

**LAW OF EMPLOYEE PENSION AND WELFARE BENEFITS**

**Second Edition**

**2011 Supplement**

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(Pub. 3158)

## Chapter 1 – Origins and Reasons for Employee Benefits and ERISA

P. 4

**Replace** second paragraph after “D. Who Has Retirement Benefits?” with the following:

Participation rates vary considerably by income. In 2009 only 13 percent of workers in the bottom 10 percent of earnings participated in a defined contribution pension plan compared to 55 percent of the highest paid workers. Only 4 percent of the bottom 10 percent earners participated in a defined benefit plan compared to 51 percent of the highest earners.

P. 6

**Add:** before [3]

In 2004, McDonald’s began to offer an improved retirement plan in order to reduce turnover, particularly by its restaurant managers. It initiated a 401(k) plan with automatic enrollment. Employees who put 5 percent of their salary in the plan receive a company match as high as 11 percent.

P. 11

**Add:** before Questions and Problems

Some employers use health care benefits to reduce employee turnover. According to the Wall Street Journal (August 31, 2009), Burgerville, a regional restaurant chain, agree to pay 90 percent of health care premiums for its hourly employees who work at least 20 hours a week. Burgerville claims the plan, which costs it over \$4 million a year, pays for itself. After instituting the plan, Burgerville saw its turnover of employees fall by over 50 percent, sharply dropping training costs that exceed \$1,000 per each new employee.

P. 20

**Replace** bracketed material in first paragraph with following:

[Ed. In 2011, all compensation from employment up to \$106,800 (adjusted annually for inflation) was taxed at a rate of 6.2 percent for both the employee and the employer. The higher a worker’s compensation, the higher are a worker’s Social Security retirement benefits. In 2011, the average monthly benefit for a retired worker is \$1,169, while the maximum monthly benefit for an individual commencing benefits at the normal retirement age of 66 is \$2,366. Social Security benefits are adjusted annually for inflation.]

## Chapter 2 – Employee Pension Plans

P. 33

**Replace** first sentence in second full paragraph with following:

In 2011, an employee cannot contribute more than \$16,500 to a 401(k) plan.

P. 35

**Add:** as third paragraph under “[b] Reasons for Popularity of 401(k) Plans.”

Employee participation in 401(k) plans varies by race and ethnicity. Between 2001 and 2007, among eligible employees white participation was 77.4 percent, Black participation was 69.9 percent, Hispanic participation 69.8 percent and Asian participation was 83.1 percent. The average percent of wages contributed varied similarly with Asian employees contributing the highest at 7.8 percent while Hispanic employees averaged the lowest rate at 5.9 percent.

Participation also varies by earnings with the higher paid employee participating in 401(k) plans at significantly higher rates. In 2008 the upper third of eligible income earners eligible to participate did so at a rate of 83 percent. The lowest third of eligible income earners participated at a rate of 64 percent.

P. 44

**Add:** before first paragraph:

As part of the operation of the plan, a 401(k) plan must pay a variety of fees. The administration of the plan requires record-keeping, transaction processing, and trustee services, all of which must be paid for by the plan. Because of the plan participant’s right to determine whether to participate, how much to participate and how to invest the amounts in the plan, communication with participants is vital. Consequently the plan must pay for communications with participants on a regular basis. The plan must also pay for the management of the funds including the right of participants to buy and sell securities and the right of employees to borrow money from the plan. The statutory and regulatory compliance requirements also incur fees including audits, accounting and legal services. The plan sponsor and the plan participants share these costs.

The most notorious fees are related to the investment of the plan funds. These include sales charges such as commissions, management fees, and record keeping fees. The investment related fees average about 1 percent per year of the plan assets though they vary considerably, with smaller plans usually paying higher fees than larger plans. These fees are usually paid for by the plan participants.

P. 48

Add: before [5] Cash Balance Plans

As the following cases illustrate, the courts have not decided these cases in a uniform manner.

**HECKER v. DEERE & COMPANY**

[556 F.3d 575](#) (7th Cir. 2009)

WOOD, Circuit Judge.

Even before the stock market began its precipitous fall in early October 2008, litigation over alleged mismanagement of defined contribution pension plans was becoming common. This type of litigation received a boost when, in *LaRue v. DeWolff, Boberg & Associates, Inc.*, \_\_\_ U.S. \_\_\_, 128 S. Ct. 1020, (2008), the Supreme Court held that “a participant in a defined contribution pension plan [may] sue a fiduciary whose alleged misconduct impaired the value of plan assets in the participant’s individual account.” [128 S. Ct. at 1022](#). [Section 502\(a\)\(2\)](#) of the Employee Retirement Income Security Act of 1974 (“ERISA”), [29 U.S.C. § 1132\(a\)](#), provides the basis for such an action.

The present case requires us to look further into two questions: first, how broadly does the concept of actionable misconduct sweep, and second, does someone who serves as the manager and investment advisor for a 401(k) plan, or for some of the plan’s investment options, owe fiduciary duties to the sponsor’s employees. These questions arise in a lawsuit brought by some employees of Deere & Company, which sponsors two 401(k) plans relevant to this case. Fidelity Management Trust Company (“Fidelity Trust”) is the directed and recordkeeper for the Deere plans; it also manages two of the investment vehicles available to plan participants. Fidelity Management & Research Company (“Fidelity Research”) is the investment advisor for the mutual funds offered as investment options under Deere’s plans.

Named plaintiffs Dennis Hecker, Jonna Duane, and Janice Riggins (“the Hecker group”), seeking to sue both on their own behalf and for a class of plan participants, asserted in their second amended complaint (“Complaint”) that Deere violated its fiduciary duty under ERISA by providing investment options that required the payment of excessive fees and costs and by failing adequately to disclose the fee structure to plan participants. The Hecker group also sued Fidelity Trust and Fidelity Research on the theory that they were functional fiduciaries for the class and thus they too were liable under § 502(a). All three defendants moved to dismiss for failure to state a claim, see [FED. R. CIV. P. 12\(b\)\(6\)](#). The district court concluded that the case could be resolved at that preliminary stage, granted the motions to dismiss without resolving the class certification motion, and entered judgment for the defendants. Later, the court also denied plaintiffs’ motion under Rule 59(e). We conclude that the district court correctly found that plaintiffs failed to state a claim against any of the defendants, and we therefore affirm the district court’s judgment.

I

A

In 1990, Deere engaged Fidelity Trust to serve as trustee of two of the 401(k) plans (“the Plans”) it offers to its employees. The Plans, everyone agrees, are subject to ERISA, and the three named plaintiffs are participants in them. Under its arrangement with Deere, Fidelity Trust was required to advise Deere on what investments to include in the Plans, to administer the participants’ accounts, and to keep records for the Plans.

Each Plan offered a generous choice of investment options for Plan participants: the menu included 23 different Fidelity mutual funds, two investment funds managed by Fidelity Trust, a fund devoted to Deere’s stock, and a Fidelity-operated facility called BrokerageLink, which gave participants access to some 2,500 additional funds managed by different companies. Fidelity Research advised the Fidelity mutual funds offered by the Plans. Each plan participant decided for herself where to put her 401(k) dollars; the only limitation was that the investment vehicle had to be one offered by the Plan. Each fund included within the Plans charged a fee, calculated as a percentage of assets the investor placed with it. The Hecker group alleges that Fidelity Research shared its revenue, which it earned from the mutual fund fees, with Fidelity Trust. Fidelity Trust in turn compensated itself through those shared fees, rather than through a direct charge to Deere for its services as trustee. As the Hecker group sees it, this led to a serious—in fact, impermissible—lack of transparency in the fee structure, because the mutual fund fees were devoted not only to the (proper) cost of managing the funds, but also to the (improper) cost of administering Deere’s 401(k) plans.

Distressed primarily by the fee levels, the Hecker group filed this suit individually and on behalf of a class against Deere, Fidelity Trust, and Fidelity Research, asserting that all three defendants had breached their duties under ERISA. The second amended complaint is the version on which the district court based its ruling. Paragraph 11 summarizes the plaintiffs’ theory as follows: “. . . the fees and expenses paid by the Plans, and thus borne by Plan participants, were and are unreasonable and excessive; not incurred solely for the benefit of the Plans and the Plans’ participants; and undisclosed to participants. By subjecting the Plans and the participants to these excessive fees and expenses, and by other conduct set forth below, the Defendants violated their fiduciary obligations under ERISA.”

As we have already noted, Deere appointed Fidelity Trust to be trustee of the Plans. Fidelity Trust also performed administrative tasks for the Plans and managed two of the investment options available to the participants. Deere and Fidelity Trust agreed that Deere would limit the selections available to Deere’s employees to Fidelity funds, with the exception of the Deere Common Stock Fund and some other minor guaranteed investment contracts. Fidelity Research served as the investment advisor for 23 out of the 26 investment options in the Plans. None of the Fidelity Research funds operated exclusively for Deere employees; all were available on the open market for the same fee. The Complaint alleges that Fidelity Research “maintains an active Revenue Sharing program, charging more for its services than it expects to keep in order to have additional monies with which to pay its affiliates and business partners.” Those charges, plaintiffs allege, were excessive

and unreasonable. Deere, in their view, failed to monitor Fidelity Trust's actions properly and failed to keep the participants properly informed.

A few more details about the Plans themselves are helpful. One plan was called the Savings & Investment Plan, or SIP, and the other was the Tax Deferred Savings Plan, or TDS. For all practical purposes, they operated the same way. Qualified employees could contribute up to a certain amount of their pre-tax earnings, and Deere would match those contributions in varying percentages up to 6%. Deere also made profit-sharing contributions on behalf of some participants. All participants were fully vested from the start with respect to their own contributions and were vested after three years' service with respect to the Deere contribution. By the end of 2005, the SIP had more than \$2 billion in assets; more than \$1.3 billion of that was held in Fidelity retail mutual funds. The TDS had more than \$500 million in assets by that time, \$244 million of which were held in Fidelity retail mutual funds.

## B

Almost twenty years ago, the Supreme Court observed that "ERISA abounds with the language and terminology of trust law." *Firestone Tire and Rubber Co. v. Bruch*, [489 U.S. 101, 110](#) (1989). The Act's fiduciary responsibility provisions, found at ERISA §§ 401-14, are central to the Hecker group's case. Plaintiffs begin with § 403(c)(1), which says that, except as provided in certain other parts of the statute, "the assets of a plan shall never inure to the benefit of any employer and shall be held for the exclusive purposes of providing benefits to participants in the plan and their beneficiaries and defraying reasonable expenses of administering the plan." Plan fiduciaries must discharge their duties "solely in the interest of the participants and beneficiaries." ERISA § 404(a)(1). Section 404 recognizes an exception to that duty, however, for plans that delegate control over assets directly to the participant or beneficiary. The key language reads as follows:

(c) Control over assets by participant or beneficiary

(1)(A) In the case of a pension plan which provides for individual accounts and permits a participant or beneficiary to exercise control over the assets in his account, if a participant or beneficiary exercises control over the assets in his account (as determined under regulations of the Secretary)—

(i) such participant or beneficiary shall not be deemed to be a fiduciary by reason of such exercise, and

(ii) no person who is otherwise a fiduciary shall be liable under this part for any loss, or by reason of any breach, which results from such participant's or beneficiary's exercise of control, except that this clause shall not apply in connection with such participant or beneficiary for any blackout period during which the ability of such participant or beneficiary to direct the investment of the assets in his or her account is suspended by a plan sponsor or fiduciary.

ERISA § 404(c)(1). Finally, the Hecker group relies on ERISA § 405(a), which provides that one fiduciary may be liable for breaches of fiduciary duty committed by another fiduciary under specified circumstances.

## C

The district court disposed of the case on the pleadings, as we noted above. In evaluating the case, the court had to decide whether the Complaint included “enough facts to state a claim to relief that is plausible on its face.” *Khorrami v. Rolince*, [539 F.3d 782, 788](#) (7th Cir. 2008) (quoting *Bell Atl. Corp. v. Twombly*, [550 U.S. 544](#) (2007)); see *Davis v. Indiana State Police*, [541 F.3d 760, 763-64](#) (7th Cir. 2008). Even after *Twombly*, courts must still approach motions under Rule 12(b)(6) by “constru[ing] the complaint in the light most favorable to the plaintiff, accepting as true all well-pleaded facts alleged, and drawing all possible inferences in her favor.” *Tamayo v. Blagojevich*, [526 F.3d 1074, 1081](#) (7th Cir. 2008).

Looking first at plaintiffs’ claims against Deere, the district court found that the company had complied with all applicable disclosure requirements found in ERISA. It saw nothing in the statute or regulations that required Deere to disclose the fact that Fidelity Research was sharing part of the fees it received with its corporate affiliate, Fidelity Trust. Materials furnished to plan participants did disclose the expenses actually paid to the fund managers, as plaintiffs implicitly conceded by alleging that the same fees were charged to all retail fund customers. The district court found it unremarkable that those fees included some profit margin for Fidelity Research. It also thought it “unlikely” that the fund sponsor (Deere) would be able to control the way in which the fund manager distributed its profits, particularly among related corporations. The court also noted that there were proposals to amend the regulations so that revenue sharing arrangements would be disclosed. See Proposed Rules, Department of Labor, Employee Benefits Security Administration, [71 Fed. Reg. 41,392, 41,394](#) (July 21, 2006). This, it thought, made it apparent that the present rules imposed no such obligation. Finally, the court rejected the plaintiffs’ argument that disclosure was required as a general matter of ERISA law.

The Hecker group also asserted that Deere and the Fidelity companies breached their fiduciary obligations by selecting for the Plans investment options with unreasonably high fees. ERISA, the court acknowledged, requires a fiduciary to discharge its duties “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.” ERISA § 404(a)(1)(B). But (as we already have observed) the statute also provides a “safe harbor” for plans that permit the participant to exercise control over his or her own assets. ERISA § 404(c). Assuming that the “safe harbor” provision establishes an affirmative defense, the court held that the defendants could take advantage of the defense only if the facts asserted in the Complaint established all of its necessary elements, as set forth in [29 C.F.R. § 2550.404c-1](#). It then concluded that the defendants had met that burden, explaining itself as follows:

Participants could choose to invest in twenty primary mutual funds and more than 2500 others through BrokerageLink. All of these funds were also offered to investors in the general public so expense ratios were necessarily set to attract investors in the marketplace. The expense ratios among the twenty primary funds ranges from just over 1% to as low as .07%. Unquestionably, participants were in a position to consider and adjust their investment strategy based in part on the relative cost of investing in these funds. It is untenable to suggest that all of the more than 2500 publicly available investment options had excessive expense ratios. The only possible conclusion is that to the extent participants incurred excessive expenses, those losses were the result of participants exercising control over their investments within the meaning of the safe harbor provision.

Last, the district court held that since plaintiffs had failed to state a claim against Deere for breach of fiduciary duty either for failure to disclose or for the selection of investment options, Fidelity could not be held liable either. Moreover, it added, neither Fidelity defendant had fiduciary responsibilities with respect to either of the tasks plaintiffs targeted. Under the trust agreements, Deere had the sole responsibility for the selection of plan investment funds. Thus, even if the Fidelity defendants were fiduciaries for some purposes, they were not fiduciaries for the purpose of making plan investment decisions.

