ERISA Litigation:
An Update from the Front Lines

Presentation Handout

ASPPA BENEFITS COUNCIL OF NEW ENGLAND

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I. Preemption's Effect on the Relationship between Plans and Their Service Providers **(Slide No. 1)**

A. Is it narrowing?

1. Myth v Fact

The myth is that it's getting narrower; the fact is that it's getting clearer.

B. The First Circuit: Recent decisions reflect a move away from broad, general language; the mere suggestion that a state law dispute "relates to" a plan and is thus preempted is not enough.

1. Recent decisions use more precise phrasing, thinking, and understanding.

a. Result under the more refined approach should be the same as under earlier cases in this circuit.

2. §514(a) preemption: The first avenue of preemption under ERISA **(Slide No. 1A)**

a. Refresher: This kind of preemption applies if the state law claim relates to the ERISA plan, with that requirement satisfied "if 'the trier of fact necessarily would be required to consult the ERISA plan to resolve the plaintiff's claims.'"

(1) *Goldberg v. Unum Life Ins. Co. of Am.*, 527 F. Supp. 2d 164, 169 (D. Me. 2007)) quoting *Harris v. Harvard Pilgrim Health Care*, 208 F.3d 274, 281 (1st Cir. 2000)). *See also, e.g., Hampers v. W.R. Grace & Co.,* 202 F.3d 44, 52 (1st Cir. 2000).

b. In this circuit, "a cause of action 'relates to' an ERISA plan when a court must evaluate or interpret the terms of the ERISA-regulated plan to determine liability under the state law cause of action." TEST: Where the state law cause of action cannot be decided without extensive and close review of the terms of the ERISA governed benefit plans at issue, preemption under §514(a) is mandated.

c. The state law claim is preempted if prosecution of that claim would make the ERISA governed plan and its administration subject to inconsistent oversight, regulation and administration on a state by state basis

(1) *Zipperer v. Raytheon Co.*, 493 F.3d 50 (1st Cir. 2007); *Hampers* at 52 ("[w]e have held that ERISA preempts state law causes of action for damages where the damages must

be calculated using the terms of an ERISA plan").

3. §502 preemption: The second avenue for preemption under ERISA **(Slide No. 2)**

   a. Refresher: arises by operation ERISA's carefully calibrated and purposely reticulated causes of action and remedies. The law is clear: A state cause of action that would disturb the congressional legislative balance reflected in a given statutory section of ERISA by adding an additional cause of action to the mix is preempted.

   b. Put another way, a cause of action "that duplicates, supplements, or supplants the remedies provided by ERISA runs afoul of Congressional intent and is preempted."

      (1) *E.g. Zipperer* at 53 ("causes of action that provide alternative enforcement mechanisms to ERISA's own enforcement scheme" are preempted); *Goldberg* at 171("[i]n addition to § 514 preemption, ERISA provides for complete preemption under § 502(a). . . a state cause of action that would fall within the scope of [§502(a)'s] remedial scheme is preempted as conflicting with the intended exclusivity of the remedies provided for by ERISA's remedial scheme, even if those causes of action would not necessarily be preempted by section 514(a)"); *Gallagher v. Cigna Healthcare of Me., Inc.*, 538 F. Supp. 2d 286, 293 (D. Me. 2008).

C. Why does it matter for the Plan/TPA/Vendor Relationship? **(Slide No. 3)**

1. In a falling out, the wronged party cannot rely on preempted state law causes of action, such as breach of contract, fraud, misrepresentation, etc.

2. If you are the plan sponsor, this creates a particular conundrum: If the vendor/TPA is not a fiduciary, your state law causes of action will be preempted, and you have very little or no recourse after the fact in a dispute with the vendor/TPA: **(Slide No. 4)**

   a. Note: If state law causes of action and the nature of the dispute do not require evaluation of plan terms, then preemption can be avoided.

   b. But if the dispute requires consulting the plan terms, then those claims are preempted:

      (1) Example: TPA allegedly misspends or makes errors in determining benefits under plan terms. Whether dispute is framed as a breach of contract claim or something else, it can only be resolved by looking at and evaluating the plan

terms, and thus would be preempted under current First Circuit law.

c. Meanwhile, ERISA based claims, which are all that remain, are very limited:

(1) Claims for breach of fiduciary duty are not available if the vendor/TPA is not a fiduciary.

