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Memorandum

Prime ERISA Areas for Supreme Court's Review

by Kathryn J. Kennedy[*]

INTRODUCTION

This article focuses on four distinct areas of ERISA litigation that are in need of clarification by the Supreme Court during the current or upcoming terms. They involve the evidence to be considered in a benefits denial claim under the *de novo* standard of review; the standard of review in a breach of fiduciary case where a profit sharing plan invests in employer stock that is declining in value (the so-called ''stock drop'' cases); an employer's modification or termination of retiree health care benefits in collective-bargaining contexts in light of the terms of the employee benefits plan and the collectively bargained agreement; and the plan administrator's enforcement of subrogation clauses under a health care plan. While *certiorari* has been petitioned in three of the areas and so far granted in only one of them, *these are still important issues that involve splits within the circuits*. Thus, they are all likely candidates for Supreme Court review, either this term or next. The article will provide some historical context so that the reader can put the current controversies into an understandable framework, but also show why resolution of these controversies is so essential in moving forward under ERISA law.

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BACKGROUND

The four distinct areas of ERISA litigation that will be discussed involve the three most common causes of action made available under ERISA — ERISA §§502(a)(1)(B), 502(a)(2) and 502(a)(3). Thus, a brief review of these three causes of action will provide the necessary background to see how these four distinct areas interplay with these causes of action. Once these areas are put in perspective, each of the four areas will then be discussed in depth.

ERISA oversees the voluntary delivery of employee benefits through plans from an employer, as a plan sponsor, to its employees and their beneficiaries.[1] It attempts to balance the rights of plan participants and beneficiaries with the burdens imposed on plan sponsors who voluntarily extend employee benefits.[2] If a participant or beneficiary alleges that he or she has been denied benefits promised under the plan or otherwise harmed due to some violation of ERISA or the plan, there are three causes of action made available under ERISA, each providing different remedies. The first cause of action is an ERISA §501(a)(1)(B) claim to recover promised benefits, enforce plan rights, or clarify plan rights.[3] Such cause permits legal and equitable relief. The second cause of action is for a breach of the fiduciary's duty claim under ERISA §502(a)(2).[4] This cause of action specifically refers to ERISA §409 for the specific type of relief

[1] ERISA §1. P.L. 93-406, codified as amended in various sections of 26 and 29 United States Code (USC). All section references in this article are to ERISA section numbers and the Department of Labor (DOL) regulations thereunder, unless otherwise noted.

[2] *Id.* Congress's rationale in passing ERISA included both the need to have minimum standards to ensure the equitable nature of employee benefits plans and their financial health.

[3] ERISA §502(a)(1)(B).

[4] ERISA §502(a)(2).

available which subjects the fiduciary to personal liability to make good to the plan any losses and to disgorge any profits resulting from such breaches, as well as being liable for other equitable or remedial relief. While denial of plan benefits could be formulated as a breach of fiduciary duty (i.e., failure to enforce the terms of the plan), the Supreme Court has rejected that premise and has provided that this second cause of action applies to breaches of fiduciary duties that have resulted in harm to the plan as a whole, not individual harm.[5] However, recovery may be available to the individual to the extent the plan is able to allocate some or all of the recovery to the individual's benefit or account balance.[6] The third cause of action under ERISA §502(a)(3) permits ''appropriate equitable relief'' to the participant or beneficiary for general violations under ERISA or under the terms of the plan.[7] Such cause has been referred to as a ''catch-all cause of relief'' and is designed to ''redress such violations'' of ERISA or to ''enforce any provisions of this title or the terms of the plan,''[8] that rise to the level that justify equitable relief. Traditionally, equitable relief was available only when legal relief was inadequate, but could be denied by the courts on discretionary grounds.[9]

As to the first cause of action mentioned — recovery of plan benefits — ERISA was silent on the appropriate judicial standard of review. There have been three Supreme Court decisions on the subject, most recently the 2010 case of *Conkright v. Frommert*.[10] By now, it is clear that the more deferential standard of review applies assuming that the plan grants sufficient discretionary authority to the plan fiduciary, even in contexts where the plan fiduciary is operating under a conflict of interest. However, in the *de novo* context, which applies if discretionary authority has not been granted or not exercised by the plan fiduciary, little has been said by the Supreme Court about the Court's ability to view evidence outside the scope of the administrative record. Two recent Supreme Court cases, raised in non-ERISA contexts, have caught the attention of the ERISA plaintiff's bar. If applied in the ERISA contexts, they could alter the scope of evidence that could be considered in a *de novo* ERISA benefit claim case and the deference extended to the governmental agencies interpreting ERISA's fiduciary standards, which calls in question the applicable judicial standard of review.

As to the second cause of action mentioned — breach of fiduciary duty — there are two ERISA contexts that are in need of Supreme Court review. The first involves offering employer stock as a profit sharing plan's investment option and the second involves termination or modification of retirees' benefits under an employee benefits health plan. Both have been the subject of much litigation and have resulted in a split among the circuits. The first involves a tension between ERISA's fiduciary standards of prudence and diversification and Congress's willingness to allow employers to establish and maintain employer profit sharing plans that invest primarily in employer stock or that permit employer stock as an investment option. When the value of the employer stock declines in value, the issue arises as to when the fiduciary's duty of prudence overrides the terms of the plan and requires divestment of such stock by the plan fiduciary. Given the split in the circuits, *certiorari* in a Second Circuit case had been requested, but was denied in October 2012.

The second breach-of-fiduciary context involves the vesting of retiree health benefits. ERISA clearly permits vesting schedules by employers for pension and profit sharing plans, but not health plans.[11] However, in the collectively bargained context, the collective bargaining agreement (CBA) may vest such retiree health benefits, thereby preventing the employer's ability to terminate or modify such benefits under the employee benefits plan. Thus, it raises the question as to whether the employer's abrogation of its promise to continue health care coverage to retirees could be a breach of its fiduciary duty under ERISA. While the Supreme Court has denied *certiorari* on this issue in both the collectively bargained and non-collectively bargained contexts, the issue is alive and ripe for Supreme Court review given the amount of money at stake under these plans and the split in the circuits.[12] This is of particular importance as employers modify the health care plans for active employees in light of the requirements of the Affordable Care Act (ACA).[13] Most commentators agree that the costs imposed by ACA to impose universal insurance cover-

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[5] *See Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 140–42 (1985).

[6] *See LaRue v. DeWolff, Boberg & Associates, Inc.*, 552 U.S. 248 (2008).

[7] ERISA §502(a)(3).

[8] *Id.*

[9] *See* Russell Weaver, Elaine W. Shoben, Michael E. Kelly, *Principles of Remedies Law*, Thomson West, p. 7 (2007).

[10] 130 S. Ct. 1640 (2010) (holding that a single honest mistake by the plan administrator of the plan's interpretation was not sufficient to strip the administrator of deference for subsequent related interpretations of the plan).

[11] ERISA §203.

[12] *See Sullivan v. CUNA Mut. Ins.*, 649 F.3d 553 (7th Cir. 2011), *cert. denied*, 80 U.S.L.W. 3632 (5/14/12), citing the Supreme Court decision in 31 S. Ct. 1866 (2011), and *Bender v. Newell Window Furnishings Inc.*, 681 F.3d 253 (6th Cir. 2012), *cert. denied*, *Newell Window Furnishings Inc. v. Bender*, 81 U.S.L.W. 3193 (10/9/12).

[13] P.L. 111-148. The Patient Protection and Affordable Care

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age will increase the costs of employer-provided coverage between 2% to 5% in the immediate future.[14]

The third cause of action involves violations of ERISA or the terms of the plan that rise to the level to justify appropriate equitable relief under the catch-all cause of action of ERISA §502(a)(3). The Supreme Court's decision in *CIGNA Corp. v. Amara*[15] represents a shift in the Court's original thinking, potentially expanding the scope of equitable relief that can be provided and signaling the level of harm that must be shown for relief. Prior to the Court's ruling, the circuits were split on the issue as to whether the plan's claim for reimbursement under its subrogation clause was fully enforceable against the plan participant or beneficiary. As the Supreme Court has granted *certiorari* in a Third Circuit case, *U.S. Airways v. James McCutchen*, we'll hopefully see some clarity in this area of law.[16]

ISSUE ONE — JUDICIAL STANDARD OF REVIEW

In the area of ERISA litigation, much judicial ink has been spilled on the subject of the judicial standard of review in benefits claims or plan interpretation contexts, which involve an ERISA §502(a)(1)(B) cause of action. While ERISA clearly provides for a cause of action for denial of plan benefits, it was silent on the issue of the applicable standard of review (i.e., whether the courts will give deference to the plan administrator's determination). Thus, after ERISA's enactment in 1974, much litigation abounded as to the applicable standard of review, borrowing from contract law, labor law and trust law.[17] Due to the split in the circuits, the Supreme Court took *certiorari* in the 1989 Third Circuit's case of *Firestone v. Bruch*.[18] The case involved a severance pay plan in which the employer administered the plan and self-funded the benefits.[19] The Supreme Court noted that "ERISA abounds with the language and terminology of trust law" and thus, it turned to trust law to determine the appropriate judicial standard of review.[20] Under trust law, the courts look to the explicit terms of the plan or trust to determine if there is intent to grant discretionary powers.[21] If such powers exist, a deferential standard of review applies.[22] If such discretionary language was absent, the *de novo* standard applied as the principles of contract law required discretionary powers to be extended only by the express terms of the document.[23] In the case at hand, the Court found the severance pay plan lacking in its grant of discretionary powers, and thus, reversed and remanded the case for *de novo* review.[24] As an aside, the Court noted that had the deferential standard of review applied and the plan administrator was operating under a conflict of interest (e.g., employer was both self-funding and administrating the plan, as was the case in *Firestone*), such factor should be considered in applying the deferential standard of review.[25]

Following the *Firestone* decision, plan sponsors were quick to insert the necessary language into their plan document to confer discretionary authority. Issues arose under welfare benefit plans that were fully or partially insured and therefore subject to insurance policies, which were more difficult to change to insert the necessary discretionary grants of powers.[26] However, a conflict among the circuits arose as to how to apply the deferential standard in the context of conflicted fiduciaries — a common situation where the employer administered and self-funded benefits under

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Act, as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), are collectively known as the Affordable Care Act (ACA).

[14] According to a 2012 health care reform survey conducted by Willis Human Capital Practice, a unit of Willis Group Holdings, the majority of employers with employer-provided health care plans expect an increase of at least 2% but not more than 5% as a result of ACA, *available at* http://www.insurancebroadcasting.com/news/Willis-2722738-1.html.

[15] 131 S. Ct. 1866 (2011).

[16] 663 F.3d 671 (3d Cir. 2011), *cert. granted*, 80 U.S.L.W. 3707 (6/25/12).