After the court dismissed their case, plaintiffs moved for reconsideration under [FED. R. CIV. P. 59\(e\)](#), asserting that they had new evidence that would establish (1) the defendants' breach of duty in assessing fees and choosing investment options, (2) the fact that the defendants' failure to provide information about revenue sharing was an independent violation of ERISA, and (3) the impropriety of the court's evaluating the "safe harbor" defense on a motion to dismiss. Finding nothing new in their arguments or evidence, the court denied the motion. Later, it awarded costs in the amount of \$54,396.57 for Deere and \$163,814.43 for the two Fidelity defendants. This appeal followed. In addition to briefs from the parties, the court has had the benefit of *amicus curiae* briefs filed by the Secretary of Labor (supporting plaintiffs) and by a consortium composed of the ERISA Industry Committee, the National Association of Manufacturers, and the American Benefits Council (supporting defendants).

## II

The Hecker group has offered numerous reasons for sending this case back to the district court. For convenience, we have organized the issues as follows: (1) did the district court commit a procedural error warranting reversal by considering documents outside the pleadings; (2) were the Fidelity defendants "functional" fiduciaries of the Plans with respect to the selection of investment options, the structure of the fees, or the provision of information regarding the fee structure; (3) did Deere or the Fidelity defendants breach any fiduciary duties toward plaintiffs, and if so, are they protected by the § 404(c) affirmative defense; (4) did the district court abuse its discretion in denying plaintiffs' Rule 59(e) motion; and (5) did the court err in its costs award to the defendants, either by giving excessive costs or by including items that are not authorized by [28 U.S.C. § 1920](#)?

## 2. Functional Fiduciaries

Before we delve into the question whether any of the defendants breached a fiduciary duty, we must identify who owed such duties to plaintiffs with respect to the actions at issue here. Deere does not contest the fact that it owed some fiduciary duties to the plan participants; it argues instead that plaintiffs have too expansive a concept of its fiduciary responsibilities and, in any event, that it did not breach any fiduciary duty. Fidelity Trust and Fidelity Research, in contrast, argue that they were not fiduciaries at all. The Hecker group appears to concede that neither Fidelity entity was a named fiduciary under the Trust Agreement. It argues, however, that one or both of the Fidelity entities functioned as a fiduciary under ERISA § 3(21)(A). In order to find that they were “functional fiduciaries,” we must look at whether either Fidelity Trust or Fidelity Research exercised discretionary authority or control over the management of the Plans, the disposition of the Plans’ assets, or the administration of the Plans.

The Hecker group first argues that Fidelity Trust exercised the necessary control to confer fiduciary status by its act of limiting Deere’s selection of funds through the Trust Agreement to those managed by Fidelity Research. But what if it did? Plaintiffs point to no authority that holds that limiting funds to a sister company automatically creates discretionary control sufficient for fiduciary status. To the contrary, as Fidelity points out, there are cases holding that a service provider does not act as a fiduciary with respect to the terms in the service agreement if it does not control the named fiduciary’s negotiation and approval of those terms. *Chi. Dist. Council of Carpenters Welfare Fund v. Caremark, Inc.*, [474 F.3d 463](#) (7th Cir. 2007); *Schulist v. Blue Cross of Iowa*, [717 F.2d 1127](#) (7th Cir. 1983). In any event, the Trust Agreement gives Deere, not Fidelity Trust, the final say on which investment options will be included. The fact that Deere may have discussed this decision, or negotiated about it, with Fidelity Trust does not mean that Fidelity Trust had discretion to select the funds for the Plans.

Plaintiffs retort that, notwithstanding the language of the Trust Agreement, Fidelity Trust exercised *de facto* control over the selection of the funds and Deere rubber-stamped its recommendations. That is not, however, what the Complaint alleges. It asserts instead that Fidelity Trust “played a role in the selection of investment options,” and it concedes that Deere had “final authority,” *id.* Merely “playing a role” or furnishing professional advice is not enough to transform a company into a fiduciary. *Pappas v. Buck Consultants, Inc.*, [923 F.2d 531, 535](#) (7th Cir. 1991); *Farm King Supply, Inc. Integrated Profit Sharing Plan & Trust v. Edward D. Jones & Co.*, [884 F.2d 288, 292](#) (7th Cir. 1989). Many people help develop and manage benefit plans—lawyers and accountants, to name two groups—but despite the influence of these professionals we do not consider them to be Plan fiduciaries. This is not a case like *Johnson v. Georgia*, [19 F.3d 1184, 1189](#) (7th Cir. 1994), on which plaintiffs rely, because in that case the fiduciary both managed a defined-benefits plan and had ultimate authority over the selection of funds. Nor do we find plaintiffs’ reference to the district court’s decision in *Haddock v. Nationwide Fin. Servs.*, [419 F. Supp. 2d 156](#) (D. Conn. 2006), helpful or

persuasive, since the service provider in that case had the authority to delete and substitute mutual funds from the plan without seeking approval from the named fiduciary.

There is an important difference between an assertion that a firm exercised “final authority” over the choice of funds, on the one hand, and an assertion that a firm simply “played a role” in the process, on the other hand. The Complaint on which the Hecker group proceeded made the latter allegation, not the former. It gave no notice to the defendants that they would be required to defend on the former basis. For that reason, we reject plaintiffs’ tardy effort to present the *de facto* fiduciary argument, and we make no comment on the possible scope of the “functional fiduciary” concept.

Plaintiffs also argue that Fidelity Research, and possibly Fidelity Trust, exercised discretion over the disposition of the Plans’ assets by determining how much revenue Fidelity Research would share with Fidelity Trust. The Fidelity defendants (with the support in this instance of the Department of Labor) respond that the fees that Fidelity Research collected were not Plan assets under ERISA § 401(b)(1). The fees were drawn from the assets of the mutual funds in question, which, as the statute provides, are not assets of the Plans:

In the case of a plan which invests in any security issued by a [mutual fund], the assets of such plan shall be deemed to include such security but shall not, solely by reason of such investment, be deemed to include any assets of such [mutual fund].

*Id.* Once the fees are collected from the mutual fund’s assets and transferred to one of the Fidelity entities, they become Fidelity’s assets-again, not the assets of the Plans. *See also Caremark*, [474 F.3d at 476 n.6](#).

We conclude that the Complaint fails to state a claim against either Fidelity Trust or Fidelity Research based on the supposition that either one is a “functional fiduciary.” Plaintiffs’ effort to proceed against these companies thus fails at the threshold.

### 3. Fiduciary Duties and the Safe Harbor Defense

#### a. Violation of Fiduciary Duty

We are thus left with the claim against Deere. Plaintiffs’ allegations can be distilled into two assertions: (1) Deere breached its fiduciary duty by not informing the participants that Fidelity Trust received money from the fees collected by Fidelity Research, and (2) Deere imprudently agreed to limit the investment options to Fidelity Research funds and therefore offered only investment options with excessively high fees. We analyze each claim in turn, beginning with the fee distribution.

Critical to plaintiffs’ case is the proposition that Deere and Fidelity had a duty to disclose the revenue-sharing arrangements that existed between Fidelity Trust and Fidelity Research. They point to a number of facts in support of their theory. From 1991 through 2007, Deere and Fidelity Trust amended their agreement 27 times to add new Fidelity services and products and to adjust the

administrative costs that Deere paid up front to Fidelity Trust. Those costs decreased over time, as Fidelity Trust shifted to a system whereby it recovered its costs from the Deere participants in the same way as it did from outside participants—that is, Fidelity Research would assess asset-based fees against the various mutual funds, and then transfer some of the money it collected to Fidelity Trust.

The Hecker group’s case depends on the proposition that there is something wrong, for ERISA purposes, in that arrangement. The district court found, to the contrary, that such an arrangement (assuming at this stage that the Complaint accurately described it) violates no statute or regulation. We agree with the district court. Plaintiffs feel misled because the SPD supplements left them with the impression that Deere was paying the administrative costs of the Plans, even though in reality the participants were paying through the revenue sharing system we have described. But, as Deere and Fidelity both point out and the Complaint acknowledges, the participants were told about the total fees imposed by the various funds, and the participants were free to direct their dollars to lower-cost funds if that was what they wished to do. The SPD supplements told participants to look to the fund prospectuses for detailed information on fund-level expenses, and the prospectuses in fact furnished that information. In its brief, Deere points to the Magellan Fund Prospectus as an example. That prospectus broke down the Fund’s total annual operating expenses paid from fund assets (0.59%) as follows: management fee, 0.39%; distribution or service fees, none; other expenses, 0.20%.

The fact that there were no *additional* fees borne by Deere is immaterial. While Deere may not have been behaving admirably by creating the impression that it was generously subsidizing its employees’ investments by paying something to Fidelity Trust when it was doing no such thing, the Complaint does not allege any particular dollar amount that was fraudulently stated. How Fidelity Research decided to allocate the monies it collected (and about which the participants were fully informed) was not, at the time of the events here, something that had to be disclosed. It follows, therefore, that the Hecker group failed to state a claim against Deere based on the revenue-sharing arrangement and the lack of disclosure about it.

These conclusions go a long way toward disposing of plaintiffs’ claims that the non-disclosure of the revenue-sharing breached the general fiduciary duty imposed on Deere by § 404(a)(1). Before such a violation can be found, there must be either an intentionally misleading statement, see *Varsity Corp. v. Howe*, [516 U.S. 489, 505](#) (1996), or a material omission, see *Anweiler v. American Elec. Power Serv. Corp.*, [3 F.3d 986, 992](#) (7th Cir. 1993). The Complaint does not allege that the representation in the SPD supplement—that Deere paid the administration expenses for the Plans—was an intentional misrepresentation. To the contrary, plaintiffs have since submitted evidence with their Rule 59(e) motion showing that Deere believed that Fidelity Trust’s services were free.

The only question is thus whether the omission of information about the revenue-sharing arrangement is material. Deere disclosed to the participants the total fees for the funds and directed the participants to the fund prospectuses for information about the fund-level expenses. This was enough. The total fee, not the internal, post-collection distribution of the fee, is the critical figure

for someone interested in the cost of including a certain investment in her portfolio and the net value of that investment. Plaintiffs argue that some investors may have expected better management from a fund with a higher fee, but, as the Magellan Fund Prospectus illustrates, participants had access to information about management expenses as a percentage of fund assets. The later distribution of the fees by Fidelity Research is not information the participants needed to know to keep from acting to their detriment. See *Bowerman v. Wal-Mart Stores, Inc.*, [226 F.3d 574, 589-91](#) (7th Cir. 2000). The information is thus not material, and its omission is not a breach of Deere's fiduciary duty.

We turn next to plaintiffs' contention that Deere violated its fiduciary duty by selecting investment options with excessive fees. In our view, the undisputed facts leave no room for doubt that the Deere Plans offered a sufficient mix of investments for their participants. Thus, even if, as plaintiffs urge, there is a fiduciary duty on the part of a company offering a plan to furnish an acceptable array of investment vehicles, no rational trier of fact could find, on the basis of the facts alleged in this Complaint, that Deere failed to satisfy that duty. As the district court pointed out, there was a wide range of expense ratios among the twenty Fidelity mutual funds and the 2,500 other funds available through BrokerageLink. At the low end, the expense ratio was .07%; at the high end, it was just over 1%. Importantly, all of these funds were also offered to investors in the general public, and so the expense ratios necessarily were set against the backdrop of market competition. The fact that it is possible that some other funds might have had even lower ratios is beside the point; nothing in ERISA requires every fiduciary to scour the market to find and offer the cheapest possible fund (which might, of course, be plagued by other problems).

As for the allegation that Deere improperly limited the investment options to Fidelity mutual funds, we find no statute or regulation prohibiting a fiduciary from selecting funds from one management company. A fiduciary must behave like a prudent investor under similar circumstances; many prudent investors limit themselves to funds offered by one company and diversify within the available investment options. As we have noted several times already, the Plans here directly offered 26 investment options, including 23 retail mutual funds, and offered through BrokerageLink 2,500 non-Fidelity funds. We see nothing in the statute that requires plan fiduciaries to include any particular mix of investment vehicles in their plan. That is an issue, it seems to us, that bears more resemblance to the basic structuring of a Plan than to its day-to-day management. Compare *Hughes Aircraft Co. v. Jacobson*, [525 U.S. 432, 443-44](#) (1999); *Lockheed Corp. v. Spink*, [517 U.S. 882, 890](#) (1996). We therefore question whether Deere's decision to restrict the direct investment choices in its Plans to Fidelity Research funds is even a decision within Deere's fiduciary responsibilities. On the assumption that it is, however, we nonetheless conclude that taking the allegations in the Complaint in the light most favorable to plaintiffs, no breach of a fiduciary duty on Deere's part has been described.

#### b. Safe Harbor Defense

Even if we have underestimated the fiduciary duties that Deere had to its plan participants, the district court's judgment in favor of the defendants must stand if that court correctly decided

that the safe harbor provided in § 404(c) is available to them. This was the ground on which the district court primarily relied. If the defense is available, it provides an alternate ground for affirmance.

Although ERISA normally imposes a fiduciary duty on plan managers, the statute modifies that rule for plans that provide for individual accounts and allow a participant or beneficiary “to exercise control over the assets in his account.” ERISA § 404(c)(1). First, the participant must have the right to exercise independent control over the assets in her account and in fact exercise such control. Next, the participant must be able to choose “from a broad range of investment alternatives,” [29 C.F.R. § 2550.404c-1\(b\)\(1\)\(ii\)](#). As we noted in *Jenkins v. Yager*, [444 F.3d 916](#) (7th Cir. 2006), “prominent among [the conditions a plan must meet] is that it must provide at least three investment options and it must permit the participants to give instructions to the plan with respect to those options at least once every three months. [29 C.F.R. § 2550.404c-1\(b\)\(2\)\(c\)](#).” [444 F.3d at 923](#). Third, the participant must be given or have the opportunity to obtain “sufficient information to make informed decisions with regard to investment alternatives available under the plan.” [29 C.F.R. § 2550.404c-1\(b\)\(2\)\(i\)\(B\)](#). . . .

\* \* \*

Plaintiffs would like us to decide whether the safe harbor applies to the selection of investment options for a plan, but in the end we conclude that this abstract question need not be resolved to decide this case. Even if § 404(c) does not always shield a fiduciary from an imprudent selection of funds under every circumstance that can be imagined, it does protect a fiduciary that satisfies the criteria of § 404(c) and includes a sufficient range of options so that the participants have control over the risk of loss. *Cf. Langbecker v. Electronic Data Sys. Corp.*, [476 F.3d 299, 310-11](#) (5th Cir. 2007); and *Unisys*, [74 F.3d at 445](#) (holding that a fiduciary that committed a breach of duty in making an investment decision for a Plan may nevertheless take advantage of the § 404(c) defense). The regulation addresses the investment options by stipulating that the § 404(c) defense is available only if the plan offers “a broad range of investment alternatives.” [29 C.F.R. § 2550.404c-1\(b\)\(3\)](#). The necessary broad range exists “only if the available investment alternatives are sufficient to provide the participant or beneficiary with a reasonable opportunity to” accomplish three goals: the ability materially to affect potential return and degree of risk in the investor’s portfolio; a choice from at least three investment alternatives each of which is diversified and has materially different risk and return characteristics; and the ability to diversify sufficiently so as to minimize the risk of large losses. *Id.* §§ 2550.404c1(b)(3)(i)(A)-(C).