(2) ERISA likely leaves the plan sponsor with only prospective equitable relief, to order the vendor/TPA to handle the plan in a certain way. As a practical matter this does you no good if the relationship has ended and you are concerned about remedying past wrongs/errors by the vendor/TPA.

(a) ERISA §502(a) provides that a fiduciary (e.g. a plan sponsor) may prosecute only claims for breach of fiduciary duty or "(A) to enjoin any act or practice which violates any provision of this title or the terms of the plan, or (B) to obtain other appropriate equitable relief (I) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan." 29 U.S.C. § 1132.

3. Practice pointer for the plan sponsor? **(Slide No. 5)**

a. Explicitly make your vendor/TPA a fiduciary, if you want to be able to hold it accountable in hard dollars for losses from errors

(1) If the vendor/TPA is a fiduciary, then you can recover on a breach of fiduciary duty theory, and the existence or not of the state law claims becomes unimportant

b. If the vendor/TPA is not a fiducary, then a plan sponsor must proactively, while the vendor/TPA is still in that role, oversee what it is doing and:

(1) use soft power (the threat to terminate the contract, withhold payments if allowed under the contract, etc) to force the vendor/TPA to change how they it is handling the plan and make up or avoid financial losses to the plan from its work, or

(2) use hard power (pursue equitable relief to compel different handling of the plan than what is causing the problem)

4. Practice pointer for the vendor/TPA **(Slide No. 6)**

a. Fiduciary status carries additional risk as well as responsibility. A vendor/TPA can limit potential downside from a falling out with the plan sponsor by avoiding fiduciary status.

b. A vendor/TPA that is a fiduciary should be paid for that enhanced role and the increased litigation exposure

II. Preemption Part II - What the State Can Make You Do **(Slide No. 7)**

Absent the impact of the savings clause, the state, through its legislature (i.e., by statute) or by regulatory agency (including the MCAD) cannot impose additional regulatory burdens or dictate coverages or plan terms to an ERISA governed plan

A. This is the minimum scope of such preemption of the state's power over your plans in states within the first circuit

Compare Judge Saylor's decision in *O'Leary v. Provident Life & Acc. Ins. Co.*, 456 F. Supp. 2d 285 (D. Mass. 2006)

B. What does this mean in practicality and reality for the plan sponsor and its vendors, particularly any TPA that actually administers a plan's terms?

1. It means, for instance, that the MCAD cannot pursue a regulatory investigation and penalties against you for allegedly discriminatory plan terms.

2. Two different federal district court judges in Massachusetts have made the same ruling: the MCAD could not investigate and prosecute the question of whether an employee benefit plan, by certain distinctions among classes in the benefits it provides, is discriminatory or otherwise violates state law.

See Colonial Life & Acc. Ins. Co. v. Medley, 2008 U.S. Dist. LEXIS 103850 (D. Mass. Sept. 30, 2008); and *Partners Healthcare Sys. v. Sullivan*, 497 F. Supp. 2d 42, 44 (D. Mass. 2007)

C. Unanswered Questions: What does this mean for the state's power to impose the Massachusetts Health Care Reform Act on employers?

a. Does it impose sufficient additional burdens and restrictions on the benefit plans and the decisions and operations of plan sponsors in offering health plans that it should be deemed preempted?

b. My take: Probably yes.

c. There has been a solid string of cases, with none to the contrary until very recently, finding that state plans requiring employers to provide health insurance or make payments effectively dictated terms to the employer for the plan, and thus were preempted

d. To the opposite is the recent decision in *Golden Gate Restaurant Ass'n v. City and County of San Francisco*, 546 F.3d 639 (9th Cir. 2008).

III. Breach of Fiduciary Duty Litigation and the Continuing Evolution of Fiduciary Status **(Slide No. 8)**

A. A Plan's fiduciaries are the Named Fiduciaries, and those who exercise discretion over plan management or control of plan assets

1. ERISA's fiduciary duty provisions reserves fiduciary liability for "named fiduciaries," defined either as those individuals listed as fiduciaries in the plan documents, or those who are otherwise identified as fiduciaries pursuant to a plan-specified procedure. See 29 U.S.C. § 1102(a)(2); see also 29 U.S.C. § 1105(c)(1)(permitting allocation of fiduciary responsibility pursuant to the plan instrument).