[17] *See* Kathryn J. Kennedy, "Judicial Standard of Review in ERISA Benefit Claim Cases," 50 *Amer. U. L. Rev.* 1083, 1096 (2001) (summarizing the pre-1989 ERISA caselaw as to the appropriate standards of review).

[18] 489 U.S. 101 (1989).

[19] *Id.* at 105.

[20] *Id.* at 110–11.

[21] *Id.* at 92–93.

[22] *Id.* at 111–12.

[23] *Id.* at 112–13.

[24] *Id.* at 115.

[25] *Id.*

[26] *See Guisti v. General Electric Co.*, 733 F. Supp. 141, 146–47 (N.D.N.Y. 1990) (holding that although accidental death policy gives responsibility to adjust claims of beneficiaries, there was no language giving express grant of discretion), and *Howard v. National Educ. Ass'n. of NY*, 911 F. Supp. 48, 52 (N.D.N.Y. 1995) (holding that because insurance policy did not expressly grant Hartford Life sufficient discretion, a *de novo* standard of review applied).

See Brief for the National Association of Insurance Commissioners as Amicus Curiae Supporting Respondent at 9–10, *Metlife v. Glenn*, 554 U.S. 105 (2009) (commenting that the National Association of Insurance Commissioners (NAIC) affirmed the discretionary Clauses Model Act in 2002 which prohibits the use of discretionary clauses in health insurance policies). See also Henry Quillen, "State Prohibition of Discretionary Clauses in ERISA — Covered Benefit Plans," 32 *J. Pension Planning & Compliance* 67 (Summer 206) and Jo-el J. Meyer, "States Beef Up Ban on 'Discretionary Clauses' as Courts Rule Out ERISA Hurdle," 37 *BNA Pens. & Ben. Rptr.* 377 (2/16/10).

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the plan or where the plan was insured by an insurance company who also administered benefits under the plan.[27] Due to the conflict, the Supreme Court granted *certiorari* in the case of *Metropolitan Life Insurance Co. v. Glenn*.[28] The case involved an insurer's denial of disability benefits that it insured under an employer-provided plan.[29] Two issues were resolved. The first issue addressed whether there was a *per se* or structural conflict implicit in the context of the plan administrator who ''both evaluates the claims for benefits and pay benefits claims.''[30] In a unanimous decision, the Court held that there was a *per se* conflict if the employer pays the benefits and evaluates the claims.[31] A similar holding results if the insurer insured the benefits and evaluates the claims.[32]

The second issue was how the conflict affects the application of the discretionary standard of review. In a five-to-four decision, the Supreme Court affirmed that *Firestone*'s deferential standard of review did not revert to a *de novo* standard of review in cases of conflict of interest.[33] The Court cited two administrative law cases for the proposition that there was no ''clear cut'' formula for applying the deferential standard in conflicted cases.[34] Instead, the *Glenn* Court cited a ''combination of factors'' approach to be used in weighing the extent of the conflict in tainting the decision.[35] The dissents criticized this approach as ''leav[ing] the law more uncertain, more unpredictable than it found it''[36] and ''gobbledygook.''[37]

This ''combination of factors'' approach left the circuits just as confused post-*Glenn* as they were pre-*Glenn*,[38] as predicted by Chief Justice Roberts in the *Glenn* dissent. The Supreme Court granted *certiorari* again in *Conkright v. Frommert*.[39] This case involved a conflicted plan administrator's second interpretation of a defined benefit formula, which involved an interest rate to be used in determining offsets for prior distributions.[40] The Second Circuit had held that the plan administrator's original interpretation of the plan formula violated ERISA and thus was an abuse of discretion and therefore not entitled to deference.[41] The issue before the Supreme Court was whether the lower court should show deference to the plan administrator's subsequent interpretation of the plan, instead of evaluating the merits of the plan administrator's interpretation.

The four dissenters from the *Glenn* decision, joined by Justice Alito from *Glenn*'s majority, wrote the majority opinion in *Conkright*, which began with the famous sentences ''People make mistakes. Even administrators of ERISA plans.''[42] The Court noted that ''a single honest mistake'' by the plan administrator's interpretation of the plan was insufficient to strip ''the administrator of that deference for subsequent related interpretations of the plan.''[43] The *Conkright* decision affirmed the *Firestone* precedent and appears to extend greater deference to conflicted plan administrators going forward.[44] The Court in *Conkright* remanded the case to the lower court to apply the abuse of discretion standard regarding the plan administrator's subsequent interpretation.[45] In a previous article written by this author, it was noted that the Supreme Court ignored the fact that qualified defined benefit plans, under Title II of ERISA, are not entitled to grant discretionary authority to the plan administrator to determine the interest rate used in determining the plan's benefits due to the Title II's ''definitely deter-

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[27] *See* Kathryn J. Kennedy, ''*Conkright*: A Conundrum for Future Courts, An Opportunity for Congress,'' *2010 NYU Rev. of Employee Benefits and Executive Compensation*, 16-15–16-27.

[28] 554 U.S. 105 (2008) (with Justice Breyer writing for the majority, joined by Justices Alito, Breyer, Ginsburg, Souter and Stevens, and Justices Roberts, Scalia and Thomas dissenting to the ''combination of factors'' approach used by the majority).

[29] *Id.* at 108–09.

[30] *Id.* at 112.

[31] *Id.*

[32] *Id.* at 113–15. Post-*Glenn*, there is presently a split among the circuits as to whether a board consisting of an equal number of union and employer representatives in the collectively bargained context is inherently conflicted. *See Durakovic v. Building Service 32 BJ Pension Fund*, 609 F.3d 133, 139 (2d Cir. 2010) (holding there is an inherent conflict of interest) and *Anderson v. Suburban Teamsters of N. Ill. Pension Fund Bd. of Trs.*, 588 F.3d 641, 648 (9th Cir. 2009) (holding there is not an inherent conflict of interest within the meaning of *Glenn*).

[33] *Id.* at 115.

[34] *Id.* at 117 (citing *Citizens to Preserve Overton Park, Inc. v. Volp*, 401 U.S. 402, 415–17 (1971) which involved the review of governmental decision for abuse of discretion) and *Universal Camera Corp. v. NLRB*, 340 U.S. 474 (1951) which involved the review of agency factfinding).

[35] *Id.* at 118 (referring to ''several different, often case-specific, factors, reaching a result by weighing all together'' and referencing to comment d of the Restatement §187). *Id.*

[36] *Id.* at 122.

[37] *Id.* at 130, n. 3.

[38] *See* Kennedy, above note 27, 16-42–16-50.

[39] 130 S. Ct. 1640 (2010) (with the *Glenn* dissent writers, Justices Roberts, Scalia and Thomas writing for the majority, along with Justice Alito, and the *Glenn* majority justices now dissenting).

[40] *Id.* at 1645.

[41] *Id.* at 1646.

[42] *Id.* at 1644.

[43] *Id.* at 1644.

[44] *Id.* at 1643.

[45] *Id.* at 1651.

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minable'' benefits requirement.[46] But the Court ignored the terms of Title II of ERISA and limited itself to the requirements under Title I as it afforded the participants their cause of action. Post *Conkright*, only three recent circuit cases have found an abuse of discretion in the context of conflicted plan administrators, which demonstrates the extent of the plan administrator's discretion in determining benefits.[47]

If the deferential standard of review is applicable, the courts are limited to the administrative record.[48] However, the result is different if the courts are applying the *de novo* standard.[49] In a *de novo* review, the plan administrator's decision is not relevant, as the court must decide the issue. So after *Firestone*, the issue arose as to what evidence the court should consider when applying the *de novo* standard (that is, could the court go beyond the administrative records and if so, in what circumstances would it do so?). The Sixth Circuit is the lone circuit that confines the court to the administrative record in such circumstances.[50] Many courts allow evidence to be presented that was not in the administrative record.[51] The *Quisinberry v. Life Insurance Co. of North America* case, out of the Fourth Circuit, authorized lower courts to consider evidence outside the administrative record *but only* when the circumstances dictated that additional evidence was necessary (e.g., the administrative record was weak).[52] In contrast, the Seventh Circuit held differently in a 2009 opinion. In *Krolnik v. Prudential Ins. Co.*, the court noted that a *de novo* review did not limit the court's review to the administrative record, but instead called for an independent review by the court.[53] Thus, the *de novo* standard should be treated similar to any other trial for the court to decide the matter, in lieu of remanding the matter to the plan administrator. This holding also applies in the Tenth and Eleventh Circuits, where the courts routinely permit evidence beyond the administrative record in *de novo* contexts.[54] Such a holding leads to an expansion of discovery and evidence. Whether this split in the circuits will be resolved by the Supreme Court is unclear as *certiorari* has not been granted. However, there are two recent Supreme Court cases in non-ERISA contexts that may signal how it would rule as to the deference extended under the standard of review in benefit denials cases, as well as breach of fiduciary duty cases.

In a Patent and Trade Office (PTO) examiner's denial of a patent application under Patent Act §145, the lower court granted summary judgment by applying the deferential ''substantial evidence'' standard of the

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[46] *See* Kennedy, above note 27, 16-63–16-70. *See also* IRC §§401(a) and 401(a)(25) (Title II of ERISA) requiring that interest rates and actuarial assumptions used in determining the defined benefit's plan formula be set forth in the plan document and determined without actuarial discretion).

[47] *See Salomaa v. Honda Long Term Care Disability Plan*, 637 F.3d 958 (9th Cir. 2011) (holding that the insurer abused its discretion by paying no attention to the reports of the doctors who had cared for the plaintiff, requiring objective evidence for a condition that has no objective test for verification and disregarding the grant of Social Security disability benefits to the plaintiff); *DuPerry v. Life Ins. Co. of North America*, 2632 F.3d 860 (4th Cir. 2011) (holding that a conflicted plan administrator abused its discretion by failing to counter the evidence presented by the plaintiff, noting that procedures should have been established to handle the subjective symptoms associated with the plaintiff's medical condition); *Wrenn v. Principal Life Ins. Co.*, 636 F.3d 921 (8th Cir. 2011) (holding that the plan administrator abused its discretion in limiting hospitalization for 10 days on the theory that the complaint was for mental health treatment instead of malnutrition, which was a physical condition).

[48] *See Miller v. United Welfare Fund*, 72 F.3d 1066 (2d Cir. 1995); *Bernstein v. Capitalcare, Inc.*, 70 F.3d 783 (4th Cir. 1995); *Bellaire General Hosp. v. Blue Cross*, 97 F.3d 822 (5th Cir. 1996); *Yeager v. Reliance Std. Life Ins. Co.*, 88 F.3d 376 (6th Cir. 1996); *Krawczyk v. Harnischfeger Corp.*, 41 F.3d 276, 279 (7th Cir. 1994); *Cash v. Wal-Mart Group Health Plan*, 107 F.3d 637 (8th Cir. 1996); *Snow v. Standard Ins. Co.*, 87 F.3d 327 (9th Cir. 1996); *Sandoval v. Aetna Life & Cas. Ins. Co.*, 967 F.2d 377, 381 (10th Cir. 1992); *Lee v. Blue Cross*, 10 F.3d 1547, 1550 (11th Cir. 1994). *But see Wildbur v. ARCO Chem. Co.*, 974 F.2d 631, 639–42 (5th Cir. 1992) (allowing outside evidence in the context of issues involving uniform plan construction). The courts define the ''administrative record'' as the evidence produced by the plan administrator in connection with its benefits determination.