Interestingly, in light of the inclusion of the BrokerageLink facility in the plans available to the Deere participants, the regulation also notes that “[w]here look-through investment vehicles are available as investment alternatives to participants and beneficiaries, the underlying investments of the look-through investment vehicles shall be considered in determining whether the plan satisfies the requirements of [the regulation].” *Id.* § 2550.404c-1(b)(3)(ii). The 2,500 mutual funds available through BrokerageLink had fees ranging from .07% to 1%. Any allegation that these options did not provide the participants with a reasonable opportunity to accomplish the three goals outlined in

the regulation, or control the risk of loss from fees, is implausible, to use the terminology of *Twombly*. Plaintiffs complain that non-Fidelity funds were available only through BrokerageLink, but that is immaterial under this regulation. If particular participants lost money or did not earn as much as they would have liked, that disappointing outcome was attributable to their individual choices. Given the numerous investment options, varied in type and fee, neither Deere nor Fidelity (assuming for the sake of argument that it somehow had fiduciary duties in this respect) can be held responsible for those choices.

\* \* \*

The judgment of the district court is AFFIRMED.

### **HECKER v. DEERE & COMPANY**

[569 F.3d 708](#) (7th Cir. 2009)

#### ORDER

Appellants filed their Petition for Panel Rehearing and Petition for Rehearing En Banc on March 9, 2009. Appellee Deere & Company and Appellees Fidelity Management Trust Company and Fidelity Management & Research Company filed their Answers to the Petition on April 6, 2009. In addition, three *amicus curiae* briefs in support of rehearing or rehearing *en banc* were filed in conjunction with the Petition: one from the Secretary of Labor (filed March 20, 2009), one from the AARP and other groups (filed March 18, 2009), and one from a group of law professors (filed March 20, 2009). No judge asked for a vote on the petition for rehearing *en banc*, and all members of the panel have voted to deny the petition for rehearing, with the following addition to the original opinion, *Hecker v. Deere & Co.*, [556 F.3d 575](#) (7th Cir. 2009):

The Secretary of Labor has made a number of points in her *amicus* brief that deserve a brief response. First, she argues that the panel has erred by failing to give appropriate deference to her interpretation of the regulation implementing ERISA § 404(c), [29 C.F.R. § 2550.404c-1](#). But, as the Secretary herself acknowledges, the panel did not ignore any language in the regulation proper. Instead, it did not give the weight that the Secretary believes is due to some language in a footnote to the preamble to the regulation. (We are speaking here of the version of the regulation that was in force at the time relevant to this suit; it should go without saying that the Secretary is free to propose and enact new regulations addressed more specifically to the way in which choice of investment options in a plan relates to the safe harbor provision, if she believes that this would be appropriate.) In her brief, the Secretary explains that she presently “interprets her regulation to mean that, even if the plan otherwise qualifies as a section 404(c) plan, the fiduciary is not relieved by 404(c) from liability for plan losses resulting from the imprudent selection and monitoring of an investment option offered by the plan . . . .” As support for that statement, she cites [56 Fed. Reg. 10724, 10732 n.21](#) (Mar. 13, 1991); DOL Opinion Letter No. 98-04A, 1998WL 326300 at \*3 n.1 (May 28, 1998); DOL Information Letter to Douglas O. Kant, 1997WL 1824017 at \*2 (Nov. 26, 1997) (Kant Letter).

This is enough, she asserts, to make that proposition a rule, entitled to deference under *Chevron USA Inc. v. Natural Resources Defense Council, Inc.*, [467 U.S. 837, 842-43](#) (1984), rather than a more informal statement of administrative practice, entitled only to respect under the standards of *United States v. Mead Corp.*, [533 US. 218, 229-30](#) (2001), which in turn relies on *Skidmore v. Swift & Co.*, [323 US. 134](#) (1944).

With respect, we cannot agree with the Secretary that the footnote in the preamble is entitled to full *Chevron* deference. The panel did defer to the Secretary's concerns, to the extent that it refrained from making any definitive pronouncement on "whether the safe harbor applies to the selection of investment options for a plan." *Hecker*, [556 F.3d at 589](#). Instead, as we explain further in this order, we left this area open for future development, whether on the basis of a different set of pleadings, or on the basis of a regulation directed to this issue. The Secretary admits that the panel's primary holding – that there was no duty to scour the market to find the fund with the lowest imaginable fees, and that the fees themselves in the Funds identified in the complaint could not be deemed imprudent because they were offered at the same prices to the general public – does not call into question the validity of even the preamble to the Secretary's regulation, much less the regulation taken as a whole. Thus, her real quibble is with the panel's alternate holding that the complaint the court was evaluating contained enough information to warrant the conclusion that Deere was entitled to the safe harbor defense. In our view, the Secretary's concern is more hypothetical than real. She fears that some case in the future may arise in which a Plan fiduciary acts imprudently by selecting an overpriced portfolio of funds, and that this opinion will somehow immunize the fiduciary from accountability for that decision.

The panel's opinion, however, stands for no such broad proposition. It was limited to the complaint before the court, as supplemented by the materials the panel found were properly before the district court. Applying the pleading standards enunciated in *Bell Atlantic Corp. v. Twombly*, [550 US. 544](#) (2007), we concluded that these plaintiffs failed to state a claim for the kind of fiduciary misfeasance the Secretary describes. At the time we wrote, the Court had not yet handed down *Ashcroft v. Iqbal*, [129 S. Ct. 1937](#) (2009). *Iqbal* reinforces *Twombly*'s message that "[a] claim has facial plausibility when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Id.* at 1949. The Court explained further that "where the well-pleaded facts do not permit the court to infer more than the mere possibility of misconduct, the complaint has alleged – but it has not 'show[n]' – 'that the pleader is entitled to relief.' Fed. Rule Civ. Proc. 8(a)(2)." *Id.* at 1950.

The Secretary also fears that our opinion could be read as a sweeping statement that any Plan fiduciary can insulate itself from liability by the simple expedient of including a very large number of investment alternatives in its portfolio and then shifting to the participants the responsibility for choosing among them. She is right to criticize such a strategy. It could result in the inclusion of many investment alternatives that a responsible fiduciary should exclude. It also would place an unreasonable burden on unsophisticated plan participants who do not have the resources to pre-screen investment alternatives. The panel's opinion, however, was not intended to

give a green light to such “obvious, even reckless, imprudence in the selection of investments” (as the Secretary puts it in her brief). Instead, the opinion was tethered closely to the facts before the court. Plaintiffs never alleged that any of the 26 investment alternatives that Deere made available to its 401(k) participants was unsound or reckless, nor did they attack the BrokerageLink facility on that theory. They argued – and especially in their Petition for Rehearing they continue to argue – that the Plans were flawed because Deere decided to accept “retail” fees and did not negotiate presumptively lower “wholesale” fees. The opinion discusses a number of reasons why that particular assertion is not enough, in the context of these Plans, to state a claim, and we adhere to that discussion.

We add another point that was raised earlier but that we did not mention in the opinion: the complaint is silent about the services that Deere participants received from the company sponsored plans. It would be one thing if they were treated exactly like all other retail market purchasers of Fidelity mutual fund shares; it would be quite another if, for example, they received extra investment advice from someone dedicated to the Deere accounts, or if they received other extra services. If the Deere participants received more for the same amount of money, then their effective cost of participation may in fact have approached wholesale levels. We return, therefore, to the general point made in the opinion: *this* complaint, alleging that Deere chose *this* package of funds to offer for its 401(k) Plan participants, with this much variety and this much variation in associated fees, failed to state a claim upon which relief can be granted.

We therefore DENY the Petition for Rehearing and Petition for Rehearing *En Banc*.

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The reasoning in the *Hecker* case was not fully accepted by the Eight Circuit when it reviewed another case involving 401(k) fees.

**JEREMY BRADEN v. WAL-MART STORES, INC.**

[588 F.3d 585](#) (8th Cir. 2009)

MURPHY, Circuit Judge.

Jeremy Braden, an employee of Wal-Mart and participant in its employee retirement plan (Plan), brought this putative class action against appellees—Wal-Mart and various executives involved in the management of the Plan. Braden alleges that they violated fiduciary duties imposed by the Employee Retirement Income Security Act (ERISA). Appellees moved for dismissal under [Federal Rules of Civil Procedure 12\(b\)\(1\)](#) and [12\(b\)\(6\)](#). The district court granted the motion, concluding that Braden lacked constitutional standing to assert claims based on breaches of fiduciary duty prior to the date he first contributed to the Plan and that he otherwise failed to state any

plausible claim upon which relief could be granted. Braden timely appealed. We reverse and remand for further proceedings.

## I.

Wal-Mart's "Profit Sharing and 401(k) Plan" is an "employee pension benefit plan" covered by ERISA. ERISA § 3(2)(A). It is also an "individual account plan," ERISA § 3(34), establishing an individual profit sharing and 401(k) account for each participating employee. Wal-Mart is the Plan's sponsor and administrator under ERISA § 3(16). Merrill Lynch & Co., Inc. is the Plan's trustee, holding its assets in trust and providing various administrative services necessary to the maintenance of participants' accounts.

At the end of 2007, the Plan had over one million participants and nearly \$10 billion in assets. Individual participants directed investment of the assets in their Plan accounts by selecting from a menu of investment options. During the period relevant to Braden's claims, the available options included ten mutual funds, a common/collective trust, Wal-Mart common stock, and a stable value fund. These options were selected by Wal-Mart's Retirement Plans Committee, the Plan's named fiduciary and the entity responsible for the operation, investment policy, and administration of the Plan.

Jeremy Braden began working for Wal-Mart in May 2002. He became eligible to participate in the Plan in June 2003 and made his first contribution on October 31, 2003. . . .

Braden filed his complaint on March 27, 2008, alleging five causes of action against Wal-Mart and the individual appellees, executives serving on or responsible for overseeing the Retirement Plans Committee. The gravamen of the complaint is that appellees failed adequately to evaluate the investment options included in the Plan. It alleges that the process by which the mutual funds were selected was tainted by appellees' failure to consider trustee Merrill Lynch's interest in including funds that shared their fees with the trustee. The result of these failures, according to Braden, is that some or all of the investment options included in the Plan charge excessive fees. He estimates that these fees have unnecessarily cost the Plan some \$60 million over the past six years and will continue to waste approximately \$20 million per year.

Braden alleges extensive facts in support of these claims. He claims that Wal-Mart's retirement plan is relatively large and that plans of such size have substantial bargaining power in the highly competitive 401(k) marketplace. As a result, plans such as Wal-Mart's can obtain institutional shares of mutual funds, which, Braden claims, are significantly cheaper than the retail shares generally offered to individual investors. Nonetheless, he alleges that the Plan only offers retail class shares to participants. Braden also avers that seven of the ten funds charge 12b-1 fees, which he alleges are used to benefit the fund companies but not Plan participants.

Braden alleges further that the relatively high fees charged by the Plan funds cannot be justified by greater returns on investment since most of them underperformed lower cost alternatives. In support of this claim, he offers specific comparisons of each Plan fund to an

allegedly similar but more cost effective fund available in the market. In comparison to an investment in index funds, Braden estimates that the higher fees and lower returns of the Plan funds cost the Plan some \$140 million by the end of 2007.

Finally, the complaint also alleges that the mutual fund companies whose funds were included in the Plan shared with Merrill Lynch portions of the fees they collected from participants' investments. This practice, sometimes called "revenue sharing," is used to cover a portion of the costs of services provided by an entity such as a trustee of a 401(k) plan, and is not uncommon in the industry. Braden alleges, however, that in this case the revenue sharing payments were not reasonable compensation for services rendered by Merrill Lynch, but rather were kickbacks paid by the mutual fund companies in exchange for inclusion of their funds in the Plan. The Plan's trust agreement requires appellees to keep the amounts of the revenue sharing payments confidential.

\* \* \*

The district court dismissed all claims. . . .

III.

A.

\* \* \*

With these principles in mind, we turn to Braden's complaint. Count I alleges that appellees breached the fiduciary duties of prudence and loyalty imposed upon them by ERISA § 404. In order to state a claim under this provision, a plaintiff must make a prima facie showing that the defendant acted as a fiduciary, breached its fiduciary duties, and thereby caused a loss to the Plan. Only the issue of breach is disputed here.

\* \* \*

Focusing on this standard of liability, the district court found the complaint inadequate because it did not allege sufficient facts to show how appellees' decision making process was flawed. We conclude that the district court erred in its application of Rule 8. Accepting Braden's well pleaded factual allegations as true, he has stated a claim for breach of fiduciary duty.

The district court erred in two ways. It ignored reasonable inferences supported by the facts alleged. It also drew inferences in appellees' favor, faulting Braden for failing to plead facts tending to contradict those inferences. Each of these errors violates the familiar axiom that on a motion to dismiss, inferences are to be drawn in favor of the non-moving party. . . .

\* \* \*

. . . The complaint alleges that the Plan comprises a very large pool of assets, that the 401(k) marketplace is highly competitive, and that retirement plans of such size consequently have the ability to obtain institutional class shares of mutual funds. Despite this ability, according to the

allegations of the complaint, each of the ten funds included in the Plan offers only retail class shares, which charge significantly higher fees than institutional shares for the same return on investment. The complaint also alleges that seven of the Plan's ten funds charge 12b-1 fees from which participants derive no benefit. The complaint states that appellees did not change the options included in the Plan despite the fact that most of them underperformed the market indices they were designed to track. Finally, it alleges that the funds included in the Plan made revenue sharing payments to the trustee, Merrill Lynch, and that these payments were not made in exchange for services rendered, but rather were a quid pro quo for inclusion in the Plan.

The district court correctly noted that none of these allegations directly addresses the process by which the Plan was managed. It is reasonable, however, to infer from what is alleged that the process was flawed. Taken as true, and considered as a whole, the complaint's allegations can be understood to assert that the Plan includes a relatively limited menu of funds which were selected by Wal-Mart executives despite the ready availability of better options. The complaint alleges, moreover, that these options were chosen to benefit the trustee at the expense of the participants. If these allegations are substantiated, the process by which appellees selected and managed the funds in the Plan would have been tainted by failure of effort, competence, or loyalty. Thus the allegations state a claim for breach of fiduciary duty. See *Roth*, 16 F.3d at 918-19.<sup>7</sup>

These are of course only inferences, and there may well be lawful reasons appellees chose the challenged investment options. It is not Braden's responsibility to rebut these possibilities in his complaint, however. . . .

\* \* \*

B.

ERISA and its associated regulations impose upon fiduciaries extensive and specific obligations of disclosure. . . .

\* \* \*

Braden claims that appellees breached their duty of loyalty by failing to disclose to participants complete and accurate material information about the Plan funds and the process by which they were selected. His nondisclosure claims can be separated into two groups. One group relates to the performance of and fees charged by the Plan funds and the other to the revenue sharing payments to Merrill Lynch. With respect to the former, Braden alleges that appellees should have disclosed that (1) the funds charged higher fees than readily available alternatives designed to track the same market indices; (2) the funds underperformed readily available and more cost effective alternatives; (3) all of the fees were paid from Plan assets and they consequently depleted participants' retirement savings; (4) all of the Plan funds offered retail shares despite the fact that

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<sup>7</sup> In concluding that Braden has stated a claim, we do not suggest that a claim is stated by a bare allegation that cheaper alternative investments exist in the marketplace. It is clear that "nothing in ERISA requires every fiduciary to scour the market to find and offer the cheapest possible fund." *Hecker*, 556 F.3d at 586.

Wal-Mart had access to institutional shares; (5) the 12b-1 fees charged by several of the funds did not benefit participants, and comparable alternatives charged no such fees; and (6) appellees did not select the Plan funds or continually evaluate them based on the reasonableness of the fees they charged. In connection with the revenue sharing payments, Braden alleges that appellees should have disclosed (1) the amounts of the payments; (2) that they were retained by Merrill Lynch and not in turn paid to the Plan; and (3) that the payments were made in exchange for inclusion of certain funds in the Plan.