2. ERISA also extends fiduciary liability to functional fiduciaries – persons who act as fiduciaries, although not explicitly denominated as such, by performing at least one of several enumerated functions with respect to a plan.

a. "a person is a fiduciary with respect to a plan to the extent (I) he exercises any discretionary authority or discretionary control respecting management or disposition of its assets, (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan." 29 U.S.C. § 1002(21)(A).

B. The key issue with regard to the relationship of TPAs and other vendors to the plan is the unnamed fiduciary issue and their status as a functional fiduciary

1. If the plan names the TPA as a fiduciary, then look no further.

2. But if qualifies as an unnamed fiduciary, or functional fiduciary, then risks increase, because the TPA is exposed to breach of fiduciary duty liability. However, unless this status, or the risk of it, was anticipated***,*** pricing for it may not have been built in by the service provider

C. DOL guidelines on administering a company's plans and whether that renders the administrator a functional fiduciary under the statutory language **(Slide No. 9)**

1. If the final decision making authority on paper does not rest with the TPA, but instead with the plan sponsor who hired the administrator/service

provider then the TPA is probably not a fiduciary

2. If the governing plan/benefit terms are dictated not by theTPA, but instead by the plan sponsor who retained the TPA, then the TPA is probably not a fiduciary.

3. 29 CFR 2509.75-8: **(Slide No. 10)**

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

(1) Application of rules determining eligibility for participation or benefits;

(2) Calculation of services and compensation credits for benefits;

(3) Preparation of employee communications material;

(4) Maintenance of participants' service and employment records;

(5) Preparation of reports required by government agencies;

(6) Calculation of benefits;

(7) Orientation of new participants and advising participants of their rights and options under the plan; **(Slide No. 10A)**

(8) Collection of contributions and application of contributions as provided in the plan;

(9) Preparation of reports concerning participants' benefits;

(10) Processing of claims; and

(11) Making recommendations to others for decisions with respect to plan administration?

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

advice with respect to any money or other property of the plan and has no authority or responsibility to do so."

4. The state of the law: This is arguably a key issue open to exploration in litigation, and yet one might say that it is a settled point simply by accretion of years of unreflective broad application of the rule by courts. **(Slide No. 11)**

    a. The case law outside the First Circuit is almost uniform and the case law within the First Circuit is uniform that a TPA meeting the DOL Guidelines insulates the TPA's administration of the plan, so long as the plan sponsor retained final decision making authority and provided the plan terms.

    b. Did the DOL really intend to go this far? It's unclear.

        (1) But years of decisions has made it so.

        (2) The DOL guidelines are now afforded great weight and afford broad protection of TPAs seeking to avoid fiduciary status

            (a) A third party administrator is not a fiduciary where it engages in the routine work of claims adjustment, such as making benefit determinations and otherwise administering claims under a benefit plan, by applying the "policies, interpretations, rules, practices and procedures" dictated by a plan sponsor. 29 C.F.R. 2509.75-8. The First Circuit has explicitly adopted and applied the Department of Labor's interpretation of this issue. *Terry v. Bayer Corp*., 145 F.3d 28, 35-36 (1st Cir. Mass. 1998) ("[a]n interpretive bulletin issued by the Department of Labor bears this out, stating that an entity which merely processes claims is not a fiduciary").

5. Practice Pointers: **(Slide No. 12)**

    a. Plan Sponsors must plan for this, and if the plan sponsor intends to retain final authority, the plan sponsor should not assume that a TPA will be liable as a functional fiduciary, even if the plan sponsor has delegated essentially all day in and day out functions to the TPA

    b. TPAs can protect themselves against fiduciary exposure in cases where they are not a named fiduciary by leaving such final authority, even if just on paper, in the hands of the hiring plan sponsor and applying the plan sponsor's benefit plan terms as written

c. The conundrum though:

(1) somewhere in the middle of those extremes lies the reality of most plan sponsor/TPA relationships

