviate disease, just as it is not an amount paid to diagnose, cure, treat or prevent disease."

*Burgess v. UNUM Life Ins. Co., No. 95-cv-0229, 1995 WL 581151, at *2 n.3 (N.D. Cal. Sept. 25, 1995). In dicta, the court noted that "[l]ong-term disability coverage is explicitly exempted from COBRA, since it is not considered a 'medical benefit' as defined by COBRA."*

b) COBRA excludes life insurance benefits

Similar to excluding disability benefits from its continuation coverage requirement, courts have also held that COBRA excludes life insurance benefits from the benefits provided under a "group health plan."

See:

*Mays v. UNUM Life Ins. Co. of Am., No. 95-C-1168, 1995 WL 317102, at *5-1 n.1 (N.D. Ill. May 23, 1995). COBRA does not appear to mandate continuation coverage for life insurance.*

Jefferson v. Reliance Standard Life Ins. Co., 818 F. Supp. 1523, 1524-25 (M.D. Fla. 1993), rev'd on other grounds, 85 F.3d 642 (11th Cir. 1996). "[Because] [t]he definition of medical care does not include or reference life or accidental death and dismemberment benefits . . . 'group health plan' under the provisions of ERISA and COBRA does not contemplate life or accidental death and dismemberment. Thus a plan sponsor is not required under ERISA and COBRA to offer continuation of coverage for life or accidental death and dismemberment benefits."

c) COBRA provides an extended period of coverage for the disabled

Qualified beneficiaries disabled within sixty days of their termination are eligible for COBRA continuation coverage for twenty-nine months, rather than the normal eighteen months of coverage. See 29 U.S.C. §§ 1162(2)(A)(viii). To be eligible for the twenty-nine month coverage period, the individual must be considered disabled under Title II or XVI of the Social Security Act. See 29 U.S.C. § 1162(2)(A)(viii). To be eligible for the eleven month extension, the qualified beneficiary must have been disabled within the meaning of Title II or XVI of the Social Security Act, within sixty days of his termination. Marsh v. Omaha Printing Co., 218 F.3d 854, 855 (8th Cir. 2000). Additionally, the individual must inform the plan provider of the disability determination within the initial eighteen-month continuation coverage period. Id.; see 29 U.S.C. § 1162(2)(A)(viii).

F. MORTALITY TABLE LITIGATION

In December 2018, a new wave of pension litigation emerged, as class action complaints combining actuarial science with ERISA claims were filed against major corporations. The complaints include claims for declaratory and equitable relief under ERISA § 502(a)(3), for reformation of the pension plan recovery of benefits under §§ 502(a)(1) and (3), and for breach of fiduciary duty under §§ 1104 and 502(a)(3).

1. The Lawsuits

In December 2018, four putative class action lawsuits were filed targeting large corporate pension plans for allegedly applying unreasonable actuarial equivalence factors, including purportedly “outdated” mortality tables, when calculating plan benefits payable in various annuity forms of distribution or at early retirement. Masten v. Metropolitan Life Insurance Company, 1:18-cv-11229 (S.D.N.Y. Dec. 3, 2018); Martinez Torres v. American Airlines, Inc., 4:18-cv-00983 (N.D. Tex. Dec. 11, 2018); DuBuske, et al. v. PepsiCo, Inc., 7:18-cv-11618 (S.D.N.Y. Dec. 12, 2018); Smith v. U.S. Bancorp, 0:18-cv-03405 (Minn. Dec. 14, 2018). In April and May 2019, two similar class actions were filed, respectively, against two other corporations. Smith v. Rockwell Automatic, Inc., 19-cv-00505 (E.D. Wis. Apr. 8, 2019); Duffy v. Anheuser-Busch Companies, LLC, 19-cv-1189 (E.D. Mo. May 6, 2019). In all six lawsuits, the plaintiffs, who are all retired employees of the defendant companies or spouses of retired or deceased employees of the companies, allege that this practice has caused participant and survivor annuitants (and, in one case, early retirees) to receive lower payments than they should under ERISA. The complaints contain similar allegations and were all filed by the same plaintiffs’ law firms.

2. Complaint Allegations

The putative class actions in this first wave of mortality table litigation were filed, respectively, against six large companies, and, in most cases, against the companies’ respective benefits committees, in federal courts across the country. The complaints focus on the joint and survivor annuities or early retirement benefits that are available in the corporations’ defined benefit plans; the annuities provide reduced benefits to retired participants while they are alive, in exchange for the continuation of pension payments to the participants’ spouses after the participants die. See Metropolitan Life Insurance Company, 1:18-cv-11229 (focusing on joint and survivor annuities); American Airlines, Inc., 4:18-cv-00983 (same); PepsiCo, Inc., 7:18-cv-11618 (same); U.S. Bancorp, 0:18-cv-03405 (focusing on early retirement benefit elections).

In order to determine the benefit payment amounts, actuarial assumptions are applied to calculate the present value of the future payments of each type of benefit; these assumptions are based on a set of mortality tables (or, a series of rates that predict how many people at given age will die before attaining the next higher age) and long-term interest rates. As stated in the complaints, the present value of a retiree’s alternative annuity benefits (i.e., joint and survivor annuities) must be sufficiently equal to the present value of the retiree’s default benefit (i.e., single life annuity), so that the

two forms of payment are “actuarially equivalent.” Complaint, ¶ 7, Metropolitan Life Ins. Co., 1:18-cv-11229; Complaint, ¶ 4, American Airlines, Inc., 4:18-cv-00983; Complaint, ¶ 4, PepsiCo, Inc., 7:18-cv-11618. Likewise, a retiree’s early retirement benefit must be actuarially equivalent to the normal retirement benefit that the participant would receive at age 65 under the applicable plan’s terms, based on reasonable actuarial assumptions about future interest rates and life expectancies. Complaint, ¶ 4, U.S. Bancorp, 0:18-cv-03405.

The plaintiffs allege in the complaints that the pension plans at issue used actuarial equivalence factors that had not been updated in decades in order to calculate the payment amounts under the various alternative joint and survivor annuities or the early retirement benefit options. Four of the cases focus on the specific mortality table designated in the relevant plan document; in suits against Metropolitan Life and Rockwell Automation, the plans used a table from 1971, and in suits against American Airlines and Anheuser-Busch, the plans used the “1984” table, which was published in 1976 and based on data from 1965-1970. Complaint, ¶ 5, Anheuser-Busch, LLC, 4:19-cv-1189. The plaintiffs allege, in those suits, that the older mortality tables predict that people will die at a faster rate than current mortality tables, which means that the reductions applied to participant benefits are overstated. *E.g.*, Complaint, ¶ 6, American Airlines, Inc., 4:18-cv-00983; Complaint, ¶ 8, Metropolitan Life Ins. Co., 1:18-cv-11229.

A suit against U.S. Bancorp alleges that although the plan at issue does not identify an interest rate or a mortality table, it sets forth fixed early commencement factors (“ECFs”)—*i.e.*, the percentage of the benefit that a participant would receive at the plan’s normal retirement rate—that have not changed since at least 2002 “despite dramatic increases in longevity.” Complaint, ¶ 50, U.S. Bancorp, 0:18-cv-03405. In a complaint against PepsiCo, the plaintiffs claim that the simplified, flat factors used in the PepsiCo Salaried Plan are “lower than the conversion factor that would be generated using reasonable market mortality tables and interest rates.” Complaint, ¶ 46, PepsiCo, Inc., 7:18-cv-11618.

As the complaints allege, “[u]sing an older mortality table with accelerated death rates decreases the present value” of a benefit and “ultimately, the monthly payment that retirees receive” under their plan. Complaint, ¶ 7, Metropolitan Life Ins. Co., 1:18-cv-11229; Complaint, ¶ 4, American Airlines, Inc., 4:18-cv-00983; Complaint, ¶ 4, PepsiCo, Inc., 7:18-cv-11618. Plaintiffs allege that this is because mortality rates have improved over time with advances in medicine and better collective lifestyle habits, and therefore people who have retired recently are expected to live longer than those who retired in previous generations. Complaint, ¶ 8, Metropolitan Life Ins. Co., 1:18-cv-11229; Complaint, ¶ 6, American Airlines, Inc., 4:18-cv-00983. The complaints note that the Society of Actuaries, an independent actuarial group, publishes the mortality tables that are the most widely-used by defined benefit plans when doing these conversions, and the group published new mortality tables in 1971, 1983, 1984, 1994, 2000, and 2014. Complaint, ¶ 46, U.S. Bancorp, 0:18-cv-03405; Complaint, ¶ 43 n. 10, PepsiCo, Inc., 7:18-cv-11618; Complaint, ¶ 43, Metropolitan Life Ins. Co., 1:18-cv-11229; Complaint, ¶ 43, American Airlines, Inc., 4:18-cv-00983.

The American Airlines and Metropolitan Life complaints state that “using a high interest rate may counterbalance the effects of an old mortality table,” so the plans’ stated mortality and interest assumptions “must be viewed together to determine if they produce a reasonable, and equivalent, benefit for participants and beneficiaries.” Complaint, ¶ 48, American Airlines, Inc., 4:18-cv-00983; Complaint, ¶ 50, Metropolitan Life Ins. Co., 1:18-cv-11229. The PepsiCo complaint also acknowledges that the mortality rates and interest rates “collectively affect whether an optional benefit is actuarially equivalent to a [single life annuity],” (Complaint, ¶ 7, PepsiCo, Inc., 7:18-cv-11618) and the U.S. Bancorp complaint notes that the ECF is based on both an interest rate and a mortality table. Complaint, ¶ 43, U.S. Bancorp, 0:18-cv-03405. In the cases where the targeted plans had a fixed interest rate—5 percent in U.S. Bancorp and American Airlines, and 6 percent in Metropolitan Life—the complaints indicate that the stated rate, by itself, was reasonable, but, taken together, the mortality and interest rates are unreasonable. The complaints do not indicate at what point the combined factors became unreasonable.

Further, the complaints contain allegations that the corporations and their respective benefits committees breached their fiduciary duties under ERISA by relying on those purportedly outdated mortality tables and thus “following the plan in violation of ERISA.” Complaint, ¶¶ 90-92, Metropolitan Life Ins. Co., 1:18-cv-11229; Complaint, ¶¶ 90-92, American Airlines, Inc., 4:18-cv-00983; Complaint, ¶¶ 101-03, U.S. Bancorp, 0:18-cv-03405; Complaint, ¶¶ 73-75, PepsiCo, Inc., 7:18-cv-11618. The plaintiffs allege that because the “unreasonable conversion factors...do not provide for actuarially equivalent options,” the plan paid “unreasonably low benefits” and “participants and beneficiaries illegally forfeit[ed] and los[t] vested benefits.” Complaint, ¶ 74, PepsiCo, Inc., 7:18-cv-11618; Complaint, ¶ 90, Metropolitan Life Ins. Co., 1:18-cv-11229; Complaint, ¶¶ 6, 50, U.S. Bancorp, 0:18-cv-03405; Complaint, ¶ 90, American Airlines, Inc., 4:18-cv-00983. The lawsuits also include two additional counts for declaratory and equitable relief, and for reformation of the plans and recovery of benefits pursuant to ERISA § 502(a).

Ultimately, the plaintiffs in the complaints seek reformation of the plans to conform to ERISA, payment of future benefits in accordance with the reformed plans as required under ERISA, and payment of any amount improperly withheld. E.g., Complaint, ¶ 12, American Airlines, Inc., 4:18-cv-00983; Complaint, ¶ 14, Metropolitan Life Ins. Co., 1:18-cv-11229; Complaint, ¶ 7, U.S. Bancorp, 0:18-cv-03405; Complaint, ¶ 11, PepsiCo, Inc., 7:18-cv-11618.

3. Ongoing Litigation

In February 2019, motions to dismiss were filed by the defendants in the American Airlines, Metropolitan Life, PepsiCo, and U.S. Bancorp lawsuits. Motion to Dismiss, Metropolitan Life Insurance Company, 1:18-cv-11229 (S.D.N.Y. Feb. 21, 2019); Motion to Dismiss, American Airlines, Inc., 4:18-cv-00983 (N.D. Tex. Feb. 12, 2019); Motion to Dismiss, PepsiCo, Inc., 7:18-cv-11618 (S.D.N.Y. Feb. 15, 2019); Motion to Dismiss, U.S. Bancorp, 0:18-cv-03405 (C.D. Minn. Feb. 19, 2019). Only some of these motions have been resolved so far.

See:

Metropolitan Life Insurance Company, 1:18-cv-1122. Metropolitan Life's ("MetLife") motion is still pending. MetLife argues that the plaintiffs did not adequately explain the problems with MetLife's methodology and did not explain what an appropriate early retirement conversion factor would be. MetLife argues that "[i]n the absence of this essential information, there is no means to determine whether, let alone the extent to which, Plaintiffs are not receiving actuarially equivalent benefits," and, therefore, the complaint "fails to satisfy the requirements for pleading a plausible claim under ERISA." Further, MetLife argues that the plaintiffs cannot claim that they did not receive the benefits their plan promised, because the plan explicitly stated how the benefit payments would be calculated. MetLife also points out that the plaintiffs cannot argue that the plan terms are illegal because there is no requirement under ERISA to use any particular set of actuarial assumptions in benefit calculations. Defendants additionally contend that the plaintiffs failed to properly seek equitable relief and that the claims of one of the named plaintiffs are barred by the applicable six-year statute of limitations.

U.S. Bancorp, 0:18-cv-03405. U.S. Bancorp's motion to dismiss, which argued that ERISA does not allow for a private right of action to enforce regulations under the tax code and does not limit the actuarial factors companies can use to calculate pensions, was denied. 2019 WL 2644204 (D. Minn. June 27, 2019). The court held that discovery would "reveal whether [the plaintiffs'] allegations are correct," but that they had "alleged a plausible claim that the ECFs fail to provide the participants with an actuarially equivalent benefit in violation of § 1054(c)(3)." 2019 WL 2644204, at *3 (D. Minn. June 27, 2019). More recently, the plaintiffs have moved to certify their class, and trial is scheduled for Fall 2021.

In *American Airlines, Inc.*, the court denied American Airline's motion to dismiss. *Torres v. Am. Airlines, Inc.*, 416 F. Supp. 3d 640, 651 (N.D. Tex. 2019). In doing so, the court agreed with the plaintiffs that they relied upon Treasury Regulations had "no bearing on the issues" in the case: "whether optional forms of pension benefits chosen by participants and beneficiaries under the Plans are 'actuarially equivalent' to an SLA, as required under ERISA § 205." *Id.* at 646–47. The case settled and was dismissed in July 2020.

In contrast, the court in *PepsiCo, Inc.*, 7:18-cv-11618, initially granted PepsiCo's motion to dismiss based on ERISA's anti-forfeiture clause, Section 203(a). *DuBuske v. PepsiCo, Inc.*, No. 18-cv-11618, 2019 WL 4688706, at *1 (S.D.N.Y. Sept. 25, 2019). PepsiCo's motion argued that there is no private right of action under ERISA to enforce regulations issued under the tax code, and that ERISA does not limit the actuarial factors that companies can use when calculating pensions. But the court

*then vacated its order on a subsequent motion to alter judgment and gave leave to amend and consider only a claim under ERISA Section 205(d). 2019 WL 5864995, at *2 (S.D.N.Y. Nov. 8, 2019). The parties then voluntarily dismissed the case in November 2019.*

G. CHURCH PLAN LITIGATION

Retirement and welfare plans that have been established by churches or church-related organizations may qualify as “church plans” exempt from the requirements of ERISA. See 29 U.S.C. § 1002(33); Advocate Health Care Network v. Stapleton, 137 S. Ct. 1652, 1656 (2017). Historically, ERISA defined “church plan” to mean “a plan established and maintained . . . for its employees . . . by a church or by a convention or association of churches.” Advocate Health Care Network, 137 S. Ct. at 1656 (quoting 29 U.S.C. § 1002(33).)

In 1980, Congress expanded the definition of “church plan” in two ways. First, the amendment stated that for purposes of the church-plan definition, an “employee of a church” would include an employee of a church-affiliated organization. Id. at 1656 (citing 29 U.S.C. § 1002(33)(C)(ii)(II).) Second, the amendment added the following provision:

A plan established and maintained for its employees . . . by a church or by a convention or association of churches includes a plan maintained by an organization . . . the principal purpose or function of which is the administration or funding of a plan or program for the provision of retirement benefits or welfare benefits, or both, for the employees of a church or a convention or association of churches, if such organization is controlled by or associated with a church or a convention or association of churches.

29 U.S.C. § 1002(33)(C)(i). This amendment addressed what the Supreme Court has called “principal-purpose organizations”—organizations whose main job is to fund or manage a benefit plan for the employees of churches or church affiliates. See Advocate Health Care Network, 137 S. Ct. at 1656-57.

For decades, the IRS interpreted this statutory language to mean that plans maintained by a principal-purpose organization did not need to have been established and maintained by a church to constitute “church plans” under U.S.C. § 1002(33). See Advocate Health Care Network, 137 S. Ct. at 1657. The other two federal agencies responsible for administering ERISA—the Department of Labor and the Pension Benefit Guaranty Corporation—also took this view. See id.

In a recent wave of litigation, current and former employees of hospitals and other agencies filed class actions alleging that their employers’ pension plans do not fall within ERISA’s church-plan exemption because they were not established by a church. See Advocate Health Care Network, 137 S. Ct. at 1657. Three separate Circuit

Courts of Appeal agreed with the employees' position and held that such plans were not exempt from ERISA's requirements. See Kaplan v. Saint Peter's Healthcare Sys., 810 F.3d 175, 177 (3d Cir. 2015); Stapleton v. Advocate Health Care Network, 817 F.3d 517, 523 (7th Cir. 2016); Rollins v. Dignity Health, 830 F.3d 900, 906 (9th Cir. 2016). These courts held that, even after the 1980 amendment, a plan could only be exempt from ERISA under 29 U.S.C. § 1002(33)(A) if it were established by a church. See, e.g., Kaplan, 810 F.3d at 181.

In 2017, the Supreme Court reversed the judgment of all three Circuit Courts and held that a plan maintained by a principal-purpose organization qualifies as a "church plan" regardless of whether it was established by a church. See Advocate Health Care Network, 137 S. Ct. at 1663. The Court reasoned that the amended statute was most naturally read to mean that a plan maintained by a principal-purpose organization would qualify as a plan "established and maintained by a church." Id. at 1659.

Although the Supreme Court's decision in Advocate Health Care Network resolved one of the most litigated issues regarding the church plan ERISA exemption, the Court left other issues involved, including when an organization is a principal-purpose organization and the necessary level of association with a church that a principal-purpose organization must show to qualify as a church plan.

H. 401(K) FEE LITIGATION

Beginning in approximately 2006, plaintiffs began bringing a new form of ERISA litigation cause of action. These new claims alleged breaches of fiduciary duty and prohibited transactions based on the management of 401(k) plan assets and related fees paid to plan service providers. See, e.g., LaRue v. DeWolff, Boberg & Assocs., Inc., 552 U.S. 248 (2008); Renfro v. Unisys Corp., 671 F.3d 314 (3d Cir. 2011); Spano v. Boeing Co., 633 F.3d 574 (7th Cir. 2011). While investment and administrative fees have decreased overall, the continued wave of fee and expense litigation cases reflects the increasing importance of defined contribution plans in the landscape of employee retirement plans. See, e.g., Brotherston v. Putnam Invs., LLC, 907 F.3d 17 (1st Cir. 2018); see also Marks v. Trader Joe's Co., Case No. 2-19-cv-10942 (C.D. Cal. Dec. 30, 2019 (filed)).