The district court dismissed these claims, concluding that ERISA does not require disclosure of revenue sharing arrangements and that the other information Braden sought was not material. We disagree.

Information is material if there is a substantial likelihood that nondisclosure “would mislead a reasonable employee in the process of making an adequately informed decision regarding benefits to which she might be entitled.” *Kalda*, [481 F.3d at 644](#) (quoting *Krohn v. Huron Mem’l Hosp.*, [173 F.3d 542, 551](#) (6th Cir. 1999) (alteration omitted)). In the context of this case, materiality turns on the effect information would have on a reasonable participant’s decisions about how to allocate his or her investments among the options in the Plan.

\* \* \*

Braden’s nondisclosure claim relating to fees parallels his claim for breach of fiduciary duty. He alleges, for example, that appellees had a duty to disclose to participants that Plan funds charged higher fees than comparable funds, that Wal-Mart had access to more cost effective institutional shares, and that appellees did not select or evaluate the funds on the basis of the fees they charged. A reasonable trier of fact could find that failure to disclose this information would mislead a reasonable participant in the process of making investment decisions under the Plan. See *Kalda*, [481 F.3d at 644](#). For example, participants might conclude in light of this information that Plan funds were not selected using appropriate criteria and might therefore direct their investments toward other options. Accordingly, Braden has stated a claim under ERISA § 404.

By the same token, Braden’s allegations are sufficient to state a claim that appellees breached their duty of loyalty by failing to disclose details about the revenue sharing payments. Braden alleges that those payments corrupted the fund selection process—that each fund was selected for inclusion in the Plan because it made payments to the trustee, and not because it was a prudent investment. If true, this information could influence a reasonable participant in evaluating his or her options under the Plan. . . . ERISA’s duty of loyalty may require a fiduciary to disclose latent conflicts of interest which affect participants’ ability to make informed decisions about their benefits.

\* \* \*

C.

Section 406(a)(1) of ERISA, “supplements the fiduciary’s general duty of loyalty to the plan’s beneficiaries . . . by categorically barring certain transactions deemed ‘likely to injure the pension plan.’” *Harris Trust & Sav. Bank v. Salomon Smith Barney Inc.*, [530 U.S. 238, 241-42](#) (2000). . . .

Braden alleges that appellees violated these sections of the statute by causing the Plan to engage in prohibited transactions with the trustee, Merrill Lynch. As trustee and as an entity “providing services to” the Plan, Merrill Lynch was a “party in interest” within the meaning of § 406. ERISA § 3(14). Braden alleges that the revenue sharing payments made by the Plan funds to Merrill Lynch were “kickbacks” in exchange for inclusion in the Plan, rather than reasonable compensation for actual services performed. Accordingly, he argues that these payments were prohibited by §§ 406(a)(1)(C) and (D) and not exempted by § 408(b)(2).

\* \* \*

We conclude that Braden has stated a claim under § 406(a)(1)(C). The complaint alleges that appellees caused the Plan to enter into an arrangement with Merrill Lynch, a party in interest, under which Merrill Lynch received undisclosed amounts of revenue sharing payments in exchange for services rendered to the Plan. . . .

For the reasons discussed, we vacate the judgment of the district court and remand for further proceedings consistent with this opinion.

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Plaintiffs continue to claim that fiduciaries of 401(k) plans failed to meet their duties of loyalty and prudence when selecting the funds available to the plan participants.

**TIBBLE v. EDISON INTERNATIONAL**

2010 WL 2757153 (C.D. Cal.)

(C.D. Cal. July 8, 2010)

STEPHEN V. WILSON, District Judge.

**I. INTRODUCTION AND PROCEDURAL BACKGROUND**

Plaintiffs filed this class action on August 16, 2007 on behalf of the Edison 401(k) Savings Plan (“the Plan”) and all similarly-situated participants and beneficiaries of the Plan, against Defendants Edison International (“Edison”), Southern California Edison Company (“SCE”), the Southern California Edison Company Benefits Committee (“Benefits Committee”), the Edison International Trust Investment Committee (“TIC”), the Secretary of the SCE Benefits Committee, SCE’s Vice President of Human Resources, and the Manager of SCE’s Human Resources Service Center (collectively, “Defendants”). Plaintiffs sought to recover damages pursuant to ERISA § 502(a), for alleged financial losses suffered by the Plan, in addition to injunctive and other equitable relief based on alleged breaches of Defendants’ fiduciary duties. ERISA §§ 404, 406.

On June 30, 2009, the Court granted Plaintiffs' motion for class certification. . . .

....

After the ruling on the summary judgment motions, two issues remained for trial: (1) whether the Defendants violated their duty of loyalty by selecting for the Plan certain retail mutual funds that provided for favorable revenue-sharing arrangements but charged higher fees to Plan participants than other funds; and (2) whether the Defendants violated their duty of prudence by selecting for the Plan a money market fund that allegedly charged excessive management fees. In preparing for (and during) trial, the Plaintiffs amended their first theory of liability to conform to proof. Specifically, as to the mutual funds, Plaintiffs argued that Defendants violated both their duty of loyalty and their duty of prudence by investing in the retail share classes of six mutual funds instead of the institutional share classes of those same funds. The retail share classes of the six mutual funds offered more favorable revenue-sharing arrangements to SCE but charged the Plan participants higher fees than the institutional share classes. . . .

....

Having thoroughly examined the evidence, considered the arguments of both sides, and made the following factual findings, the Court concludes that Defendants violated their duty of prudence under ERISA § 404(a) by choosing to invest in the retail share class rather than the institutional share class of the William Blair Small Cap Growth Fund, the MFS Total Return Fund, and the PIMCO (Allianz) RCM Global Tech Fund. The Court awards damages accordingly, as set forth below.

The Court concludes that Defendants did not breach their fiduciary duties of loyalty or prudence by failing to switch into the institutional share classes of the Berger (Janus) Small Cap Value Fund, the Allianz CCM Capital Appreciation Fund, and the Franklin Small-Mid Cap Value Fund upon the occurrence of certain events within the limitations period.

Finally, the Court finds that Defendants did not breach their fiduciary duty of prudence by investing in the Money Market Fund managed by State Street Global Advisors or by failing to negotiate a lower management fee.

## **II. FINDINGS OF FACT**

### **A. Background**

....

Defendant SCE Benefits Committee ("Benefits Committee") and its members are among the named fiduciaries of the Plan. The Benefits Committee is the Plan Administrator and is responsible for the overall structure of the Plan. Members of the Benefits Committee are chosen by the SCE Chief Executive Officer and are required to report to the SCE Board of Directors. . . .

....

### **C. Investment Selection Process**

As stated above, the TIC and the Sub-TIC (collectively, “the Investment Committees”) have the authority to decide whether to select, maintain or replace the investment options in the Plan, so long as such choices are consistent with the overall structure of the Plan as described above. . . .

....

### **D. Mutual Funds**

[T]he Plan began offering a mutual fund window to Plan participants in March 1999 in response to collective bargaining negotiations. At any given time, the Plan’s mutual fund window consisted of approximately 40 retail mutual funds for participants to choose from.

#### **1. Revenue Sharing**

Before the addition of the mutual funds to the Plan in 1999, SCE paid the entire cost of Hewitt Associates’ record-keeping services. These services include things such as mailing prospectuses, maintaining individual account balances, providing participant statements, operating a website accessible by Plan participants that allows participants to conduct transactions and obtain information about the Plan’s investment options, and answering inquiries from Plan participants regarding their investment options. The fees for these services were paid by SCE, not the Plan participants.

With the addition of the mutual funds to the Plan, however, certain “revenue sharing” was made available to SCE that could be used to offset the cost of Hewitt Associates’ record-keeping expenses. “Revenue sharing” is a general term that refers to the practice by which mutual funds collect fees from mutual fund assets and distribute them to service providers, such as recordkeepers and trustees-services the mutual funds would otherwise provide themselves. . . . Each type of fee is collected out of the mutual fund assets, and is included as a part of the mutual fund’s overall expense ratio. The expense ratio is the overall fee that the mutual fund charges to investors for investing in that particular fund, which includes 12b-1 fees as well as other fees, such as management fees. These fees are deducted from the mutual fund assets before any returns are paid out to the investors.

In 1999, when retail mutual funds were added to the Plan, some of the mutual funds offered revenue sharing which was used to pay for part of Hewitt Associates’ record-keeping costs. Hewitt Associates then billed SCE for its services after having deducted the amount received from the mutual funds from revenue sharing. In short, revenue sharing offsets some of the fees SCE would otherwise pay to Hewitt Associates.

The use of revenue sharing to offset Hewitt Associates’ record-keeping costs was discussed with the employee unions during the 1998-99 negotiations. Specifically, the unions were advised that

revenue sharing fees would result in some of the administrative costs of the Plan being partially offset from mutual funds' revenue sharing payments to Hewitt Associates. Additionally, this arrangement was disclosed to Plan participants on approximately seventeen occasions after the practice began in 1999.

....

#### **a. Overall trend toward reduced revenue sharing**

From July 2002 to October 2008, the investment selections for the Plan demonstrate a general trend toward selecting mutual funds with reduced revenue sharing. During this period, Defendants made 39 additions or replacements to the mutual funds in the Plan's investment line-up. In 18 out of 39 instances, Defendants chose to replace an existing mutual fund that offered revenue sharing with a mutual fund that provided less revenue sharing or no revenue sharing at all. . . .

....

Additionally, there is no evidence that Defendants were motivated by revenue sharing when deciding to add or retain the six specific mutual fund share classes at issue in this case, as discussed further below.

### **3. Mutual Fund Share Classes**

Certain mutual funds offer their investors retail and institutional share classes. Institutional share classes are available to institutional investors, such as 401(k) plans, and may require a certain minimum investment. Institutional share classes often charge lower fees (i.e., a lower expense ratio) because the amount of assets invested is far greater than the typical individual investor. The investment management of all share classes within a single mutual fund is identical, and managed within the same pool of assets. In other words, with the exception of the expense ratio (including revenue sharing), the retail share class and the institutional share class are managed in identical fashion.

### **4. The Six Mutual Funds At Issue**

Plaintiffs contend that Defendants violated their fiduciary duties of loyalty and prudence by investing in the retail share classes rather than the institutional share classes of the following six mutual funds: (1) Janus Small Cap Value Fund ("Janus Fund"); (2) Allianz CCM Capital Appreciation Fund ("Allianz Fund"); (3) Franklin Small-Mid Cap Growth Fund ("Franklin Fund"); (4) William Blair Small Growth Fund ("William Blair Fund"); (5) PIMCO RCM Global Tech Fund ("PIMCO Fund"); and (6) MFS Total Return A Fund ("MFS Total Return Fund"). The retail share classes of each of these funds had higher expense ratios than the institutional share classes; the higher fees were directly related to the fact that the retail share classes offered more revenue sharing.

....

### **C. Legal Standard: Breach of Fiduciary Duty**

ERISA is intended to “promote the interests of employees and their beneficiaries in employee benefit plans.” *Shaw v. Delta Air Lines, Inc.*, [463 U.S. 85, 90](#), 103 S. Ct. 2890, 77 L. Ed. 2d 490 (1983). In enacting ERISA, “the crucible of congressional concern was misuse and mismanagement of plan assets by plan administrators.” *Mass. Mut. Life Ins. Co. v. Russell*, [473 U.S. 134, 140 n.8](#), 105 S. Ct. 3085, 87 L. Ed. 2d 96 (1985) (citations omitted). To effectuate this concern, Congress imposed a number of detailed duties on plan fiduciaries. *DiFelice v. U.S. Airways, Inc.*, [497 F.3d 410, 417](#) (4th Cir. 2007). ERISA § 404, codifies the duties of loyalty and care owed by a plan fiduciary:

(a) (1) . . . [A] fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and—

(A) for the exclusive purpose of:

(i) providing benefits to participants and their beneficiaries; and

(ii) defraying reasonable expenses of administering the plan;

(B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims;

...

ERISA § 404(a)(1)(A) and (B). Subsection (a)(1)(A) codifies the duty of loyalty, while subsection (a)(1)(B) articulates the duty of prudence. These duties are “the highest known to the law.” *SEC v. Capital Consultants, LLC*, [397 F.3d 733, 751](#) (9th Cir. 2005).

## 1. Duty of Loyalty

The duty of loyalty requires a fiduciary to “discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries.” ERISA § 404(a)(1)(A). A fiduciary must “act with complete and undivided loyalty to the beneficiaries of the trust,” and must make any decisions in a fiduciary capacity “with an eye single to the interests of the participants and beneficiaries.” *Leigh v. Engle*, [727 F.2d 113, 123](#) (7th Cir. 1984) (quotations omitted); see *Donovan v. Bierwirth*, [680 F.2d 263, 272 n.8](#) (2d Cir. 1982); *DiFelice*, [497 F.3d at 418-19](#). These responsibilities have their source in the common law of trusts. *Pegram v. Herdrich*, [530 U.S. 211, 224](#), 120 S. Ct. 2143, 147 L. Ed. 2d 164 (2000). As Judge Cardozo famously stated: “Many forms of conduct permissible in a workaday world for those acting at arm’s length are forbidden to those bound by fiduciary ties. A trustee is held to something stricter than the morals of the marketplace. Not honesty alone, but the punctilio of an honor the most sensitive, is then the standard of behavior.” *Meinhard v. Salmon*, [249 N.Y. 458, 464](#), 164 N.E. 545 (Ct. App. 1928).

Although ERISA’s duty of loyalty gains definition from the law of trusts, there is an important distinction provided for by the statute’s provisions. See *Variety Corp. v. Howe*, [516 U.S. 489](#),

[497](#) (1996) (“We also recognize . . . that trust law does not tell the entire story.”); *DiFelice*, [497 F.3d at 417](#) (“The common law of trusts, therefore, ‘will inform, but will not necessarily determine the outcome of, an effort to interpret ERISA’s fiduciary duties.’”) (quoting *Variety Corp.*, [516 U.S. at 497](#)). Under ERISA, “a fiduciary may have financial interests adverse to beneficiaries, but under trust law a trustee is not permitted to place himself in a position where it would be for his own benefit to violate his duty to the beneficiaries.” *Bussian v. RJR Nabisco, Inc.*, [223 F.3d 286, 295](#) (5th Cir. 2000). Thus, unlike in trust law, ERISA contemplates that in many circumstances a plan fiduciary will “wear two hats,” and may have conflicting loyalties. . . .

Consistent with this rule, a fiduciary does not breach his duty of loyalty by pursuing a course of conduct which serves the interests of the plan’s beneficiaries while at the same time “incidentally benefitting” the plan sponsor or even the fiduciary himself. . . .

## **2. Duty of Prudence**

ERISA requires that a fiduciary act with the “care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims.” ERISA § 404(a)(1)(B). Like the duty of loyalty, the duty of prudence is “the highest known to the law.” *Howard v. Shay*, [100 F.3d 1484, 1488](#) (9th Cir. 1996) (quoting *Donovan v. Bierwirth*, [680 F.2d 263, 272 n.8](#) (2d Cir.1982)).

. . . .