[49] *Firestone*, 489 U.S. at 112.

[50] *See Wulf v. Quantum Chem. Corp.*, 26 F.3d 1368 (6th Cir. 1994); *Perry v. Simplicity Eng'g*, 900 F.2d 963 (6th Cir. 1990).

[51] *See Masella v. Blue Cross & Blue Shield*, 936 F.2d 98 (2d Cir. 1991); *Luby v. Teamsters Health, Welfare & Pension Trust Funds*, 944 F.2d 1176 (3d Cir. 1991); *Casey v. Uddeholm Corp.*, 32 F.3d 1094, 1099 (7th Cir. 1994); *Donatelli v. Home Ins. Co.*, 992 F.2d 763 (8th Cir. 1993); *Kirwan v. Marriott Corp.*, 10 F.3d 784, 789 (11th Cir. 1989).

[52] *Quisinberry v. Life Ins. Co. of North America*, 987 F.2d 1017 (4th Cir. 1993). Other courts have adopted this view. *See Mongeluzo v. Baxter Travenol Long Term Disability Benefit Plan*, 46 F.3d 938 (9th Cir. 1995); *Donatelli v. Home Ins. Co.*, 992 F.2d 763 (8th Cir. 1993); *Hall v. UNUM Life Ins. Co. of America*, 300 F.3d 1197, 1201 (10th Cir. 2002) (acknowledging the split within the circuits).

[53] *See Krolnik v. Prudential Ins. Co.*, 570 F.3d 841, 844 (7th Cir. 2009).

[54] *See Kellogg v. Metropolitan Life Ins. Co.*, 549 F.3d 818, 828 (10th Cir. 2008) (applying *de novo* review to MetLife's initial decision even though plan at issue vested sole discretion in plan administrator to determine benefits eligibility); *Rasenack ex rel. Tribolet v. AIG Life Ins. Co.*, 585 F.3d 1311, 1314–18 (10th Cir. 2009) (applying *de novo* review even though administrator eventually issued decision denying claimant's appeal, but after claimant already filed suit because administrator failed to enter decision within temporal limits of the plan and ERISA); *Moon v. Am. Home Assurance Co.*, 888 F.2d 86, 89 (11th Cir. 1989) (allowing the parties to submit evidence outside of the administrative record).

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Administrative Procedure Act.[55] On appeal, the Federal Circuit vacated the judgment and allowed new evidence to be introduced at trial, subject only to the limitations under the federal rules of evidence and civil procedure.[56] The Supreme Court affirmed and remanded, holding that the patent statute did not impose evidentiary limits on the lower court, nor did it establish a heightened standard of review for the PTO faculty findings.[57] According to the Court, ''[i]f new evidence is presented on a disputed question of fact, the district court must make *de novo* factual findings that take account of both the new evidence and the administrative record before the PTO.''[58] If such reasoning is applied in ERISA *de novo* contexts, it would impose no evidentiary limits on the courts and permit courts to go beyond the administrative record. In actuality, there are not many ERISA trials occurring — that could be as a result of very few *de novo* review cases being tried or that the administrative record is adequate in the cases that do come to trial. Thus, it is not clear whether the Supreme Court would grant *certiorari* if requested.

In another non-ERISA case that may be of interest in breach of fiduciary duty claims, the Court limited the deference extended to U.S. Department of Labor's (DOL) interpretation of its own ambiguous regulations through its later *amicus briefs* in the opinion of *Christopher v. SmithKline Beecham Corp.*[59] Normally, the courts extend deference to an agency's interpretation of its own regulations, even if its opinions are later advanced in legal briefs, under the standard of *Auer v. Robbins*.[60] However, in *Christopher*, the Supreme Court noted that the deference was not universal and clearly would not apply when a subsequent agency's interpretation was followed by an acute period of inaction, producing the potential for unfair surprise.[61] The case involved a situation in which the DOL had a nonenforcement policy for years but was changing its position and reasoning of its regulations through later *amicus briefs*.[62] In an ERISA breach of fiduciary duty claim, the court applies the various ERISA duties of loyalty, prudence, diversification and exclusive benefit to the alleged facts.[63] The *Christopher* case raises issues as to the level of deference that courts would confer on the DOL's interpretations of its regulations as advanced through its *amicus briefs*, especially if its reasoning has changed or the agency disclaims its regulations. This matter is present in the second issue presented in this paper — stock drop cases — as the DOL's interpretation in *amicus briefs* is contrary to that applied by the lower courts and has not been previously formulated in its regulations.[64]

ISSUE TWO — STOCK DROP CASES

As mentioned above, the applicable judicial standard of review is also a topic of discussion in the context of causes of action for breach of a fiduciary duty, particularly in plans that are required or are able to offer employer stock as a plan's investment option. Under ERISA's fiduciary standard, the conduct of a plan fiduciary is subject to a standard of prudence, which requires the person or entity 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 in the conduct of an enterprise of a like character and with like aims.''[65] For trustees with investment authority, ERISA also requires the fiduciary to diversify the plan's investments.[66] Likewise, the prohibited transaction rules prohibit the sale or exchange of property between the plan and a disinterested party (i.e., someone or entity presumed to have a conflict of interest when dealing with the plan), including the investment in employer stock unless permitted under the statutory exemptions.[67] ERISA also requires plan fiduciaries to act in accordance with the terms of the plan to the extent those terms are consistent with ERISA.[68]

Employee stock ownership plans (ESOPs) are designed to invest *primarily* in qualifying employer stock, and as such, their terms require the trustees to

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[55] *Kappos v. Hyatt*, 132 S. Ct. 1690 (2012).

[56] *Id.* at 1692.

[57] *Id.* at 1693.

[58] *Id.*

[59] 132 S. Ct. 2156, 2165 (2012). The district court had granted summary judgment to the respondent. In response, the petitioners filed a motion claiming that the district court had erred in extending deference to the DOL's interpretation of the pertinent regulations. Such interpretation had been announced in an *amicus brief* filed by the DOL in a similar action in the Second Circuit. *See* Brief for Secretary of Labor as *Amicus Curiae* in *In re Novartis Wage and Hour Litigation*, No. 09-0437. The district court rejected that argument and the Ninth Circuit affirmed. As the Ninth Circuit's decision conflicts with the Second Circuit's in *In re Novartis Wage and Hour Litigation*, 611 F.3d 141, 153–55 (2d Cir. 2010) (holding that the DOL's interpretation was entitled to controlling deference, the Supreme Court took *certiorari*.

[60] 519 U.S. 452, 117 S. Ct. 9095 (1997).

[61] *Christopher*, 132 S. Ct. at 2167.

[62] *Id.* at 2159–60. This case involved the DOL's interpretation as to whether pharmaceutical detailers were exempt as outside salesmen under the Fair Labor Standards Act.

[63] *See Bidwell v. Univ. Medical Center, Inc.*, 685 F.3d 613, 616 (6th Cir. 2012).

[64] See ''ERISA Litigation, Procedure, Preemption and Other Title I Issues,'' 374 *BNA Comp. Plan. J.* A-60(1).

[65] ERISA §404(a)(1)(B).

[66] ERISA §404(a)(1)(C).

[67] ERISA §406(a)(1).

[68] ERISA §404(a)(1)(D).

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invest in such stock.[69] To encourage their establishment, Congress exempted ESOPs and other eligible individual account plans from ERISA's diversification requirement and its prudence requirement as it relates to diversification, as well as the prohibited self-dealing requirements.[70] But the statute was silent as to when the plan language, requiring or permitting investment in employer stock, becomes inconsistent with the fiduciary's prudence duty, thereby requiring the fiduciary to disobey the terms of the plan in terms of purchasing or even requiring the sale of employer stock.

While the Supreme Court weighed in on the appropriate judicial standard of review in benefit denial cases in the *Firestone* decision, it expressly stated that it was not setting forth the appropriate standard of review for actions under ERISA's other remedial provisions, including breach of fiduciary duty claims.[71] However, there is dictum in the Supreme Court's *Varity Corp. v. Howe* decision that indicates that characterizing the plan administrator's denial of benefits claim as a breach of fiduciary claim would not necessarily change the standard of review.[72] The rationale for that statement was that the *Firestone* decision was decided using the same trust law doctrines that would apply to standards of fiduciary conduct.[73]

In the context of reviewing a breach of fiduciary duty under an ESOP plan, the Third Circuit in the seminal case of *Moench v. Robertson*, faced this issue head-on.[74] First, it held that the ESOP fiduciaries could be held liable under ERISA for their decision to invest in employer stock per the plan's direction, as ERISA only required that the ''primary purpose of the plan'' be to invest in employer securities.[75] Hence, the fiduciaries could not use as a defense that it had to continue to invest in employer securities as the sole form of investment.[76] Second, the court faced the issue of whether the fiduciary was required to ignore the provisions of the plan and diversify the plan's investments in light of changing circumstances. In fashioning an appropriate judicial standard of review, the Third Circuit used the *Firestone* rationale to turn to trust law.[77] Under trust law, where the trust requires the fiduciary to invest in a particular stock, the trustee was required to comply unless ''compliance would be impossible . . . or illegal'' or a ''deviation is otherwise approved by the court'' — a considerably high hurdle to rebut.[78] As ERISA did not require the ESOP fiduciary to invest *solely* in employer securities, the court would presumptively assume that the fiduciary would so invest pursuant to the terms of the plan unless the investments ''no longer serve the purpose of the trust or the settlor's intent.''[79]

Thus, on the issue of the appropriate standard of review, the Third Circuit stated that it would normally hold the trustee's action to the prudent person standard, which was subject to a *de novo* standard of review.[80] However, in this unique situation where the plan gave ''unfettered discretion'' to the fiduciary to interpret the plan to invest in employer securities, the court would defer to the fiduciary and invoke an arbitrary and capricious standard of review.[81] The court fashioned the presumption as follows: ''[A]n ESOP fiduciary who invests the assets in employer stock is entitled to a presumption that it acted consistently with ERISA by virtue of that decision. However, the plaintiff may overcome that presumption by establishing that the fiduciary abused its discretion by investing in employer securities.''[82]

The court duly noted that ESOP fiduciaries that are also directors of the corporation ''serve two masters'' and thus, the ''more uncertain the loyalties of the fiduciary, the less discretion it has to act.''[83] The court's goal was to balance the Congressional purpose of allowing ESOPs with ERISA's stringent fiduciary duties.[84] Because the plaintiff had pled the ''precipitous decline'' in company stock, along with insider knowledge by the fiduciary of the stock's ''impending col-

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[69] ERISA §407(b).