1. Typical parties

a) Plaintiffs

In the typical case, Plaintiffs are current or former individual 401(k) plan participants who seek to bring their claims on behalf of a class of plan participants. See, e.g., Tibble v. Edison Int'l, 843 F.3d 1187 (2016). An important consideration is whether plaintiffs have standing to bring their claims. See Abbott v. Lockheed Martin Corp., No. 06-cv-0701-MJR, 2009 WL 839099, at *8 (S.D. Ill. Mar. 31, 2009) (holding that investing in one investment option in the plan conferred standing over allegations relating to any plan option).

b) Defendants

In the typical 401(k) fee case, the defendants fall into two broad categories, corporate defendants and service providers.

The typical corporate defendants in 401(k) excessive fee litigation are Fortune 500 corporate defendants who sponsor large, or “jumbo,” 401(k) plans. Board committees and individual officers and directors are also often included in the defendant roster. See, e.g., Tibble, 843 F. 3d at 1187 (naming committee and officer defendants); Tatum v. RJR Pension Inv. Comm., 761 F.3d 346, 371 (4th Cir. 2014) (“this and other courts have routinely found committees to be proper defendant-fiduciaries”); Taylor v. United Techs. Corp., No. 06-cv-1494 (WWE), 2007 WL 2302284, at *1 (D. Conn. Aug. 9, 2007) (naming committee defendants); Kanawi v. Bechtel Corp., 590 F. Supp. 2d 1213, 1219 (N.D. Cal. 2008) (same). Important considerations are whether these board and officer defendants are proper defendants under ERISA’s enforcement scheme and whether they actually exercise discretion over the challenged conduct. See, e.g., Schmalz v. Sovereign Bancorp, Inc., 868 F. Supp. 2d 438, 459 (E.D. Pa. 2012) (dismissing claims against individual director defendants where allegations failed to support plaintiffs’ claim that each director exercised discretion over management and administration of plan).

Some cases also involve service providers who are retained to provide administrative services to the plan. A sub-set of cases include bundled service provider entities as defendants. See, e.g., Tussey v. ABB, Inc., 746 F.3d 327 (8th Cir. 2014); Hecker v. Deere & Co., 556 F. 3d 575 (7th Cir. 2009) (bringing suit against Fidelity); Pledger v. Reliance Tr. Co., 240 F. Supp. 3d 1314 (N.D. Ga. 2017). These entities often provide record-keeping, trustee, and investment management services for a combination of hard-dollar fees and asset-based fees. In other cases, plaintiffs have alleged breach of fiduciary duties based on overpayment to separate service providers. See, e.g., Kruger v. Novant Health, Inc., 131 F. Supp. 3d 470 (M.D.N.C. 2015) (alleging payment of excessive fees to administrator and record-keeper and to brokerage company providing advisory services). In addition, some cases identify investment advisory firms that were previously subsidiaries or otherwise related to the corporate co-defendant as defendants in these lawsuits. Kanawi, 590 F. Supp. 2d at 1219 (naming former in-house investment advisory division of Bechtel as defendant).

See:

Hecker v. Deere & Co., 556 F.3d 575, 583-84 (7th Cir. 2009). Plaintiffs appealed the dismissal of their complaint against a “bundled” service provider defendant, Fidelity. Fidelity argued that it was neither a named nor a “functional” fiduciary because it exercised no authority or control over the management, disposition or administration of plan assets. The court held that limiting the fund options available for selection or “playing a role” or furnishing professional advice is not enough to transform a company into a fiduciary.

Leimkuehler v. Am. United Life. Ins. Co., 713 F.3d 905 (7th Cir. 2013). A plan trustee sued a service provider for alleged undisclosed revenue sharing arrangements, claiming the service provider was liable under ERISA as a fiduciary. The court held the provider of annuities did not become a functional fiduciary, merely by selecting funds and share classes to include on the menu of investment options for 401(k) plan customers.

Renfro v. Unisys Corp., 671 F.3d 314 (7th Cir. 2011). Plan participants filed a putative class action against their employer, benefit plan, and directed trustee of the plan. The court held the directed trustee that had provided the mix and range of investment options for the plan did not owe any fiduciary duty under ERISA with respect to the negotiation of its fee compensation.

But see:

Spano v. Boeing Co., No. 06-cv-743, 2007 WL 1149192, at *3 (S.D. Ill. Apr. 18, 2007). The court denied the motion to dismiss, ruling that Fidelity's fiduciary status was a question of fact dependent on the amount of discretion exercised over the management of the plan inappropriate for determination at the pleadings stage.

2. Typical claims

The specific claims alleged in these cases have evolved over time, but some key themes and forms of claim have emerged.

a) Excessive fees

In varying degrees of specificity, 401(k) fee lawsuits allege that employers or plan sponsors improperly allowed plan service providers to be paid unreasonable and excessive fees. They further allege that the excessive payments violate the duty of prudence the fiduciaries owe the plan and its participants under ERISA § 404. Suits have challenged a variety of arrangements, including payments to investment fund managers, investment administrators, record keepers, trustees, and “bundled” service providers which offer some or all of these services. See, e.g., Hecker, 556 F.3d at 578. Some claims allege that fee arrangements with service providers include hidden “revenue-sharing arrangements” in addition to “hard dollar” payments resulting in overall excessive fees. See, e.g., Taylor v. United Techs. Corp., No. 3:06-cv-1494, 2009 WL 535779, at *11 (D. Conn. Mar. 3, 2009).

Still other claims assert that fiduciaries did not take advantage of the plan's size in negotiating for lower fee arrangements or soliciting bids for competing record keeping services. See, e.g., George v. Kraft Foods Global, Inc., 641 F.3d 789, 798 (7th Cir. 2011) (solicitation of competing bids); Braden v. Wal-Mart Stores, Inc., 588 F.3d 585, 595–96 (8th Cir. 2009) (negotiation for lower fee arrangement). However, in evaluating these claims, some courts have held that there is no duty to scour the market

to find the fund with the lowest imaginable fees and fees set against the backdrop of market competition are reasonable. Hecker, 569 F.3d at 710; Abbott, 2009 WL 839099, at *8-9; Velazquez v. Mass. Fin. Svcs. Co., 320 F. Supp. 3d 252, 259 (D. Mass. 2018).

Specifically with respect to service provider defendants, courts have recognized that service providers are not acting as fiduciaries when they negotiate their compensation at arm's length with a plan fiduciary. See McCaffree Fin. Corp. v. Principal Life Ins. Co., 811 F.3d 998, 1002 (holding that an investment advisor "owed no duty to plan participants during its arm[s]-length negotiations with" plaintiff); Hecker, 556 F.3d at 583 (stating a party is not a fiduciary "with respect to the terms in the service agreement if it does not control the named fiduciary's negotiation and approval of those terms"); see also Scott v. Aon Hewitt Fin., Advisors, LLC, No. 17-cv-679, 2018 WL 1384300, at *8 (N.D. Ill. Mar. 19, 2018).

b) Imprudent decision-making for 401(k) plans

Alleged fiduciary duty breaches in 401(k) fee litigation have also alleged the imprudent selection of fund options, investment styles, or account structures, and the imprudent selection of service providers and negotiation of fee arrangements. George, 641 F.3d at 797 (reversing grant of summary judgment for defendants and finding fiduciaries could have acted imprudently when not making a decision about investment and traditional drag); Tibble, 2010 WL 2757153, at *30 (finding defendant breached duty of prudence); Wildman v. Am. Century Svcs. LLC, 362 F. Supp. 685 (W.D. Mo. 2019) (holding that fiduciary of a plan sponsored by an asset manager was not required to consider competitors' funds where funds chosen are prudent options).

In evaluating these claims, courts consider what a prudent fiduciary would have done under similar circumstances. See, e.g., Meiners v. Wells Fargo & Co., 898 F.3d 820, 822 (8th Cir. 2018); Wildman, 362 F. Supp. at 703. Courts have held that a fiduciary need not take a particular investment course to meet the prudent person standard and that "20/20 hindsight" opinions that plan fiduciaries should have made different decisions are insufficient to establish a breach of fiduciary duty. Hecker, 556 F.3d at 586 (finding no violation in selection of fund options from one investment company and one investment style); Taylor, 2009 WL 535779, at *10-11 (holding no violation in selection of mutual funds); Kanawi, 590 F. Supp. 2d at 1230 (same); Abbott, 2009 WL 839099, at *6 (finding no violation in failing to secure separate account or for not following a particular investment strategy for fund named "stable value").

Plaintiffs in 401(k) fee litigation have also alleged that defendants failed to capture revenue streams because they failed to monitor or negotiate beneficial fee arrangements with regard to revenue-sharing, securities lending, float, and other practices. See, e.g., Tussey, 746 F.3d at 331-32 (revenue-sharing and float); see also Hecker, 556 F.3d at 585 (revenue-sharing); Taylor, 2009 WL 535779, at *15 (float). In cases alleging improper use of float income, an important consideration is whether the float income is a plan asset. In Tussey, for example, the plaintiffs argued that the float income was a plan asset because the plan owned the funds. But in rejecting this argument, the Eighth Circuit held that the plaintiffs "failed to show the float was a Plan

asset under the circumstances of the case” since the participants did not cite to any evidence that the Plan was “the funder of the check or the owner of the funds in the redemption account.” 746 F.3d at 340; see also, In re Fidelity ERISA Float Litig., No. 13-cv-10222, 2015 WL 1031497 (D. Mass. Mar. 11, 2015).

c) Prohibited transactions

ERISA Section 406(a)(1) enhances the fiduciary’s general duties to the plan’s beneficiaries by categorically barring certain transactions believed to pose a high risk of fiduciary self-dealing or deemed likely to injure the pension plan. Abraha v. Colonial Parking, Inc., 243 F. Supp. 3d 179, 190 (D.D.C. 2017); see also Braden, 588 F.3d at 600. In such situations, the burden of proof is on the party to the self-dealing transaction to justify its fairness. Id. at 602. Plaintiffs have attempted to present a variety of claims regarding the management of 401(k) investments by asserting prohibited transactions under ERISA § 406. Braden, 588 F.3d at 600 (alleging that fiduciaries violated ERISA by causing Plan to engage in prohibited transaction with the trustee, who plaintiff claimed received “kickbacks” from investment funds); In re Northrop Grumman Corp. ERISA Litig., No. 06-cv-06213, 2015 WL 10433713 (N.D. Cal. May 31, 2017) (denying summary judgment based on finding that payment of excessive administrative fees could constitute a prohibited transaction); Kanawi, 590 F. Supp. 2d at 1227-28, 1231 (alleging investment administration company with ties to corporate defendant improperly benefited from certain investment decisions and transactions).

These prohibitions, however, are subject to a number of statutory exemptions, including that fiduciaries are not barred from “[c]ontracting or making reasonable arrangements with a party in interest for ... services necessary for the establishment or operation of the plan, if no more than reasonable compensation is paid therefore.” 29 U.S.C. § 1108(b)(2). A key concept related to these claims is that incidental benefits do not necessarily indicate an ERISA violation. See, e.g., Taylor, 2009 WL 535779, at *14 (finding that decision-making process turned on considerations of participants’ best interests rather than any fee incentive).

d) Failure to disclose or misrepresentation

Plaintiffs in 401(k) fee litigation have also often coupled their breach of fiduciary duty and prohibited transactions claims with a separate breach of fiduciary duty claim asserting that the defendants failed to disclose, or misrepresented, the challenged practice to plan participants. The failure to disclose revenue-sharing fees theory has been addressed – and rejected – by numerous courts. See Hecker, 556 F.3d at 586 (holding no duty to disclose revenue-sharing); Taylor, 2007 WL 2302284, at *4 (dismissing non-disclosure of revenue sharing claim); Abbott, 2009 WL 839099, at *13 (granting summary judgment on non-disclosure of revenue sharing claim). But see Terraza v. Safeway Inc., 241 F. Supp. 3d 1057, 1072 (N.D. Cal. 2017) (finding plan fiduciaries satisfied duty to disclose revenue sharing payments by sending notices to plan participants providing that “each investment has a fee associated with it to cover the cost of managing the investments”); Braden, 588 F.3d at 599–600 (reversing dismissal by district court and finding that plaintiff alleged sufficient facts to find

defendants breached duty to disclose when they did not disclose alternative fund investments with lower fees or the fee-sharing arrangement with trustees); Kanawi v. Bechtel Corp., No. 06-cv-05566, 2007 WL 5787490, at *2 (N.D. Cal. May 15, 2007) (denying motion to dismiss non-disclosure of revenue-sharing claim due to possibility of intentional misrepresentation theory).

Further, where the underlying practice is not found to violate ERISA, the failure to disclose that practice does not violate the duty to disclose. E.g., Taylor, 2009 WL 535779, at *14. A key consideration is whether any purported misrepresentation or omitted information is material. Hecker, 556 F.3d at 586 (finding information sought was not material, and its omission not a breach of fiduciary duty); Terraza, 241 F. Supp. 3d at 1073 (same); Taylor, 2009 WL 535779, at *13 (same). For a more detailed analysis of these claims, see Section V.B.

3. Relief plaintiffs seek in fee litigation

Plaintiffs have sought a wide variety of equitable and legal relief in the typical 401(k) fee lawsuit. Monetary relief includes direct losses (i.e. experienced as a direct result of the breach of fiduciary duty) and so-called “investment losses” (i.e. losses allegedly attributable to the ups and downs of the financial market). Equitable relief sought includes disgorgement of fees, removal of fiduciaries and an accounting of plan assets.

See:

Wildman v. Am. Century Servs. LLC, 362 F. Supp. 3d 685 (W.D. Mo. 2019). Plan participants' sought equitable disgorgement of ill-gotten profits resulting from alleged breach of fiduciary duties by employer, plan sponsor, and members of committee that administered defined-contribution 401(k) retirement plan.

Tussey v. ABB Inc., No. 2:06-cv-04305, 2017 WL 6343803 (W.D. Mo. Dec. 12, 2017). Fiduciaries breached their fiduciary duties by acting on improper motives when they replaced Wellington Fund, an established fund that invested in stocks and bonds in a generally static ratio, with Freedom Funds, a family of target-date funds. The court held the proper method for calculating damages was to compare the performance of the Wellington Fund with the relevant Freedom Fund.

Pledger v. Reliance Tr. Co., 240 F. Supp. 3d 1314 (N.D. Ga. 2017). Plaintiffs sought equitable relief in the form of court-ordered restitution or disgorgement to restore alleged ill-gotten proceeds and profits resulting from defendants' fiduciary breaches. The court held that plaintiffs did not seek appropriate equitable relief where plaintiffs failed to allege how money damages would be inadequate relief for alleged violations.

4. Other procedural issues

a) ERISA § 404(c) defense

ERISA § 404(c) provides a fiduciary a “safe harbor” from liability where the plan provides individual accounts and it permits a participant to exercise control over the assets in the account. 29 U.S.C. § 1104(c). Where a fiduciary satisfies the criteria of § 404(c), and includes a sufficient range of options so that the participants have control over the risk of loss, a fiduciary is shielded from liability from an imprudent selection of funds. Hecker, 556 F.3d at 589; see also Loomis v. Exelon Corp., 658 F.3d 667, 673 (7th Cir. 2011). For a more detailed discussion of Section 404(c), see Section XV.D.2.f.

b) Statute of limitations

ERISA § 413 governs breach of fiduciary duty claims and imposes a limitations period of six years of the claim’s underlying facts or three years after the plaintiff has actual knowledge of the claim. In cases of fraud or concealment, § 413 provides a six-year statute of limitations from the date of discovery. See, e.g., Sec’y U.S. Dept. of Labor v. Kwasny, 853 F.3d 87, 93 (3d Cir. 2017) (applying three-year limitations period to breach of fiduciary duty claim where plaintiff received complaint that allowed it to be referred for enforcement); Fish v. GreatBanc Trust Co., 749 F.3d 671, 674 (7th Cir. 2014) (explaining presumptive limitation period of six years applied except when plaintiff has gained actual knowledge of breach or violation).

I. LITIGATION WITH DOL

1. Background

The Department of Labor (“DOL”), along with the Internal Revenue Service (“IRS”) and the Pension Benefit Guarantee Corporation (“PBGC”), is responsible for enforcing ERISA’s requirements. While the IRS primarily focuses on ERISA’s qualification requirements and PBGC focuses on defined benefit plan funding and insurance requirements, the DOL is responsible for enforcing ERISA’s fiduciary and prohibited transactions provisions.

ERISA Section 504 gives Secretary of the Labor the authority to investigate actual or potential ERISA violations, 29 U.S.C. § 1134(a), and Section 502 of ERISA gives the Secretary the authority to enforce ERISA through civil litigation, 29 U.S.C. § 1132(a). Within the DOL, the Employee Benefit Security Administration (“EBSA”) is the agency primarily responsible for investigating and enforcing ERISA fiduciary duty violations. EBSA’s “primary objectives” include “improve[ing] ERISA compliance by recovering losses and unjust profits stemming from misconduct by plan fiduciaries and service providers and . . . increase[ing] the deterrent impact of its enforcement efforts on employee benefit plans, participants, and beneficiaries.” U.S. Dept. of Labor, *FY 2018-2022 Strategic Plan*, at 25.

In fiscal year (“FY”) 2018, EBSA was responsible for overseeing approximately 649,000 retirement plans, 2.2 million health plans, and a similar number

of other welfare benefit plans. EBSA Fact Sheet 2018, *ERISA: Department of Labor Investigations, Enforcement, and Litigation* (2018). If EBSA is unable to secure voluntary compliance from the entities or individuals it is investigating, it may refer the case to the Solicitor of Labor for litigation.

The DOL litigates ERISA cases relatively rarely. In FY 2018, for example, EBSA completed 1,329 civil investigations and referred 111 of them for litigation. EBSA Fact Sheet 2018. The DOL filed suit in only 56 of those cases—representing only 50% of cases referred for litigation, and less than 5% of investigations closed. Id. And in recent years, DOL civil actions have been decreasing.

2. DOL Litigation Priorities

EBSA and the Solicitor of Labor work together to “determine which cases are appropriate for litigation, considering the ability to obtain meaningful relief through litigation, cost of litigation, viability of other enforcement options, and agency enforcement priorities.” EBSA Fact Sheet 2018. EBSA’s investigations, and thus the DOL’s civil actions, are targeted toward its National Enforcement Priorities, National Enforcement Projects, and various regional projects. Id.

EBSA has two National Enforcement Priorities: The Major Case Enforcement Priority and the Employee Contributions Initiative. The Major Case initiative “focus[es] on . . . cases that have the greatest potential to have a significant impact on large numbers of plans or plan participants” and ensures that EBSA’s resources are directed to major cases. The Dept. of Labor, Employee Benefits Security Administration: Enforcement, available at <https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/enforcement>. The Employee Contributions Initiative focuses on the investigation of delinquent employee contributions. Id.

EBSA’s National Enforcement Projects include (1) the Employee Stock Ownership Plan Project, which “identifies and corrects violations of ERISA in connection with ESOPs,” (2) the Plan Investment Conflicts Project, which “investigates issues related to fiduciary service provider compensation and conflicts of interest in relation to plan asset vehicles,” (3) the Abandoned Plan Program, which “facilitates the termination of, and distribution of benefits from individual account pension plans that have been abandoned by their sponsoring employers,” and (4) the Protecting Benefits Distribution Project, which “focuses on ensuring that participants are paid retirement benefits that remain stagnant and may be at risk due to plan sponsor actions or failures to act.” Id. The Protecting Benefits Distribution Project encompasses the Terminated Vested Participant Project, which “ensures that defined benefit plans maintain adequate records and procedures for contacting terminated participants with vested account balances,” the Distressed Plan Sponsors project, which “seek[s] to protect participant benefits placed at risk by a plan sponsor’s financial distress, and the Custodial Abandoned Plans project, which “ensure[s] abandoned plans are properly administered or expeditiously wound up.” Id.