The prudence standard is not that of a prudent lay person, but rather that of a prudent fiduciary with experience dealing with a similar enterprise. *Whitfield*, [682 F. Supp. at 194](#) (citing *Mazzola*, [716 F.2d at 1231-21](#)). To determine whether the fiduciary has met the prudence standard, “the court focuses not only on the merits of the transaction, but also on the thoroughness of the investigation into the merits of the transaction.” *Howard*, [100 F.3d at 1488](#). The question is whether, “at the time they engaged in the challenged transactions, [the fiduciaries] employed the appropriate methods to investigate the merits of the investment and to structure the investment.” *Mazzola*, [716 F.2d at 1232](#). . . .

. . . .

## **D. Challenged Conduct by the Plan Fiduciaries**

### **1. Mutual Fund Investments**

Plaintiffs contend that Defendants violated both their duty of loyalty and their duty of prudence when they invested in the retail share classes rather than the institutional share classes of . . . the mutual funds. . . .

#### **a. Duty of Loyalty**

As to the duty of loyalty, Plaintiffs contend that, when deciding to invest in the retail share classes rather than the cheaper institutional share classes of these funds, Defendants were improperly motivated by a desire to capture more revenue sharing for SCE even though doing so increased the fees charged to Plan participants. Plaintiffs contend that Defendants put the interests of SCE in offsetting the record-keeping costs to Hewitt Associates above the interests of the Plan participants in paying lower fees.

....

... With regard to each of the ... funds added to the Plan in 2003, the Investment Committees chose to invest in the fund share class with the lowest expense ratio and the lowest revenue sharing, with the exception of one fund, the Vanguard Mid-Cap Index Fund, which had no revenue sharing in either share class. Thus, the decisions made by the fiduciaries at the 2003 meetings clearly were not motivated by a desire to increase revenue sharing.

....

In sum, the Court concludes that there is no evidence that the Plan fiduciaries engaged in actual disloyal conduct. The Plan fiduciaries did not make fund selections with an eye toward increasing revenue sharing and did not put the interests of SCE above those of the Plan participants. For these reasons, Plaintiffs' duty of loyalty claim fails.

## **b. Duty of Prudence**

Plaintiffs' duty of prudence argument is simple: Plaintiffs contend that, even if the Plan fiduciaries were not improperly motivated by revenue-sharing benefits, it was objectively imprudent for the Plan fiduciaries to decide to invest (or to continue to invest) in retail share classes of the six mutual funds where identical investments were available in the institutional share classes for lower fees. In other words, a prudent person managing his own funds would invest in the cheaper share class, all else being equal, because doing so saves money.

....

In sum, the Plan fiduciaries simply failed to consider the cheaper institutional share classes when they chose to invest in the retail share classes of the William Blair, PIMCO, and MFS Total Return funds. Defendants have not offered any credible explanation for why the retail share classes were selected instead of the institutional share classes. In light of the fact that the institutional share classes offered the exact same investment at a lower fee, a prudent fiduciary acting in a like capacity would have invested in the institutional share classes. Defendants violated their duty of prudence when selecting the retail share classes of the William Blair Fund, the PIMCO Fund, and the MFS Total Return Fund. Damages resulting from the breach are discussed *infra* at Section IV.

....

## **2. Fees of the Money Market Fund**

Plaintiffs' final argument is that Defendants breached their duty of prudence by requiring Plan participants to pay excessive investment management fees for the Money Market Fund. Plaintiffs contend that Defendants either: (1) should have negotiated lower fees with the investment manager of the Money Market Mutual Fund, State Street Global Advisers ("SSgA"), and that had they done so, Defendants could have secured lower fees, or (2) Defendants should have invested in a similar money market fund with another investment manager that charged lower fees. Plaintiffs contend that Defendants' failure to take either of these actions resulted in the Plan participants paying fees that were, at times, twice the amount of a reasonable fee.

. . . [Ed. According to the court the evidence showed that the fees charged were well within the range of competitive, reasonable money market funds.]

. . . For the reasons stated above, Plaintiffs cannot show that the fees for the Money Market Fund exceeded the reasonable range of fees for comparably performing money market funds or that the decision to select and maintain the Money Market Fund was otherwise objectively imprudence. Thus, Plaintiffs' prudence claim fails with regard to the Money Market Fund.

#### **IV. DAMAGES AND OTHER RELIEF**

Defendants' decisions to invest in the retail share classes rather than the institutional share classes of the William Blair Fund, the PIMCO Fund, and the MFS Total Return Fund caused the Plan participants substantial damages. . . .

. . . .

. . . Plaintiffs should identify and measure the difference in investment fees between the retail share classes included in the Plan and the less expensive institutional share classes that were available but not selected for the Plan. . . .

Finally, damages should account for the fact that had the Plan fiduciaries not invested in the more expensive retail share classes, the Plan participants would have had more money invested and therefore would have earned more money over the course of time, so called "lost investment opportunity." In calculating lost investment opportunity, Plaintiffs should use the returns of the funds in which the assets actually are (and have been) invested. . . .

. . . .

#### **V. CONCLUSION**

For the reasons stated above, the Court rules as follows:

. . . .

Defendants breached their duty of prudence under ERISA by investing in retail share classes rather than institutional share classes of the William Blair Fund, the PIMCO Fund, and the MFS Total Return Fund. . . .

....

Defendants did not breach their duty of prudence by investing in the Money Market Fund managed by SSgA or by failing to negotiate a different management fee for the Money Market Fund at any point from 1999 to the present.

-----

A single law firm, Schlichter Bogard & Denton, filed complaints in about dozen cases alleging that 401(k) plan fiduciaries breached their fiduciary duties by paying excessive plan fees for plan investments in 2006 and 2007. Although not all of the cases have been successful, to date, three of the cases have reached multimillion dollar settlements. In one case awarding the firm \$5.05 million, or one-third of the \$15.15 million settlement, plus almost \$700,000 in costs, the judge declared, “Since filing this action, Class Counsel has devoted very substantial costs and attorney time to pursuing this case and several other 401(k) fee cases which were the first of their kind. The record reflects that these cases, collectively, have brought sweeping changes to fiduciary practices within 401(k) plans and have changed the 401(k) industry for the benefit of employees and retirees throughout the country.” *Will v. General Dynamics Corp.*, [2010 U.S. Dist. LEXIS 123349 \\*8](#) (S. D. Ill.) The court also noted that the firm’s work illustrated “an exceptional” example of a firm acting as “a private attorney general risking large sums of money and investing many thousands of hours for the benefit of employees and retirees.” *Id.*

P. 49:

Replace first full paragraph with the following:

Many cash balance plans come about by the conversion of existing overfunded traditional defined benefit plans into cash balance plans. In the following case, the Court describes one such conversion.

CIGNA CORPORATION v. AMARA (PART I)  
[131 S. Ct. 1866](#) (2011)

Justice BREYER delivered the opinion of the Court.

In 1998, petitioner CIGNA Corporation changed the nature of its basic pension plan for employees. Previously, the plan provided a retiring employee with a defined benefit in the form of an annuity calculated on the basis of his preretirement salary and length of service. The new plan provided most retiring employees with a (lump sum) cash balance calculated on the basis of a defined annual contribution from CIGNA as increased by compound interest. Because many employees had

already earned at least some old-plan benefits, the new plan translated already-earned benefits into an opening amount in the employee's cash balance account.

\* \* \*

I

\* \* \*

A

Under CIGNA's pre-1998 defined-benefit retirement plan, an employee with at least five years service would receive an annuity annually paying an amount that depended upon the employee's salary and length of service. Depending on when the employee had joined CIGNA, the annuity would equal either (1) 2 percent of the employee's average salary over his final three years with CIGNA, multiplied by the number of years worked (up to 30); or (2) 1 2/3 percent of the employee's average salary over his final five years with CIGNA, multiplied by the number of years worked (up to 35). Calculated either way, the annuity would approach 60 percent of a longtime employee's final salary. A well-paid longtime employee, earning, say, \$160,000 per year, could receive a retirement annuity paying the employee about \$96,000 per year until his death. The plan offered many employees at least one other benefit: They could retire early, at age 55, and receive an only-somewhat-reduced annuity.

In November 1997, CIGNA sent its employees a newsletter announcing that it intended to put in place a new pension plan. The new plan would substitute an "account balance plan" for CIGNA's pre-existing defined-benefit system. The newsletter added that the old plan would end on December 31, 1997, that CIGNA would introduce (and describe) the new plan sometime during 1998, and that the new plan would apply retroactively to January 1, 1998.

Eleven months later CIGNA filled in the details. Its new plan created an individual retirement account for each employee. (The account consisted of a bookkeeping entry backed by a CIGNA-funded trust.) Each year CIGNA would contribute to the employee's individual account an amount equal to between 3 percent and 8.5 percent of the employee's salary, depending upon age, length of service, and certain other factors. The account balance would earn compound interest at a rate equal to the return on 5-year treasury bills plus one-quarter percent (but no less than 4.5 percent and no greater than 9 percent). Upon retirement the employee would receive the amount then in his or her individual account-in the form of either a lump sum or whatever annuity the lump sum then would buy. As promised, CIGNA would open the accounts and begin to make contributions as of January 1, 1998.

But what about the retirement benefits that employees had already earned prior to January 1, 1998? CIGNA promised to make an initial contribution to the individual's account equal to the value of that employee's already earned benefits. And the new plan set forth a method for calculating that initial contribution. The method consisted of calculating the amount as of the employee's (future)

retirement date of the annuity to which the employee's salary and length of service already (i.e., as of December 31, 1997) entitled him and then discounting that sum to its present (i.e., January 1, 1998) value.

An example will help: Imagine an employee born on January 1, 1966, who joined CIGNA in January 1991 on his 25th birthday, and who (during the five years preceding the plan changeover) earned an average salary of \$100,000 per year. As of January 1, 1998, the old plan would have entitled that employee to an annuity equal to \$100,000 times 7 (years then worked) times 1 2/3 percent, or \$11,667 per year-when he retired in 2031 at age 65. The 2031 price of an annuity paying \$11,667 per year until death depends upon interest rates and mortality assumptions at that time. If we assume the annuity would pay 7 percent until the holder's death (and we use the mortality assumptions used by the plan), then the 2031 price of such an annuity would be about \$120,500. And CIGNA should initially deposit in this individual's account on January 1, 1998, an amount that will grow to become \$120,500, 33 years later, in 2031, when the individual retires. If we assume a 5 percent average interest rate, then that amount presently (i.e., as of January 1, 1998) equals about \$24,000. And (with one further mortality-related adjustment that we shall describe *infra*), that is the amount, more or less, that the new plan's transition rules would have required CIGNA initially to deposit. Then CIGNA would make further annual deposits, and all the deposited amounts would earn compound interest. When the employee retired, he would receive the resulting lump sum.

The new plan also provided employees a guarantee: An employee would receive, upon retirement, either (1) the amount to which he or she had become entitled as of January 1, 1998, or (2) the amount then in his or her individual account, whichever was greater. Thus, the employee in our example would receive (in 2031) no less than an annuity paying \$11,667 per year for life.

B

1

The District Court found that CIGNA's initial descriptions of its new plan were significantly incomplete and misled its employees. In November 1997, for example, CIGNA sent the employees a newsletter that said the new plan would "significantly enhance" its "retirement program," would produce "an overall improvement in ... retirement benefits," and would provide "the same benefit security" with "steadier benefit growth." App. 990a, 991a, 993a. CIGNA also told its employees that they would "see the growth in [their] total retirement benefits from CIGNA every year," *id.*, at 952a, that its initial deposit "represent[ed] the full value of the benefit [they] earned for service before 1998," Record E-503 (Exh. 98), and that "[o]ne advantage the company will not get from the retirement program changes is cost savings." App. 993a.

In fact, the new plan saved the company \$10 million annually (though CIGNA later said it devoted the savings to other employee benefits). Its initial deposit did not "represen[t] the full value of the benefit" that employees had "earned for service before 1998." And the plan made a significant number of employees worse off in at least the following specific ways:

First, the initial deposit calculation ignored the fact that the old plan offered many CIGNA employees the right to retire early (beginning at age 55) with only somewhat reduced benefits. This right was valuable. For example, as of January 1, 1998, respondent Janice Amara had earned vested age-55 retirement benefits of \$1,833 per month, but CIGNA's initial deposit in her new-plan individual retirement account (ignoring this benefit) would have allowed her at age 55 to buy an annuity benefit of only \$900 per month.

Second, as we previously indicated but did not explain the new plan adjusted CIGNA's initial deposit downward to account for the fact that, unlike the old plan's lifetime annuity, an employee's survivors would receive the new plan's benefits (namely, the amount in the employee's individual account) even if the employee died before retiring. The downward adjustment consisted of multiplying the otherwise-required deposit by the probability that the employee would live until retirement—a 90 percent probability in the example of our 32-year-old. And that meant that CIGNA's initial deposit in our example—the amount that was supposed to grow to \$120,500 by 2031—would be less than \$22,000, not \$24,000 (the number we computed). The employee, of course, would receive a benefit in return—namely, a form of life insurance. But at least some employees might have preferred the retirement benefit and consequently could reasonably have thought it important to know that the new plan traded away one-tenth of their already-earned benefits for a life insurance policy that they might not have wanted.

Third, the new plan shifted the risk of a fall in interest rates from CIGNA to its employees. Under the old plan, CIGNA had to buy a retiring employee an annuity that paid a specified sum irrespective of whether falling interest rates made it more expensive for CIGNA to pay for that annuity. And falling interest rates also meant that any sum CIGNA set aside to buy that annuity would grow more slowly over time, thereby requiring CIGNA to set aside more money to make any specific sum available at retirement. Under the new plan CIGNA did not have to buy a retiring employee an annuity that paid a specific sum. The employee would simply receive whatever sum his account contained. And falling interest rates meant that the account's lump sum would earn less money each year after the employee retired. Annuities, for example, would become more expensive (any fixed purchase price paying for less annual income). At the same time falling interest meant that the individual account would grow more slowly over time, leaving the employee with less money at retirement.

Of course, interest rates might rise instead of fall, leaving CIGNA's employees better off under the new plan. But the latter advantage does not cancel out the former disadvantage, for most individuals are risk averse. And that means that most of CIGNA's employees would have preferred that CIGNA, rather than they, bear these risks.

The amounts likely involved are significant. If, in our example, interest rates between 1998 and 2031 averaged 4 percent rather than the 5 percent we assumed, and if in 2031 annuities paid 6 percent rather than the 7 percent we assumed, then CIGNA would have had to make an initial deposit of

\$35,500 (not \$24,000) to assure that employee the \$11,667 annual annuity payment to which he had already become entitled. Indeed, that \$24,000 that CIGNA would have contributed (leaving aside the life-insurance problem) would have provided enough money to buy (in 2031) an annuity that assured the employee an annual payment of only about \$8,000 (rather than \$11,667).

We recognize that the employee in our example (like others) might have continued to work for CIGNA after January 1, 1998; and he would thereby eventually have earned a pension that, by the time of his retirement, was worth far more than \$11,667. But that is so because CIGNA made an additional contribution for each year worked after January 1, 1998. If interest rates fell (as they did), it would take the employee several additional years of work simply to catch up (under the new plan) to where he had already been (under the old plan) as of January 1, 1998, a phenomenon known in pension jargon as "wear away."

\* \* \*

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In the excerpt on page 49 in the text, Edward Zelinsky explains how the use of a "wear away" provision disproportionately disadvantages older workers. As noted on page 54 of the text, wear away provisions are now prohibited. [IRC § 411\(b\)\(5\)\(B\)\(iii\)](#); ERISA § 204(b)(5)(B)(iii).