[70] ERISA §§404(a)(2), 407(d)(3), and 408(e)(3)(A); *see also Martin v. Feilen*, 965 F.2d 660, 664–65 (8th Cir. 1992), and *Brown v. American Life Holdings, Inc.*, 190 F.3d 856, 860 (8th Cir. 1999).

[71] *Firestone*, 489 U.S. at 108.

[72] *Varity Corp. v. Howe*, 516 U.S. 489, 514–15 (1996).

[73] *Id.* (citing Restatement (Second) of Trusts §187, ''[w]here discretion is conferred upon the trustee with respect to the exercise of a power, its exercise is not subject to control by the court, except to prevent an abuse by the trustee of his discretion.'').

[74] *Moench v. Robertson*, 62 F.3d 553 (3d Cir. 1995), *cert. denied*, *Harris v. Hirsch*, 63 U.S.L.W. 3624 (2/21/95).

[75] *Id.* at 556.

[76] *Id.* at 568.

[77] *Id.* at 564–66.

[78] *Id.* at 571.

[79] *Id.* (noting that Restatement (Third) §227(b) requires the trustee to diversify the investments of the trust, but §227(d) permits such duty to be waived under the terms of the trust).

[80] *Id.* at 563.

[81] *Id.* at 571.

[82] *Id.*

[83] *Id.* at 572. The expression of the standard in the context of a conflicted fiduciary sounds very much like the sliding scale standard that was predominant with the circuits in applying the deferential judicial standard of review in benefits denial cases, prior to the Supreme Court's decision in *Metropolitan Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008). While the Third Circuit did not accept the sliding scale until 2000 (which post-dates the *Yard-Man* decision), it was aware of its existence within the various circuits. *See Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 392 (3d Cir. 2000) (quoting from an earlier unpublished opinion in *Pinto v. Reliance Standard Life Ins. Co.*, 156 F.3d 1225 (3d Cir. 1998)).

[84] *Id.* at 571.

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lapse and its members' own conflicted status,'' the court remanded the matter to the district court for further proceedings in order to develop the record.[85] By relying on trust law for the standard of review, the court wanted overwhelming evidence that the fiduciary should ignore the terms of the plan in the light of the unfolding facts.

The Third Circuit applied the *Moench* presumption of reasonableness at the *pleading* stage when it was considering the evidentiary record on a motion for summary judgment.[86] Thus, the plaintiffs must plead sufficient facts to rebut the presumption (i.e., a plaintiff must ''show that the ERISA fiduciary could not have believed reasonably that continued adherence to the ESOP's direction was in keeping with the settlor's expectations of how a prudent trustee would operate'').[87] The Third Circuit, in the case of *Edgar v. Abaya, Inc.*, expanded the use of the *Moench* presumption to non-ESOP plans where employer stock is simply one of the many investment options made available under an eligible individual account plan.[88] Its reasoning was that ERISA's exception from the duty to diversify and duty of prudence (to the extent it requires diversification) applies to all eligible individual account plans, not just ESOPs.[89] The court noted that the *Moench* presumption could be rebutted by alleging evidence of ''circumstances not known to the settlor and not anticipated by him'' that investing in employer securities ''would defeat or substantially impair the accomplishment of the purposes of the trust.''[90] However, in that case, plaintiffs failed to present the ''type of dire situation'' that would require the fiduciary to disobey the terms of the plan.[91] It found persuasive the reasoning of the Ninth Circuit that ''mere stock fluctuations, even those that trend down significantly'' did not demonstrate the ''deteriorating financial circumstances'' required to rebut the presumption.[92]

The Fifth Circuit has also adopted the *Moench* presumption or abuse of discretion standard, as well as the Seventh Circuit.[93] While the Fifth Circuit declined to apply the *Moench* presumption *only* in cases where the company was about ''to collapse,'' it did note that the presumption was a ''substantial shield'' and could ''only be rebutted if unforeseen circumstances would defeat or substantially impair the accomplishment of the trust's purposes.''[94] Although the Ninth Circuit initially rejected the *Moench* presumption, it later reversed.[95] The Ninth Circuit requires the presumption to be rebutted by allegations that ''clearly implicate the company's viability as an ongoing concern'' or that present ''a precipitous decline in the employer's stock . . . combined with evidence that the company is on the brink of collapse or is undergoing serious mismanagement.''[96] The First Circuit decided not to apply the presumption but instead use ERISA's statutory prudence standard in assessing a fiduciary's decision to invest in employer stock.[97]

The Second Circuit addressed the issue and adopted the *Moench* presumption in two decisions, rendered on the same day, in the cases of *In re Citigroup ERISA Litig.* and *Gearren v. McGraw-Hill*.[98] In the case of *In re Citigroup ERISA Litig.*, the plaintiffs were covered under Citigroup's 401(k) plans which offered employer stock as an investment option.[99] Due to the sharp drop in the stock price from 2007 through 2008, the plaintiffs alleged the fiduciaries breached their fiduciaries' duties of prudence and loyalty by not di-

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[85] *Id.* at 572.

[86] *Id.*

[87] *Id.*

[88] *See Edgar v. Abaya, Inc.*, 503 F.3d 340, 347 (3d Cir. 2007).

[89] *Id.* Likewise ERISA's exemption from the prohibited transaction rules relating to the acquisition or sale of a plan of qualifying employer securities applies to all eligible individual account plans. *See* ERISA §408(e)(3)(A).

[90] *Id.* at 348, quoting from Restatement (Second) §227 comment g.

[91] *Id.*

[92] *Id.* at 349, quoting *Wright v. Oregon Metallurgical Corp.*, 360 F.3d 1090, 1094 (9th Cir. 2004).

[93] *See Kirschbaum v. Reliant Energy, Inc.*, 526 F.3d 243, 254 (5th Cir. 2008), *Summers v. State Bank & Trust Co.*, 453 F.3d 404, 410 (7th Cir. 2006) (citing *Moench v. Robertson*, 62 F.3d 553, 571–72 (3d Cir. 1995), and *Howell v. Motorola, Inc.*, 633 F.3d 552, 568–69 (7th Cir. 2011) (applying the *Moench* presumption at the motion to dismiss stage).

[94] *See Kirschbaum*, 526 F.3d at 256.

[95] *See Quan v. Computer Scis. Corp.*, 623 F.3d 870, 881 (9th Cir. 2010), where the Ninth Circuit acknowledges that it had declined to adopt the *Moench* presumption in the cases of *In re Syncor ERISA Litig.*, 516 F.3d 1095, 1102 (9th Cir. 2008), and *Wright v. Oregon Metallurgical Corp.*, 360 F.3d 1090, 1098 n. 3 (9th Cir. 2004).

[96] *Id.* at 882 (citing *Wright*, 360 F.3d at 1099 n. 5 (9th Cir. 2004)).

[97] *Bunch v. W.R. Grace & Co.*, 555 F.3d 1, 10 (1st Cir. 2009) (noting that if the court applied the *Moench* presumption in the case at hand, the ''purpose of the presumption is controverted and the standard transforms into a sword to be used against the prudent fiduciary.'' According to the court, use of the presumption would ''lead us to judge a fiduciary's action in hindsight.''). *Id.*

[98] *In re Citigroup ERISA Litig.*, 662 F.3d 128, 138 (2d Cir. 2012), *cert. denied*, *Gray v. Citigroup Inc.*, 81 U.S.L.W. 320 (10/15/12); *Gearren v. McGraw-Hill*, 660 F.3d 605, 610 (2d Cir. 2012), *cert. denied*, 81 U.S.L.W. 3208 (10/14/12). Citigroup had been involved in the subprime-mortgage market, reporting subprime-related losses of $18.1 billion for the fourth quarter of 2007 and substantial losses through 2008. Its stock price declined from Jan. 1, 2007 through Jan. 15, 2008 from $55.70 to $26.94. *In re Citigroup ERISA Litig.*, 662 F.3d at 134.

[99] *In re Citigroup ERISA Litig.*, 662 F.3d at 133–34.

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vesting the plans of employer stock.[100] The district court dismissed the complaint and upon appeal, the Second Circuit affirmed.[101] In a case of first impression, the Second Circuit adopted the *Moench* presumption for both ESOPs and other eligible individual account plan.[102] It stated that the only facts sufficient to overcome the presumption of prudence would be to show that the employer was in a ''dire situation'' objectively unforeseeable by the settlor, citing to the Third Circuit's opinion in *Edgar v. Abaya, Inc*.[103] The abuse of discretion standard should be applied to the fiduciary's conduct ''rather than results'' to avoid ''second-guess[ing]'' the fiduciary's decision.[104] But similar to the Fifth Circuit, it declined to require proof of the employer's ''impending collapse.''[105]

The DOL filed an amicus brief in the *Citigroup* case, rejecting the use of the *Moench* presumption as adopted by the Second, Third, Fifth, Sixth and Ninth Circuits. Instead it recommended the use of the standard prudent standard.[106] That brief was filed in connection with a petition for rehearing of the decision to accept the *Moench* presumption. The DOL argued that ERISA's fiduciary standards are illusory in the context of employer stock plans if applied only in ''dire'' circumstances.[107] But if the presumption is adopted, the DOL supports using it as an evidentiary matter, not a pleading requirement.[108]

Similar to the other cases, the Second Circuit viewed the *Moench* presumption as a standard of review to be applied at the pleading stage, as opposed to an evidentiary presumption.[109] In a later opinion, the Second Circuit affirmed the dismissal of a complaint against JP Morgan even though the stock fell about 55% during a given period.[110] According to the court, the plaintiffs failed to allege ''dire circumstances'' that would have caused the fiduciary to remove employer stock as a plan's investment option.[111]

In contrast, the Sixth Circuit has adopted the *Moench* presumption but describes it differently and refers to it as the *Kuper* presumption, from the seminal case in its circuit.[112] There, the *Kuper* presumption is characterized as one of reasonableness.[113] To rebut the presumption, the plaintiff would need to show that ''a prudent fiduciary acting under similar circumstances would have made a different investment decision,'' which is the statutory prudence standard.[114] While the Sixth Circuit has said that it has adopted the *Moench* presumption, it addressed the question in *Pfeil v. State St. Bank and Trust Co.*, as to whether the presumption created a ''heightened pleading standard'' such that sufficient facts had to be stated to survive a motion to dismiss.[115] Instead, it stated that the presumption of reasonable as stated in *Kuper* was an evidentiary presumption to be applied to a fully developed evidentiary record.[116]

Distinguishing its holding from its sister circuits, the Sixth Circuit used the reasonableness presumption, requiring the plaintiff to prove that ''a prudent fiduciary acting under similar circumstances would have made a different investment decision.''[117] While such standard is a ''demanding burden,'' it does not require proof of a ''dire situation,'' ''impending collapse'' or ''on the brink of bankruptcy'' to rebut the presumption, as required under the ''more narrowly-defined tests'' used by the Second, Third, Fifth and Ninth Circuits.[118] Hence, the *Moench* presumption has to be rebutted with the fuller evidentiary record

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[100] *Id.* at 134.