See:

Perez v. City National Corp., 176 F. Supp. 3d 945 (C.D. Cal. 2016). The Secretary filed a complaint alleging that defendant's Profit Sharing Plan lost more than \$4 million when fiduciaries "engaged in self-dealing" by receiving compensation from the Plan.

Acosta v. Saakvitne, 355 F. Supp. 3d 908 (D. Haw. 2019). The Secretary filed a complaint against ESOP trustee, company, and company executives, alleging they violated ERISA by using the ESOP to purchase the company's shares for more than they were worth.

Acosta v. Calderon, No. 16-cv-0964, 2017 WL 4011962 (D. Md. Sept. 11, 2017). The Secretary filed a complaint against defendant fiduciaries for failing to forward employee contributions and to remit mandatory prevailing wage employer contributions to the Plan.

XVI. PLAINTIFFS MAY KNOWINGLY AND VOLUNTARILY RELEASE OR WAIVE ERISA RIGHTS OR CLAIMS

A. EMPLOYERS MAY CONDITION BENEFITS ON A WAIVER OF ERISA RIGHTS AND CLAIMS.

Employers may condition the payment of benefits on the execution of a release of employment-related rights and claims. Lockheed Corp. v. Spink, 517 U.S. 882, 894 (1996). Courts generally allow employees to waive rights and claims arising under ERISA in exchange for the payment of benefits if the waiver is knowing and voluntary. See, e.g., Howell v. Motorola, Inc., 633 F.3d 552, 559 (7th Cir. 2011) (holding that general release of claims under ERISA was effective because the waiver was made knowingly and voluntarily); Chaplin v. NationsCredit Corp., 307 F.3d 368, 373 (5th Cir. 2002) (explaining that general release discharging all claims against employer is effective to discharge ERISA claims); Yak v. Bank Brussels Lambert, 252 F.3d 127, 131 (2d Cir. 2001) (acknowledging employee may waive rights under ERISA); Smart v. Gillette Co. Long-Term Disability Plan, 70 F.3d 173, 181 (1st Cir. 1995) (explaining that participation in employee welfare benefit plan is a waivable right); Finz v. Schlesinger, 957 F.2d 78, 82 (2d Cir. 1992) (explaining that individual may waive rights to participate in pension plan). The validity of an individual's waiver of pension benefits or ERISA claims, however, is subject to closer scrutiny than the individual's waiver of general contract terms. Yak, 252 F.3d at 131.

See:

Petersen v. E.F. Johnson Co., 366 F.3d 676, 680 (8th Cir. 2004). The court held that the company was permitted to condition benefits under its new plan on the employees' waiver of rights to claims under the old plan.

Loskill v. Barnett Banks, Inc. Severance Pay Plan, 289 F.3d 734, 737-38 (11th Cir. 2002), cert. denied, 537 U.S. 1167 (2003). Plan included a no cut-back provision under which benefits that accrued prior to an amendment of the plan terms could not be reduced or eliminated by that amendment. After the employer merged with a larger company, it adopted a release which it required as a condition to payment of severance benefits. Plaintiff refused to sign the release and sued, claiming that the release violated the no cut-back provision. The court held the release did not violate the no cut-back provision because the release did not alter the amount of benefits to which plaintiff was entitled, but served only as a condition precedent to receipt of benefits.

*Levy v. Young Adult Inst., Inc., No. 13-cv-2861, 2016 WL 6092705, at *17 (S.D.N.Y. Oct. 18, 2016), aff'd, 744 F. App'x 12 (2d Cir. 2018). The court held that, when the employment agreement explicitly set forth the ERISA rights the employee would be waiving, the waiver was enforceable, especially where the employee was a "sophisticated businessman who negotiated his contract over a period of months with the help of counsel."*

Krackow v. Jack Kern Profit Sharing Plan, No. 00-cv-2550, 2002 WL 31409362, at *8 (S.D.N.Y. May 29, 2002). The court found that there was no breach of fiduciary duty in the employer's attempt to secure a waiver of pension benefits, because when an employer negotiates waivers of ERISA claims it is not acting as a fiduciary.

But see:

Cirulis v. UNUM Corp., 321 F.3d 1010, 1014 (10th Cir. 2003). Defendant offered plaintiff a severance package conditioned on release of legal claims and a non-solicitation covenant. Plaintiff had only seven days to consider the release and was denied the opportunity to negotiate amendment of the terms, and was ultimately denied severance benefits for failure to sign. Court held that, because plaintiff did not receive notice that severance benefits would be predicated on assent to the non-solicitation covenant, employer could not condition payment of benefits on assent to this release.

Courts have also considered when a beneficiary may waive his or her spouse's rights to pension death benefits arising under an ERISA plan. Section 1055(c)(2)(A) of ERISA provides that a beneficiary may only waive his or her spouse's right to the benefits if: (1) the spouse consents in writing; (2) the spouse consents to the named beneficiary, and the named beneficiary (or form of benefits) may not be changed without the spouse's consent; and (3) the spouse's consent is witnessed by a notary public or plan representative. 29 U.S.C. § 1055(c)(2)(A). Courts strictly enforce these requirements. See Hagwood v. Newton, 282 F.3d 285, 289 (4th Cir. 2002) (holding that prenuptial agreement was ineffective to waive rights under ERISA because it did not conform to Section 1055(c)(2)(A) requirements and was executed before marriage); Lasche v. George W. Lasche Basic Profit Sharing Plan, 111 F.3d 863, 866 (11th Cir. 1997) (holding that prenuptial agreement was ineffective waiver and explaining that subjective intent of surviving spouse is irrelevant to whether waiver was effectively made). But see Butler v. Encyclopedia Britannica, Inc., 41 F.3d 285, 294 (7th Cir. 1994) (holding that the third requirement of a witness only entails the usual notarization procedures and does not require the notary or plan representative to ensure that the spouse's consent is informed and knowing).

The Supreme Court has held that, even if a former spouse has purported to waive his or her rights to plan benefits through a common-law waiver that the former spouse signed as part of a divorce decree, the plan administrator is obligated to abide by the participants' beneficiary designations under the plan. Kennedy v. Plan Adm'r for DuPont Sav. and Inv. Plan, 555 U.S. 285, 300-01 (2009). In Kennedy, the court held that such a common law waiver was not a "qualified domestic relations order," and it was ineffective if the participant's beneficiary designation pursuant to the plan continued to name the former spouse as a beneficiary. Id. at 300. The Court adopted this position to promote a "straightforward rule of hewing to the directives of the plan documents" and ERISA's goal of uniform and standard procedures for benefit administration. Id.

See:

Boyd v. Metro. Life Ins. Co., 636 F.3d 138, 143-44 (4th Cir. 2011). *Plan administrator properly followed plan documents by paying deceased plan participant's husband and not giving effect to a separation agreement in which the husband had agreed to waive his claim to the benefits.*

Following Kennedy, courts have clarified that Kennedy does not preclude lawsuits brought by the deceased participant's estate against the designated beneficiary based on a valid common law waiver to recover benefits from the ERISA-authorized beneficiary. See, e.g., Andochick v. Byrd, 709 F.3d 296, 301 (4th Cir. 2013) (holding that ERISA does not preempt post-distribution suits against ERISA beneficiaries to enforce state law waivers).

1. ERISA's anti-alienation provision does not bar waiver of pension benefits.

ERISA requires that "each pension plan shall provide that benefits provided under the plan may not be assigned or alienated." 29 U.S.C. § 1056(d)(1). Generally, however, courts do not construe the "anti-alienation" provision to bar a knowing and voluntary waiver of pension benefits. Rhoades v. Casey, 196 F.3d 592, 598 (5th Cir. 1999) (holding that anti-alienation provision does not bar knowing and voluntary waiver of retirement benefits as part of settlement agreement).

The Seventh Circuit explained in Licciardi v. Kropp Forge Division Employees' Retirement Plan, 990 F.2d 979, 982 (7th Cir. 1993), that "the anti-alienation provision was not intended to bar the settlement of disputes over pension rights." The Licciardi court distinguished between pension *entitlements*—the rights guaranteed to the employee under the terms of the plan—and *contestable* pension claims. If the release were construed broadly enough to actually eliminate pension *entitlements*, then it would potentially run afoul of the anti-alienation provision. Id. The provision does not, however, protect "contestable" pension claims. Id.

See:

Hakim v. Accenture U.S. Pension Plan, 718 F.3d 675, 682 (7th Cir. 2013). *A contested claim seeks benefits above and beyond the benefits a plaintiff believes he is entitled to under the plan, such as benefits resulting from the plan administrator's violation of ERISA.*

Kickham Hanley P.C. v. Kodak Ret. Income Plan, 558 F.3d 204, 213 (2d Cir. 2009). *Although "pension entitlements are subject to the anti-alienation provision, contested pension claims are not and may be knowingly and voluntarily released as part of a settlement resolving an actual or potential dispute over pension benefits."*

Lynn v. CSX Transp., Inc., 84 F.3d 970, 975 (7th Cir. 1996). *The anti-alienation provision does not apply to "contested" (i.e., either actually or*

constructively contested) pension claims. If a claimant does not actually contest a claim but is aware that a claim exists at the time a release is signed, the claimant has constructively contested the claim for purposes of the anti-alienation provision.

Lumpkin v. Envirodyne Indus., Inc., 933 F.2d 449, 455 (7th Cir. 1991). Plaintiffs argued that the anti-alienation provision was a total bar to any express or implied waiver of pension benefits. The court disagreed, explaining that a rigid application of the anti-alienation provision would be inconsistent with the policy goal of encouraging settlement of legal disputes.

2. Employees may not waive prospective ERISA claims.

Like many other federal statutory rights, ERISA claims may not be waived prospectively. Wright v. Sw. Bell Tel. Co., 925 F.2d 1288, 1293 (10th Cir. 1991); see also Barron v. UNUM Life Ins. Co. of Am., 260 F.3d 310, 317 (4th Cir. 2001); Reighard v. Limbach Co., 158 F. Supp. 2d 730, 733 (E.D. Va. 2001) (discussing that other federal rights cannot be waived prospectively). In Wright, the plaintiff sought and was denied long-term disability benefits, and he ultimately was terminated from his job. 925 F.2d at 1289. After filing a discrimination charge with the EEOC, the plaintiff raised a grievance through the collective bargaining agreement and received a lump-sum settlement from his employer. Id. at 1290. The check, however, contained a general release of all claims, which his employer had typed on the back of the check above the endorsement line. Id. Plaintiff filed Title VII and ERISA claims against his employer three years later. Id.

While the court held that the release was effective to waive the pending employment discrimination claims, it also held that the waiver was ineffective to waive the ERISA claims because neither the plaintiff nor his employer could have known about the claim at the time the plaintiff signed the waiver, even though the transaction at issue in the ERISA claim occurred *prior to* the release signing. Id. at 1293. The Wright case suggests that whether a release involves the waiver of prospective rights turns not on whether conduct giving rise to a claim has occurred (as in the statute of limitations), but on whether there is either (1) a claim pending or (2) the plaintiff has notice that a claim may exist at the time the waiver is made. Thus, under Wright, if the plaintiff does not know that a claim against her employer may exist, then a general waiver of her rights and claims is ineffective to waive ERISA claims that may arise in the future.

See:

Barron v. UNUM Life Ins. Co. of Am., 260 F.3d 310, 317 (4th Cir. 2001). Employee agreed to release plan from any past, present, or future liability. The court held the release did not apply to future claims relating to events that were not known by the parties at the time employee signed release.

Sullivan v. AT & T, Inc., No. 08-cv-1089, 2010 WL 905567, at *4 (N.D. Tex. Mar. 12, 2010). Employee argued that his waiver did not release his claim of ERISA estoppel, which arose more than four years after he executed the waiver. The court held that employee's claim for ERISA estoppel, which was unknown on the date the waiver was executed, was not waived.

Reighard v. Limbach Co., 158 F. Supp. 2d 730, 733 (E.D. Va. 2001). Employee signed an agreement at the onset of employment agreeing, among other things, not to sue employer for any claims arising from involuntary termination. After employee was involuntarily terminated, he raised several ERISA claims in the district court. The district court denied defendant's motion to dismiss, holding that a release of future ERISA claims is ineffective as inconsistent "with the general rule that waivers of prospective statutory federal rights are void."

3. Waivers of welfare benefits might not need to be knowing and voluntary.

As discussed in Section XV.E, there are several differences between welfare benefits and pension benefits. The First Circuit has held that a welfare benefit waiver is not entitled to the same level of heightened scrutiny as a pension benefit waiver. *Rivera-Flores v. Bristol-Myers Squibb Caribbean*, 112 F.3d 9, 13 n.5 (1st Cir. 1997). Instead, waivers of pension benefits are subject to contract law principles of federal common law. *Morais v. Cent. Beverage Corp. Union Emps.' Supp. Ret. Plan*, 167 F.3d 709, 711 (1st Cir. 1999).

But see:

Melton v. Melton, 324 F.3d 941, 945-46 (7th Cir. 2003). In evaluating whether a waiver by a designated beneficiary of an ERISA-regulated life insurance plan was effective, the court observed that it was "more concerned with whether a reasonable person would have understood that she was waiving her interest in the proceeds or benefits in question than with any magic language contained in the waiver itself."

Manning v. Hayes, 212 F.3d 866, 874 (5th Cir. 2000). An attempted waiver by a designated beneficiary of an ERISA-regulated life insurance plan must be "explicit, voluntary and made in good faith."

Sharkey v. Ultramar Energy Ltd., 70 F.3d 226, 231 (2d Cir. 1995). "We see no reason to apply a lower level of scrutiny to waivers of severance claims under ERISA than we do to pension claims. . . . [I]f ERISA applies to the Severance Plan . . . the district court must subject it to the 'close scrutiny' called for [by earlier rulings]."

B. WHETHER A WAIVER IS KNOWING AND VOLUNTARY DEPENDS ON THE TOTALITY OF THE CIRCUMSTANCES.

To determine whether a waiver of ERISA rights and claims was knowing and voluntary, some appellate courts—including the Second, Third, Sixth, Seventh, Eighth, Tenth, and D.C. Circuits—have adopted a multi-factor totality of the circumstances test. See, e.g., Howell, 633 F.3d at 559; Rivera-Flores, 112 F.3d at 12. The list of factors is not exhaustive, and “no single fact or circumstance is entitled to talismanic significance on the question of waiver.” Smart, 70 F.3d at 181. While the test may vary slightly depending on the jurisdiction, courts generally look to the following factors:

- (1) The plaintiff’s education and business experience;
- (2) The amount of time the plaintiff had possession of or access to the agreement before signing it;
- (3) The role of plaintiff in deciding the terms of the agreement;
- (4) The clarity of the agreement;
- (5) Whether the plaintiff was represented by or consulted with an attorney, as well as whether the employer encouraged the employee to consult an attorney and whether the employee had a fair opportunity to do so; and
- (6) Whether the consideration given in exchange for the waiver exceeds employee benefits to which the employee was already entitled by contract or law.

Howell, 633 F.3d at 559. A release need not specifically mention ERISA for the claim to be waived effectively; so long as the waiver satisfies the “knowing and voluntary” analysis, it is enough that the release “unambiguously reveal an intent to cover every imaginable cause of action.” Chaplin v. NationsCredit Corp., 307 F.3d 368, 373 (5th Cir. 2002). The party seeking to enforce the waiver has the burden to prove the waiver’s validity. Id. at 372.

If any language on the waiver’s face speaks directly to one of the six factors, a court may bar the parties from seeking to address that factor through extrinsic evidence. In Morais v. Central Beverage Corp. Union Employees’ Supplemental Retirement Plan, 167 F.3d 709, 713 (1st Cir. 1999), the plaintiff asserted that he was offered the waiver without the opportunity to obtain independent advice. The agreement, which the plaintiff signed, stated that the plaintiff had consulted with attorneys and union officials, and signed the agreement after consultation. Id. at 713 n.7. Applying basic contract law principles, the court held that the agreement was

conclusive evidence that the plaintiff had, in fact, received access to adequate independent consultation. Id. at 713-14.

Demonstrating that no single element of the test is dispositive, the Morais court explained that the dramatic discrepancy between the plaintiff's level of education and sophistication and that of the defendants, the plan and its administrator, was offset by the consultation and advice the plaintiff had received—or at least that the agreement stated he had received. Id. at 714. Access to legal counsel, or a legal education and background, can be important evidence in the evaluation of the “education and experience” and the “consultation” prongs of analysis. In Finz v. Schlesinger, 957 F.2d 78, 83 (2d Cir. 1992), the court considered it significant evidence that the plaintiff had been a former New York Supreme Court justice, indicating that it was “clear that Finz, an astute lawyer, knew exactly the bargain he was making.” If the plaintiff had access to any legal advice (or has a legal background), it will be difficult to claim that he did not make a knowing and voluntary waiver.

Despite courts' general admonition that no single factor is entitled to greater weight than the others, the consideration factor is significant because, if a waiver is not supported by consideration, it will probably fail. In contrast, a waiver will survive if it is supported by consideration which is beyond that to which the plaintiff is already entitled by operation of law or contract and beyond those benefits which the employer has gratuitously conveyed to the plaintiff prior to asking for the release of claims. In Gorman v. Earmark, Inc., 968 F. Supp. 58, 62 (D. Conn. 1997), the plaintiff's former employer argued that the release the plaintiff signed was supported by “(1) payment of his salary until the end of the month; (2) payment of his health insurance through the next month; (3) payment for his stock in Earmark and for promissory notes that were not yet due.” The evidence showed that the former employer had already gratuitously offered to extend plaintiff's salary and benefits three weeks prior to asking him to sign a release. Id. at 61. In denying summary judgment, the court concluded that a fact-finder could determine that the lump sum payment defendant made was compensation for plaintiff's stocks and notes, and therefore, funds to which plaintiff was already entitled under prior contracts. Id. at 63. Moreover, a fact-finder also could have concluded that the extension of salary and benefits was past consideration, which could not have supported the release. Id. If it appears that the employer is attempting to support the release of ERISA rights with the discharge of pre-existing legal duties, Gorman indicates that such a release is probably not supported by consideration. Furthermore, if it seems from the circumstances surrounding the signing of the waiver that there was fraudulent inducement, misrepresentation, mutual mistake or duress, then the waiver may justly be set aside. DePace v. Matsushita Elec. Corp. of Am., No. 02-cv-4312, 2004 WL 1588312, at *17 (E.D.N.Y. July 16, 2004).

While courts have generally concluded that a knowing and voluntary release of ERISA claims is valid, courts must still interpret the terms of the specific release in question to determine if they cover the claims the plaintiff seeks to assert. E.g., Brieger v. Tellabs, Inc., 473 F. Supp. 2d 878, 885 (N.D. Ill. 2007) (citing Curran v. Kwon, 153 F.3d 481, 488, n. 12 (7th Cir. 1998)). This is an issue of contract law and requires the court to interpret the release.