### **Chapter 3 – Welfare Benefits**

P. 93:

**Replace** last carryover paragraph with the following:

After over a year of negotiation and debate, in March, 2010 Congress enacted legislation designed to reform the American healthcare system – the Patient Protection and Affordable Care Act (PPACA). The legislation has been described as "seminal" as the enactment of ERISA. The fundamental purpose of the new healthcare legislation is to require all individuals to be covered by either an employer-sponsored group health plan or by an individual health insurance policy providing "minimum essential coverage." To ensure that individuals can purchase health insurance at a reasonable cost, the law requires the states to establish "insurance exchanges" to help individuals find coverage. The legislation creates tax credits to help lower-income individuals pay for the cost of health insurance and imposes tax penalties on covered employers who fail to provide covered employees with mandated health care coverage. In addition, it provides a tax credit for small employers who elect to provide coverage while imposing a fee on individuals who fail to obtain "adequate insurance."

PPACA includes a number of employer mandates, such as extending coverage for children up to age 26, prohibiting preexisting condition exclusions, prohibiting lifetime limits on the dollar value of "essential health benefits" for any participant or beneficiary, and requiring plans to provide

certain preventive services without imposing any cost-sharing on these benefits. Some of the requirements, such the prohibition on lifetime limits, are effective in 2010 while others, such the prohibition on preexisting condition exclusions, will not be effective until as late as 2014. Some of the mandates apply to all employer-sponsored plans, such as the prohibition on preexisting condition exclusions; others, such the requirement that certain preventive services be provided without any cost-sharing, do not apply to “grandfathered” plans, generally defined as plans that were in existence at the time the legislation was enacted in March 2010.

The new law is more than 2,400 pages long and will likely affect almost every American in some way. The final impact of the legislation, however, may not be fully known for decades.

As of June 2011, 26 lawsuits had been filed challenging PPACA. Decisions on the merits have only been reached in a few of the cases. In two cases, the district court declared that PPACA’s individual mandate violates the Commerce Clause. *See* Virginia ex rel. Cuccinelli v. Sebelius, [728 F. Supp. 2d 768, 782](#) (E.D. Va. 2010) (finding individual mandate severable); Florida ex rel. Bondi v. U.S. Dept. of Health & Human Services, [2011 US Dist LEXIS 8822](#) (N.D. Fla. Jan. 31, 2011) (striking down entire law). In three other cases, districts courts upheld the individual mandate against a Commerce Clause challenge. *See* Liberty Univ., Inc. v. Geithner, [753 F. Supp. 2d 611, 633](#) (W.D. Va. 2010); Thomas More Law Ctr. v. Obama, [720 F. Supp. 2d 882, 893](#) (E.D. Mich. 2010); Mead v. Holder, [766 F. Supp. 2d 16](#) (D.D.C. 2011). All of those decisions have been appealed.

P. 95:

**Add** as fourth full paragraph before 3-5 Questions and Problems

On February 17, 2009, President Obama signed the American Recovery and Reinvestment Act of 2009 (the “ARRA”), which, among other things, provides federal assistance for payment of COBRA premiums for eligible employees (and their covered dependents) who lose group health plan coverage due to an involuntary termination of employment during the period September 1, 2008, through December 31, 2009. Specifically, the ARRA provides a subsidy of 65 percent of the COBRA continuation coverage premiums for eligible individuals for a maximum of 9 months, so that eligible individuals only have to pay 35 percent of the COBRA premium in order to receive coverage. For individuals who file joint returns, the subsidy is phased out for modified adjusted gross income between \$250,000 and \$290,000. For all other individuals, the subsidy is phased out for modified adjusted gross income between \$125,000 and \$145,000. IRS [Notice 2009-27](#) defines “involuntary termination” broadly to mean an employer-initiated termination where the employee was willing and able to continue performing services.

The health benefit coverage eligibility period has been extended twice since the enactment of the ARA, most recently by the Continuing Extension Act of 2010 (“CEA”). The CEA extended the eligibility period for premium assistance through May 31, 2010, and the maximum premium assistance period is now 15 months.

**Add** before 3-7 Questions and Problems

Effective for plan years beginning on or after September 23, 2010, PPACA prohibits all employer-sponsored healthcare plans from imposing preexisting condition exclusion limitations for children under age 19. Beginning in 2014, all employer-sponsored healthcare plans will be prohibited from imposing preexisting condition exclusion limitations for any plan participants.

**Add** to end of first full paragraph:

On October 3, 2008, President Bush signed the Emergency Economic Stabilization Legislation, which, among other things, eliminated the sunset provision under which the Mental Health Parity Act would have expired on December 31, 2008, and added new requirements extending the mental health parity requirements to substance use disorder benefits for plan years beginning after October 3, 2009. Under the new law, the same deductibles, co-pays, cost sharing, out-of-pocket limits, and treatment limits must apply to mental illness and substance use disorders as apply to physical conditions. The law does not require that plans provide mental health or substance use disorder benefits, but if a plan offers coverage for mental illness or substance abuse, the law requires that the plan do so to the same extent as for physical healthcare.

**Add** before [2] Retiree Health Benefits

[d] Mandates Under the Patient Protection and Affordable Care Act (PPACA)

The landmark healthcare legislation enacted in March 2010 imposes a number of mandates on employer-sponsored healthcare plans. The effective dates vary. In addition, some of the mandates are imposed on all employer-sponsored plans while others are not imposed on “grandfathered” plans, that is, plans that were in existence when the legislation was enacted in March 2010.

Effective for plan years beginning after September 23, 2010, all employer-sponsored plans must extend dependent coverage to adult children up to age 26, regardless of the child’s marital or student status. Prior to 2014, grandfathered plans are only required to provide coverage for an adult child if he or she is not eligible to enroll in an eligible employer-sponsored health plan other than the grandfathered health plan. Coverage provided to the adult child is not taxable to the employee.

Effective in 2014, all employer-sponsored plans are prohibited from applying a waiting period that exceeds 90 days.

Effective in 2011, PPACA prohibits all employer-sponsored plans from imposing any lifetime limits on “essential benefits.” PPACA does not define the term “essential benefits.” Instead, it directs

the Secretary of the Department of Health and Human Services to define the term, but requires that the following general categories and items and services be included among “essential benefits”:

ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care. Beginning in 2014, annual caps on essential benefits will be prohibited. Lifetime and annual limits may be imposed on specific covered benefits that are not considered essential benefits. Effective in 2014, all employer-sponsored plans will be required to offer essential benefits in order to be considered “qualified.”

Employer-sponsored group health plans that are adopted after March 23, 2010, must provide certain preventive care coverage without cost to covered employees. The preventive care coverage must include, among other things, certain immunizations for children and certain preventive care and screenings for women and children.

[e] Brief Overview of Health Insurance Exchanges and Employer Pay or Play Provisions of the Patient Protection and Affordable Care Act

The new healthcare reform law establishes an exchange framework, operated by the states, to act as a clearinghouse for the purchase of health insurance by individuals and small businesses. Effective January 1, 2014, the states are required to establish an American Health Benefits Exchange (“Exchange”) that facilitates the purchase of individual or group health insurance plans. Insurance policies offered through the Exchange must offer “essential benefits” which may be supplemented by the state, and must meet certain cost-sharing requirements.

Effective in 2014, an employer that fails to offer a plan with qualifying benefits will be assessed a penalty if has more than 50 full-time equivalent employees. Even if the employer offers a plan with qualifying benefits, a different but similar set of penalties will come into play if eligible employees opt out of coverage under the employer-sponsored plan and instead purchase subsidized insurance through an exchange. Specifically, if a covered employer does not offer coverage to covered employees, the employer will be assessed a penalty of 1/12 times \$2,000 per month per fulltime employee, excluding the first 30 employees. Employers that offer coverage will be subject to a penalty for each employee who purchases coverage in the exchange if either (1) the employer’s coverage is deemed “unaffordable” for the employee because it exceeds 9.8 percent of his or her household income; or (2) the plan’s actuarial value is less than 60 percent. The penalty is equal to 1/12 times \$3,000 per month for each non-covered employee who meets the criteria described above, subject to a ceiling equal to the amount of the penalty to which the employer would be subject if it did not offer coverage (1/12 times \$2,000 per month per fulltime employee, excluding the first 30 employees).

Small employers (those with fewer than 50 full time equivalent employees) are not required to provide healthcare coverage to their employees. Beginning in 2010, however, employers with fewer

than 25 full time equivalent employees with average wages of less than \$50,000 are eligible for tax credits if they provide health insurance to their employees.

Beginning in 2018, an excise tax will be imposed if the aggregate value of employer-sponsored health insurance coverage for an employee exceeds a threshold amount, the so-called “Cadillac tax.” The tax is equal to 40 percent of the aggregate value that exceeds the threshold amount. For 2018, the threshold amount is \$10,200 for individual coverage and \$27,500 for family coverage, multiplied by the “health cost adjustment percentage” and increased by the “age and gender adjusted excess premium amount.”

Page 108

**Add:** after *Yard-Man*

The Third Circuit held that a plaintiff can only prevail for a claim of vested welfare benefits by proof of a clear and express statement by the employer who promised such benefits. In *UAW v. Skinner Engine Co.*, [188 F.3d 130](#) (3<sup>rd</sup> Cir. 1999), the court rejected the employee-friendly inference announced in *Yard-Man*.

Page 118

**Add** after 3-13 Questions and Problems

[6] Early Retiree Reinsurance Program

Enacted in March, 2010, the Patient Protection and Affordable Care Act creates a temporary early retiree reinsurance program. Under the program, employers can obtain a reimbursement equal to 80% of the claim costs between \$15,000 and \$90,000 for early retirees who are age 55 or older and not yet eligible for Medicare. Reimbursements apply to coverage under the retiree health plan for the employees’ spouses and/or dependents. The plan must use the proceeds it receives to lower health costs for enrollees. The program became effective in June 2010 and funds are available on a first-come first-served basis. The program is scheduled to end upon the earlier of January 1, 2014 or when the \$5 billion funding for the program runs out. As of May 3, 2011, over \$2.4 billion in reimbursements had been paid to approved plan sponsors and the HHS stopped accepting new applications to participate in the program on May 6, 2011. On May 26, 2011, the original cosponsors of the early retiree reinsurance program introduced a bill which would provide an additional \$5 billion of funding for the program.

Page 120

**Add** to end of fourth paragraph:

Effective for tax years beginning on or after January 1, 2013, the 7.5 percent floor for the itemized deduction of medical expenses will increase to 10 percent.

P. 123

**Add** to end of last full paragraph:

In 2011, the HDHP must have an annual deductible of at least \$1,200 for individual coverage and \$2,400 for family coverage, and must limit annual out-of-pocket expenses to no more than \$5,950 for individuals and \$11,900 for families. In 2011, the statutory dollar amount applicable to contributions to HSAs is \$3,050 for a single-coverage HDHP and \$6,150 for a family-coverage HDHP.

#### **Chapter 4 – Regulation of Employee Benefits**

P. 129

Replace *Burke v. Kodak Retirement Income Plan* with the following:

CIGNA CORPORATION v. AMARA (PART II)

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

Justice BREYER delivered the opinion of the Court.

[In 1998 CIGNA converted its final average pay defined benefit plan into a cash balance plan. The accrued benefits of participants under the final average pay plan were converted into cash balance benefits with participants being provided the greater of their final average pay benefit or their cash balance benefit, sometimes referred to as a “greater of A and B” benefit. As a result, some plan participants did not accrue any additional benefits for a period of time – until their cash balance benefit exceeded their final average pay benefit. The district court found that CIGNA’s descriptions of the new plan were incomplete and misleading and that plan participants who read the descriptions believed that their benefit under the converted plan was equal to the value of their final average pay benefit plus additional accruals under the cash balance plan, sometimes referred to as an “A plus B” benefit.]

\* \* \*

The District Court concluded, as a matter of law, that CIGNA's representations (and omissions) about the plan, made between November 1997 (when it announced the plan) and December 1998 (when it put the plan into effect) violated:

\* \* \*

(b) ERISA §§ 102(a) and 104(b), which require a plan administrator to provide beneficiaries with summary plan descriptions and with summaries of material modifications, "written in a manner calculated to be understood by the average plan participant," that are "sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan."

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II

\* \* \*

A

The District Court ordered relief in two steps. Step 1: It ordered the terms of the plan reformed (so that they provided an "A plus B," rather than a "greater of A or B" guarantee). Step 2: It ordered the plan administrator (which it found to be CIGNA) to enforce the plan as reformed. One can fairly describe step 2 as consistent with § 502(a)(1)(B), for that provision grants a participant the right to bring a civil action to "recover benefits due ... under the terms of his plan." And step 2 orders recovery of the benefits provided by the "terms of [the] plan" as reformed.

But what about step 1? Where does § 502(a)(1)(B) grant a court the power to change the terms of the plan as they previously existed? The statutory language speaks of "enforc[ing]" the "terms of the plan," not of changing them. The provision allows a court to look outside the plan's written language in deciding what those terms are, i.e., what the language means. See *UNUM Life Ins. Co. of America v. Ward*, [526 U.S. 358, 377-379](#) (1999) (permitting the insurance terms of an ERISA-governed plan to be interpreted in light of state insurance rules). But we have found nothing suggesting that the provision authorizes a court to alter those terms, at least not in present circumstances, where that change, akin to the reform of a contract, seems less like the simple enforcement of a contract as written and more like an equitable remedy.

Nor can we accept the Solicitor General's alternative rationale seeking to justify the use of this provision. The Solicitor General says that the District Court did enforce the plan's terms as written, adding that the "plan" includes the disclosures that constituted the summary plan descriptions. In other words, in the view of the Solicitor General, the terms of the summaries are terms of the plan.

Even if the District Court had viewed the summaries as plan "terms" (which it did not), however, we cannot agree that the terms of statutorily required plan summaries (or summaries of plan modifications) necessarily may be enforced (under § 502(a)(1)(B)) as the terms of the plan itself. For one thing, it is difficult to square the Solicitor General's reading of the statute with ERISA § 102(a), the provision that obliges plan administrators to furnish summary plan descriptions. The syntax of that provision, requiring that participants and beneficiaries be advised of their rights and obligations "under the plan," suggests that the information about the plan provided by those disclosures is not

itself part of the plan. Nothing in § 502(a)(1)(B) (or, as far as we can tell, anywhere else) suggests the contrary.

Nor do we find it easy to square the Solicitor General's reading with the statute's division of authority between a plan's sponsor and the plan's administrator. The plan's sponsor (e.g., the employer), like a trust's settlor, creates the basic terms and conditions of the plan, executes a written instrument containing those terms and conditions, and provides in that instrument "a procedure" for making amendments. ERISA § 402. The plan's administrator, a trustee-like fiduciary, manages the plan, follows its terms in doing so, and provides participants with the summary documents that describe the plan (and modifications) in readily understandable form. §§ 3(21)(A), 101(a), 102, 104. Here, the District Court found that the same entity, CIGNA, filled both roles. But that is not always the case. Regardless, we have found that ERISA carefully distinguishes these roles. See, e.g., *Varity Corp.*, [516 U.S., at 498](#). And we have no reason to believe that the statute intends to mix the responsibilities by giving the administrator the power to set plan terms indirectly by including them in the summary plan descriptions. See *Curtiss-Wright Corp. v. Schoonejongen*, [514 U.S. 73, 81-85](#) (1995).