[101] *Id.* at 135.

[102] *Id.* at 138.

[103] *Id.* at 140. *See also Gearren*, 660 F.3d at 610. In a later unpublished decision of *Glaxosmithkline ERISA Litig.*, No. 11-2289-cv (2d Cir. 2012), the Second Circuit affirmed the reasoning of *In re Citigroup ERISA Litig.*, and affirmed the district court's dismissal of the case as the events alleged and the 30% stock drop were not that dire so as to form the basis for a successful breach of fiduciary case. These cases also involve allegations that the fiduciaries breached their duty to disclose materially adverse facts to the participants regarding the employer's financial health. *See Edgar v. Avaya, Inc.*, 503 F.340, 349–50 (3d Cir. 2007).

[104] *In re Citigroup ERISA Litig.*, 662 F.3d at 140.

[105] *Id.* (citing *Wright v. Or. Metallurgical Corp.*, 360 F.3d 1090, 1099 (9th Cir. 2004), noting that ''[m]ere stock fluctuations, even those that trend downhill significantly, are insufficient to establish the requisite imprudence to rebut the *Moench* presumption.'').

[106] *See* Brief for Solicitor General as Amicus Curiae in Citigroup ERISA Litigation, No. 09-3804-CV (2d Cir.). According to the DOL, its position is consistent with its longstanding position that notwithstanding the terms of the plan document, fiduciaries are judged, based on all relevant facts, on the prudence of investing plan assets in qualifying employer securities. *See* U.S. Dep't of Labor Opinion Letter No. 90-05A, 1990 WL 172964, at *3 (3/29/90), and U.S. Dep't of Labor Opinion Letter No. 83-6A, 1983 WL 22495, at *1–*2 (1/24/83).

[107] Brief for Solicitor General as Amicus Curiae in Citigroup ERISA Litigation, No. 09-3804-CV (2d Cir.).

[108] *Id.*

[109] *In re Citigroup ERISA Litig.*, 662 F.3d at 139.

[110] *Fisher v. JP Morgan Chase & Co.*, 469 Fed. Appx. 57 (2d Cir. 2012), *cert. denied*, No. 12-298 (11/13/12).

[111] *Id.* at 58.

[112] *See Kuper v. Iovenko*, 66 F.3d 1447, 1459 (6th Cir. 1995).

[113] *Id.*

[114] *Id.*

[115] *See Pfeil v. State St. Bank and Trust Co.*, 671 F.3d 585, 593 (6th Cir. 2012) (stating that at least 14 district courts in its circuit declined to apply the presumption at the pleading stage).

[116] *Id.* (citing *Kuper*, 66 F.3d at 1459, proposing that the reasonableness presumption was a standard of review to be applied to the fiduciary's decision and hence an evidentiary presumption and not a pleading requirement).

[117] *Id.* at 594–95.

[118] *Id.*

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rather than just the pleadings.[119] This opinion was cited again by the Sixth Circuit in a published decision of *Dudenhoefer v. Fifth Third Bancorp*[120] and an unpublished decision of *Griffin v. Flagstar Bancorp Inc.*[121] In the *Dudenhoefer* decision, the DOL filed an amicus brief, arguing that the presumption was an evidentiary one, not simply a pleading requirement, and thus the district court had erred by applying it at the pleading stage.[122]

A few months after the *Pfeil* decision, the Eleventh Circuit joined its five sister circuits in adopting the *Moench* presumption, phrasing it as a standard of review of fiduciary action (i.e., abuse of discretion).[123] It stated that the plaintiffs must plead sufficient facts ''to raise a plausible inference that the fiduciary abused its discretion by following the plan's terms.''[124] But then it concluded the plaintiff's allegations that a 16.5% drop in the price of the employer stock over a period of two months did not show that the fiduciary was aware of the ''type of dire situation which would require [the fiduciary] to disobey the terms of the Plan,'' quoting from the Third Circuit case of *Edgar*.[125]

Certiorari was applied for in both Second Circuit cases *Citigroup* and *Gearren* on two issues: (1) whether the fiduciary's decision to invest in employer stock is prudent absent a showing of ''dire'' circumstances or pending bankruptcy (i.e., a relaxed fiduciary standard) and (2) whether the plaintiffs need to plead facts to prove that the fiduciary had knowledge of the employer's ''dire'' circumstances or pending bankruptcy in order to survive a motion to dismiss (i.e. at the pleading stage).[126] Given the split in the circuits and the DOL's amicus brief advocating against reliance of the *Moench* presumption, it was hoped that the Supreme Court would grant *certiorari* and resolve the conflicts. Unfortunately, the Supreme Court denied *certiorari* in both cases.[127] Given the growing divide among the circuits on this issue and the fact that these plans cover millions of participants holding billions of dollars in employer stock, it is likely that the Supreme Court will have to face this issue this term or next.

ISSUE THREE — TERMINATION OF RETIREES' HEALTH CARE BENEFITS

While ERISA clearly protects retirees' pension benefits from being terminated or cut back retroactively, there is no similar protection for retirees' health care benefits.[128] Thus, it would not be a violation under ERISA for an employer to modify or terminate retirees' health care benefits. The courts have affirmed that an employer's retiree health care plan that contains a ''reservation of rights'' clause to retroactively eliminate or reduce benefits generally permits employers to do so. The leading case in the non-union context is the *Sprague v. General Motors Corp.* case.[129]

Just recently, in *Sullivan v. CUNA Mut. Ins.*, the Seventh Circuit affirmed that view even though the summary plan description (SPD) did not contain such reservation of rights clause, citing the Supreme Court decision in *CIGNA Corp. v. Amara*, for the proposition that the SPD could not override the terms of the plan.[130] While the Supreme Court denied *certiorari* in the *Sullivan* decision probably due to the lack of a split among the circuits, there is a split in the circuits when this issue appears in the collectively bargained context. However, the Supreme Court just denied a petition for review of the Sixth Circuit decision that held the employer liable for retiree health care benefits and reimbursement of Medicare Part B premiums pursuant to the collective bargaining agreement.[131] Thus, clarification on this issue in the collectively bar-

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[119] *Id.* at 596. The Eleventh Circuit has rejected the Sixth Circuit's position that the presumption of reasonableness is not a pleading requirement. *See Lanfear v. Home Depot, Inc.*, 679 F.3d 1267, 1281 (11th Cir. 2012).

[120] 692 F.3d 410, 417 (6th Cir. 2012).

[121] No. 11-1497 (6th Cir., *unpublished* 7/23/12).

[122] The U.S. Department of Labor filed an amicus brief in May 2011, arguing that the Sixth Circuit should not use a presumption of prudence. *See* Brief for Solicitor General as Amicus Curiae in *Dudenhoefer v. Fifth Third Bancorp*, No. 11-3012.

[123] *Lanfear*, 679 F.3d at 1281 (citing the Third Circuit's opinion in *Moench*, 62 F.3d at 570-1). The Eleventh Circuit characterized the presumption as a standard of review, which can be overcome only by showing that the ''fiduciary abused its discretion by investing in employer securities.'' *Id.* at 1279.

[124] *Id.* at 1281.

[125] *Id.* at 1282, citing *Edgar*, 503 F.3d at 348.

[126] Brief for Plaintiffs-Appellants, *In Re Citigroup ERISA Litig.*, 2009 WL 7768348 (12/18/09).

[127] *In re Citigroup ERISA Litig.*, 662 F.3d 128, 138 (2d Cir. 2012), *cert. denied*, *Gray v. Citigroup Inc.*, 81 U.S.L.W. 320 (10/15/12), and *Gearren v. McGraw-Hill*, 660 F.3d 605, 610 (2d Cir. 2012), *cert. denied*, 81 U.S.L.W. 3208 (10/14/12).

[128] *See* ERISA §§3(1) and 201(1). Welfare benefits under ERISA ''do not vest unless and until the employer says they do.'' *See Grosz-Salomon v. Paul Revere Life Ins. Co.*, 237 F.3d 1154, 1160 (9th Cir. 2001). An employer is ''generally free under ERISA, for any reason at any time, to adopt, modify, or terminate'' welfare benefits unless ''[it] contractually cedes its freedom.'' *Inter-Modal Rail Ems. Ass'n v. Atchison, Topeka & Santa Fe Ry. Co.*, 520 U.S. 510, 515 (1997) (quoting *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995) (internal quotation marks omitted).

[129] *Sprague v. General Motors Co.*, 133 F.3d 388 (6th Cir. 1998).

[130] *Sullivan v. CUNA Mut. Ins.*, 649 F.3d 553 (7th Cir. 2011), *cert. denied*, 80 U.S.L.W. 3632 (5/14/12) (citing the Supreme Court decision in 131 S. Ct. 1866 (2011)).

[131] *See Bender v. Newell Window Furnishing, Inc.*, 681 F.3d

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gaining context may not be forthcoming for some time, despite the combination of rising health care costs, the mass exodus of employers abandoning retiree health plans, and the large number of employees expected to retire within the next decade. Also, as employers alter their health coverage for active employees in light of the mandates of the Affordable Care Act (ACA), they are likely to consider comparable changes under the retirees' health plans.[132] Such combinations may be creating the perfect storm, flooding the courts with litigation on the issue, one that will ultimately have to be resolved by the Supreme Court.

In the context of collectively bargained plans, they are governed by *both* ERISA and the Labor Management Relations Act (LMRA), and ERISA's preemption clause does not preempt other federal laws, such as LMRA.[133] Thus, the issue of whether retirees' health care benefits can later be modified or terminated in the collectively bargained context involves the interplay between the plan document governed by ERISA and the terms of the collectively bargained agreement (CBA) governed by LMRA. When health care benefits are later modified or terminated, retirees generally proceed to sue under both §301 of LMRA and §502 of ERISA. The seminal case came out of the Sixth Circuit with *International Union, United Automobile, Aerospace, and Agricultural Implement Workers of America (UAW), and Local 134 v. Yard-Man Inc.*[134] In that case, the collective bargaining agreement stated that ''[w]hen a former employee has attained the age of 65 years, then the [c]ompany will provide insurance benefits equal to the active group benefits . . . for the former employee and his spouse.''[135] As retiree benefits are not mandatory subjects of collective bargaining, the court reasoned that once employees bargained to forgo current wages in exchange for retiree benefits, they were assured that such benefits would continue regardless of the bargains reached in later agreements.[136] Thus, the court held that retiree benefits were in effect a ''status benefit'' and should be inferred to continue as long as the beneficiary remained a retiree.[137] It noted that the benefits were not to be inferred to be terminable in nature, and thus, the employer must continue the retirees' benefits beyond the expiration of the collective bargaining agreement.[138] This ''inference'' is referred to as the *Yard-Man* standard and has been used to create a presumption of lifetime benefits for retirees unless the collective bargaining agreement provides otherwise.