For example, in Breiger v. Tellabs, Inc., plaintiffs argued that a general release stating that it did not extend to “any vested benefits” did not bar their claims for additional benefits they claimed they would have received but for the fiduciaries’ breach. Id. In their motion for summary judgment, the defendants countered that the release explicitly relinquished claims arising under ERISA and that, because the plaintiffs knowingly and voluntarily entered into the release and received adequate consideration in the form of severance packages, they were barred from bringing any claims relating to the plan. Id. The court sided with the plaintiffs on defendants’ summary judgment motion because it believed there was a factual issue as to whether the plaintiffs understood a “release that expressly excepted claims for vested benefits [would] bar a claim that the signatory received a lower level of vested benefits as a result of defendants’ fiduciary breaches.” Id. at 886 (citing Nelson v. Ipalco Enter., Inc., No. 02-cv-477, 2005 WL 1924332, at *5-6 (S.D. Ind. Aug. 11, 2005)).

C. POSSIBLE TENDER BACK REQUIREMENT MAY BAR CHALLENGES TO ERISA WAIVERS.

Some courts may require plaintiffs, who have signed waivers but then attempted to bring ERISA claims anyway, to offer to tender back the additional consideration they received in exchange for signing the waiver before they may pursue the ERISA claims or even challenge the validity of the waivers. See Livingston v. Bev-Pak, Inc., 112 F. Supp. 2d 242, 249 (N.D.N.Y. 2000); Bittinger v. Tecumseh Prods. Co., 83 F. Supp. 2d 851, 872 (E.D. Mich. 1998), aff’d, 201 F.3d 440 (6th Cir. 1999); Harless v. Research Inst. of Am., 1 F. Supp. 2d 235, 242-43 (S.D.N.Y. 1998). These courts hold that, under the common law, a party who has accepted benefits in exchange for a waiver of claims must tender back that benefit before the party may challenge the release. See, e.g., Livingston, 112 F. Supp. 2d at 249. The Third Circuit has rejected any requirement that a plaintiff must tender back any consideration received before bringing an ERISA lawsuit. Jakimas v. Hoffmann-LaRoche, Inc., 485 F.3d 770, 784 (3d Cir. 2007). The court reasoned such a requirement would deter plaintiffs from bringing meritorious claims. Id. Other courts have not decided whether the tender back requirement is a condition precedent to pursuing an ERISA claim. See Hogan v. E. Enters./Boston Gas, 165 F. Supp. 2d 55, 65 n.14 (D. Mass. 2001) (stating that First Circuit has yet to address whether tender back is a requirement).

In Oubre v. Entergy Operations, Inc., 522 U.S. 422, 427 (1998), the Supreme Court rejected such a tender back requirement for plaintiffs bringing age discrimination claims under the Age Discrimination in Employment Act (“ADEA”). Because the Older Workers Benefit Protection Act of 1990 (“OWBPA”) established strict guidelines for the validity of an ADEA waiver, the Court determined that courts could not impose additional requirements such as a tender back requirement. Id. The Fifth Circuit, whose decision was overruled in Oubre, has since held that the OWBPA, by its own terms, addresses only waivers of age discrimination claims, and therefore, waivers of ERISA claims remain subject to common law doctrines. See Chaplin, 307 F.3d at 375. Chaplin indicates that the Fifth Circuit would impose a common law tender back requirement on plaintiffs who challenge waivers of ERISA claims.

XVII. SPECIAL CONSIDERATIONS FOR PLAN FIDUCIARIES RELATING TO SECURITIES LITIGATION

Under the Private Securities Litigation Reform Act (PSLRA), institutional investors occupy a uniquely advantageous position. See Andrew S. Gold, *Experimenting with the Lead Plaintiff Selection Process in Securities Class Actions: A Suggestion for PSLRA Reform*, 57 DEPAUL L. REV. 447, 450-52 (2008); see also Craig C. Martin & Matthew H. Metcalf, *The Fiduciary Duties of Institutional Investors in Sec. Litig.*, 56 BUS. LAW. 1381 (2001). First, institutional investors often wield more influence in directing (or preventing) class actions to which they are parties because of the relative size of their securities holdings. See Joseph A. Grundfest & Michael A. Perina, *The Pentium Papers: A Case Study of Collective Institutional Investor Activism in Litig.*, 38 ARIZ. L. REV. 559, 561 (1996). Second, such investors also enjoy statutory advantages in obtaining lead-plaintiff status in those actions. See 15 U.S.C. § 77z-1(a)(3)(B)(iii)(I)(bb); Switzenbaum v. Orbital Scis. Corp., 187 F.R.D. 246, 251, n.7 (E.D. Va. 1999) (appointing group of affiliated institutions as lead counsel and noting congressional preference, evidenced by the PSLRA, for selection of institutional investors over individual claimants). Although the dual roles of litigant and fiduciary have many common goals, institutional investors should be mindful of the limits and requirements of their fiduciary duties when they seek to evaluate, undertake, or pursue securities litigation.

See:

In re Cendant Corp. Litig., 182 F.R.D. 144, 146-47 (D.N.J. 1998) (subsequent history omitted). *The court held the class of plaintiffs would be best represented by institutional investors that held large and varied interests in the various securities at issue in the litigation.*

In re Cal. Micro Devices Sec. Litig., 965 F. Supp. 1327, 1330 (N.D. Cal. 1997). *Actions of institutional investors as lead plaintiffs allayed court's fears about adequacy of settlement, even though settlement was similar to earlier proposal rejected by the court. Settlement included substantial cash payment to plaintiffs.*

In re Cal. Micro Devices Sec. Litig., 168 F.R.D. 257, 275 (N.D. Cal. 1996), class cert. and proposed settlement granted, 965 F. Supp. 1327 (N.D. Cal. 1997). *Institutional investors were uniquely suited by virtue of their sophistication, size of interest, and fiduciary duties to represent class of plaintiffs in action.*

A. FIDUCIARY DUTIES IN SECURITIES LITIGATION

“[A]ny institutional investor subject to ERISA must consider how litigating a securities class action case on behalf of plaintiffs that are not beneficiaries of its investment plan comports with its fiduciary responsibilities. In addition, other plaintiffs in securities class actions seeking appointment as lead plaintiff have argued that the

fiduciary obligations of institutional investors to their beneficiaries may prevent them from fairly and adequately representing the investor class.” Martin & Metcalf, supra, at 1404.

1. The duty of loyalty

To fulfill their duty of loyalty, ERISA fiduciaries must “discharge [their] duties with respect to a plan solely in the interest of the participants and beneficiaries” and for the “exclusive purpose” of providing benefits to participants and beneficiaries. 29 U.S.C. § 1104(a)(1)(A)(i). Litigation concerning the duty of loyalty has arisen most often in the context of self-dealing transactions, such as a fiduciary’s use of plan assets to benefit non-fiduciaries. See, e.g., Duer Constr. Co. v. Tri-County Bldg. Trades Health Fund, 132 F. App’x 39, 44 (6th Cir. 2005). The duty is also implicated by strategic litigation considerations such as whether to seek lead-plaintiff status. See Martin & Metcalf, supra, at 1405-06. See Section V of this handbook for further discussion of the Duty of Loyalty.

See:

Rothstein v. Am. Int’l Grp., Inc., 837 F.3d 195, 208-09 (2d Cir. 2016). *The requirement that plan decisions be made “solely in the interest” of participants and beneficiaries “imposes a duty on the [trustees] to avoid placing themselves in a position where their acts as officers or directors of the corporation will prevent their functioning with the complete loyalty to participants demanded of them” as fiduciaries.*

Duer Constr. Co. v. Tri-County Bldg. Trades Health Fund, 132 F. App’x 39, 44 (6th Cir. 2005). *By putting the union’s interests ahead of those of participating employees, the fund and its union-affiliated chairman violated their fiduciary duties of loyalty under 29 U.S.C. § 1104(a).*

Gregg v. Transp. Workers of Am. Int’l, 343 F.3d 833, 840-41 (6th Cir. 2003). *The duty of loyalty requires a fiduciary to make all decisions regarding a plan “with an eye single to the interests of the participants and beneficiaries” and must “act for the exclusive purpose of providing benefits to plan beneficiaries.”*

2. The duty of care

ERISA also imposes on fiduciaries a strict duty of care that requires that a fiduciary act “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 like character and with like aims.” 29 U.S.C. § 1104(a)(1)(B); see Brundle v. Wilmington Tr., N.A., 919 F.3d 763, 770 (4th Cir. 2019). The Second Circuit has described the duty as an “unwavering duty . . . to make decisions with a single-minded devotion to a plan’s participants and beneficiaries and, in so doing, to act as a prudent person would in a similar situation.” Morse v. Stanley, 732

F.2d 1139, 1145 (2d Cir. 1984). See Sections VI-VIII for further discussion of the duty of care.

See:

White v. Martin, 286 F. Supp. 2d 1029, 1041 (D. Minn. 2003). *Fiduciary's ignorance of the Canadian non-resident tax incurred by the fund as a result of fiduciary's decision to invest through a Canadian firm constituted a breach of the duty of prudence.*

Conner v. Mid S. Ins. Agency, 943 F. Supp. 647, 658-59 (W.D. La. 1995). *Whether a plan can pay for an asset is not the only relevant question in evaluating potential plan investments. The opportunity cost of the chosen investment, or the expected return on investments which would be made if the chosen investment was not made, is also important. If investment A will yield X dollars and investment B will yield X+1 dollars, this seriously calls into question investment in A, and to not even consider investment B is certainly imprudent.*

But see:

In re Unisys Sav. Plan Litig., 173 F.3d 145, 152-54 (3d Cir. 1999). *The fiduciaries performed a sufficiently prudent investigation in investing in guaranteed-income contracts issued by an insurance company that went into receivership because the investigation was performed in part by an experienced investment consultant who used reliable information provided by national ratings services. Moreover, the fiduciaries made their own evaluation of the investment risks and did not "passively" accept the consultant's appraisal.*

B. ACTING AS LEAD PLAINTIFF

Congress's intent in enacting the PSLRA was to prevent "lawyer driven litigation" and "ensure that parties with significant financial interests in the litigation 'will participate and exercise control over the selection and actions of plaintiff[s] counsel.'" *Roszenboom v. Van der Moolen Holding*, No. 03-cv-8284, 2004 WL 816440, at *2 (S.D.N.Y. Apr. 14, 2004) (quoting H.R. REP. NO. 104-369, at 32 (1995) (Conf. Rep.)), as reprinted in 1995 U.S.C.C.A.N. 697, 730). Having institutional investors serve as lead plaintiff for the action is the best method for achieving that purpose. Id.

Under the PSLRA, therefore, institutional investors enjoy a statutory advantage in obtaining lead-plaintiff status in shareholder class actions. See 15 U.S.C. § 77z-1(a)(3)(B)(iii)(I)(bb); Switzenbaum, 187 F.R.D. at 251. Although the PSLRA imposes no duty on institutional investors to undertake lead-plaintiff status, see 15 U.S.C. § 77z-1(a)(2)(A)(iii), such status may prove advantageous.

Any party wishing to act as lead plaintiff may apply to the court to be so appointed, but institutional investors are aided by a statutory scheme that creates a

rebuttable presumption that the appropriate lead plaintiff is the one who (i) has either filed the complaint or made a motion to serve as lead plaintiff, (ii) has the largest financial interest in the relief sought by the class, and (iii) otherwise satisfies the requirements of Rule 23 of the Federal Rules of Civil Procedure. See 15 U.S.C. § 77z-1(a)(3)(B)(iii)(I). A party that satisfies those three factors is presumed to be the most adequate plaintiff. Id. Because the distinguishing factor among competing lead plaintiffs is generally the largest financial interest, institutional investors generally are entitled to the presumption. The presumption can be rebutted only through a showing that the presumptively most adequate plaintiff either: (i) will not fairly and adequately protect the interests of the class or (ii) is subject to unique defenses which render it incapable of adequately representing the class. See 15 U.S.C. § 77z-1(a)(3)(B)(iii)(II)(aa)-(bb).

If more than one investor seeks lead-plaintiff status, the court can compare its financial interest in the litigation to that of the other lead-plaintiff candidates. Neither Congress nor the circuit courts have established a test to determine in such circumstances which investor should become the lead plaintiff. Some district courts, however, have adopted the four-factor test first applied by Lax v. First Merchants Acceptance Corp., No. 97-cv-2715, 1997 WL 461036, at *5 (N.D. Ill. Aug. 11, 1997). The Lax court outlined the four factors as follows:

1. The number of shares purchased during the class period;
2. The number of net shares purchased during the class period;
3. The total net funds expended during the class period; and
4. The approximate loss suffered.

See Pirelli Armstrong Tire Corp. Ret. Med. Benefits Tr. v. LaBranche & Co., Inc., No. 03-cv-8264, 2004 WL 1179311, at *7 (S.D.N.Y. May 27, 2004); see also In re Cendant Corp. Litig., 264 F.3d 201, 223, 262 (3d Cir. 2001) (citing Lax favorably and affirming district court's appointment of lead plaintiff where said appointment turned upon which shareholder held the largest financial stake); Brady v. Top Ships Inc., 324 F. Supp. 3d 335, 349 (E.D.N.Y. 2018) (applying factors to determine which candidate for lead plaintiff had the largest financial interest); Horowitz v. Sunedison, Inc., No. 4:15-cv-1769, 2016 WL 1161600, at *3-4 & n.5 (E.D. Mo. Mar. 24, 2016) (applying Lax factors). But see In re Critical Path, Inc., 156 F. Supp. 2d 1102, 1107-08 (N.D. Cal. 2001) (discussing Lax factors but ultimately adopting test that equates "largest financial interest" with potential recovery, which renders determinative the net number of shares purchased during the class period); In re Ribozyme Pharm. Sec. Litig., 192 F.R.D. 656, 659-660 (D. Colo. 2000) (noting Lax factors but instead adopting retention value test, which compares prices before and after class period); In re Network Assocs., Inc. Sec. Litig.,

76 F. Supp. 2d 1017, 1027 (N.D. Cal. 1999) (treating as determinative net shares purchased during class period).

1. Benefits of lead-plaintiff status

In deciding whether to take on lead-plaintiff status, institutional investors weigh the potential benefits against the increased obligations the status creates. Institutional investors typically have advantages of both resources and sophistication over smaller investors; as a result, they are in a unique position to negotiate settlements that are beneficial both to litigants and to the company that is the subject of litigation. See In re Cendant Corp. Litig., 182 F.R.D. 144, 149 (D.N.J. 1998); H.R. REP. NO. 104-369, at 32 (1995) (Conf. Rep.), as reprinted in 1995 U.S.C.C.A.N. 697, 730. Not only do institutional investors often have a large and continuing stake in the health of the company, but their significant resources and comparatively large interests in the company may give them a greater ability to resist pressure to agree to a less-than-optimal settlement in the interests of a quick resolution.

In Cendant, three large pension funds acting as lead plaintiffs obtained what was at the time the largest settlement ever in a shareholder class action. Mitchell Pacelle, *Cendant Agrees in Its Settlement to Change Corporate Governance*, WALL ST. J., Dec. 8, 1999, at A4. The court selected the funds to act as lead plaintiffs over the objection of a number of other applicants, reasoning that the group of funds had sufficient interests in the range of securities involved to ensure adequate representation of the class. Cendant, 182 F.R.D. at 149. The group was able to negotiate not only a substantial monetary settlement but also a change in Cendant's corporate structure, giving shareholders a bigger say in the repricing of stock options and the composition of the board of directors. Pacelle at A4. The group was also able to minimize attorney fees. Id.

In another case, In re California Micro Devices Securities Litigation, 168 F.R.D. 257 (N.D. Cal. 1996) (Cal. Micro Devices I), class cert. and proposed settlement granted, 965 F. Supp. 1327 (N.D. Cal. 1997) (Cal. Micro Devices II), the court appointed institutional investors (pension funds) to act as lead plaintiff after refusing to accept a proffered pre-certification settlement because of the court's serious reservations about the possibility of collusion between the company and proposed lead counsel. The court noted that the two pension funds were appropriate lead plaintiffs because, as institutional investors, they (1) had by far the largest financial interests in the class action, (2) were in a superior position to evaluate the company's claims of imminent bankruptcy, and (3) had a fiduciary responsibility to the investors represented by the class action. Cal. Micro Devices I, 168 F.R.D at 275. Subsequently, the court accepted a settlement negotiated by the funds despite its similarities to the earlier-proposed settlement, largely because "[t]he presence of interested and able class representatives reduces substantially the agency problems associated with class actions and correspondingly reassures the court about the bona fides of the proposed settlement." Cal. Micro Devices II, 965 F. Supp. at 1330. In addition, the court noted that the settlement was overall better for investors than the first proposed settlement had been.

Id. at 1331 (stating “the terms of the present deal offer class members far more cash up front and a greater assurance of ultimately achieving further recoveries”).

There is also a cap in the PSLRA that prohibits a person from taking on lead-plaintiff status in more than five securities class actions during any three year period absent court approval. 15 U.S.C. § 78u-4(a)(3)(B)(vi). If the party seeking lead-plaintiff status has already served in that capacity in excess of the cap, there is a rebuttable presumption against its appointment. In re UNUM Provident Corp. Sec. Litig., No. 03-cv-049, 2003 U.S. Dist. LEXIS 24633, at *19-23 (E.D. Tenn. Nov. 6, 2003) (holding presumption against institutional investor was not overcome as court felt investor was being spread too thin, and there was available an adequate alternate lead plaintiff with a significant financial interest). A party may rebut the presumption against its appointment by, for example, demonstrating that no matter its repeat lead-plaintiff performance, it is “precisely the sort of lead plaintiff envisioned” by the PSLRA. See Naiditch v. Applied Micro Circuits Corp., No. 01-cv-0649, 2001 WL 1659115, at *2 (S.D. Cal. Nov. 5, 2001) (appointing institutional investor that had served as lead plaintiff eleven times in the past three years because the investor was experienced in securities litigation and well resourced, and the appointment accorded with the PSLRA’s goal of transferring control of private securities litigation from lawyers to investors). Courts have considerable discretion in determining whether the presumption has been rebutted. See id.

2. Fiduciary duties and the obligations of lead plaintiffs

Despite the advantages of acting as lead plaintiff, institutional investors must carefully evaluate the intersection between the obligations of a lead plaintiff and their fiduciary obligations under ERISA before petitioning to be appointed lead plaintiffs. Although the PSLRA has existed since 1995, courts continue to interpret and apply it in new ways. ERISA fiduciary duties are interpreted broadly, and thus, institutional investors should take careful note of the situations in which their conduct as lead plaintiffs could subject them to liability to plan beneficiaries under ERISA. Martin & Metcalf, supra, at 1405; see generally Wesley Kobylak, Annotation, “Dual Loyalty” Considerations in Determining Propriety, Under Employee Retirement Income Security Act, (29 U.S.C. § 1001 et seq.), of Actions of Officers and Sponsor Corporation Serving as Trustees of Employee Pension Plan, 64 A.L.R. FED. 602 (1983).

Both the duty of loyalty and the duty of care are implicated in the decision to take on lead-plaintiff status. The duty of loyalty, for example, precludes ERISA fiduciaries from using plan assets to benefit those who are not plan beneficiaries and from acting in a manner other than with the single goal of benefiting plan beneficiaries. See Gregg v. Transp. Workers of Am. Int’l, 343 F.3d 833, 840-41 (6th Cir. 2003). These are considerations that could come into conflict with the lead plaintiff’s obligation to place the interests of the represented class foremost. On the other hand, courts have also indicated that fiduciary obligations to plan beneficiaries are in keeping, rather than at odds, with the obligations of representing the class. See Cal. Micro Devices I, 168 F.R.D. at 275. For a fuller discussion of the duty of loyalty, see Section V of this Handbook.