Finally, we find it difficult to reconcile the Solicitor General's interpretation with the basic summary plan description objective: clear, simple communication. See ERISA § 102(a). To make the language of a plan summary legally binding could well lead plan administrators to sacrifice simplicity and comprehensibility in order to describe plan terms in the language of lawyers. Consider the difference between a will and the summary of a will or between a property deed and its summary. Consider, too, the length of Part I of this opinion, and then consider how much longer Part I would have to be if we had to include all the qualifications and nuances that a plan drafter might have found important and feared to omit lest they lose all legal significance. The District Court's opinions take up 109 pages of the Federal Supplement. None of this is to say that plan administrators can avoid providing complete and accurate summaries of plan terms in the manner required by ERISA and its implementing regulations. But we fear that the Solicitor General's rule might bring about complexity that would defeat the fundamental purpose of the summaries.

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

\* \* \*

### III

Section 502(a)(3) invokes the equitable powers of the District Court. We cannot know with certainty which remedy the District Court understood itself to be imposing, nor whether the District Court will find it appropriate to exercise its discretion under § 502(a)(3) to impose that remedy on remand. We need not decide which remedies are appropriate on the facts of this case in order to

resolve the parties' dispute as to the appropriate legal standard in determining whether members of the relevant employee class were injured.

The relevant substantive provisions of ERISA do not set forth any particular standard for determining harm. They simply require the plan administrator to write and to distribute written notices that are "sufficiently accurate and comprehensive to reasonably apprise" plan participants and beneficiaries of "their rights and obligations under the plan." ERISA § 102(a); see also ERISA §§ 104(b), 204(h). Nor can we find a definite standard in the ERISA provision, § 502(a)(3) (which authorizes the court to enter "appropriate equitable relief" to redress ERISA "violations"). Hence any requirement of harm must come from the law of equity.

Looking to the law of equity, there is no general principle that "detrimental reliance" must be proved before a remedy is decreed. To the extent any such requirement arises, it is because the specific remedy being contemplated imposes such a requirement. Thus, as CIGNA points out, when equity courts used the remedy of estoppel, they insisted upon a showing akin to detrimental reliance, i.e., that the defendant's statement "in truth, influenced the conduct of" the plaintiff, causing "prejudic[e]." Eaton § 61, at 175; see 3 Pomeroy § 805. Accordingly, when a court exercises its authority under § 502(a)(3) to impose a remedy equivalent to estoppel, a showing of detrimental reliance must be made.

But this showing is not always necessary for other equitable remedies. Equity courts, for example, would reform contracts to reflect the mutual understanding of the contracting parties where "fraudulent suppression[s], omission[s], or insertion[s]," 1 Story § 154, at 149, "material[ly] ... affect[ed]" the "substance" of the contract, even if the "complaining part[y]" was negligent in not realizing its mistake, as long as its negligence did not fall below a standard of "reasonable prudence" and violate a legal duty. 3 Pomeroy §§ 856, 856b, at 334, 340-341; see Baltzer, [115 U.S., at 645](#); Eaton § 307(b).

Nor did equity courts insist upon a showing of detrimental reliance in cases where they ordered "surcharge." Rather, they simply ordered a trust or beneficiary made whole following a trustee's breach of trust. In such instances equity courts would "mold the relief to protect the rights of the beneficiary according to the situation involved." Bogert § 861, at 4. This flexible approach belies a strict requirement of "detrimental reliance."

To be sure, just as a court of equity would not surcharge a trustee for a nonexistent harm, 4 Scott & Ascher § 24.9, a fiduciary can be surcharged under § 502(a)(3) only upon a showing of actual harm-proved (under the default rule for civil cases) by a preponderance of the evidence. That actual harm may sometimes consist of detrimental reliance, but it might also come from the loss of a right protected by ERISA or its trust-law antecedents. In the present case, it is not difficult to imagine how the failure to provide proper summary information, in violation of the statute, injured employees even if they did not themselves act in reliance on summary documents-which they might not themselves have seen-for they may have thought fellow employees, or informal workplace

discussion, would have let them know if, say, plan changes would likely prove harmful. We doubt that Congress would have wanted to bar those employees from relief.

The upshot is that we can agree with CIGNA only to a limited extent. We believe that, to obtain relief by surcharge for violations of §§ 102(a) and 104(b), a plan participant or beneficiary must show that the violation injured him or her. But to do so, he or she need only show harm and causation. Although it is not always necessary to meet the more rigorous standard implicit in the words "detrimental reliance," actual harm must be shown.

We are not asked to reassess the evidence. And we are not asked about the other prerequisites for relief. We are asked about the standard of prejudice. And we conclude that the standard of prejudice must be borrowed from equitable principles, as modified by the obligations and injuries identified by ERISA itself. Information-related circumstances, violations, and injuries are potentially too various in nature to insist that harm must always meet that more vigorous "detrimental harm" standard when equity imposed no such strict requirement.

#### IV

We have premised our discussion in Part III on the need for the District Court to revisit its determination of an appropriate remedy for the violations of ERISA it identified. Whether or not the general principles we have discussed above are properly applicable in this case is for it or the Court of Appeals to determine in the first instance. Because the District Court has not determined if an appropriate remedy may be imposed under § 502(a)(3), we must vacate the judgment below and remand this case for further proceedings consistent with this opinion.

It is so ordered.

Justice SOTOMAYOR took no part in the consideration or decision of this case.

Justice SCALIA, with whom Justice THOMAS joins, concurring in the judgment.

I agree with the Court that § 502(a)(1)(B) of ERISA does not authorize relief for misrepresentations in a summary plan description (SPD). I do not join the Court's opinion because I see no need and no justification for saying anything more than that.

Section 502(a)(1)(B) of ERISA states that a plan participant or beneficiary may bring a civil action "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." ERISA defines the word "plan" as "an employee welfare benefit plan or an employee pension benefit plan or a plan which is both," ERISA § 3(3), and it requires that a "plan" "be established and maintained pursuant to a written instrument," § 402(a)(1). An SPD, in contrast, is a disclosure meant "to reasonably apprise [plan] participants and beneficiaries of their rights and obligations under the plan." § 102(a). It would be peculiar for a document meant to "apprise" participants of their rights "under the plan" to be itself part of the "plan." Any doubt that it is not is eliminated by ERISA's repeated differentiation of SPDs from the "written instruments" that constitute a plan, see, e.g., §§ 109(c),

104(b)(2) and ERISA's assignment to different entities of responsibility for drafting and amending SPDs on the one hand and plans on the other, see ERISA §§ 3(1), (2)(A); 104(b)(1); Beck v. PACE Int'l Union, [551 U.S. 96, 101](#), (2007). An SPD, moreover, would not fulfill its purpose of providing an easily accessible summary of the plan if it were an authoritative part of the plan itself; the minor omissions appropriate for a summary would risk revising the plan.

Nothing else needs to be said to dispose of this case. The District Court based the relief it awarded upon ERISA § 502(a)(1)(B), and that provision alone. It thought that the "benefits" due "under the terms of the plan," ERISA § 502(a)(1)(B), could derive from an SPD, either because the SPD is part of the plan or because it is capable of somehow modifying the plan. Under either justification, that conclusion is wrong. An SPD is separate from a plan, and cannot amend a plan unless the plan so provides. See Curtiss-Wright Corp. v. Schoonejongen, [514 U.S. 73, 79, 85](#) (1995). I would go no further.

\* \* \*

I agree with the Court that an SPD is not part of an ERISA plan, and that, as a result, a plan participant or beneficiary may not recover for misrepresentations in an SPD under § 502(a)(1)(B). Because this is the only question properly presented for our review, and the only question briefed and argued before us, I concur only in the judgment.

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**Add** after 4-9 QUESTIONS AND PROBLEMS

**CRAWFORD v. TRW AUTOMOTIVE U.S. LLC**

[560 F.3d 607](#) (6th Cir. 2009)

BOYCE F. MARTIN, JR., Circuit Judge.

Plaintiffs, a class of former TRW Automotive employees, allege that TRW violated the Employee Retirement and Income Security Act by closing the plant where they worked to interfere with the vesting of their retirement benefits. The district court disagreed, and granted the company's motion for summary judgment. We affirm.

I.

TRW, an indirect subsidiary of TRW Automotive Holdings Corporation, owned and operated the Van Dyke plant where plaintiffs worked. Van Dyke, a 370,000 square foot facility, was part of TRW's North American Braking and Suspension Group: workers there manufactured front suspension components for various car makers. Its employees, represented by the United Auto Workers, were covered by a collective bargaining agreement between TRW and the UAW, and a defined pension plan. Under the pension plan, employees who retired with thirty or more years of "benefit service" were entitled to retirement benefits; they earned benefit service for each year that they worked over 1680 hours, though if laid-off they only needed 170 hours to get a year's credit.

Employees who retired with 10 years of service and were 55 or older were entitled to an early benefit.

TRW claims that, as of 2004, it faced overcapacity problems which hampered profits. In response, it organized a group to research the costs and benefits of shutting down some of its North American plants. That group identified the Van Dyke plant as a prime candidate for closure. But, before making that leap, TRW considered a few alternatives. Most significantly, it considered placing at Van Dyke work for DaimlerChrysler, though this was only assembly work and not the manufacturing kind typical of Van Dyke. Ultimately, however, the company decided that Van Dyke was in fact not the right place, and the DaimlerChrysler work wound up (the record is unclear precisely how) at a plant located on Mancini Drive owned by the Kelsey-Hayes Company, a separate subsidiary of TRW Holdings. (The Mancini plant employees are not represented by a union and they do not have a defined-benefit pension plan.) So Van Dyke's days became numbered.

Shortly before TRW shut Van Dyke down, however, the company discussed with the UAW the possibility of preferentially hiring laid-off Van Dyke employees to the Mancini plant and "bridging" the benefits of Van Dyke employees who were close to vesting. TRW also offered a severance to employees who opted out of their available retiree benefits. But the two sides failed to reach an agreement and TRW closed Van Dyke in January 2007. At that time, three employees missed the 30-year retirement mark by less than one year of benefit service (all three had been laid-off in 2005), and four others missed the 30-year mark by less than two years.

Plaintiffs, a certified class of former Van Dyke employees, sued, alleging that TRW violated ERISA § 510 by (1) failing to recall employees following a layoff, (2) refusing to transfer employees to the Mancini Drive facility, and (3) improperly discharging employees to interfere with their attainment of retirement eligibility. The district court granted summary judgment to TRW on all counts, and also later dismissed plaintiffs' motion for relief from the judgment on the basis of new evidence. Plaintiffs appeal.

## II.

\* \* \*

### A.

Plaintiffs contend that the district court improperly granted TRW summary judgment because the company violated ERISA when it laid them off in connection with closing the Van Dyke plant. ERISA § 510 makes it "unlawful for any person to discharge, fine, suspend, expel, discipline, or discriminate against a participant or beneficiary ... for the purpose of interfering with the attainment of any right to which such participant may become entitled under [an employee benefit plan]." This section was designed to prevent "employers from discharging or harassing" employees to preclude "them from obtaining vested pension rights." *West v. Butler*, [621 F.2d 240, 245](#) (6<sup>th</sup> Cir.1980). Of course, not only is this illegal, it is also bad business: because providing benefits is discretionary (and so part of total employee-compensation), firing older employees to reduce

pension costs both creates animosity between employer and employee and makes employees' compensation less certain, and thus employees will demand higher wages to offset this heightened risk of being fired inopportunistly; as a result, employers will have to pay employees higher wages to attract and keep them. See Maria O'Brien Hylton, *Insecure Retirement Income, Wrongful Plan Administration and Other Employee Benefits Woes-Evaluating ERISA at Age Thirty*, [53 Buff. L. Rev. 1193, 1204-11](#) (2005). But some employers are foolish, and thus Congress enacted § 510 to provide a remedy. Plaintiffs assert that TRW "discharge[d]" them to "interfer[e]" with their attainment of full retirement benefits in violation of § 510.

So the primary question here is whether the plaintiffs proffered enough evidence of this improper motive to get to a jury. But first we must dismiss two errant contentions: TRW asserts that ERISA interference claims in the plant sale or closing context are never actionable and plaintiffs assert that TRW violated section 510 by failing to recall or transfer them following their discharge. Neither is correct.

1.

TRW overreaches in stating that employees may never challenge discharges that result from a plant-closing decision. While "[e]mployers or other plan sponsors are generally free under ERISA ... to adopt, modify or terminate" pension benefit plans, *Coomer v. Bethesda Hosp. Inc.*, [370 F.3d 499, 508](#) (6th Cir.2004), this discretion does not permit them to discharge employees or alter their plan rights to "circumvent the provision of promised benefits." *Inter-Modal Rail Empl. Ass'n v. Atchison, Topeka & Santa Fe Ry.*, [520 U.S. 510, 515](#)(1997) (internal quotations omitted).

Of course, the D.C. Circuit has pointed out that Congress's use of the term "discharge" in § 510 comes in the context of other individually focused terms like "fine, suspend, expel, [and] discipline." *Andes v. Ford Motor Co.*, [70 F.3d 1332, 1337](#) (D.C.Cir.1995). TRW latches onto this to say that broad or class-based claims are never actionable. But, as the D.C. Circuit and other courts have routinely recognized, the term "discharge," by definition, is not so limited and thus covers employees fired or laid-off, either individually or as a group, and thus the statutory language gives any "discharged" employee a right to sue, whether via class-action or individually. See, e.g., *Gavalik v. Cont'l Can Co.*, [812 F.2d 834, 838](#) (3d Cir.1987). Indeed, the *Andes* court explicitly pointed out the possibility that some employer might unscrupulously sell or close a plant to shake off employees on the cusp of establishing benefit eligibility. [70 F.3d at 1338](#).

2.

Plaintiffs similarly overreach in claiming that TRW was legally required to recall many of them back to or to transfer them to the Mancini plant. As stated above, § 510 includes a list of prohibited actions, including improperly "discharg[ing], fin[ing], expel[ling]," and "discriminat[ing]." But nowhere is "transferring" or "recalling" listed. Neither have plaintiffs identified case law giving effect to such a claim. This is not surprising: the sine qua non of a § 510 claim is the presence of some adverse action done to interfere with an employee's rights, and had plaintiffs not been laid-off, whether or not there was a transfer would have been irrelevant because plaintiffs would still have

been accruing benefits; similarly, recall would have been irrelevant if there was no discharge or it was lawful, because employees would have no more right to be hired than someone who had never worked for TRW. In other words, the whole game is whether TRW unlawfully discharged plaintiffs.

Also, TRW's decision to recall some employees and not others was not discriminatory because those decisions were seniority based, and at least two employees accrued enough pension credits to retire with benefits after being recalled. Finally, the employees' collective bargaining agreement provided that benefits accrued only at the Van Dyke plant, so plaintiffs also lacked plan rights to be recalled. See *McGath v. Auto-Body North Shore, Inc.*, [7 F.3d 665, 670](#) (7<sup>th</sup> Cir.1993).

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## B.