(2) the current broad reading of the guidelines suggests that the TPA can have essentially functional control of all aspects, with just formal final decision making authority resting with the plan sponsor, and the TPA still having this protection

(3) but beware of arguments to the contrary: a good litigator could draw the line further in the direction of fiduciary status attaching by attacking whether the plan sponsor actually applied its authority and substantively was involved in the determination of the plan terms, rather than just holding those authorities, powers, and roles on paper

IV. Excessive Fee Litigation in 401(k) Plans **(Slide No. 13)**

A. What are "excessive fees?" There is no simple definition. However, plan participants may complain about fees, and their lawyers, particularly class action lawyers, will claim that particular sets of fees on investment options in a 401(k) plan are too high, equaling a breach of fiduciary duty.

B. For litigation exposure purposes, it is hard to really know what fees are excessive except in hindsight, in a battle of experts

C. But this means that defensively, the litigation issues are preset by the business activities, and that the best defense to such suits is by establishing and documenting a particular, defensible course of conduct in selecting the investment options, including considering their fees and expenses

D. This is because the fiduciary's responsibility, and potential exposure for excessive fees charged by vendors in the investment option products, is not one of perfection, but rather of a reasonable and diligent level of prudence

1. An ERISA fiduciary must act for the exclusive benefit of plan participants. 29 U.S.C. § 1104(a)(1). He must exhibit the care, skill, prudence, and diligence that a prudent person acting in like capacity would use in similar circumstances. *Id.* In enforcing these duties, the Court looks at both the merits of a transaction and the thoroughness of the fiduciary's decision making process. *See Kanawi v. Bechtel Corp.*, 2008 U.S. Dist. LEXIS 99185 (N.D. Cal. Nov. 3, 2008) **(Slide No. 14)**

E. *Kanawi v. Bechtel* has been trumpeted lately as a case really establishing some protection for fiduciaries against excessive fee claims, so long as they follow prudent practices that are consistent with industry norms in selecting the investment

options

1. In *Kanawi*, the court held that "A decision to pay the mutual fund management fees must be guided by a consideration of what would be in the best interests of the Plan participants and beneficiaries, and the process used to make that decision must be prudent." The court found that fees in question were not patently unreasonable, or that the process used to select them and pay them was imprudent . The court found that the evidence did not show that the fiduciaries " abrogated their duties in reviewing the Plan's performance" but that instead "The record show[ed] that the Committee met regularly to discuss the Plan's investments and sought the advice of [knowledgeable vendors] to ensure that it was making proper decisions. " On this evidence, the court found that the fiduciaries "acted prudently and within their sound business judgment in maintaining the funds at issue." The court further noted, with regard to performance and presumably fees as well, that some of the selected funds underperformed, but that the structure of the plan's fund choices was customary for 401(k) plans, that "the evidence showed that [the fiduciaries] regularly reviewed the performance of the Plan's investments and considered alternatives. Substantively, the overall performance of the Fremont Mutual Funds was competitive with the industry standard." The court held that "the test of prudence [that the fiduciaries must live up to] is one of conduct and not performance [and that] it is easy to opine in retrospect that the Plan's managers should have made different decisions, but such 20/20 hindsight musings are not sufficient to maintain a cause of action alleging a breach of fiduciary duty."

F. *Kanawi* and cases like it have been presented in industry media and in presentations like this one as essentially saying that a plan's investment choices, and their selection, that is consistent with industry norms are protected from liability from breach of fiduciary duty claims based on excessive fees existing in the plan. This may be reading too much into cases like these, which are often very fact-specific.

G. So where does that leave plan sponsors and fiduciaries with regard to excessive fee issues? **(Slide No. 15)**

1. Best practices defense.

2. Run it like you would an RFP for any other services (or at least get competing proposals)

3. Use multiple proposals from different vendors to put together the investment options, and have them benchmark fees and expenses in a transparent manner against industry standards

4. Consider having those reviewed by inside or outside expertise that is not offering to administer, set up or manage the 401(k)

5. Then monitor all of this regularly

6. Your defense, if ever challenged, becomes what more could a reasonably prudent person in that situation have done?

V. The New Securities Class Action Litigation **(Slide No. 16)**

A. I have said it so many times on my blog, and it has been repeated so many other places as well, that it is now commonplace:

1. ERISA litigation is the new securities class action

2. With regard to stock drop cases involving company stock contained as an investment option in company defined contribution plans and ESOP plans

3. It is easier to come after you on such class action claims under ERISA because your stock went down, for instance because of option backdating or non disclosure of material information, then to pursue a traditional securities law class action

4. Why?

a. Reason number 1: years of legislative and jurisprudential development that has been something of a backlash against securities class action cases. On the other hand, using ERISA to pursue them instead is relatively new, and there has not been sufficient time for such barriers to rise up to date

b. Reason number 2, and linked to reason number 1 is that, indeed, the courts are still working out exactly how the two regimes should be merged and interact, including to what extent should procedural or liability or damages defenses that would apply to a securities case be adopted and applied in a similar ERISA action

c. Case law right now is trending towards adopting some defenses into the ERISA regime, related to the timing of disclosures of misconduct and whether and how they may have damaged participants

d. But simultaneously allowing a broader scope of a case as an ERISA breach of fiduciary duty theory than would be possible under a securities theory

(1) Judge Gertner's recent decision in *Bendaoud. v. Hodgson*, 2008 U.S. Dist. LEXIS 72788 (D. Mass. 2008), is a key case in this regard, making clear that if the participant can show that he or she could have done better in an alternative investment than company stock, that is enough to make out a damages claim

(2) and since these cases normally settle, rather than be tried, if they don't get defeated on motions to dismiss or for summary judgment, these types of easier standards that are available in ERISA breach of fiduciary duty claims rather than securities action involving company stock increase the likelihood that the case will survive paper practice and eventually settle

e. Long term trend/prediction? **(Slide No. 17)**

(1) there will be some narrowing and clearly some judicial development of the case law to reign in excesses. But in the current business climate, in which financial companies and financial company stock in particular is going to be distrusted, there may be some reluctance by the judiciary to creating barriers to these types of cases being adjudicated on their merits and instead dismissed on the papers

B. Practice pointer: The need for best practices as a proactive defense to this type of large dollar risk, in terms of both defense costs and potential settlement value, cannot be overstated.

1. Ask does it make sense to have company stock as an option? How does it stack up against other benefits?

2. Treat it like any other investment option in terms of evaluating whether to offer it - bring in an outside expert to evaluate whether the plan should offer it, should continue to offer it if it has previously, and, if it has done so previously, should stop doing so and sell it off.

VI. ERISA Plan Litigation Issue: Electronic Discovery **(Slide No. 18)**

A. What is Electronic Discovery?

B. Why is it important?

C. Why is it qualitatively and quantatively different than other discovery, which lawyers and clients have been dealing with effectively for many years?

1. It's costly

2. Large volume

3. Difficult to manage retroactively during litigation, if it wasn't intelligently stored for accurate search during its business lifespan (as opposed to its second life in litigation)

D. It's particularly problematic for plan sponsors and vendors:

1. Asymmetry

a. Plan participants, or a class of plan participants, are not going to face large volumes of electronic discovery that needs to be produced

2. Huge volume

a. Even a medium size benefit plan is going to generate a large amount of claim forms, emails, electronically stored data

3. A lack of case law imposing court control over requests for electronic data and limiting its production to the greatest extent possible

E. The only possible practice tip? Organize, retain and store your electronic business data in a manner that can most effectively be recreated and effectively searched after the fact.

VII. ERISA Plan Litigation Issue: *LaRue v. DeWolff, Boberg & Assocs., Inc.,* 128 S. Ct. 1020 (2008) **(Slide No. 19)**

A. One of two key ERISA cases decided last term by the Supreme Court

B. The functional holding: individual participants in a 401(k) account can sue for breach of fiduciary duty that affects only their own account

C. The three opinions of the Court provide subsidiary issues, however:

1. The majority: defined contribution plans are not necessarily subject to the same rule of law as has been determined and applied to defined benefit plans.

a. The real issue here: this opens up to challenge any issue that a consensus among the courts or controlling appellate or Supreme Court authority has already resolved, only in cases involving defined benefit plans.

b. Any litigation over a contested issue involving a defined contribution plan, where one side (presumably the defendant/fiduciary) argues that the issue has already been decided in the past in its favor, can involve relitigation of that issue as though it had never before been decided, if the prior case law/consensus/rule of law was developed involving defined benefit plans. This is a real opening up of a pandora's box, and unsettles the case law.

c. Why then does the majority focus on this?