Given the breadth of the obligations falling under the duty of care, institutional investors could be subject to liability for pursuing a lead-plaintiff position without first thoroughly investigating the merits of doing so. See Martin & Metcalf, supra, at 1407. In particular, the duty of care arguably obligates the institutional investor to carefully weigh the assumption of lead-plaintiff status just as it would weigh any investment of the plan's resources. Cf. 29 C.F.R. § 2550.404a-1(b)(i); Chao v. Merino, 452 F.3d 174, 184-85 (2d Cir. 2006). Thus, the institutional investor's wisest course in considering whether to pursue lead-plaintiff status is to employ all means of investigation an ERISA fiduciary typically employs in weighing risk or possible investments, such as hiring expert consultants. See In re Unisys Sav. Plan Litig., 173 F.3d at 150-52. For a fuller discussion of the duty of care, see Sections VI-VII of this Handbook.

In situations where the institutional investor continues to have a stake in the company in question or might consider having one in the future, actions taken in furtherance of litigation should also be evaluated for their effects on the plan's overall investment strategy. For instance, insider information gained during litigation could limit the plan's ability to trade in the company's shares. Continued holding of said shares could also create tensions with the plan's lead-plaintiff obligations to represent the interests of past shareholders who are also plaintiffs. Jill E. Fisch, *Class Action Reform: Lessons from Securities Litigation*, 39 ARIZ. L. REV. 533, 546 (1997). In addition, plan information divulged in discovery on the lead-plaintiff issue could be used to the disadvantage of plan beneficiaries. Id. In some circumstances, however, plan fiduciaries may find themselves compelled by their fiduciary duties to assume lead-plaintiff status where it is the only way of securing the optimal result for plan beneficiaries. In sum, institutional investors must approach lead-plaintiff status with the same careful and impartial investigation that they must apply to any investment opportunity. See Martin & Metcalf, supra, at 1407.

See also:

In re Network Assocs., Inc., Sec. Litig., 76 F. Supp. 2d 1017, 1021-22 (N.D. Cal. 1999). *Widely varied interests among competing applicants for lead-plaintiff status in a PSLRA suit called into question the presumption that any single investor or group of investors had sufficiently similar interests to other class members to provide adequate representation.*

Gluck v. CellStar Corp., 976 F. Supp. 542, 548 (N.D. Tex. 1997). *Institutional investor was adequate lead plaintiff despite objection that investor held interests in the disputed securities and so would allegedly litigate the case with an eye toward balancing its long term interests with the interests of the class.*

3. Competitive bidding for lead-plaintiff-counsel status

When deciding whether to seek lead-plaintiff status, institutional investors should be aware that, should the court decide to utilize a competitive-bidding process,

the bids submitted will probably be available to the public. See generally In re Cendant Corp., 260 F.3d 183 (3d Cir. 2001). The Third Circuit in Cendant vacated sanctions imposed against a losing bidder, reasoning that the district court's order sealing the bids was improper and contrary to the PSLRA. Id. at 201; see also In re Lucent Techs., Inc. Sec. Litig., 327 F. Supp. 2d 426, 433 (D.N.J. 2004) (holding that, even though lead counsel were appointed via the sealed-bid auctions prohibited by *Cendant*, each lead plaintiff had since approved those selections and so counsel were "properly appointed" under the PSLRA).

The Cendant court reasoned first that "[w]hile not explicitly denominated as such, the bids were essentially submitted in the form of motions to be appointed lead counsel" and were therefore public documents. 260 F.3d at 193. The court further held that making the bid information available to the class members was essential because the "only stage at which class members can exercise effective control is in the selection of class counsel." Id. In addition, the court found that its position was supported by the language and legislative history of the PSLRA. Id. at 196. Thus, institutional investors should bear in mind both that their fiduciary obligations are fully in force when they decide to act as lead plaintiffs and that their actions in bidding for that status are open to public scrutiny.

XVIII. PROFESSIONAL RESPONSIBILITY CONSIDERATIONS FOR ATTORNEYS DEALING UNDER ERISA

This section addresses the major professional responsibility concerns attorneys in the ERISA context face. As with most ethical considerations, however, there is seldom a definitive rule that attorneys must follow. To further complicate the issue, no uniform ethical standard applies nationwide. Nonetheless, an ERISA attorney must have a basic idea of the unique ethical concerns that can arise. Therefore, this Handbook will serve to highlight major professional responsibility issues and provide a starting point for more extensive research.

“An employee benefits practitioner is well advised to give careful attention to the ethical complexities of entity representation, multiple representation, and fiduciary representation, which are the hallmarks of employee benefits practice.” Gwen T. Handelman et al., *Standards of Lawyer Conduct in Employee Benefits Practice: Part 1*, 24 J. PENSION PLAN. & COMPL. 10, 10 (Summer 1998).

A. GOVERNING RULES FOR ATTORNEYS DEALING WITH ERISA

No uniform ethical standard applies to all ERISA attorneys. Instead, an attorney may be subject to state or federal ethical standards that vary from jurisdiction to jurisdiction and from court to court. As a general rule, most states (but not all) have adopted some variation of the ABA Model Rules of Professional Conduct. Most federal courts apply ethical rules derived from the state law where the federal court sits, but also may look to the ABA and federal common law. As a result, ERISA attorneys should research the applicable standards of the particular court before which they practice. See generally Handelman et al., *supra*; H. Geoffrey Moulton, Jr., *Federalism and Choice of Law in the Regulation of Legal Ethics*, 82 MINN. L. REV. 73 (1997) (discussing varying applications of ethical standards across country).

See:

In re ProEducation Int'l, Inc., 587 F.3d 296, 299 (5th Cir. 2003). *Both the ABA Model Rules of Professional Conduct and the state professional conduct rules were used to decide a motion to disqualify.*

Cole v. Ruidoso Mun. Sch., 43 F.3d 1373, 1383 (10th Cir. 1994). *“Motions to disqualify are governed by two sources of authority. First, attorneys are bound by the local rules of the court in which they appear. Federal district courts usually adopt the Rules of Professional Conduct of the states where they are situated. Second, . . . they are decided by applying standards developed under federal law,” including “the ethical rules announced by the national profession.”*

But see:

In re Am. Airlines, Inc., 972 F.2d 605, 610 (5th Cir. 1992). *A motion to disqualify was addressed by federal law because it was before a federal*

court. “[M]otions to disqualify are substantive motions affecting the rights of the parties and are determined by applying standards developed under federal law.”

B. ETHICAL CONCERNS WHEN AN ATTORNEY BECOMES A FIDUCIARY

One of ERISA’s most important ethical considerations is that an attorney may become a fiduciary. Fiduciary status can subject an attorney to various forms of liability. If an attorney is directly named as a plan fiduciary, it is fairly clear that the lawyer may be a fiduciary. On the other hand, a lawyer may be surprised to know that he or she can become a fiduciary indirectly simply by performing certain functions as stated in ERISA § 3(21) (29 U.S.C. § 1002(21)), such as by exercising discretionary control over the plan’s management or the disposition of its assets, rendering investment advice for a fee, or having discretionary authority over the plan’s administration. Liss v. Smith, 991 F. Supp. 278, 303 (S.D.N.Y. 1998).

Therefore, it is important for lawyers to understand what functions can indirectly impose fiduciary status under 29 U.S.C. § 1002(21).

1. Fiduciary liability by exercising discretion over ERISA plan or its assets

ERISA dictates that a person, such as an attorney, may become a fiduciary by exercising discretionary authority or control over the management of an ERISA plan or its assets. 29 U.S.C. § 1002(21)(A)(i). An attorney will not, however, become a fiduciary simply by performing usual professional functions. See JEFFREY D. MAMORSKY, EMPLOYEE BENEFITS LAW—ERISA AND BEYOND, EMPLOYEE BENEFITS LAW, § 12.03 (2002); 29 C.F.R. § 2509.75-5 D-1 Q (noting that “ attorneys . . . performing their usual professional functions will ordinarily not be considered fiduciaries” but could be fiduciaries “if the factual situation in a particular case falls within one of the categories described in” 29 U.S.C. § 1002). The important consideration is whether the attorney exercised discretionary or ministerial authority or control. If the attorney performs purely ministerial functions (mandatory act without personal discretion), he will not be an ERISA fiduciary. On the other hand, if an attorney exercises discretionary authority or control, it is possible that an attorney will become subject to ERISA fiduciary status.

Compare (cases in which attorney was found not to be a fiduciary):

Hatteberg v. Red Adair Co., 79 F. App’x 709, 716 (5th Cir. 2003). *Merely giving legal advice to an ERISA plan, even if the administrators followed attorneys’ advice, does not make attorneys de facto controllers of the plan.*

Mellon Bank, N.A. v. Levy, 71 F. App’x 146, 148-49 (3d Cir. 2003). *An attorney who merely gave legal advice on a transaction and did not control the plan’s final decision was not a fiduciary.*

S. Illinois Carpenters Welfare Fund v. Carpenters Welfare Fund of Illinois, 326 F.3d 919, 922 (7th Cir. 2003). Plaintiffs' claim against lawyer for welfare fund failed because lawyer "did not control the fund" and thus "was not an ERISA fiduciary."

Custer v. Sweeney, 89 F.3d 1156, 1162 (4th Cir. 1996). "[T]he mere fact that an attorney represents an ERISA plan does not make the attorney an ERISA fiduciary because legal representation of ERISA plans rarely involves the discretionary authority or control required by the statute's definition of 'fiduciary.'"

S. Council of Indus. Workers v. Ford, 83 F.3d 966, 968 (8th Cir. 1996). Lawyer "did not become a plan fiduciary merely by" controlling settlement proceeds.

Pappas v. Buck Consultants, Inc., 923 F.2d 531, 535 (7th Cir. 1991). Court held that actuary was not an ERISA fiduciary after recognizing "[o]ther courts that have considered the question have refused to fit professionals like accountants or attorneys within the statutory definition [of an ERISA fiduciary] when all they have done is advise the trustees of an ERISA plan."

With (cases in which attorney was found to be a fiduciary):

Liss v. Smith, 991 F. Supp. 278, 303 (S.D.N.Y. 1998). An attorney with large influence over a fund may exercise discretionary control and attorney failed to act as a prudent (or competent) fund counsel when he did not advise the trustees as to their fiduciary duties or his innumerable conflicts of interest.

See also:

Chapman v. Klemick, 3 F.3d 1508, 1511 (11th Cir. 1993). Attorney representing trust fund beneficiary did not become fiduciary when he received settlement funds to which the trust asserted subrogation rights because he had no discretionary control over the funds. The court also emphasized that "imposing fiduciary status willy-nilly would make banks and law firms extremely wary of ERISA plans as customers and clients."

Assocs. in Adolescent Psychiatry, S.C. v. Home Life Ins. Co., 941 F.2d 561, 570 (7th Cir. 1991). In holding that a financial consulting firm specializing in designing pension fund plans and its employees were not ERISA fiduciaries, the court likened their role that of an attorney. "That lawyers . . . may render services to employers, plan trustees, and plan beneficiaries does not give them any decision-making authority over the plan or plan assets; the power to act for the plan is essential to status as a fiduciary under ERISA."

2. Fiduciary liability by having discretionary authority or responsibility over an ERISA plan

Here, ERISA does not emphasize an “exercise” of authority. Instead, the requirement is that the attorney simply “has” discretionary authority or responsibility in an ERISA plan’s administration. 29 U.S.C. § 1002(21)(A)(iii). Nonetheless, cases addressing this requirement, and the first requirement of an “exercise of discretion,” will likely overlap in practice.

See:

Bell v. Pfizer, Inc., 626 F.3d 66, 73-74 (2d Cir. 2010), abrogation on other grounds recognized by Osberg v. Foot Locker, Inc., 862 F.3d 198, 212 n.12 (2d Cir. 2017). A person is a fiduciary to the extent that he “has any discretionary authority or discretionary responsibility in the administration of the plan,” but only “to the extent that he has or exercises the described authority or responsibility.”

F.H. Krear & Co. v. Nineteen Named Trustees, 810 F.2d 1250, 1260 (2d Cir. 1987). District court did not err in refusing to rule that a lawyer was a fiduciary as a matter of law when facts showed that he negotiated contracts but lacked authority to determine what amount the trustees would actually pay.

3. Fiduciary liability for rendering paid investment advice

To avoid attaining fiduciary status, an attorney should be wary of advising on fund investments. Under 29 U.S.C. § 1002(21)(A)(ii), one who renders investment advice (or has a responsibility to do so) regarding an ERISA plan’s assets, and receives a fee, can become a fiduciary. Some courts addressing this issue, however, have referred to the Labor and Treasury Departments’ definition of investment advice. See 26 C.F.R. § 54.4975-9 (providing regulations from Department of Treasury); 29 C.F.R. § 2510.3-21 (providing regulations from Department of Labor). This definition adds the requirements that the investment advisor either have some discretionary control or that the advisor give investment advice on a regular basis.

See:

Gerosa v. Savasta & Co., 329 F.3d 317, 321 n.3 (2d Cir. 2003). In the Second Circuit, “attorneys . . . are not ordinarily fiduciaries unless they render investment advice or are given special authority over plan management.”

Rutledge v. Seyfarth, Shaw, Fairweather & Geraldson, 201 F.3d 1212, 1220 (9th Cir. 2000), partial abrogation on other grounds recognized by Depot, Inc. v. Caring for Montanans, Inc., 915 F.3d 643, 666-67 (9th Cir. 2019). An attorney was not a fiduciary when he only performed traditional attorney services, which did not include giving investment advice.

Yeseta v. Baima, 837 F.2d 380, 385 (9th Cir. 1988). An attorney was not a fiduciary because he did not have discretionary control or render investment advice for a fee.

Barton v. Mitsubishi Cement Corp., No. 07-cv-03509, 2008 WL 4286985, at *6 (C.D. Cal. Sept. 15, 2008). An attorney was not a fiduciary because she did not give individualized investment advice and was not paid a fee.

Mellon Bank, N.A. v. Levy, No. 01-cv-1493, 2002 WL 664022, at *7 (E.D. Pa. Apr. 22, 2002), affirmed by *Mellon Bank, N.A. v. Levy*, 71 F. App'x 146 (3d Cir. 2003). An attorney was not a fiduciary because he did not have discretionary control or render unsolicited investment advice.

See Section III.A of this Handbook for additional discussion of how fiduciary status can arise under ERISA.

C. ETHICAL CONCERNS WHEN AN ATTORNEY IS NOT A FIDUCIARY

Even if an attorney is not a fiduciary under the previous analysis, he still may be subject to ERISA liability. In particular, a non-fiduciary attorney may be liable as a party in interest according to 29 U.S.C. § 1002(14)(B) if he participates in “prohibited transactions” under ERISA § 406(a)(1)(C) and (D), 29 U.S.C. § 1106(a)(1)(C)-(D). The United States Supreme Court held in Harris Trust & Savings Bank v. Salomon Smith Barney Inc., 530 U.S. 238, 241 (2000), that a non-fiduciary party in interest can be held liable for knowingly participating in transactions that are prohibited by § 406(a). Court decisions have subjected attorneys who participate in prohibited transactions to equitable liability under § 502(a)(3) and (5), civil penalties under § 502(i) and (l), and excise taxes under I.R.C. § 4975. See Handelman et al., supra, at 18.

See also:

Mertens v. Hewitt Assocs., 508 U.S. 248, 252-54 (1993). ERISA does not expressly authorize suits against non-fiduciaries who knowingly participate in a fiduciary’s breach of fiduciary duty, and, because the parties did not dispute the issue, the Court left undecided the question of whether a non-fiduciary violated ERISA by participating in a fiduciary’s breach. Subsequent cases have established that equitable relief is appropriate for those non-fiduciaries that conduct prohibited transactions.

Rutledge v. Seyfarth, Shaw, Fairweather & Geraldson, 201 F.3d 1212, 1220 (9th Cir. 2000), partial abrogation on other grounds recognized by Depot, Inc. v. Caring for Montanans, Inc., 915 F.3d 643, 666-67 (9th Cir. 2019). A plaintiff may have a cause of action against a non-fiduciary attorney who knowingly participates in a fiduciary’s prohibited transaction.

Reich v. Stangl, 73 F.3d 1027, 1034 (10th Cir. 1996). The court recognized equitable actions based on ERISA and parallel IRS codes by stating that “the language of sections 406(a) and 502(a)(5) of ERISA, the

legislative history of ERISA, the decisions of other circuits, the Supreme Court's decision in Mertens, the policies underlying ERISA, and 26 U.S.C. § 4975(h) [of the IRC] establish that the Secretary may bring a civil action for equitable relief under section 502(a)(5) against a party in interest who has engaged in a prohibited transaction."

Cf.:

L.I. Head Start Child Development Services, Inc. v. Frank, 165 F. Supp. 2d 367, 369 (E.D.N.Y. 2001). The court indicated that attorneys alleged to have knowingly participated in trustees' breach of fiduciary duty under ERISA section 404 may well have to return legal fees they collected in an improper transaction, denying attorneys' motion to dismiss.

1. Collecting attorney fees from ERISA plan assets may constitute a "prohibited transaction" that subjects an attorney to liability

"Two problems often arise under prohibited transactions rules in connection to collection of attorneys fees supplied from plan assets. First, the payment of more than 'reasonable' fees from plan assets may constitute a prohibited transaction. Second, the payment of attorney fees from plan assets for [certain] services . . . may constitute a prohibited transaction . . ." Handelman et al., supra, at 19-20. In particular, attorneys who represent plan fiduciaries may encounter situations where an ERISA plan provides for the payment of attorneys' fees. When an ERISA plan provides fees, however, the attorney must remain wary of potential ethical issues.

a) Fees collected from an ERISA plan must be reasonable

An attorney must receive reasonable fees if an ERISA plan pays the fees. 29 U.S.C. § 1108(b)(2) exempts from the definition of "prohibited transactions" reasonable arrangements with a party in interest for legal services that are necessary for an ERISA plan's establishment or operation. If an attorney receives more than reasonable fees, however, this transaction will not be exempt under ERISA § 408 and the attorney may be liable as a party to a prohibited transaction.

See:

Rutledge v. Seyfarth, Shaw, Fairweather & Geraldson, 201 F.3d 1212, 1220-22 (9th Cir. 2000), partial abrogation on other grounds recognized by Depot, Inc. v. Caring for Montanans, Inc., 915 F.3d 643, 666-67 (9th Cir. 2019). An allegation of excessive attorneys' fees charged to the plan is an allegation of a prohibited transaction and any state claim related to the excessive fees is preempted by ERISA.

Nieto v. Ecker, 845 F.2d 868, 873 (9th Cir. 1988). "Some of the allegations in the complaint, if true, establish that [the attorney] participated in such

‘prohibited transactions’ with the Funds by receiving excessive compensation for legal services”

In addition, the IRS defines unreasonable compensation as compensation paid that “may not exceed what is reasonable under all the circumstances.” 26 C.F.R. § 1.162-7(b)(3). In general, the regulations allow for “such amount as would ordinarily be paid for like services by like enterprises under like circumstances.” *Id.* The relevant circumstances to consider are those existing at the date when the contract for services was made, not those existing at the date when the contract is questioned. *Id.*

b) An attorney may still be liable even if fees are reasonable if the services were not “performed on the plan’s behalf”

Attorneys must remain aware that even reasonable fees may constitute “prohibited transactions.” Handelman et al, *supra*, at 20. ERISA dictates that a plan’s payment of attorneys’ fees must be for services “necessary for the establishment or operation of the plan.” 29 U.S.C. § 1108(b)(2). If an attorney receives payment for services that were not necessary, payment may constitute a prohibited transaction and subject the attorney to liability as a party in interest. As a result, lawyers should remain wary of circumstances where there is doubt as to whether an ERISA plan should be paying the attorneys’ fees.