The Eleventh Circuit has adopted the *Yard-Man* standard.[139] In contrast, the First, Third, Fourth, Fifth, Seventh, Eighth, and Tenth Circuits do not apply the *Yard-Man* inference, thereby burdening plaintiffs to show that the collective bargaining agreement expressly intended the benefits to vest.[140]

The Ninth Circuit recently addressed the issue in the case of *Alday v. Raytheon* as to whether retirees were contractually entitled to receive premium-free health care coverage from the employer until age 65.[141] Beginning in 2004, the employer began to charge the retirees premiums for health coverage.[142] The court reviewed both the CBAs and employer health plans for the years in question and held that the CBA was the sole agreement between the parties over those years and such terms could not be altered or re-

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253 (6th Cir. 2012), *cert. denied*, *Newell Window Furnishings Inc. v. Bender*, 81 U.S.L.W. 3193 (10/9/12).

[132] ACA revises the annual dollar limits on essential health benefits and requires coverage of certain preventative services for non-grandfathered health plans.

[133] ERISA §514.

[134] 716 F.2d 1476 (6th Cir. 1983), *cert. denied*, 52 U.S.L.W. 3551 (1/23/64).

[135] *Id.* at 1480.

[136] *Id.* at 1482.

[137] *Id.*

[138] *Id.*

[139] *See Carriers Container Council, Inc. B. Mobile S.S. Ass'n Inc.-Intern. Longshoreman's Ass'n, AFL-CIO Pension Plan and Trust*, 896 F.2d 1330 (11th Cir. 1990).

[140] *See Senior v. NSTAR Electric and Gas Group.*, 449 F.3d 206, 217 (1st Cir. 2006) (rejecting the use of the *Yard-Man* presumption); *Int'l Union, United Automobile, Aerospace & Agricultural Implement Works of Am., UAW v. Skinner Engine Co.*, 188 F.3d 130, 139 (3d Cir. 1999), and *Gable v. Sweetheart*, 35 F.3d 851, 855 (4th Cir. 1994), *cert. denied*, 63 U.S.L.W. 3721 (4/3/95) (both holding that the vesting of welfare benefits creates an ''extra-ERISA commitment'' and thus, the courts should not lightly infer the employer's commitment without clear and express language); *Int'l Assn. of Machinists v. Masonite Corp.*, 122 F.3d 228, 231 (5th Cir. 1997) (questioning the *Yard-Man* inference); *Rossetto v. Pabst Brewing Co.*, 217 F.3d 539, 543 (7th Cir. 2000), *cert. denied*, 66 U.S.L.W. 3789 (1988) (citing *Bidlack v. Wheelabroator Corp.*, 993, F.2d 603, 606–07 (7th Cir. 1993) (for the presumption that the employee's entitlement to benefits expires with the collective bargaining agreement, but can be overcome with a showing of either patent or latent ambiguity, beyond silence); *Maytag Corp. v. Int'l Union*, 687 F.3d 1076 (8th Cir. 2012), *reh'g denied*, 2012 U.S. App. LEXIS 20701 (10/3/12) (holding that the union as representative of the retirees had the burden to prove vesting and that the plan's unambiguous reservation of rights clause was sufficient to defeat the allegation that the retiree welfare benefits were vested, as the Supplemental Insurance Arrangement between the union and the employer contained no ''unambiguous vesting language''); *Anderson v. Alpha Portland Indus.*, 836 F.2d 1512, 1516–17 (8th Cir. 1989) (holding the union as representative of the retiree class has the burden of proof); *Deboard v. Sunshine Precious Metals Inc.*, 208 F.3d 1228, 1240–41 (10th Cir. 2000) (given the ambiguities in the plan, the court turns to the extrinsic evidence to show an intent to vest the welfare benefits).

[141] *Alday v. Raytheon*, 620 F.3d 1219, 1222 (9th Cir. 2012).

[142] *Id.*

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scinded.[143] As the CBAs' terms designated a specific duration — ''until the retiree attains age 65'' — the retirees' coverage did not expire with the expiration of the CBA.[144] The court then held that the CBA gave the retirees a contractual right to premium-free health coverage and such express guarantee survived the expiration of the CBA.[145] The court rejected the employer's reliance on the plans' reservation of rights clauses as they were not incorporated into the CBAs with respect to its duty to pay for retiree health coverage and the CBAs, according to their terms, expressly denied the employer's ability to unilaterally alter its contractual commitment under the CBAs.[146]

But even the Sixth Circuit appears to be limiting its application of the *Yard-Man* inference in recent years. It has rejected its use in the context of retirees' disability benefits.[147] The circuit limits such use to individuals who attained retiree status at the time the employer attempted to modify the benefits.[148] Hence, the *Yard-Man* inference would not apply if the employees had not retired as of the expiration of the CBA.[149] Under the *Yard-Man* logic that retiree benefits are a type of ''status benefit'' which the parties can assume will continue as long as the retiree stays a retiree, such logic does not apply to active workers and non-vested benefits which ''the union may choose to forgo . . . in future negotiations in favor of more immediate compensation.''[150] Thus, nonvested welfare benefits may be terminated at the expiration of the CBA.

Most recently, the Sixth Circuit in the case of *Bender v. Newell Window* addressed the issue of whether a successor corporation was liable for the predecessor's liabilities (i.e., continuation of retiree health benefits) and if so, whether retiree health care benefits had vested under the earlier CBAs.[151] It stated that the *Yard-Man* rule was not a legal presumption that retiree welfare benefits were perpetual, but simply created an *inference* if the explicit terms of the documents or the extrinsic evidence indicated the parties' intent to vest such benefits.[152] The Sixth Circuit described the *Yard-Man* inference as a ''thumb on the scales'' or ''nudge'' to hold for vesting.[153] The court first looked at the terms of the CBA and discovered that the insurance benefits covered under the exhibits were ''agreed to for the duration of this contract.''[154] As the CBA placed no durational limit on the retirees' health benefits, it did not create any ambiguity as to whether health benefits would continue for those already retired.[155]

The court then turned to the terms of the CBA that referred to a ''booklet and policy.'' The court rejected that such language resulted in an explicit incorporation-by-reference argument so that terms of the SPD would be read into the CBA.[156] However, the court affirmed the district court's use of extrinsic evidence — including the plan's SPDs — to be considered in determining the intent to vest retiree health coverage.[157] Considering that the SPDs did not include ''an unqualified assertion of a unilateral right to end retiree medical insurance benefits without regard for existing or future CBAs'' and that the entire record of extrinsic evidence demonstrated the parties intent to vest lifetime retiree health coverage, the Sixth Circuit affirmed the district court's finding of vesting.[158]

In contrast, the Sixth Circuit just held in *Witmer v. Acument Global Technologies Inc.* that the collectively bargained agreement's reservation of rights clause did allow the employer to later modify or terminate benefits.[159] As such clause gave the employer the right to amend, modify, suspend or terminate the plan after the expiration of the collectively bargained agreement, such language was ''incompatible with a promise to create vested, unchangeable benefits.''[160]

In addition, two recent cases out of the Sixth Circuit may signal a real change in the court's thinking. In the case of *Reese v. CNH Global N.V.*, the CBA stated that the employer agreed to provide health insurance to its retirees and spouses who were receiving benefits under the employer's pension plan and not to charge premiums for such coverage.[161] The CBA noted that the group insurance plan was part of the

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[143] *Id.* at 1225.

[144] *Id.* at 1223–24.

[145] *Id.* at 1224.

[146] *Id.* at 1226.

[147] *Price v. Board of Trustees Indiana Laborer's Pension Fund*, 632 F.3d 288 (6th Cir. 2011).

[148] *Winnett v. Caterpillar*, 553 F.3d 1000 (6th Cir. 2009).

[149] *Id*. at 1011 (citing *McCoy v. Meridian Auto. Sys., Inc.*, 390 F.3d 417, 425 (6th Cir. 2004)).

[150] *Id.* (citing *Int'l Union, United Automobile, Aerospace, an Agricultural Implement Workers of America (UAW), and Local 134 v. Yard-Man Inc.*, 716 F.2d 1476, 1482 (6th Cir. 1983)).

[151] *See Bender v. Newell Window Furnishings Inc.*, 681 F.3d 253 (6th Cir. 2012), *cert. denied*, *Newell Window Furnishings Inc. v. Bender*, 81 U.S.L.W. 3193 (10/9/12).

[152] *Id.* at 261 (citing *Yolton v. El Paso Tenn. Pipeline Co.*, 435 F.3d 571, 579 (6th Cir. 2006)).

[153] *Id.*

[154] *Id.* at 263.

[155] *Id.*

[156] *Id.* at 264.

[157] *Id.* at 267.

[158] *Id.*

[159] *Witmer v. Acument Global Technologies Inc.*, 694 F.3d 774, 775–76 (6th Cir. 2012).

[160] *Id.* at 776.

[161] *Reese v. CNH Global N.V.*, 574 F.3d 315, 318 (6th Cir. 2009), *reh'g denied*, *Reese v. CNH Am. LLC*, 583 F.3d 955 (6th

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agreement and then listed that ''Medical'' and ''Prescription Drug'' benefits were available to all retirees, but did not enumerate which benefits were included.[162] The district court held that the CBA granted lifetime retiree health benefits.[163]

Upon appeal, the Sixth Circuit addressed two issues: whether the CBA granted lifetime retiree health benefits and, if so, whether the ''scope of this promise'' permitted the employer to alter or modify those benefits in the future.[164] In comparison to the *Yolton v. El Paso Tenn. Pipeline Co.*[165] case where the language of the CBA was ''nearly identical'' to the CBA in the *Reese* case, the court noted that the CBA's language tying eligibility for health care benefits to eligibility for pension benefits, coupled with the fact that the CBA did not contain specific durational clauses while other benefits did, was a ''key'' element in determining that health benefits were vested.[166] However, in the *Reese* decision, the Sixth Circuit cautioned that the analogy between pension and health care benefits was not ''perfect.''[167] While the court affirmed that the CBA language prevented the employer from terminating health care benefits for retirees, it would not be interpreted to say that the employer could never alter those benefits ''in any way, particularly when the parties have a history of doing just that and when common experience suggested that healthcare plans invariably change over time, if not from year to year.''[168] The court dismissed the argument that the retirees had reason to assume that any replacement plan would ''improve'' or ''maintain'' the same level of care.[169] Unless the CBA said otherwise, it should be interpreted as permitting modifications that are ''reasonably commensurate'' with the benefits provided under the original CBA but ''reasonable in light of changes in health care'' and consistent with the benefits afforded to the active employees.[170] Thus, the court remanded to the district court how and in what contexts the employer could modify the retirees' health care coverage.[171] Upon remand, the district court granted summary judgment to the plaintiffs on the groups that the employer could not modify the retirees' health coverage.[172]