(1) My theory

2. Justice Roberts: such claims can proceed, but not as breach of fiduciary duty case, and should instead be prosecuted as denial of benefit claims

a. Why does he take this approach?

(1) My theory

3. Justice Thomas: such claims are proper, but there is no reason to declare that rules should be different in the defined contribution context than in the defined benefit context; the language of the statute itself authorizes such claims on its plain meaning, and there is no reason to go beyond that

a. He is right that the statute alone, without judicial gloss, can allow that particular plaintiff's case to proceed, and therefore there is no need to introduce the potential mischief of either the majority's suggestion that the law should be different for defined contribution plans, or of Justice Roberts' attempt to force these types of claims into the denial of benefits prong of ERISA

D. What's the end result? An avalanche of litigation, or death by a thousand cuts? Or something else entirely?

1. There was much talk when *LaRue* was decided as to whether allowing individuals with only losses to their own accounts to bring such claims (as opposed to only when the fiduciary breaches affect the entire plan) would increase litigation. Arguments to this effect were made to the Supreme Court in *LaRue*, as a reason to preclude the participant's claim

2. There is no doubt that the actual ruling opens up more potential claims, by allowing individually injured participants to sue for breach of fiduciary duty

a. Anecdotally, there are at least some smaller cases going forward that would have otherwise not made it past the motion to dismiss stage, if the ruling had been opposite.

(1) There are not enough to be an avalanche, or even enough to be death by a thousand small cuts/cases, but there will be some losses from these types of case being out there

(2) But it will not be large because of the relatively small amount at issue in any one particular participant's account in most instances, compared to the costs of litigating such a dispute

(a) Practically speaking, the participant can't cover it, and the amounts of recovery are small enough that

it will not be easy to find a lawyer competent to handle an ERISA dispute who will do it on contingency at those amounts

3. The real litigation cost issue is the costs buried in other, larger cases, in the traditional class action or large dollar volume case that the express holding of *LaRue* - that individual plan participants can sue - does not affect, but in which the parties will engage in extensive discovery and motion practice directed at either maintaining or overturning in the defined contribution context existing rules of law created in the pension context

    a. In those types of cases, any time one side trots out a holding that is favorable to it, or even more importantly outcome determinative in its favor, that comes from a jurisprudential history involving defined benefit plans, the other side is or should attack its applicability in the defined contribution context, after the majority's opinion in *LaRue*.

VIII. ERISA Plan Litigation Issue: The New Rules on Conflict of Interest Governing Benefit Determinations **(Slide No. 20)**

A. The key issue in benefit cases is the standard of review

1. Most plans protect themselves by granting the fiduciaries or plan administrator the right to interpret and apply the plan terms, language which is generally understood as imposing an "arbitrary and capricious" standard of review if a denied benefit case is litigated

    a. This standard means that the court must uphold the administrator's benefit determination, even if the court believes it is incorrect, so long as the administrator's interpretation and decision is reasonable and supported by reasonable evidence

2. This can affect any ERISA governed plan under which benefits can be owed, from health insurance to life insurance to disability (the most heavily litigated and contentious area of dispute involving the standard of review) to employee buy outs.

    a. Even 401(k) disputes, if you apply Justice Roberts' reasoning from LaRue

B. What is a Structural Conflict of Interest?

1. The administrator who makes the benefit determination also pays the benefits if they are granted

C. How does it affect the administrator's decision making?

1. The participant/plaintiff bar's view

2. The well run/ethical plan's view

3. My view: the evidence in the courtroom will make it shake out properly in a majority of cases without regard to which standard of review applies

    a. "the assumption that the structural arrangement by definition is affecting the decision making is frequently belied by close observation of the evidence concerning the processing of particular individual claims in situations where the administrator was also the payor; the evidence simply does not support the view that outcomes are typically varying simply because the administrator is also the payor of the benefits at issue."