In particular, when an attorney represents a plan fiduciary, it may be unclear whether attorneys’ fees are necessary for the plan’s establishment or operation. Accordingly, attorneys who represent plan fiduciaries should remain cautious about accepting payment from the assets of an ERISA plan.

See:

Jordan v. Mich. Conference of Teamsters Welfare Fund, 207 F.3d 854, 861-62 (6th Cir. 2000). *A party-in-interest may receive attorneys’ fees it previously advanced to fund the litigation without engaging in a prohibited transaction.*

FirsTier Bank, N.A. v. Zeller, 16 F.3d 907, 913 (8th Cir. 1994). *An attorney may receive payment for reasonable fees where the plan documents provide for reimbursement of reasonably incurred fees.*

Iron Workers Local 25 Pension Fund v. Watson Wyatt & Co., No. 04-cv-40243, 2009 WL 3698562, at *10 (E.D. Mich. Nov. 4, 2009). *An attorney may receive a contingency fee without the fee being a prohibited transaction if the trustee did not subjectively intend to benefit the attorney at the expense of the fund.*

But see:

Martin v. Walton, 773 F. Supp. 1524, 1527 (S.D. Fla. 1991). *If an attorney represents a fiduciary who breached his fiduciary duty, acceptance of fees from an ERISA plan may constitute a prohibited transaction. "Under ERISA, however, legal fees are not permitted to a breaching fiduciary, even if the action constituting the violation were undertaken by the fiduciary in good faith and did not result in a loss to the plan."*

If a court finds that a fiduciary did not breach his fiduciary duty, it is fairly settled that a lawyer can accept reasonable payment from an ERISA plan for the fiduciary's defense. 29 U.S.C. § 1108(c)(2); *see FirsTier Bank*, 16 F.3d at 913. If the fiduciary is found to have breached his fiduciary duty, however, a lawyer generally cannot accept payment from the plan for the fiduciary's defense. *Martin*, 773 F. Supp. at 1527. The unanswered question is whether an attorney may receive fees during the litigation that determines whether a plan fiduciary breached a fiduciary duty.

See:

Moore v. Williams, 902 F. Supp. 957, 966-67 (N.D. Iowa 1995). *Plan fiduciary incurred legal expenses in defense of an alleged fiduciary breach. Because the plan had an indemnity agreement that provided for the payment of legal fees until a final adjudication on whether there was a breach of fiduciary duty, payment of attorney fees from plan assets was proper, at least until a final adjudication.*

D. OTHER ISSUES ERISA ATTORNEYS SHOULD CONSIDER

Aside from the ERISA-specific issues addressed in the previous sections, an ERISA attorney should consider several other professional responsibility issues. As a result, this Handbook will briefly highlight some areas that an attorney should consider while handling ERISA matters.

1. Entity representation

An ERISA attorney should be aware of the complexities that arise from representing entities such as corporate and union sponsors and jointly administered pension and welfare funds. An attorney should conduct specific research if they represent an entity in an ERISA action. *Handelman et al.*, *supra*, at 23-24.

See:

Iron Workers Local 25 Pension Fund v. Watson Wyatt & Co., No. 04-cv-40243, 2009 WL 3698562, at *7-8 (E.D. Mich. Nov. 4, 2009). *An attorney-client relationship only existed between attorney and the fund and not between attorney and trustees of the fund.*

Toussaint v. James, No. 01-cv-10048, 2003 WL 21738974, at *8 (S.D.N.Y. July 25, 2003). *Counsel for pension plan does not become counsel for trustees automatically because pension plans are "distinct legal entit[ies]."*

2. Multiple representation

An ERISA attorney may represent multiple parties either intentionally or unintentionally. Regardless, the attorney must remain aware that divided loyalty and conflict of interest issues may force the attorney to withdraw from the representation.

See:

Kayes v. Pacific Lumber Co., 51 F.3d 1449, 1465 (9th Cir. 1995) (quoting *Sullivan v. Chase Inv. Servs. of Boston, Inc.*, 79 F.R.D. 246, 258 (N.D. Cal. 1978)). Upholding an order that a class action attorney withdraw, the court stated “[t]he responsibility of class counsel to absent class members whose control over their attorneys is limited does not permit even the appearance of divided loyalties of counsel.”

But see:

Keilholtz v. Lennox Hearth Prods., 268 F.R.D. 330, 338 (N.D. Cal. 2010). Attorney was not disqualified in representing class when he was representing individual plaintiffs in a similar state law action.

There may also be issues with respect to the application of the attorney-client privilege in instances where an attorney represents multiple parties. See, e.g., In re Regents of the Univ. of Cal., 101 F.3d 1386, 1389 (Fed. Cir. 1996) (in a non-ERISA case, noting that “[w]hen the same attorney represents the interests of two or more entities on the same matter, those represented are viewed as joint clients for purposes of privilege”); David M. Greenwald & Michele L. Slachetka, *Jenner & Block Practice Series: Protecting Confidential Legal Information* § II.A.2 (2019) (discussing waiver of attorney-client privilege in subsequent litigation between joint clients whose interests become adverse).

3. Privilege and confidentiality

Generally, a plan fiduciary may rely on the attorney-client privilege to protect from involuntary disclosure confidential privileged communications that the fiduciary has with an attorney for the purposes of obtaining legal advice. See, e.g., United States v. Mett, 178 F.3d 1058, 1064 (9th Cir. 1999). However, when the attorney-client privilege may be asserted and against whom it may be asserted depend upon the precise circumstances of the communication. Therefore, an attorney must research the particular standards of his or her jurisdiction in evaluating the applicability of the privilege.

For example, in the ERISA context, a key consideration for the applicability of the attorney-client privilege is the so-called “fiduciary exception” to the attorney-client privilege. Under this exception, “a fiduciary of an ERISA plan ‘must make available to the beneficiary, upon request, any communications that are intended to assist in the administration of the plan.’” Bland v. Fiatallis N. Am. Inc., 401 F.3d 779, 787 (7th Cir. 2005) (quoting In re Long Island Lighting Co., 129 F.3d 268, 272 (2d Cir.

1997)). This exception is premised on the theory that when the fiduciary receives legal advice concerning the administration of the plan, the plan's participants are the "real" or "ultimate" clients and "the attorney-client privilege should not be used as a shield to prevent disclosure of information relevant to an alleged breach of fiduciary duty." Id.; In re Occidental Petro. Corp., 217 F.3d 293, 296-97 (5th Cir. 2000) (allowing plan participants to gain access to documents through fiduciary exception since plan participants were beneficiaries of ESOP plan which held stock of corporation); see also Wachtel v. Health Net Inc., 482 F.3d 225, 233 (3d Cir. 2007); Henry v. Champlain Enters., Inc., 212 F.R.D. 73, 83-87 (N.D.N.Y. 2003). Courts have found that the participants' right to access these materials is grounded in the "mutuality of interest" shared by the trustee and beneficiaries as a result of the fiduciary obligations the trustee. See Harvey v. Standard Ins. Co., 275 F.R.D. 629, 632 (M.D. Ala. 2011); see generally Craig C. Martin and Matthew H. Metcalf, *The Fiduciary Exception to the Attorney-Client Privilege*, 34 TORT & INS. L.J. (1999); David M. Greenwald & Michele L. Slachetka, *Jenner & Block Practice Series: Protecting Confidential Legal Information* § 1.1.3(b) (2019) (discussing the fiduciary exception).

See:

Solis v. Food Emplrs. Labor Relations Ass'n, 644 F.3d 221, 229 (4th Cir. 2011). There is no requirement for a showing of good cause to apply the fiduciary exception in ERISA cases. The exception also allows otherwise privileged communications between the fiduciaries and their attorneys to be discovered by the Department of Labor.

Cobell v. Norton, 212 F.R.D. 24, 27-28 (D.D.C. 2002). The court held that if a trustee claims a litigation privilege, it is the trustee's obligation to show that the communication is not required to be disclosed under the fiduciary exception.

In considering whether the fiduciary exception applies, the Third Circuit has noted that ERISA fiduciaries "come in many shapes and sizes" and that the logic underlying the fiduciary exception does not apply equally to all fiduciaries. Wachtel, 482 F.3d at 234. In Wachtel, the court considered whether the fiduciary exception would require an insurer that provided benefits to the plan to disclose its privileged communications to plan participants. The court stated that the insurer was a fiduciary under ERISA but that the insurer was significantly different from other plan fiduciaries to whom the exception has been applied. The court considered several factors, including the fact that the insurer did not pay for the advice from plan assets and that it had conflicting interests with the participants, to conclude that the insurer did not have a sufficient identity of interests with the participants for the exception to apply. Id. at 234-36. Some courts have rejected Wachtel, however. See, e.g. Moss v. UNUM Life Ins. Co., No. 5:09-cv-209, 2011 WL 321738, at *4 (W.D. Ky. Jan. 28, 2011); Smith v. Jefferson Pilot Fin. Ins. Co., 245 F.R.D. 45, 49 (D. Mass. 2007).

The Supreme Court's decision in United States v. Jicarilla Apache Nation, 564 U.S. 162 (2011), a non-ERISA case, appears to reinforce Wachtel. In Jicarilla, the

Court held the fiduciary exception did not apply to the United States when it serves as a trustee for the property of Indian tribes. In this case, the United States, in its capacity as a sovereign, was acting in its own interest. Id. at 180-83. This rationale reinforces the Wachtel holding that the fiduciary exception did not apply to an insurer because the insurer had its own unique interests. In addition, the Jicarilla Court emphasized the significance of who pays for the legal advice at issue, id. at 172, reinforcing the use of this factor in Wachtel.

The fiduciary exception also does not render all communications between a fiduciary and counsel available to plan participants. First, the exception does not apply to communications related to “settlor” functions, such as the formation, termination, or amendment of the plan. Because such conduct is not a “fiduciary” activity and does not relate to plan administration, the exception does not apply. Wachtel, 482 F.3d at 233. Similarly, advice concerning a top-hat plan, which is an unfunded plan that is often used to provide deferred compensation to corporate executives, has been found to be not subject to the fiduciary exception because ERISA’s fiduciary rules do not apply to such plans. Marsh v. Marsh Supermarkets, Inc., No. 1:06-cv-1395, 2007 WL 1021410, at *2 (S.D. Ind. Mar. 29, 2007).

As second type of communications that the fiduciary exception does not affect are communications for the fiduciary’s personal benefit or communications related to the potential liability of the fiduciary. Wachtel, 482 F.3d at 233; Mett, 178 F.3d at 1064; Theis v. Life Ins. Co. of N. Am., 768 F. Supp. 2d 908, 913 (W.D. Ky. 2011). Cf. David M. Greenwald & Michele L. Slachetka, *Jenner & Block Practice Series: Protecting Confidential Legal Information* § I.I.3(b) (2019). A fiduciary that seeks legal advice for its own personal defense in contemplation of an adversarial proceeding against the beneficiaries retains the attorney-client privilege. This exception to the fiduciary exception is premised on the idea that the communications were not made for the participants’ benefit and that there was not a mutuality of interests between the fiduciary and the participants. Mett, 178 F.3d at 1064. Courts applying this concept “limit[] the scope of advice that relates to ‘plan administration’ by excluding from it any advice whose goal is to advise the trustee about the legal implications of actions and decisions undertaken while performing its fiduciary obligations.” Fischel v. Equitable Life Assurance, 191 F.R.D. 606, 609 (N.D. Cal. 2000), rev’d in part on other grounds by 307 F.3d 997 (9th Cir. 2002).

See:

United States v. Mett, 178 F.3d 1058, 1064 (9th Cir. 1999). “On the one hand, where an ERISA trustee seeks an attorney’s advice on a matter of plan administration and where the advice clearly does not implicate the trustee in any personal capacity, the trustee cannot invoke the attorney-client privilege against the plan beneficiaries. On the other hand, where a plan fiduciary retains counsel in order to defend herself against the plan beneficiaries (or the government acting in their stead), the attorney-client privilege remains intact.”

Harvey v. Standard Ins. Co., 275 F.R.D. 629, 633 (M.D. Ala. 2011). “To determine whether a particular attorney-client communication concerns a matter of plan administration as opposed to legal advice for the fiduciary’s own benefit, courts engage in a fact-specific inquiry, examining both the content and context of the specific communication.” After determining that communications between attorney and ERISA plan administrator solely concerned plan administration, the court held that the communications were discoverable as an exception to the attorney-client privilege and work product doctrine in lawsuit by ERISA participant against insurer.

Wash.-Baltimore Newspaper Guild Local 35 v. Wash. Star Co., 543 F. Supp. 906, 909 (D.D.C. 1982). “When an attorney advises a fiduciary about a matter dealing with the administration of an employees’ benefit plan, the attorney’s client is not the fiduciary personally but, rather, the trust’s beneficiaries.” Therefore, to maintain attorney-client privilege, fiduciaries would need separate counsel from the ERISA plan. Otherwise, there could be no privilege for communications with fiduciaries regarding the plan since they are represented by the same attorney.

XIX. ERISA ESOP LITIGATION

A. OVERVIEW OF EMPLOYEE STOCK OWNERSHIP PLAN (ESOP) LITIGATION

As discussed in Subsection XV.D of this Handbook, employee stock ownership plans (“ESOPs”) are a unique kind of defined contribution retirement plan under ERISA section 406(d)(7). Congress contemplated that ESOPs would function as both “an employee retirement benefit plan and a ‘technique of corporate finance’ that would encourage employee ownership.” Moench v. Robertson, 62 F.3d 553, 568 (3d Cir. 1995) (quoting Martin v. Feilen, 965 F.2d 660, 664 (8th Cir. 1992)).

An ESOP is “a plan that primarily invests in the shares of stock of the employer that creates the plan.” Chao v. Hall Holding Co., 285 F.3d 415, 425 (6th Cir. 2002) (citing Kuper, 66 F.3d at 1457), cert. denied, 537 U.S. 1168 (2003). ESOP fiduciaries are generally “subject to the same fiduciary standards as any [ERISA] fiduciary except to the extent that the standards require diversification of investments.” Eaves v. Penn, 587 F.2d 453, 460 (10th Cir. 1978). In describing these fiduciary duties, some courts have stated that ERISA fiduciaries “must act for the exclusive benefit of plan beneficiaries” and that those duties in performing plan functions are “the highest known to the law.” See, e.g., Howard v. Shay, 100 F.3d 1484, 1488 (9th Cir. 1996) (quoting Donovan v. Bierwirth, 680 F.2d 263, 272 n.8 (2d Cir. 1982)). Another court noted that the “fiduciary standard applicable to ESOP trustees, set out in ERISA § 404, is indisputably rigorous.” Horn v. McQueen, 215 F. Supp. 2d 867, 874 (W.D. Ky. 2002). In particular, when deciding whether to invest plan assets in employer securities, ESOP fiduciaries “are governed by the ‘solely in the interest’ and ‘prudence’ tests of §§ 404(a)(1)(A) and (B).” Eaves, 587 F.2d at 459.

ESOPs frequently attract scrutiny from the U.S. Department of Labor, as well as participant litigation, often under ERISA’s prohibited transaction provision, § 406. Hall Holding, 285 F.3d at 424. Under ERISA § 406, an acquisition must be for “adequate consideration.” Id. at 425 (citing 29 U.S.C. § 1018(e)(1)). Consequently, the valuation of stock in an ESOP transaction is critical. “Adequate consideration” is “the fair market value of the asset as determined in good faith by the trustee or named fiduciary pursuant to the terms of the plan and in accordance with the regulations promulgated by the Secretary.” ERISA § 3(18)(B). There is no real market for private company stock to set the value. Nevertheless, the Department of Labor, in Proposed Regulations, has defined “fair market value” as the price at which the property would change hands between a hypothetical willing buyer and willing seller, acting at arms-length, when neither is under compulsion, both parties are willing and able, and well-informed about the property and the market for that property. DOL Prop. Reg. 29 C.F.R. § 2510.3-18(b).

It is this process of stock valuation – which is both substantive and procedural – that tends to attract the most ESOP litigation, which generally has focused on two ERISA-governed questions. First, whether the ESOP’s fiduciaries breached their duty of prudence, and second, whether they engaged in prohibited transactions.

B. ESOP VALUATION AND PRUDENCE

ESOP litigation typically alleges that a fiduciary has improperly valued the company stock held by the plan. Common issues related to the stock valuation include, but are not limited to: an immediate post-transaction drop in value; application or non-application of a control premium; prior (or lower) valuations; or “hockey stick” projections.

To assist in valuation, the Department of Labor proposed regulations in 1988 laying out the content for valuations and steps to fulfill procedural prudence. DOL Prop. Reg. 29 C.F.R. § 2510.3-18(b). Although the regulations were never finalized, they nonetheless provide guidance on an appropriate valuation process. The regulations provided that the purchase or sale of private company stock must meet two requirements. First, it must meet ERISA’s “prudence” requirement under ERISA § 404. Second, it must fall with the applicable exemptions to ERISA § 406 prohibited transaction rules. Unfortunately, the regulations were never formally adopted, but are commonly used to guide fiduciaries when engaging in ESOP transactions. Id.

A prudent valuation process requires that (1) adequate consideration (i.e., the fair market value) was charged/paid and (2) the parties transacted in good faith. To determine the fair market value of private company stock, the Department will not look to specific, set figures; rather, the fair market value may be assessed by a range of valuations determined as of the date of the transaction involving that asset, and based on written documentation of that valuation. Id. The inquiry into good faith focuses on the fiduciary’s process in conducting the valuations – did the fiduciary conduct a prudent and timely investigation and due diligence in valuing plan assets, and was the fiduciary’s valuation based on an independent assessment. DOL Prop. Reg. 29 C.F.R. § 2510.3-18(b); see Donovan v. Cunningham, 716 F.2d 1455 (5th Cir. 1983) (finding that a failure to apply sound business principles for evaluation may result in a valuation that does not reflect fair market value) and Perez v. Bruister, 823 F.3d 250 (5th Cir. 2016) (finding that fiduciaries were not reasonably justified in relying on an appraiser’s valuations where they insufficiently investigated the appraiser’s background and qualifications and failed to review the appraiser’s conclusions.)

A prudent valuation should include a statement of purpose for which the valuation was made; a statement as to the relative weight accorded to relevant valuation methodologies; and the valuation’s effective date. See DOL Prop. Reg. 29 C.F.R. § 2510.3-18(b). Further, when assets being appraised are not securities for which there is a generally recognized market, the appraiser should take additional steps to ensure that the security is properly assessed, including referencing the market price of similar securities of corporations engaged in the same or similar line of business whose securities are actively traded in a free and open market, either on an exchange or over the counter, or paying or receiving control premiums. Id. Overall, plan fiduciaries must undertake the valuation “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 [. . .].” ERISA § 404(a)(1)(B).

C. KEY RECENT DECISIONS AND CASES BROUGHT BY PRIVATE PLAINTIFFS

Subsection XV.D.2 of this Handbook discusses the mechanics of litigation related to employer stock, suits which are typically brought by participants in plans, like ESOPs, that are authorized to invest in employer securities. Indeed, private litigation class action lawsuits targeting ESOPs have increased in recent years. More than 30 new ESOP class actions have been filed in past 7 years, with settlements ranging from \$850,000 to \$25M and judgments ranging from \$339,000 to \$29.8M. With certain exceptions, plaintiffs' lawyers target the trustee who approved the ESOP purchase and sale transaction, and hone in on that fiduciary's process when conducting such ESOP transactions. The plaintiffs also often name the selling shareholders who sold their stock to the ESOP as parties-in-interest to a prohibited transaction claim, seeking to leverage the proceeds received from the ESOP as potential litigation damages.