Upon appeal to the Sixth Circuit, Judge Sutton, who wrote the initial *Reese* decision, chastised the district court for ignoring its prior opinion.[173] Noting that health care benefits and their costs fluctuate and increase, vesting in the health care context does not mean the retirees ''receive a bundle of services fixed once and for all.''[174] Hence, the employer could make reasonable changes in the retiree benefits, taking into account three considerations: whether new benefits were ''reasonably commensurate'' with the original benefits; whether the changes were ''reasonable in light of changes in health care''; and whether the new benefits were ''roughly consistent with the kinds of benefits provided to current employees.''[175] Thus, the court introduced the notion that an employer's changes to vested retirees' health benefits would be permitted if reasonable. The court then instructed the district court to take into account evidence on the following issues: (1) average annual total out-of-pocket cost to retirees (and its rate of growth) under the prior and new plans; (2) average per-beneficiary cost to the employer (and its rate of growth) under the prior and new plans; (3) the level of premiums, deductibles and copayments for retirees under the prior and new plans; (4) any difference in the quality of care under the prior and new plans; (5) differences in the prior and new plans available to current employees and those retiring today; and (6) how the new plans compare to those available by employers similar to this employer with demographically similar employees.[176] In a strongly worded dissent, Judge Donald stated that an employer's unilateral modification of vested retiree health care benefits would be a violation of the LMRA.[177]

While the most recent *Reese* case from the Sixth Circuit appears to set forth an insurmountable standard for the district court to ascertain, it does signal the court's willingness to differentiate the vesting of health care benefits from pension benefits as the former benefits have not been regarded by employers and employees alike as ''defined'' benefits and therefore not subject to any future cut-backs. It may also signal the courts' recognition that viewing retirees' health benefits as frozen defined benefits is simply unsustainable for most, if not all, employers. This is particularly true in today's environment where employers

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2009).

[162] *Id.*

[163] *Id.* at 319.

[164] *Id.* at 321.

[165] *Yolton v. El Paso Tenn. Pipeline Co.*, 435 F.3d 571 (6th Cir. 2006).

[166] *Reese v. CNH Global N.V.*, 574 F.3d at 322 (citing to *Yolton* where the tying of the two eligibility provisions ''demonstrate[s] an intent to provide lifetime benefits.'').

[167] *Id.* at 324.

[168] *Id.*

[169] *Id.* at 326.

[170] *Id.*

[171] *Id.* at 327.

[172] *Reese v. CNH Am. LLC*, 2007 U.S. Dist. LEXIS 63670 (E.D. Mich. 2007).

[173] *Reese v. CNH Am. LLC*, 694 F.3d 681, 682 (6th Cir. 2012).

[174] *Id.* at 684.

[175] *Id.* (quoting *Reese*, 574 F.3d at 326).

[176] *Id.* at 685–86.

[177] *Id.* at 687.

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are struggling to make necessary ACA changes for active employees' health coverage in light of continuing health care costs. But it does make the issue ripe for Supreme Court review, even though it declined *certiorari*.[178]

ISSUE FOUR — SCOPE OF EQUITABLE RELIEF UNDER ERISA §502(a)(3)

Equitable relief is available under all three ERISA causes of action — ERISA §§502(a)(1)(B), 502(a)(2) and 502(a)(3). Under ERISA §502(a)(1)(B), which allows for enforcement of a right to benefit recovery, payment of the promised benefits is comparable to specific performance. ERISA §502(a)(2) provides a cause of action for breaches of fiduciary duties, but relief is limited to the plan as a whole, not to a particular individual participant or beneficiary.[179] However, recovery for fiduciary breaches by the plan may be adequate for the individual if the plan allocates the recovery to the participant's benefit or account balance.[180] ERISA §502(a)(3) cause of action's sole forms of relief are injunctive or other ''appropriate equitable relief'' to redress violations of ERISA or to enforce the terms of the plan. The Supreme Court in the *Varity* decision affirmed that individual plaintiffs could seek equitable relief under ERISA §502(a)(3) as that subsection acted as a ''catchall'' or ''safety net'' for harms that ERISA §502 did not otherwise provide adequate remedy.[181] That case involved intentional misrepresentations by the employer to its employees such that they no longer had a claim for benefits as they were no longer plan participants and the remedies they sought were for individual relief, and not for the plan as a whole. Thus, the plaintiffs had to rely on ERISA §502(a)(3) or ''they [would] have no remedy at all.''[182]

However, until the 2011 case of *CIGNA Corp. v. Amara*, the Supreme Court viewed the types of relief available under ERISA §502(a)(3) very narrowly.[183] In its decision of *Mertens v. Hewitt Associates*, the Court viewed ERISA §502(a)(3) relief as those typically offered under equity (e.g., injunctions, mandamus and restitution).[184] Cases involving enforcement of a plan's terms for subrogation as an equitable remedy involve a separate line of analysis. Generally, a plan's subrogation clause will provide that the plan can enforce a claim against a participant or beneficiary for benefit claims that were later reimbursed by a third-party tortfeasor. The plan or plan administrator could not pursue relief under ERISA §502(a)(1)(B) as only a participant or beneficiary has standing. While it has standing to pursue a claim under ERISA §502(a)(2), there is no breach of fiduciary claim to allege. Hence, relief is confined for ''appropriate equitable relief'' pursuant to ERISA §502(a)(3).

The Supreme Court faced this issue in *Great-West Life & Annuity Ins. Co. v. Knudson*.[185] The insurer sought restitution from the Knudson's general assets as part of the recovered funds had been placed in a special needs trust pursuant to California law and the other had been deposited in the attorney's client trust account.[186] The Court held that equitable restitution allowed the imposition of a constructive trust or equitable lien but only if it could be traced to ''particular funds or property in the defendant's possession.''[187] Since Knudson did not have the funds in question, the insurer was asking for legal relief which was not available in equity.[188] Thus, the plan could not enforce its claim for reimbursement.[189]

Later, in the case of *Sereboff v. Mid Atlantic Medical Services, Inc.*, the plan administrator had been able to identify specific funds within the beneficiary's possession and control.[190] Backing away from the *Great-West* decision, the Court upheld the terms of the plan, by contrasting this case from the *Great-West* case, on the theory that the case involved an equitable lien by agreement type of relief, which was not subject to the asset tracing rules of equitable restitution.[191] While the Sereboffs argued that equitable defenses (e.g., made whole doctrine) should have considered by the lower court as this was an equitable subrogation action, the Court stated such defenses

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[178] *Bender v. Newell Window Furnishings Inc.*, 681 F.3d 253 (6th Cir. 2012), *cert. denied*, *Newell Window Furnishings Inc.*, 81 U.S.L.W. 3193 (10/9/12).

[179] *See Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 142 (1985).

[180] *See LaRue v. DeWolff, Boberg & Associates, Inc.*, 552 U.S. 248 (2008) (confining the results of the *Massachusetts Mutual Life Ins. Co.* case to defined benefit plans).

[181] *See Varity Corp. v. Howe*, 516 U.S. 489, 512 (1996). *See Frommert v. Conkright*, 433 F.3d 254, 270 for the proposition that the other courts of appeals and Supreme Court cases would hold that if relief were available under ERISA §502(a)(1)(B), then the plaintiff should not pursue a cause under ERISA §502(a)(3). *See also Wilkins v. Mason Tenders District Council Pension Fund*, 445 F.3d 572, 578 (2d Cir. 2006).

[182] *See Varity*, 516 U.S. at 515.

[183] *CIGNA Corp. v. Amara*, 131 S. Ct. 1866 (2011).

[184] *Mertens v. Hewitt Associates*, 508 U.S. 248, 256 (1993).

[185] *Great-West Life & Annuity Ins. Co v. Knudson*, 534 U.S. 204 (2002).

[186] *Id.* at 214.

[187] *Id.* at 213.

[188] *Id.* at 214–15.

[189] *Id.* at 221.

[190] *Sereboff v. Mid Atlantic Medical Services, Inc.*, 547 U.S. 356 (2006).

[191] *Id.* at 367–68.

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were ''beside the point'' in the context of an equitable lien established by agreement.[192] Thus, the Court left open the question of how traditional equitable defenses should be considered in ascertaining what constitutes ''appropriate equitable relief.''

Cases post-*Sereboff* but pre-*Amara* that follow the terms of the plan permitting subrogation and allowing full reimbursement recovery under ERISA §502(a)(3) include those from the Fifth, Seventh, Eighth, and Eleventh Circuits.[193] Thus, these cases rely on contract interpretation to provide for full reimbursement, absent any equitable defense arguments, such as the make-whole or common fund defenses. The equitable defense of ''make-whole'' was a general equitable principle of insurance that the insurer could not enforce a right of subrogation until the insured had been fully compensated for his or her injuries, and thus, been made whole.[194] Under the common fund doctrine, a plaintiff who recovers funds for the benefits of someone else is entitled to reasonable attorney fees from such funds.[195] However, there are two cases post-*Amara* — out of the Third and Ninth Circuits — that have narrowed the meaning of ''appropriate'' equitable relief in the context of subrogation.

CIGNA Corp. v. Amara breathed some life back into the equitable remedy afforded under ERISA §502(a)(3), which affords ''appropriate equitable relief'' to enforce ERISA or the terms of the plan on behalf of participants and beneficiaries.[196] That decision involved the conversion of a traditional defined benefit plan to a cash balance plan, resulting in revised SPD and various announcements concerning plan changes.[197] The district court had held that the SPDs and other disclosures were incomplete and misleading, resulting in ''likely harm'' to warrant legal relief.[198] In turning to the remedy, the district court reformed the terms of the plan to reflect the SPD and then applied ERISA §501(a)(1)(B) relief to provide benefits to the participants in accordance with the terms of the plan.[199] The Second Circuit affirmed[200] and the Supreme Court granted *certiorari*.[201] The Supreme Court reversed and remanded, with a unanimous decision (eight in the majority, with Justice Sotomayor recusing herself, and Justices Scalia and Thomas filing a concurring opinion).[202] Three important issues were covered.

First, the Court held that the SPD did not constitute part of the plan document and thus its terms could not be enforced under ERISA §502(a)(1)(B).[203] This resolved the conflict among the circuits that participants could receive benefits in accordance with the terms of the SPD.[204] According to the Court, altering the terms of the plan, akin to reforming the contract, was less like ''simple enforcement of a contract as written and more like an equitable remedy.''[205] Plus the Court noted that the plan sponsor was responsible for the terms of the paper, whereas the plan administrator had the power to summarize those terms in the SPD.[206] Often the plan sponsor and plan administrator are not the same party.[207]

Second, the Court stated that the participants in this case could receive equitable relief under ERISA §502(a)(3) for monetary relief against the fiduciary for a breach of fiduciary duty.[208] This result was a surprise to the benefits community as *Mertens v. Hewitt Associates* held that a claim for money damages under ERISA §502(a)(3) against a non-fiduciary was legal, and not equitable, in nature, and therefore did not fall within the scope of its equitable relief.[209] Post-*Mertens*, the courts had limited monetary relief for breaches of fiduciary duties to cases where there was harm to the plan (i.e., claims under ERISA

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[192] *Id.* at 368 n.2 (noting that the district court and court of appeals had not considered whether the insurer's claim was ''appropriate'' and thus the Supreme Court declined to rule of the issue for the first time).