        (1) Taken from the Boston ERISA and Insurance Litigation Blog, www.bostonerisalaw.com, May 1, 2008

D. The circuit courts' views are diverse:

1. The First Circuit did not give it weight

    a. Under the current law of this circuit, merely pointing out that a plan administrator is also the entity that pays any benefits found due under the plan is insufficient to warrant departure from the applicable arbitrary and capricious standard of review. *See, e.g., Wright v. R.R. Donnelley & Sons Co. Group Benefits Plan*, 402 F.3d 67, 75 (1st Cir. 2005) ("[T]he fact that the plan administrator will have to pay the plaintiff's claim out of its own assets does not change the arbitrary and capricious standard of review.") (citation and internal punctuation omitted); *Doyle v. Paul Revere Life Ins. Co.*, 144 F.3d 181, 184 (1st Cir. 1998) (same). To warrant subjecting a plan administrator's benefits eligibility determination to a stricter standard of review, a plaintiff must point to some evidence suggesting that its decision was actually influenced by improper factors.

    b. The First Circuit accepted the law and economics argument that the marketplace would punish companies that did that, so there was no reason for the courts to factor it in or allow it to affect the standard of review. Instead, the marketplace prevents it from being a factor

        (1) Does this economic justification hold up in practice?

2. Other circuits were all over the map:

    a. The circuits have adopted varying approaches to the issue of whether the structural conflict that arises when an insurer both

reviews and pays claims justifies less deferential review. In addition to this Court, the Seventh and Second Circuits have held that a structural conflict alone is insufficient to alter the standard of review. Instead, these circuits require an actual showing that the conflict of interest affected the benefits decision before there will be any alteration in the standard of review. *See Rud v. Liberty Life Assurance Co.*, 438 F.3d 772, 776-77 (7th Cir. 2006) (holding that a structural conflict of interest, without more, does not affect the standard of review); *Sullivan v. LTV Aerospace & Def. Co.*, 82 F.3d 1251, 1255-56 (2d Cir. 1996) (holding that a claimant must show that a conflict of interest affected the benefits decision, but if such showing is made, de novo review applies).

However, seven other circuits have held that a structural conflict warrants alteration to the standard of review, although six of these circuits apply less deferential review within the arbitrary and capricious framework. Of these six circuits, all except one have adopted a "sliding scale" approach to the standard of review, in which the court applies less deferential review to the extent that a conflict of interest exists. *See, e.g., Fought v. Unum Life Ins. Co. of Am.*, 379 F.3d 997, 1004 (10th Cir. 2004) (per curiam) (explaining that "the court must decrease the level of deference given to the conflicted administrator's decision in proportion to the seriousness of the conflict" (internal citation and quotation omitted)); *Pinto*, 214 F.3d at 379 (expressly adopting a "sliding scale method, intensifying the degree of scrutiny to match the degree of the conflict"); *Vega v. Nat'l Life Ins. Servs., Inc.*, 188 F.3d 287, 297 (5th Cir. 1999) (*en banc*) (explaining that "[t]he greater the evidence of conflict on the part of the administrator, the less deferential our abuse of discretion standard will be"); *Woo v. Deluxe Corp.*, 144 F.3d 1157, 1161-62 & n.2 (8th Cir. 1998) (explicitly adopting the sliding scale approach while noting that "not every funding conflict of interest per se warrants heightened review"); *Doe v. Group Hosp. & Med. Servs.*, 3 F.3d 80, 87 (4th Cir. 1993) (applying less deference "to the degree necessary to neutralize any untoward influence resulting from the conflict"). The Ninth Circuit employs a "substantially similar" approach, but with a "conscious rejection of the 'sliding scale' metaphor" on the ground that "[a] straightforward abuse of discretion analysis allows a court to tailor its review to all the circumstances before it." *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 967-68 (9th Cir. 2006)(*en banc*).

The Eleventh Circuit uses a different framework. It first determines, under *de novo* review, whether the decision was wrong; if it was, and if an inherent conflict of interest exists, "the burden shifts to the claims administrator to prove that its interpretation of the plan is not tainted by self-interest." *HCA Health Servs., Inc. v. Employers Health Ins. Co.*, 240 F.3d 982, 993-94 (11th Cir. 2001). The claims

administrator may then meet this burden "by showing that its wrong but reasonable interpretation of the plan benefits the class of participants and beneficiaries." *Id*. at 994-95.