For example, the plaintiffs in Fish v. GreatBanc Tr. Co., No. 09-cv-1668, 2016 WL 5923448 (N.D. Ill. Sept. 1, 2016) ("Fish") – former employees of Antioch, a closely-held company, and vested participants in Antioch's ESOP – asserted violations of ERISA §§ 404, 405 and 406 against Antioch's ESOP Advisory Committee and Board of Directors, arising out of a 2003 tender offer transaction. In that transaction, all non-ESOP shareholders tendered their shares; yet the ESOP declined the tender offer (the "2003 Transaction"). As a result, the ESOP's interest in the company increased from approximately 43% to 100%. After the transaction, Antioch's shares dropped precipitously, and the company eventually had to go through Chapter 11 bankruptcy. Id.

Prior to the 2003 Transaction, Antioch allocated any dividends or distributions paid on the common stock held in the Antioch ESOP 75% based on the annual compensation of each participant and 25% based on the account balances of each participant. Id. This allocation method, which the IRS approved in 1999, allowed Antioch's newer employees to share more in Antioch's increasing revenue and profits. Id. In late 2002, however, the IRS issued a Technical Advice Memorandum ("TAM") ruling that a similar method of allocation such distributions was improper and, instead, distributions must be allocated 100% on account balance. Id.

Although the TAM was applicable to only a specific taxpayer, the TAM was an indication of the IRS's potential position for similarly situated companies. Id. As such, Antioch engaged GreatBanc, an independent ESOP trustee, to explore options to reapportion the ESOP distributions the ESOP. Id. To assist in that process, GreatBanc engaged an independent financial adviser and independent legal counsel. Id. Following an extensive due diligence and negotiation process, GreatBanc declined to tender Antioch shares held by the Antioch ESOP in response to the tender offer, and Antioch purchased all outstanding shares of its stock held outside of the Antioch ESOP as part of tender offer transaction designed to leave the company 100% ESOP-owned. Id.

In the years following the 2003 Transaction, Antioch sales dropped dramatically and the company was forced to reorganize its capital structure through a

Chapter 11 bankruptcy in 2008. The new capital structure did not include an ESOP. *Id.* Contending that shares of Antioch stock became worthless as a result of the 2003 Transaction, plaintiffs initiated this action. *Id.* Following a bench trial, however, the United States District Court for the Northern District of Illinois found that GreatBanc did not breach its fiduciary duty—the record showing that the trustee conducted a “thorough and vigorous review of the [2003] Transaction and worked diligently to protect the ESOP’s interest negotiating better Transaction terms.” *Id.* at *51. Essentially, the process in which the trustee engaged for the 2003 Transaction was a prudent process. *See id.* The court also found that the Antioch Board of Directors satisfied its duty to monitor the trustee, and any duty to inform which it may have had (although, the court did not decide whether ERISA imposes such a duty to inform). *Id.* at *49-50.

The Fish court also considered, but did not decide, whether the 2003 Transaction was at least “an indirect use of plan assets for the benefit of a party in interest.” *Id.* at *61. The court determined, however, that the 2003 Transaction satisfied the “adequate consideration” exemption because they established that Antioch paid fair market value based on the reliable expert advice and opinions. *Id.*

In *Brundle v. Wilmington Trust, N.A.*, 241 F. Supp. 3d 610 (E.D. Va. 2017) (“*Brundle*”), affirmed, No. 17-1873 (4th Cir. Mar. 21, 2019), an ESOP purchased 100% of company stock in December 2013 for \$201 million. Six months later, all of the company’s stock was sold to a competitor. Plaintiffs alleged that Wilmington Trust N.A. (“*Wilmington*”), a transactional ESOP trustee, overpaid for the employer’s stock and improperly received fees in violation of ERISA § 406(b)(2).

The United States District Court for the Eastern District of Virginia found that *Wilmington* did not violate §§ 406(b)(2) or 406(b)(3) (did not act on behalf of adverse party, fees were reasonable), but violated § 406(a) by approving ESOP purchase for more than fair market value. *Id.* The district court believed that *Wilmington* had failed to: adequately consider pre-transaction valuation report for 2013; probe its appraiser’s reliance on company projections; investigate appropriateness of the valuation reports’ control premium; and probe its appraiser’s decision to round up certain estimates in its report. *Id.* Essentially, the court found the *Wilmington* did not conduct a prudent process. *See id.* Despite finding “no evidence . . . that the participants in this ESOP have actually suffered a loss,” the district court estimated damages as the amount the ESOP allegedly overpaid, which the court determined was \$29.7 million.

The United States Court of Appeals for the Fourth Circuit affirmed the entirety of the district court’s opinion. *See Brundle v. Wilmington Trust, N.A.*, No. 17-cv-1873 (4th Cir. Mar. 21, 2019). The Fourth Circuit noted that the ESOP trustees bear a “heavy” burden to prove transactions are for “adequate consideration,” as defined herein. *Id.*

In both of these matters, as well as other private party ESOP litigation, courts carefully look to the conduct of the ESOP fiduciaries in assessing stock valuation,

as judged under ERISA's "prudent man" standard of care, and whether they engaged in any non-exempt prohibited transactions. Id. at 2; see also Perez, 823 F.3d at 263.

D. KEY RECENT DECISIONS AND CASES BROUGHT BY THE DOL

The Department of Labor has the power to investigate and enforce an ESOP's compliance with ERISA. Although the Department of Labor has not proposed or finalized ESOP regulations since 1988, it has voiced some guidance on issues with ESOP compliance in other ways, the results of which are often public and provide guidance for other ESOPs to note.

For example, in 2014, the Department of Labor and GreatBanc entered into a settlement agreement to resolve a pending enforcement action. GreatBanc agreed to follow certain policies and procedures when serving as a trustee or other fiduciary to an ESOP. Under the settlement's terms: GreatBanc was not permitted to use a valuation advisor who had performed a preliminary valuation for the same ESOP plan sponsor. Further, it was required to provide a written analysis of the reasons for choosing any particular valuation advisor, and disclose the other advisors that it considered, as well as their qualifications and references. GreatBanc was also required to document the ESOP's valuation analysis, and to consider a claw-back arrangement in the event of adverse circumstances. The Department has since entered into similar process agreements with four other ESOP institutional trustees.

See:

Acosta v. First Bankers Trust Services, Inc., Maran, Inc., et al. No. 12-cv-8648 (S.D.N.Y. 2012); Acosta v. First Bankers Trust Services, Inc., et al., No. 12-cv-8649 (S.D.N.Y. 2012); Acosta v. First Bankers Trust Services, Inc., et al., No. 12-cv-4450 (D.N.J. 2012). The Department of Labor reached agreements in these three lawsuits, in which the Department alleged that First Bankers Trust Services, Inc. ("FBTS") violated ERISA when it approved stock purchases by three ESOPs. Specifically, the Department alleged that FBTS, who served as a trustee and fiduciary of the ESOP in each of these actions, approved transactions without undertaking the due diligence required of an ERISA fiduciary, and ultimately caused the ESOPs to overpay by millions of dollars for the stock they purchased. As part of the settlement agreements, FBTS agreed to pay more than \$15.75 million to the plans and reform its procedures for handling ESOP transaction.

Indeed, ESOP enforcement has been designated as a "national priority" by the Department of Labor, which has filed 38 enforcement actions since October 2010. The Department has also opened hundreds of ESOP investigations in recent years. Although casting a wide net in enforcement targets and legal theories, the Department has made it clear that ESOP valuations are an area of chronic problem, and that it is particularly concerned about blind acceptance of unrealistic growth projections.

See:

Acosta v. Vinoskey, 310 F. Supp. 3d 662 (W.D. Va. 2018). The Department of Labor brought action against an employer, its CEO and certain other alleged fiduciaries violated ERISA by approving an ESOP's purchase of the employer's stock at an allegedly inflated price. In particular, the Department challenges the fiduciary's reliance on valuation report and, in essence, challenges whether the fiduciary's process was prudent. Although judgment was granted on certain issues, a genuine issue of fact still remained as to whether the process was prudent and, as such, the matter proceeded to trial.

Perez v. First Bankers Tr. Servs., Inc., No. 12-cv-4450, 2017 WL 1232527 (D.N.J. Mar. 31, 2017). The Department of Labor asserted that First Bankers Trust Services, Inc. ("FBTS") breached its duties of loyalty and prudence, and engaged in a prohibited transaction with respect to an ESOP's purchase of employer stock. The district court concluded that FBTS breached its duty of prudence by, among other actions: (1) delegating all of its responsibilities to a third party, including entirely relying upon information provided by and valuation advisor without adequate questioning and discussion, and (2) implementing a process with procedural deficiencies. FBTS breached its duty of loyalty by failing to conduct a thorough investigation and requisite due diligence, and failing to negotiate the purchase price of the stock. Further, FBTS committed a prohibited transaction as it could not demonstrate adequate consideration was paid in the stock purchase transaction.

E. CHALLENGES TO ESOP SALES TRANSACTIONS

Although most ESOP litigation to date has challenged the valuation paid by the ESOP to acquire company stock, two recent cases have taken a new approach – by challenging the valuation received by the ESOP to sell a company. These complaints allege that an ESOP was underpaid in a transaction, and thus, the participants were harmed.

In *Godfrey v. GreatBanc Trust Co.*, No. 18-cv-07918, filed in the United States District Court for the Northern District of Illinois, an ESOP owned 100% of company stock. In December 2015, the ESOP sold a percentage of the company, allegedly to benefit corporate insiders by allowing the company to spinoff a subsidiary. *Id.* After buying back those same shares in the next calendar year, the ESOP sold the entire company for a higher per share reporting value than the previous transaction. *Id.* Plaintiffs argue that the trustee breached its fiduciary duties and committed a prohibited transaction by failing to determine whether a sale of stock from the ESOP was in the best interests of the beneficiaries and participants and whether the ESOP received fair market value. *Id.*

The plaintiffs in *Rush v. GreatBanc Trust. Co.*, No. 19-cv-00738, also filed in United States District Court for the Northern District of Illinois, allege that the fiduciaries intentionally avoided marketing an ESOP-owned company to competitors because the competitor may have taken over day-to-day control of the company's operations. Id. This alleged action may have led the company to be sold for less than it could have been sold, and thus the ESOP's participants and beneficiaries were harmed. Id.

XX. MULTIEMPLOYER PLAN LITIGATION

A multiemployer plan (sometimes referred to as a Taft-Hartley plan) is a collectively-bargained plan in which the employees of more than one employer participate. Many of the same claims that can be brought against the plan itself or the sponsor of a single employer plan can be brought against a multiemployer plan or its plan sponsor, including benefit claims and fiduciary duty breach claims. In addition, participating employers in a multiemployer plan can be subject to the plan sponsor's statutory claims for contributions. Such claims are specific to multiemployer plans and are discussed throughout this chapter.

Under ERISA and the Internal Revenue Code, a plan is a multiemployer plan only if it (1) is a plan to which more than one employer is required to contribute, (2) is maintained pursuant to one or more collective bargaining agreements between one or more employee organizations and more than one employer, and (3) satisfies other requirements the Department of Labor prescribes. 29 U.S.C. § 1002(37); 26 U.S.C. § 414(f)(1).

A multiemployer plan may be a welfare plan, a pension plan (including a defined benefit plan or a defined contribution plan), or both. Multiemployer defined benefit plans make up the majority of multiemployer plans and have special contribution rules.

Under DOL regulations, a multiemployer plan must be established for a substantial business purpose. 29 C.F.R. § 2510.3-37(c). A labor organization's interest in securing an employee benefit plan for its members is a substantial business purpose. *Id.*

The following factors are relevant for purposes determining whether a multiemployer plan is established for a substantial business purpose: (1) the extent to which the plan is maintained by a substantial number of unaffiliated contributing employers and covers a substantial portion of the trade, craft, or industry in terms of employees or in a locality or geographic area; (2) the extent to which the plan provides benefits more closely related to years of service within the trade, craft, or industry rather than with an employer; (3) the extent to which collective bargaining takes place on matters other than employee benefits plans between the employee organization and the employers maintaining the plan; and (4) the extent to which the administrative burden and expense of providing benefits through single-employer plans would be greater than through a multiemployer plan. *Id.* The merger of plans, in and of itself, does not create a multiemployer plan unless the substantial business purpose rule is met.

Under ERISA, its board of representatives, made up of union and employer representatives, is the plan sponsor, and the board is responsible for the plan's administration. 29 U.S.C. § 1002(16)(B). In most cases, the board members are elected or appointed to their positions—the management trustees by the participating employers and the labor trustees by the union. Each trustee must act in the sole interest

of the plan and its participants, regardless of who elected the trustee. 29 U.S.C. § 1104(a)(1).

See:

Hearn v. McKay, 603 F.3d 897, 902 (11th Cir. 2010). *Board of trustees, composed of union appointees and employer appointees, that administers a plan has duty to act exclusively for the benefit of the plan’s participants and beneficiaries.*

A. GOVERNING STATUTES

Various legislative enactments govern multiemployer plans. The Labor Management Relations Act of 1947 (“LMRA”) first recognized multiemployer plans’ ability to receive and hold contributions from employers. See 29 U.S.C. § 186(c)(5). The LMRA imposes a number of restrictions on employer contributions. ERISA, enacted more than twenty years later, imposed important funding and fiduciary obligations upon multiemployer plans and established the Pension Benefit Guaranty Corporation (“PBGC”). See 29 U.S.C. § 1001 et seq. The Multiemployer Pension Plan Amendments Act of 1980 (“MPPAA”), which amended ERISA’s Title IV, established liability on employers withdrawing from the plan (“withdrawal liability”). Pub. L. No. 96-364, effective September 26, 1980. Most recently, the Multiemployer Pension Reform Act of 2014 (“MPRA”) was enacted to address funding obligations for severely underfunded multiemployer plans that are in danger of becoming insolvent. Pub. L. No. 113-235, Div. O, effective December 16, 2014.

B. FUNDING REQUIREMENTS

Employer liability for plan contributions is the principal litigation issue with regard to multiemployer plans. Multiemployer pension plans are funded by participating employers through contributions that are specified in the collective bargaining agreements. The contributions to a single employer defined benefit pension plan are typically determined by years of service and a measure of earnings. In contrast, the employer contributions in a multiemployer plan may be based on a pre-determined dollar amount for each worker or the number of hours worked by the employer’s employees. Typically, an employer that covers fewer employees will contribute less than an employer that covers more employees.

Like single-employer plans, multiemployer pension plans are required to be adequately funded. When a plan is underfunded, it does not have enough assets to pay plan participants’ present and future vested accrued benefits. Thus, in an underfunded plan, an employer’s exit may create problems for the remaining employers and the plan’s covered employees.

Due to significant underfunding for many multiemployer pension plans over the years, funding rules for these plans have been revised through the Pension Protection Act of 2006 and the MPRA. For example, the MPRA added a new option for multiemployer plans that are in critical and declining status—the ability to suspend

benefits without violating anti-cutback rules or being held liable for missed benefit payments. 29 U.S.C. § 1085(b)(2) (defining critical status); 26 U.S.C. § 432(e)(9)(A) (plan sponsor may suspend benefits); 26 C.F.R. § 1.432(e)(9)-1 (regulations governing benefit suspensions).

To be in critical and declining status, the plan (1) must meet the statutory definition of critical status based on funding levels; and (2) be projected to become insolvent within the current plan year or the next 14 to 19 plan years (depending on the ratio of inactive participants to active participants or the plan's funded percentage). 26 U.S.C. § 432(b)(6); 29 U.S.C. § 1085(b)(6).

The plan sponsor of a plan in critical and declining status that chooses to suspend benefits must submit to the IRS an application for approval in consultation with the PBGC and DOL. 26 U.S.C. § 432(e)(9)(G). The plan sponsor must also provide notice to participants and beneficiaries, contributing employers, and union representatives, concurrent with its application to the IRS. 26 U.S.C. § 432(e)(9)(F). If the IRS approves an application for suspension, participants and beneficiaries have the right to vote on the benefit suspension before it can take effect. 26 U.S.C. § 432(e)(9)(H). The suspension will be effective unless a majority of participants and beneficiaries reject the suspension. *Id.* If a majority rejects it, the plan sponsor may submit a new application to the IRS. *Id.*

While the problem of underfunded plans is not this chapter's focus, the decline in funding status of multiemployer plans and the evolution of statutes governing this topic is likely to lead to more complex employer withdrawals from multiemployer plans as well as increased litigation.

See, e.g.,

Bd. of Trustees of IBT Local 863 Pension Fund v. C & S Wholesale Grocers, Inc., 802 F.3d 534, 545 (3d Cir. 2015) (affirming district court's holding that surcharge of 10% should not be included in withdrawing employer's annual payment of withdrawal liability on the grounds that the MPRA amended Section 1085 of ERISA to require that automatic surcharges be disregarded in determining the allocation of unfunded vested benefits to an employer).

C. EMPLOYER WITHDRAWAL

Many of the same requirements imposed on single-employer retirement plans also apply to multiemployer plans, including ERISA's vesting, funding, and fiduciary requirements. Unique to multiemployer plans, however, is the concept of withdrawal liability, a statutory requirement that forces employers to fund the payment of some benefit level even after a plan withdrawal. The necessity for withdrawal liability was fairly obvious prior to the MPPAA's enactment—employers could completely or partially withdraw from a plan with declining assets and leave the remaining employers responsible for the plan's liability. Those remaining employers were required to take on

a greater portion of the benefit costs that were already being paid and would continue to be paid to the withdrawing employer's employees. As a result of the MPPAA's enactment, exiting employers now face mandatory payments that are difficult to avoid.

MPPAA added a statutory penalty to ERISA that requires a withdrawing employer to continue to make payments for a plan's "unfunded vested benefits" that are attributable to that withdrawing employer, and generally, the plan sponsor is required to demand that the employer make such payments. 29 U.S.C. § 1382. The concept of a plan's unfunded vested benefit liability focuses on how much the plan has in assets versus how much the plan owes for the withdrawing employer's participants. The unfunded vested benefit calculation generally asks: what is the difference between the plan's assets and the current value of the plan's vested benefit obligations to participants, and then, what portion of that amount is attributable to the withdrawing employer? Statutory requirements outline the specific calculation of partial and complete withdrawal liability, the various allocation methods that may be applied, and several relief provisions that lessen the amount of withdrawal liability. See 29 U.S.C. §§ 1381, 1382, 1386, 1389, 1391. In practice, the withdrawal liability calculation can be very complex.

1. Withdrawal defined

An employer's withdrawal from a multiemployer plan may be either a complete withdrawal or a partial withdrawal, either of which may result in the employer facing liability. An employer completely withdraws from a multiemployer plan when it stops making contributions to the plan either because it permanently ceases to have an obligation to contribute under the plan, or it permanently stops all covered operations under the plan. 29 U.S.C. § 1383(a). Although "all covered operations" is not statutorily defined, it is generally held to mean the substantial cessation of normal business activity.

See:

Crown Cork & Seal Co., Inc. v. Central States Southeast and Southwest Areas Pension Fund, 982 F.2d 857, 865-66 (3rd Cir. 1992) (finding that the statutory definition of "all covered operations" is unclear, but concluding that substantial cessation of normal business activity satisfies the complete withdrawal standard).

A partial withdrawal occurs where there is a 70% contribution decline in the employer's contribution base units, or a partial cessation of the employer's contribution obligations. 29 U.S.C. § 1385(a). The employer's contribution base units refers to the unit by which the employer's contribution is measured.