[193] *See Bombardier Aerospace Employee Welfare Benefits Plan v. Ferrer, Poirot & Wansbrough*, 354 F.3d 348 (5th Cir. 2003); *Admin. Comm. of the Wal-Mart Stores, Inc. Assocs.' Health & Welfare Plan v. Varco*, 338 F.3d 680 (7th Cir. 2003); *Admin. Comm. of the Wal-Mart Stores, Inc. Assocs.' Health & Welfare Plan v. Shank*, 500 F.3d 834 (8th Cir. 2007); and *Zurich Am. Ins. Co. v. O'Hara*, 604 F.3d 1232 (11th Cir. 2010).

[194] *See CGI Techn. & Solutions Inc. v. Rose*, 683 F.3d 1113, 1121 (9th Cir. 2012), *petition for cert. filed* (8/24/12) (No. 12-240).

[195] *Id.*

[196] *CIGNA Corp. v. Amara*, 131 S. Ct. 1866 (2011).

[197] *Id.* at 1871–73.

[198] *Id.* at 1874–75.

[199] *Id.* at 1875.

[200] *Amara v. CIGNA Corp.*, 348 Fed. Appx. 627 (2d Cir. 2009).

[201] *Cigna v. Amara*, 130 S. Ct. 3500, 177 L. Ed.2d 1113 (2010).

[202] *Cigna v. Amara*, 131 S. Ct. 1866 (2011).

[203] *Id.* at 1877.

[204] *See Burke v. Kodak Ret. Income Plan*, 336 F.3d 103 (2d Cir. 2003), *cert denied, sub nom. Kodak Ret. Income Plan v. Burke*, 540 U.S. 1105 (2004) (allowing participants to rely on the SPD, upon a showing of prejudice). *Compare* Third, Seventh and Eleventh Circuit holdings that require detrimental reliance. *See Gridley v. Cleveland Pneumatic Co.*, 924 F.2d 1310, 1319 n.8 (3d Cir. 1991); *Andersen v. Chrysler Corp.*, 99 F.3d 846, 859 (7th Cir. 1996); *Branch v. G. Bernd Co.*, 955 F.2d 1574, 1578–79 (11th Cir. 1992). But see the Ninth Circuit's holding that the plan document controlled, in *Bergt v. The Retirement Plan for Pilots of Mark Air,* 293 F.3d 1139 (9th Cir. 2002).

[205] *See Cigna v. Amara*, 131 S. Ct. at 1877.

[206] *Id.*

[207] *Id.*

[208] *Id.* at 1880.

[209] *Mertens v. Hewitt Associates*, 508 U.S. 248, 257 (1993).

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§502(a)(2)).[210] The Court in the *Amara* decision limited *Mertens* to nonfiduciary claims and expanded the claims for equitable relief against fiduciaries under ERISA §502(a)(3).[211] The Court noted that equity permitted reformation to prevent fraud or mistake; equitable estoppels ''to place the person entitled to its benefits in the same position he would have been in had the representations been true'' and to ''rebuke . . . all fraudulent misrepresentation;'' and surcharge monetary remedy for breaches of fiduciary duties.[212] As an aside, Justices Scalia and Thomas in their concurrence refer to the majority's discussion on equitable relief as ''blatant dictum.[213] Given that the six of the Justices affirmed the Court's remarks about the equitable relief, lower courts have not interpreted the language as dictum.[214]

Thus, going forward, the relief sought under ERISA §502(a) will depend on the claim being sought; the specific type of remedy requested; and consideration as to whether the ERISA violation rises to the level that relief is necessary. Claims under ERISA §502(a)(1)(B) will be limited to the benefits under the terms of the plan as written, and will not be used as a remedial remedy. In contrast, equitable relief under ERISA §502(a)(3) will depend upon the specific equitable remedy being sought, the level of harm required, and requisite causation between the harm and the breach.

Third, the Court noted that equity required a showing of actual harm; however, a showing of ''detrimental reliance'' depended on the specific remedy being sought.[215] For example, courts of equity did not require ''detrimental reliance'' for reformation and surcharge remedies.[216]

New law will be developing in the area of subrogation claims under ERISA §502(a)(3), as the Supreme Court recently granted *certiorari* in the Third Circuit case of *U.S. Airways v. McCutchen.*[217] In *McCutchen*, the participant suffered an accident and received $66,866 for medical expenses from the health plan administered by the employer, but recovered $110,000 from the third-party tortfeasor (net of $66,000 after paying attorney fees).[218] Pursuant to the terms of the plan, the employer sought reimbursement for the entire amount paid to the participant for medical expenses, without allowance for legal costs.[219]

The lower court held for the plan and imposing an equitable lien by agreement or constructive trust over $66,866, which consisted of the medical benefits paid to McCutchen by U.S. Airways, rejecting the application of the made whole doctrine.[220] Upon appeal, the Third Circuit held that the full reimbursement of $66,866 constituted ''inappropriate and inequitable relief'' because it exceeded the net amount received by the participant, leaving him with less than full payment for his medical bills.[221] Such result undermined the entire purpose of the plan and would result in a ''windfall'' as the employer had not exercised its subrogation rights nor contributed attorney fees to recover from the third party.[222] Such ''windfall'' would be unjust enrichment.[223] In addition, the court cited *Amara* for the proposition that the terms of the plan allowing for full reimbursement can be modified or reformed using equitable doctrines and principles.[224] Thus, the court interpreted the term ''appropriate'' equitable relief to override the terms of the plan based on equitable principles (e.g., placing the plaintiff in a ''rightful position'').

Two related cases issued by the Ninth Circuit on the same day, also deal with the issue equitable relief. In the case of *Bilyeu v. Morgan Stanley Long Term Disability Plan*, Leah Bilyeu's long-term disability benefits under the plan were terminated and she sued for reinstatement of benefits pursuant to ERISA §502(a)(1)(B).[225] The insurer, UNUM, filed an answer and a counterclaim for reimbursement of overpaid long-term disability benefits.[226] The district court dismissed Bilyeu's claim and granted UNUM's counterclaim on summary judgment.[227] The Ninth Circuit vacated that order as UNUM had asserted the elements of equitable lien by agreement but the funds in question had been dissipated and no longer in Bilyeu's possession, indicating that a tracing requirement

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[210] *See Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 142 (1985).

[211] *See CIGNA Corp. v. Amara*, 131 S. Ct. at 1880.

[212] *Id.* at 1879–80.

[213] *Id*. at 1884.

[214] *See Kenneth Pearson v. Voith Paper Rolls*, 656 F.3d 504, 508–09 (7th Cir. 2011); *McCravy Met. Life*, 690 F.3d 176, 180 (4th Cir. 2012*); Koehler v. Aetna Health Plan*, 683 F.3d 182, 189 (5th Cir. 2012); *Skinner v. Northrup Grumman Ret. Plan*, 673 F.3d 1162, 1167 (9th Cir. 2012).

[215] *See CIGNA Corp. v. Amara*, 131 S. Ct. at 1881.

[216] *Id.*

[217] *U.S. Airways, Inc. v. McCutchen*, 663 F.3d 671 (3d Cir. 2011), *cert. granted*, 80 U.S.L.W. 3707 (6/25/12).

[218] *Id.* at 673.

[219] *Id.*

[220] *See U.S. Airways, Inc. v. McCutchen*, 2010 U.S. Dist. LEXIS 89377 (W.D. Penn. 2010).

[221] *See U.S. Airways, Inc.*, 663 F.3d at 679.

[222] *Id.*

[223] *Id.*

[224] *Id.* at 678–79.

[225] *Bilyeu v. Morgan Stanley Long Term Disability Plan*, 683 F.3d 1083, 1086 (9th Cir. 2012), *petition for cert. filed* (10/26/12) (No. 12-526).

[226] *Id.*

[227] *Id.*

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may still exist.[228] As the relief sought against Bilyeu was for personal liability, such relief was legal, and not equitable, in nature.[229] The district court's order was vacated and the case was remanded.[230]

In the case of *CGI Technologies & Solutions Inc. v. Rose*, the terms of the plan's subrogation clause expressly stated it was exempt from the responsibility of attorney fees paid in any recovery and required full reimbursement even if the participant was not made whole.[231] The district court ruled in favor of the plan in recovering the amounts paid in medical expenses, but held the plan responsible for a proportionate amount of attorney fees and costs incurred by the participant in pursuing the tort action.[232] The Ninth Circuit vacated the order and remanded the case to the district court to determine ''appropriate equitable relief'' under ERISA §502(a)(3), including traditional equitable defenses such as the make-whole and common fund doctrines.[233] The court cited the *Amara* decision for the proposition that courts ''need not honor the express terms of the [p]lan where traditional notions of equitable relief so require'' so as to be consistent with the principles of equity.[234]

While *Amara* expands the participants' ability to seek equitable relief under ERISA §502(a)(3), the courts may be engaged in the ''devil is in the details'' in formulating the full scope of such relief, especially in the context of subrogation. Thus, it will be anyone's guess as to how expansive the Supreme Court will be in fashioning equitable relief to permit monetary damages.

CONCLUSION

While there are a wide variety of ERISA issues that continue to be litigated — litigation surrounding plan fees, ERISA preemption, inference of employees' protected rights under ERISA §510, qualified domestic relations orders (QDROs), and anti-cutback issues under retirement plans — the author believes the four areas examined within this article deserve immediate Supreme Court attention to resolve several splits among the circuits and to curb future ERISA litigation. The ERISA practitioner community can expect a flurry of litigation once the ACA provisions are effective and courts begin to resolve and interpret the requirements of ERISA and ACA in the context of employer-provided health care plans.

To the extent the Supreme Court can resolve the current controversies that exist in benefit denials cases, stock drop litigation, termination and modification of retiree health care, and equitable remedies under ERISA §502(a)(3), it will ease employers' and employees' concerns over their respective rights under employee benefits plans. Going forward, such resolution may be the critical component to keeping employer-provided benefits a reality for the majority of employees in the United States, given the rising costs and complexities in providing such benefits.

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[228] *Id.*

[229] *Id.*

[230] *Id.* at 1097.

[231] *CGI Technologies & Solutions Inc. v. Rose*, 683 F.3d 1113, 1116 (9th Cir. 2012), *petition for cert. filed* (8/24/12) (No. 12-240).

[232] *Id.*

[233] *Id.* at 1123–25.

[234] *Id.* at 1121.

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