Finally, the D.C. Circuit has not yet established a standard of review in cases involving a structural conflict of interest. *See Wagener v. SBC Pension Benefit Plan-Non Bargained Program*, 366 U.S. App. D.C. 1, 407 F.3d 395, 402 (D.C. Cir. 2005) (finding that the result would be the same under either arbitrary and capricious or de novo review).

(1) Taken from the Boston ERISA and Insurance Litigation Blog, www.bostonerisalaw.com, March 30, 2007

E. The Supreme Court Addressed the Issue last term in *Metropolitan Life Ins. Co. v. Glenn*, 128 S. Ct. 2343 (2008): **(Slide No. 22)**

1. Such a conflict does not change the standard of review

a. If the plan reserved discretionary authority, then the arbitrary and capricious standard of review applied

b. It did not become *de novo* even if there was a structural conflict of interest

2. However, the conflict must be considered as a factor in deciding whether the benefit determination was arbitrary and capricious

3. How much impact it has depends on the evidence in the case of what type of impact the structural conflict can play:

a. "The conflict of interest at issue here, for example, should prove more important (perhaps of great importance) where circumstances suggest a higher likelihood that it affected the benefits decision, including, but not limited to, cases where an insurance company administrator has a history of biased claims administration. *See Langbein, supra*, at 1317–1321 (detailing such a history for one large insurer). It should prove less important (perhaps to the vanishing point) where the administrator has taken active steps to reduce potential bias and to promote accuracy, for example, by walling off claims administrators from those interested in firm finances, or by imposing management checks that penalize inaccurate decisionmaking irrespective of whom the inaccuracy benefits."

(1) *See Metropolitan Life Ins. Co. v. Glenn*, 128 S. Ct. 2343, 2350–51 (2008)

F. What does this mean for benefit disputes in the First Circuit?

1. Effect on discovery and the administrative record

a. Prior rule

(1) In reviewing an administrator's decision under the arbitrary and capricious standard, the First Circuit has always strongly supported the proposition that the universe of evidence considered by the court should be limited to the administrative record, defined as the evidence that was before the administrator at the time it made the challenged decision.

(2) "The ordinary rule is that review for arbitrariness is on the record made before the entity being reviewed. True, we have declined in cases like this one to adopt an ironclad rule against new evidence. For example, discovery may be needed because the decisional process is too informal to provide a record. And certain kinds of claims - e.g. proof of corruption - may in their nature or timing take a reviewing court to materials outside the administrative record. Still, at least some very good reason is needed to overcome the strong presumption that the record on review is limited to the record before the administrator. This is the view of virtually all of the circuits with the possible exception of the Fifth Circuit. It is almost inherent in the idea of reviewing agency or other administrative action for unreasonableness; how could an administrator act unreasonably by ignoring information never presented to it?

(a) *Liston v. Unum Corp. Officer Severance Plan*, 330 F. 3d 19, 23 (1st Cir. 2003).

b. Will now open up much more discovery, on the argument that it is needed to prove the influence of the conflict and that it should be considered a significant factor in deciding whether the administrator's decision was arbitrary and capricious

c. This will increase costs, and possibly lead to the business disruption that occurs with depositions of personnel, as is typical in other types of litigation but in the past has not been typical in denied benefits litigation where the arbitrary and capricious standard of review has applied

2. Effect on Decision Making by the District Courts

a. More Ad hoc

b. More dependent on what judge you get

c. Less predictability

(1) It is harder to foresee what the likely outcome will be

(2) The new answer: it depends, because the evidence on this point favors us, the evidence on that point favors them, and a lot will depend on how the particular decision making employee holds up in a deposition

(3) Predictability no more: whatever were the drawbacks of the prior system, it had the advantage of - relative to litigation in general - a high level of predictability

(a) if the arbitrary and capricious standard applied under the plan's terms, which it did so long as the plan expressly reserved discretionary authority to the decision maker, you could look at the administrative record, know that no further discovery or additional evidence beyond that was likely to come into play, and be able to project whether the evidence in that record was sufficient to uphold the decision under that arbitrary and capricious standard

(b) that is probably gone for good, in any case involving a structural conflict