However, an employer may suspend contributions to the plan during a labor dispute involving its employees and it will not face withdrawal liability. 29 U.S.C. § 1398. In addition, if an employer ceases to exist as a result of either a change in corporate structure or a change to an unincorporated form of business enterprise,

withdrawal liability will not be triggered so long as the change causes no interruption in employer contributions or obligations to contribute. *Id.* A reorganization that involves a change in identity, form, or place of organization will cause the successor employer to be treated as the new employer, but a withdrawal will not occur.

A stock sale also does not trigger withdrawal liability, but asset sales typically do cause a withdrawal because the seller usually ceases covered operations or ceases to have an obligation to contribute to the plan. But ERISA § 4204 permits an employer to escape withdrawal liability following a bona fide, arm's-length asset sale, if the following conditions are met: (1) the asset purchaser has an obligation to contribute to the plan in substantially the same number of contribution base units for which the seller had an obligation to contribute; (2) the purchaser provides a bond to the plan; and (3) the sales contract provides that the seller will be secondarily liable, if the buyer withdraws within five years, for any withdrawal liability that it would have had to the plan. 29 U.S.C. § 1384. Where an asset sale does trigger withdrawal liability, some courts have found the asset purchaser to be liable for the withdrawal.

See:

Tsareff v. ManWeb Servs., Inc., 794 F.3d 841, 847–48 (7th Cir. 2015). *An asset purchaser may incur successor liability when it has notice of the seller's contingent withdrawal liability from pre-purchase negotiations and due diligence review and the seller's contract explicitly refers to the seller's contingent withdrawal liability.*

2. Plan sponsor response to suspected withdrawal

When a plan sponsor suspects that an employer may have withdrawn, the sponsor may request from the employer any information needed to determine whether the withdrawal meets the statutory definition. An employer is required to respond to this request. The plan sponsor then has an obligation to determine whether an employer is withdrawing or has withdrawn from the plan. As soon as practicable after the employer withdraws, the plan sponsor must inform the employer of liability it may face and the schedule of payments to be made, and the plan sponsor must demand payment. 29 U.S.C. § 1399.

3. Calculation of withdrawal liability

If an employer withdraws from a multiemployer plan, it remains liable for its share of the plan's unfunded vested benefits, the determination of which generally requires the calculation of the allocable amount of unfunded vested benefits, followed by certain statutory adjustments and exemptions. 29 U.S.C. § 1381(b). The final value of the employer's withdrawal obligation depends on when and how the plan's assets and liabilities are valued, the actuarial assumptions used, and the plan's chosen statutory allocation method. 29 U.S.C. § 1391.

In calculating withdrawal liability, the plan sponsor is required to use one of the statutorily defined methods or a method that the PBGC approves. *Id.* The two most

common types of allocation are the direct attribution method, which traces the unfunded vested benefits to the withdrawing employer's employees, and the pro rata method, which assigns liability based on the employer's portion of the contributions over a specific period. The specific calculation methods for computing the employer's withdrawal liability are set out in ERISA § 4211. See *id.* Plan sponsors are generally free to choose among the methods for computing withdrawal liability, but the plan cannot be amended retroactively so as to apply a different liability calculation method for a withdrawal that occurred before the amendment was adopted. 29 U.S.C. § 1394(a).

4. Employer response to withdrawal liability

Following an employer's withdrawal, the employer is entitled to notice, a payment demand, and a payment schedule, but the plan sponsor generally has no obligation to inform the employer of the basis of its withdrawal liability calculation. Prior to a withdrawal, however, an employer considering withdrawal can request that the plan sponsor make an estimate of the employer's potential liability and the plan is obligated to provide it. 29 U.S.C. § 1021(l). Within ninety (90) days of the withdrawing employer's receipt of the plan's notice, the employer must raise any objections to the liability. The plan sponsor must then review any raised objections and notify the employer of the plan's decision regarding each objection. Upon the employer's receipt of this notice, either party may initiate arbitration. 29 U.S.C. § 1401(a).

5. Mandatory arbitration

Generally, arbitration is considered mandatory in withdrawal disputes.

See:

Tsareff v. ManWeb Servs., Inc., 794 F.3d 841, 850 (7th Cir. 2015). "The statute is clear: 'any dispute over withdrawal liability shall be arbitrated.'"

Robbins v. Admiral Merchants Motor Freight, Inc., 846 F.2d 1054, 1056 (7th Cir.1988). "Courts interpreting § 1401(a)(1) have been consistent in their conclusions. 'Any dispute over withdrawal liability as determined under the enumerated statutory provisions shall be arbitrated.' . . . The arbitration requirement is not viewed as a jurisdictional prerequisite but rather as an administrative remedy exhaustion requirement. . . . "Arbitrate first" is indeed a rule Congress stated unequivocally."

Teamsters Pension Tr. Fund-Bd. of Trustees of W. Conference v. Allyn Transp. Co., 832 F.2d 502, 504 (9th Cir. 1987). "[Q]uestions of statutory interpretation are not excepted from arbitration under MPPAA. . . . [B]y the express terms of § 1401(a)(1) '[a]ny dispute over withdrawal liability as determined under the enumerated statutory provisions shall be arbitrated.' . . . [A]rbitration is the initial stage of the dispute resolution process established by the statute, . . . judicial consideration is to follow, and . . . it is to take the form of a proceeding 'to enforce, vacate or modify the arbitrator's award.'"

I.A.M. Nat'l Pension Fund, Plan A, A Benefits v. Clinton Engines Corp., 825 F.2d 415, 417 (D.C. Cir. 1987)). “If either party is dissatisfied with the outcome of [sponsor] review, Congress mandates arbitration. The operative statutory language is as follows: ‘Any dispute between an employer and the plan sponsor of a multiemployer pension plan concerning a determination made under sections 1381 through 1399 of this title shall be resolved through arbitration.’ [29 U.S.C.] § 1401(a)(1). Thus, Congress’ directive is clear. Any dispute over withdrawal liability as determined under the enumerated statutory provisions shall be arbitrated. Judicial consideration of disputes is then contemplated in the context of an action by any of the parties to arbitration ‘to enforce, vacate, or modify the arbitrator’s award.’”

After the plan sponsor has reviewed the employer’s defenses, and responded to the employer accordingly, either party may initiate arbitration. 29 U.S.C. § 1401. Disputes between an employer and the plan sponsor may be resolved through arbitration if the arbitration request is made within sixty (60) days after the plan notifies the employer of its final liability determination, or within 120 days of the employer requesting review of the initial determination. *Id.* Additionally, the parties may jointly initiate arbitration within 180 days after the plan’s initial determination. *Id.* These time limits tend to be strictly enforced by courts, and if the employer fails to request arbitration, the employer usually is not permitted to challenge the assessment or determination of the amount of liability.

See:

Amalgamated Lithographers of America Lithographic Pension Plan v. Unz and Co., Inc., 670 F. Supp.2d 214, 226 (S.D.N.Y. 2009). Defendants failing to timely request arbitration as required by the MPPAA waive any defenses to the withdrawal liability assessment or any right to assert a counterclaim concerning the assessment process.

I.A.M. Nat'l Pension Fund v. TMR Realty Co., 431 F. Supp. 2d 1, 16 (D.D.C. 2006). “It is well-established that if an employer misses the Section 4219 arbitration deadline, it forfeits its defenses to the withdrawal liability assessment.”

If arbitration occurs, any dispute concerning a withdrawal liability determination can be decided by the arbitrator.

Arbitration will be conducted in accordance with “fair and equitable procedures” promulgated by the PBGC. 29 U.S.C. § 1401(a)(2). Specific rules for initiating arbitration, the appointment of an arbitrator, and the powers of the arbitrator are set out in the PBGC regulations, part 4221 of ERISA, and the American Arbitration Association’s (“AAA”) rules for withdrawal liability disputes. See 29 C.F.R. § 4221. The parties are generally free to choose the arbitrator responsible for deciding the dispute, but the arbitrator is bound to follow statutory, regulatory, and case law in reaching its decision. 29 C.F.R. § 4221.4(a); 29 C.F.R. § 4221.5(a)(1).

Plan sponsor determinations regarding withdrawal liability are presumed correct unless the party contesting the determination shows by a preponderance of the evidence that the determination was unreasonable or clearly erroneous. 29 U.S.C. § 1401(a)(3)(A). The plan's determination of its unfunded vested benefits is also presumed to be correct unless a party contesting the decision shows by a preponderance of the evidence that either (1) the actuarial assumptions and methods used were unreasonable, or (2) the plan's actuary made a significant error in applying the actuarial assumptions or methods. 29 U.S.C. § 1401(a)(3)(B)(i) and (ii). Although there is a presumption that the plan sponsor has calculated liability correctly, the employer is not prohibited from raising a defense that errors existed in the liability calculation, incorrect actuarial assumptions were used, or that the plan failed to apply certain exceptions or limits. *See id.*

6. Withdrawal liability payments

No later than sixty (60) days after the plan sponsor makes a payment demand, the employer must begin making annual payments through quarterly installments. 29 U.S.C. §§ 1399(c)(2)–(3). During arbitration, even though the issue of liability or the amount of liability may be in dispute, the withdrawing employer must continue to make quarterly liability payments. 29 U.S.C. § 1401(d). Until the arbitrator makes a final decision with respect to the question submitted for arbitration, the employer is responsible for meeting its payment obligations, and, if it fails to timely do so, the employer will be treated as being delinquent. *Id.* The plan sponsor can compel contribution through judicial action.

See:

Findlay Truck Line, Inc. v. Cent. States, Se. & Sw. Areas Pension Fund, 726 F.3d 738, 741–42 (6th Cir. 2013). “[E]ven if an employer disputes the withdrawal liability payments, the employer must make payments to the fund no later than 60 days after the fund demands such payments, and must continue to make them until the dispute has been resolved.”

All trades or businesses that are under common control are jointly and severally liable for withdrawal liability incurred by a control group member. 29 U.S.C. § 1301(b)(1).

See:

Cent. States, Se. & Sw. Areas Pension Fund v. Nagy, 714 F.3d 545, 552–53 (7th Cir. 2013). An independent owner of a withdrawing employer could be held personally liable for the employer's withdrawal liability on the basis that the owner leased property to the employer on which it conducted its business operations which constituted a trade or business that was under common control of the withdrawing employer.

Control group membership is determined by the Internal Revenue Code and corresponding Treasury regulations. Under Treasury regulations, common control may

exist in a brother-sister group and a parent-subsidary group. 26 C.F.R. § 1.414. A brother-sister group exists among two or more corporations if five or fewer persons own a controlling interest in the corporations. 26 C.F.R. § 1.414(c)-2(c). A parent-subsidary control group is a group of businesses that are under common control by a parent corporation. ^{26 C.F.R. § 1.414(c)-2(b)}.

See:

Cent. States, Se. & Sw. Areas Pension Fund v. CLP Venture LLC, 760 F.3d 745, 747 n.2 (7th Cir. 2014). “[A] ‘parent-subsidary’ group, [is one] where one or more organization is connected through a common parent . . . [and] “a ‘brother-sister’ group, [is one] where five or fewer individuals own a controlling interest and effectively control two or more organizations.”

Sole proprietors may also be liable if they constitute the participating employer, and partners and joint ventures typically fall under common control and will be jointly liable.

See:

Cent. States, Se. & Sw. Areas Pension Fund v. Nagy, 714 F.3d 545, 551 (7th Cir. 2013). *Affirming withdrawal liability for sole proprietor.*

Pension Ben. Guar. Corp. v. Beverley, 404 F.3d 243, 250–51 (4th Cir. 2005). *Affirming withdrawal liability for joint venturers.*

Shareholders of a corporation, however, are generally not liable for withdrawal liability payments unless the corporate veil is pierced.

See:

Trustees of the Graphic Commc’ns Int’l Union Upper Midwest Local 1M Health & Welfare Plan v. Bjorkedal, 516 F.3d 719, 731 (8th Cir. 2008). *There was no withdrawal liability for shareholders where there was no piercing of the corporate veil.*

The effect of this provision establishing joint and several liability for control group members is to hold accountable all control group members when one control group member is subject to liability. Importantly, the notice of liability to the withdrawing employer will be deemed to be notice to all members of the control group, and the time limits applicable to arbitration and payment will also be enforced against all members.

See:

Bd. of Trustees, Nat’l Shopmen Pension Fund v. N. Steel Corp., 657 F. Supp. 2d 155, 158 (D.D.C. 2009). “It is well settled that notice of withdrawal liability sent to one member of a controlled group constitutes notice to all members of that group.”

I.A.M. Nat'l Pension Fund v. TMR Realty Co., 431 F. Supp. 2d 1, 13–14 (D.D.C. 2006). “Courts within this jurisdiction have consistently applied th[e] rule to find that notice to one employer in a controlled group constitutes notice to all other members of that group. . . . This rule is consonant with a host of decisions from other jurisdictions.”

McDonald v. Centra, Inc., 946 F.2d 1059, 1062 (4th Cir. 1991). “[N]otice to one member of the control group constitutes notice to all members of the group.”

Trustees of Chicago Truck Drivers, Helpers & Warehouse Workers Union (Indep.) Pension Fund v. Cent. Transp., Inc., 888 F.2d 1161, 1163–64 (7th Cir. 1989). “We . . . hold that notice and demand to one member of a control group is notice and demand to all in the control group.”

IUE AFL-CIO Pension Fund v. Barker & Williamson, Inc., 788 F.2d 118, 127 (3d Cir. 1986). “[A]n acceptable reading of the statutory language is that because all trades or businesses under common control ‘shall be treated . . . as a single employer,’ notice to one should be notice to all.”

7. Availability of judicial review

Although arbitration is statutorily preferred, a judicial action may occasionally be brought prior to arbitration. These actions tend to focus on legal issues, such as whether an entity is a control group member and therefore can be considered an employer under ERISA. Proceeding to judicial review without first requesting arbitration can be risky for the parties involved because many courts prefer to hear a multiemployer plan controversy only after it has been initially arbitrated.

See:

Serv. Employees Int'l Union Nat'l Indus. Pension Fund v. Sci. & Commercial Sys. Corp., 208 F. Supp. 3d 200, 207 (D.D.C. 2016). *Employer forfeited its challenges to any specific matter relating to the determination of its liability and the schedule of payments because it never asked for arbitration.*

I.A.M. Nat'l Pension Fund, Plan A, A Benefits v. Clinton Engines Corp., 825 F.2d 415, 421–22 (D.C. Cir. 1987). *Employer's defenses against plan sponsor's assessment of liability must first be subject to arbitration in order to preserve them for judicial review.*

If the parties have gone through arbitration, a judicial action may be brought under § 4301 to enforce, adjust, or vacate an arbitrator's award.

See:

Freight Drivers & Helpers Local Union No. 557 Pension Fund v. Penske Logistics LLC, 784 F.3d 210, 214–15 (4th Cir. 2015). A party who seeks to vacate or modify an arbitration award under the MPPAA must commence an action by filing a complaint in district court.

Such action may be brought by either party no later than thirty (30) days after the award is issued. 29 U.S.C. § 1401(b)(2). In any judicial proceeding, there is a presumption that the findings of fact made by the arbitrator were correct. This presumption is rebuttable only by a clear preponderance of the evidence. 29 U.S.C. § 1401(c). In judicial proceedings, legal conclusions will be reviewed.

8. Collection actions

If neither party initiates arbitration within the prescribed time limits and the employer fails to make the appropriate contributions, the plan sponsor may bring a collection action against the withdrawing employer. 29 U.S.C. § 1401(b)(1). In addition, if arbitration proceedings have occurred and the employer fails to make required payments, the plan sponsor may bring an action. *Id.* ERISA § 4202 requires the plan trustees to assess and collect liability related to a complete or partial plan withdrawal. 29 U.S.C. § 1382. Thus, the plan sponsor may be found to have violated its fiduciary duties if it does not attempt to collect unpaid contributions from an employer that clearly owes such contributions.

See:

United Food & Commercial Workers Union-Employer Pension Fund v. Rubber Assocs., Inc., 812 F.3d 521, 525 (6th Cir. 2016). “The MPPAA provides that once a fund determines that an employer has withdrawn from its plan, the fund must notify the employer of the amount of the liability, prepare a schedule for liability payments, and demand payment in accordance with the schedule.”

In addition, if an actuary certifies a multiemployer plan to be in endangered or critical status under ERISA’s funding provisions, an employer may bring suit against the plan sponsor to compel the sponsor to adopt a funding improvement plan or to comply with the plan’s funding terms in place. *Id.*

The action to compel withdrawal liability payments is treated as an action for delinquent contributions under ERISA but, typically, since the MPPAA’s enactment, the plan sponsor will combine its ERISA action with a LMRA collection action, which provides that, to enforce an employer’s payment obligations, a suit for violation of contracts between an employer and a labor organization may be brought in any federal district court. 29 U.S.C. § 185.

See:

Elec. Workers Pension Tr. Fund of Local Union 58, IBEW v. Gary’s Elec. Serv. Co., 340 F.3d 373, 378 (6th Cir. 2003). Court had jurisdiction over

action brought by funds for past-due contributions pursuant to § 301 of the Labor Management Relations Act, as amended, 29 U.S.C. § 185, and §§ 502(g)(2) and 515 of ERISA.

Operating Eng'rs Local 324 Health Care Plan v. G & W Constr. Co., 783 F.3d 1045, 1049 (6th Cir. 2015). Affirming in part and remanding for further proceedings multiemployer pension funds' claims against employer to recover benefit payments pursuant to LMRA and ERISA

Federal district courts have concurrent jurisdiction with state courts over collection actions. An action by the plan sponsor to collect delinquent contributions can be particularly costly to the withdrawing employer because, if the plan is successful in its action, the judgment in favor of the plan may include the following: unpaid contributions; interest on the unpaid contributions; an amount equal to the greater of the interest on the unpaid contributions, or the liquidated damages provided for under the plan (not in excess of 20% of the unpaid contributions); reasonable attorney's fees and costs; and other legal or equitable relief that the court deems appropriate. 29 U.S.C. § 1132(g)(2). To recover attorney's fees under ERISA, the plan sponsor must be successful in its action to recover delinquent employer contributions. *Id.* This is in contrast to the prevailing party rule for an action by a participant or beneficiary explained below.

D. PRIVATE CAUSES OF ACTION AVAILABLE

Like a single-employer plan, a civil action may be brought by a participant or a beneficiary to recover benefits due under the plan, to enforce rights under the plan, or to clarify rights to future benefits under the plan's. 29 U.S.C. § 1132(a).

See:

Operating Engineers Local 324 Health Care Plan v. G & W Const. Co., 783 F.3d 1045, 1057 (6th Cir. 2015). Court affirmed in part multiemployer pension funds' action against employer and its president to recover delinquent fringe-benefit payments under contract between employer and union.

Bricklayers & Allied Craftworkers Local 2, Albany, N.Y. Pension Fund v. Moulton Masonry & Const., LLC, 779 F.3d 182, 190 (2d Cir. 2015). Court affirmed judgment against corporate defendant for failure to make contributions to a multiemployer plan.

Caterino v. Barry, 8 F.3d 878, 881 (1st Cir. 1993). Participants of multiemployer plan have standing to bring a claim against the plan for refusal to transfer assets in accordance with the terms of the plan.

Participants and beneficiaries also have the right to enforce other ERISA provisions in court, including claims for a breach of fiduciary duties. *Id.* Judicial review of

participant questions generally follows many of the same standards that have been developed in single-employer plan benefit claims

As in single-employer plans, attorney's fees are available in the court's discretion. Based on the Supreme Court's decision in Hardt v. Reliance Standard Life Insurance Company, the ERISA fee-shifting provision of § 1132(g)(1) likely does not require the claimant to be the prevailing party in an action against a multiemployer plan. 130 S. Ct. 2149 (2010).

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