To defeat summary judgment, the plaintiffs must show that TRW fired them for the purpose of interfering with the attainment of their retirement benefits. ERISA § 510. Plaintiffs may make this showing either through direct or circumstantial evidence, with the latter via the ubiquitous burden-shifting framework that has, like some B-movie villain, devoured nearly every area of law with which it has come into contact. See *Texas Dep't of Community Affairs v. Burdine*, [450 U.S. 248, 253](#) (1981); *McDonnell Douglas Corp. v. Green*, [411 U.S. 792](#) (1973). Plaintiffs here rely on circumstantial evidence. In the ERISA context, the burden-shifting framework first requires the plaintiffs to establish their "prima facie" case "by showing the existence of (1) prohibited employer conduct (2) taken for the purpose of interfering (3) with the attainment of any right to which the employee may become entitled." *Smith v. Ameritech*, [129 F.3d 857, 865](#) (6<sup>th</sup> Cir.1997). Although some of the cases discuss, in reference to this "prima facie" case, the need for the plaintiff to prove the existence of the employer's "specific intent," see, e.g., *Schweitzer v. Teamsters Local 100*, [413 F.3d 533, 537](#) (6<sup>th</sup> Cir.2005); *Humphreys v. Bellaire Corp.*, [966 F.2d 1037, 1043](#) (6<sup>th</sup> Cir.1992), that requirement is superfluous and not relevant (at this first stage at least) because it gets to the ultimate question of whether the employer purposefully interfered with the employee's pension rights. This confusion stems in part because the term "prima facie" as used here, does not comport with the traditional understanding of that term-namely, that plaintiffs have proven enough to get to a jury, see 9 WIGMORE ON EVIDENCE s 2494, 378-79 nn. 1, 3 (1981).

Instead, "prima facie" is *Burdine/ McDonnell Douglas* patois for the fact that the plaintiffs have shown enough to create a rebuttable presumption such that the employer must then produce evidence supporting a legitimate, non-discriminatory reason for the discharge. *Humphreys*, [966 F.2d at 1043](#); see also *Majewski v. Automatic Data Processing, Inc.*, [274 F.3d 1106, 1113-14](#) (6<sup>th</sup> Cir.2001) ("A plaintiff's burden in establishing a prima facie case is not intended to be an onerous one."). If the employer makes this showing, the burden shifts back to the plaintiff to show that this proffered reason was a "pretext"-i.e. a phony reason-and instead that the intent to interfere with the plaintiff's ERISA rights was a "motivating factor." *Id.*

The plaintiffs easily satisfy the low-threshold for establishing their prima facie case. TRW's Vice President of Operations for the Suspension Group stated that pension costs-colloquially known

within the company as “legacy” or “heritage” costs-were among the reasons to close down the plant. And that is no surprise: labor costs are often among the largest costs for a plant, and such “legacy” or retirement and benefits costs typically make up the largest portion of labor costs. Indeed, as the district court observed, the work done at Van Dyke was transferred to a non-union facility where such costs “were reduced or non-existent.” This is enough to erect the presumption and require TRW to make an evidentiary showing.

TRW thus replies that it closed Van Dyke because of its overcapacity: only 30,000 square feet of its available 300,000 square feet was being used, so roughly 26% of every sales dollar went to fixed costs and overhead. This is a strong non-discriminatory reason, especially when coupled with the fact that there are necessarily a variety of concerns at play whenever a company decides to shut down a plant.

So we reach the “pretext” stage. Plaintiffs retort that TRW’s proffered reason is phony because the plant was so poorly run; specifically, that the company could have kept Van Dyke going if it had cut a variety of possible costs and placed the DaimlerChrysler work there. Thus, plaintiffs argue, because they did not do those things, it must have been the company’s desire to interfere with their pension benefits that motivated it to close their plant. TRW, predictably, retorts that, since its stated reason concerned “business judgment,” then its reason is unassailable. In support, TRW quotes dicta from the cases, like: “Measures designed to reduce costs in general that also result in an incidental reduction in benefit expenses do not suggest discriminatory intent.” *Daughtrey v. Honeywell, Inc.*, [3 F.3d 1488, 1492](#) (11th Cir.1993).

But of course: the whole issue is whether reducing pension benefits by shutting down a plant with employees close to vesting was a “motivating factor” or was instead “incidental” because there were other, neutral, business reasons at play. See *Smith*, [129 F.3d at 865](#). “Business judgment” is not an aegis that deflects all ERISA interference liability; Congress, in enacting § 510, made clear its view that an employer may only discharge employees when neutral, non-pension right-interfering concerns animate the decision.

And, while plaintiffs may not second-guess every business decisions, the reasons supporting any decision to discharge an employee, either individually or in connection with a plant closing, may be considered “to the extent that such an inquiry sheds light on whether the employer’s proper reason for the employment action was its actual motivation.” *Wexler v. White’s Fine Furniture, Inc.*, [317 F.3d 564, 576](#) (6th Cir.2003) (en banc). In other words, business judgments are relevant insofar as plaintiffs can show that they are incredible or phony, which, while difficult, is not categorically barred, as TRW seems to think.

To support their claim that TRW’s overcapacity justification was pretext, plaintiffs point to a variety of documents indicating TRW’s desire to reduce pension costs and that reducing these costs played a definite role in TRW’s decision to shut down Van Dyke. And, of course, TRW has not denied this. Nevertheless, plaintiffs cannot satisfy their burden of persuasion. At the pretext stage, judges must still bring their judgment to bear on whether or not plaintiffs have met their burden-in effect, the

Burdine/ McDonnell Douglas framework has fallen away and the question reduces to whether plaintiffs can prove improper motivation. And, despite plaintiffs' evidence, we cannot say that TRW's reason was a mere pretext.

When the plant was shut down and the employees laid-off, only three employees were within a year of reaching eligibility, while another four were roughly two years away; a majority of the Van Dyke employees needed more than five more years for their benefits to fully vest. And two of the employees that TRW did recall-which was done on the basis of seniority per the bargaining agreement-established their benefits eligibility while working at the Mancini plant. This undercuts the plaintiffs' claim.

Although TRW vastly overstated the deference its business decisions are afforded, it is true that, when plants are shut down, there will necessarily be a variety of factors at play beyond how close certain employees might be to vesting, and thus plaintiffs have a lot to wade through to establish liability. This is not due to any presumption or legal threshold erected against their claims; the facts of these cases will always be myriad and complicated, and plaintiffs must show that the employer, in the midst of all this, in some way targeted certain employee benefits or rights for interference. This is not to say that employers always act properly-some are foolish-it is instead that the facts do not always make it obvious that this was so. To succeed, § 510 plaintiffs do not need "smoking gun" evidence, but, they do need more than plaintiffs have here. We thus affirm the district court's grant of summary judgment to TRW.

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Add after Question 3

**KENNEDY v. PLAN ADMINISTRATOR FOR DuPONT  
SAVINGS AND INVESTMENT PLAN et al.**  
[129 S. Ct. 865](#) (2009)

JUSTICE SOUTER delivered the opinion of the Court.

The Employee Retirement Income Security Act of 1974 (ERISA), [29 U.S.C. § 1001](#) *et seq.*, generally obligates administrators to manage ERISA plans "in accordance with the documents and instruments governing" them. ERISA § 404(a)(1)(D). At a more specific level, the Act requires covered pension benefit plans to "provide that benefits . . . under the plan may not be assigned or alienated," ERISA § 206(d)(1), but this bar does not apply to qualified domestic relations orders (QDROs), ERISA § 206(d)(3). The question here is whether the terms of the limitation on assignment or alienation invalidated the act of a divorced spouse, the designated beneficiary under her ex-husband's ERISA pension plan, who purported to waive her entitlement by a federal common law waiver embodied in a divorce decree that was not a QDRO. We hold that such a

waiver is not rendered invalid by the text of the antialienation provision, but that the plan administrator properly disregarded the waiver owing to its conflict with the designation made by the former husband in accordance with plan documents.

## I

The decedent, William Kennedy, worked for E.I. DuPont de Nemours & Company and was a participant in its savings and investment plan (SIP), with power both to “designate any beneficiary or beneficiaries . . . to receive all or part” of the funds upon his death, and to “replace or revoke such designation.” The plan requires “[a]ll authorizations, designations and requests concerning the Plan [to] be made by employees in the manner prescribed by the [plan administrator],” and provides forms for designating or changing a beneficiary. If at the time the participant dies “no surviving spouse exists and no beneficiary designation is in effect, distribution shall be made to, or in accordance with the directions of, the executor or administrator of the decedent’s estate.” *Id.* at 48.

The SIP is an ERISA “employee pension benefit plan,” [497 F.3d 426, 427](#) (C.A.5 2007); ERISA § 3(2), and the parties do not dispute that the plan satisfies ERISA’s antialienation provision, ERISA § 206(d)(1), which requires it to “provide that benefits provided under the plan may not be assigned or alienated.” The plan does, however, permit a beneficiary to submit a “qualified disclaimer” of benefits as defined under the Tax Code, see [26 U.S.C. § 2518](#), which has the effect of switching the beneficiary to an “alternate . . . determined according to a valid beneficiary designation made by the deceased.” Supp. Record 86-87 (Exh. 15).

In 1971, William married Liv Kennedy, and, in 1974, he signed a form designating her to take benefits under the SIP, but naming no contingent beneficiary to take if she disclaimed her interest. [497 F.3d at 427](#). William and Liv divorced in 1994, subject to a decree that Liv “is . . . divested of all right, title, interest, and claim in and to . . . [a]ny and all sums . . . the proceeds [from], and any other rights related to any . . . retirement plan, pension plan, or like benefit program existing by reason of [William’s] past or present or future employment.” William did not, however, execute any documents removing Liv as the SIP beneficiary, [497 F.3d at 428](#), even though he did execute a new beneficiary-designation form naming his daughter, Kari Kennedy, as the beneficiary under DuPont’s Pension and Retirement Plan, also governed by ERISA.

On William’s death in 2001, petitioner Kari Kennedy was named executrix and asked DuPont to distribute the SIP funds to William’s Estate. *Ibid.* DuPont, instead, relied on William’s designation form and paid the balance of some \$400,000 to Liv. *Ibid.* The Estate then sued respondents DuPont and the SIP plan administrator (together, DuPont), claiming that the divorce decree amounted to a waiver of the SIP benefits on Liv’s part, and that DuPont had violated ERISA by paying the benefits to William’s designee.

So far as it matters here, the District Court entered summary judgment for the Estate, to which it ordered DuPont to pay the value of the SIP benefits. The court relied on Fifth Circuit precedent establishing that a beneficiary can waive his rights to the proceeds of an ERISA plan ‘provided that the waiver is explicit, voluntary, and made in good faith.’

The Fifth Circuit nonetheless reversed, distinguishing prior decisions enforcing federal common law waivers of ERISA benefits because they involved life-insurance policies, which are considered “welfare plan[s]” under ERISA and consequently free of the antialienation provision. [497 F.3d at 429](#). The Court of Appeals held that Liv’s waiver constituted an assignment or alienation of her interest in the SIP benefits to the Estate, and so could not be honored. [Id. at 430](#). The court relied heavily on the ERISA provision for bypassing the antialienation provision when a marriage breaks up: under § 206(d)(3),<sup>3</sup> a court order that satisfies certain statutory requirements is known as a qualified domestic relations order, which is exempt from the bar on assignment or alienation. Because the Kennedys’ divorce decree was not a QDRO, the Fifth Circuit reasoned that it could not give effect to Liv’s waiver incorporated in it, given that “ERISA provides a specific mechanism—the QDRO—for addressing the elimination of a spouse’s interest in plan benefits, but that mechanism is *not* invoked.” [497 F.3d at 431](#).

We granted certiorari to resolve a split among the Courts of Appeals and State Supreme Courts over a divorced spouse’s ability to waive pension plan benefits through a divorce decree not amounting to a QDRO. We subsequently realized that this case implicates the further split over whether a beneficiary’s federal common law waiver of plan benefits is effective where that waiver is inconsistent with plan documents, and after oral argument we invited supplemental briefing on that latter issue, upon which the disposition of this case ultimately turns. We now affirm, albeit on reasoning different from the Fifth Circuit’s rationale.

## II

### A

By its terms, the antialienation provision, ERISA § 206(d)(1), requires a plan to provide expressly that benefits be neither “assigned” nor “alienated,” the operative verbs having histories of legal meaning: to “assign” is “[t]o transfer; as to assign property, or some interest therein,” BLACK’S LAW DICTIONARY 152 (4th rev. ed. 1968), and to “alienate” is “[t]o convey; to transfer the title to property,” [id. at 96](#). We think it fair to say that Liv did not assign or alienate anything to William or to the Estate later standing in his shoes.

The Fifth Circuit saw the waiver as an assignment or alienation to the Estate, thinking that Liv’s waiver transferred the SIP benefits to whoever would be next in line; without a designated contingent beneficiary, the Estate would take them. The court found support in the applicable Treasury Department regulation that defines “assignment” and “alienation” to include

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<sup>3</sup> Section 206(d)(3)(A) provides that the antialienation provision “shall apply to the creation, assignment, or recognition of a right to any benefit payable with respect to a participant pursuant to a domestic relations order, except that paragraph (1) shall not apply if the order is determined to be a qualified domestic relations order.”

[a]ny direct or indirect arrangement (whether revocable or irrevocable) whereby a party acquires from a participant or beneficiary a right or interest enforceable against the plan in, or to, all or any part of a plan benefit payment which is, or may become, payable to the participant or beneficiary. [26 C.F.R. § 1.401\(a\)-13\(c\)\(1\)\(ii\)](#) (2008).

See *Boggs v. Boggs*, [520 U.S. 833, 851-52](#), (1997) (relying upon the regulation to interpret the meaning of “assignment” and “alienation” in [ERISA § 206(d)(1)]). The Circuit treated Liv’s waiver as an “indirect arrangement” whereby the Estate gained an “interest enforceable against the plan.” [497 F.3d at 430](#).

Casting the alienation net this far, though, raises questions that leave one in doubt. Although it is possible to speak of the waiver as an “arrangement” having the indirect effect of a transfer to the next possible beneficiary, it would be odd usage to speak of an estate as the transferee of its own decedent’s property, just as it would be to speak of the decedent in his lifetime as his own transferee. And treating the estate or even the ultimate estate beneficiary as the assignee or transferee would be strange under the terms of the regulation: it would be hard to say the estate or future beneficiary “acquires” a right or interest when at the time of the waiver there was no estate and the beneficiary of a future estate might be anyone’s guess. If there were a contingent beneficiary (or the participant made a subsequent designation) the estate would get no interest; as for an estate beneficiary, the identity could ultimately turn on the law of intestacy applied to facts as yet unknown, or on the contents of the participant’s subsequent will, or simply on the participant’s future exercise of (or failure to invoke) the power to designate a new beneficiary directly under the terms of the plan. Thus, if such a waiver created an “arrangement” assigning or transferring anything under the statute, the assignor would be blindfolded, operating, at best, on the fringe of what “assignment” or “alienation” normally suggests.

The questionability of this broad reading is confirmed by exceptions to it that are apparent right off the bat. Take the case of a surviving spouse’s interest in pension benefits, for example. Depending on the circumstances, a surviving spouse has a right to a survivor’s annuity or to a lump-sum payment on the death of the participant, unless the spouse has waived the right and the participant has eliminated the survivor annuity benefit or designated a different beneficiary. [See Boggs, supra, at 843](#); [ERISA §§ 205(a), (b)(1)(C), (c)(2)]. This waiver by a spouse is plainly not barred by the antialienation provision. Likewise, DuPont concedes that a qualified disclaimer under the Tax Code, which allows a party to refuse an interest in property and thereby eliminate federal tax, would not violate the antialienation provision. See Brief for Respondents 21-23; [26 U.S.C. § 2518](#). In each example, though, we fail to see how these waivers would be permissible under the Fifth Circuit’s reading of the statute and regulation.

Our doubts, and the exceptions that call the Fifth Circuit’s reading into question, point us toward authority we have drawn on before, the law of trusts that “serves as ERISA’s backdrop.” *Beck v. Pace Int’l Union*, [551 U.S. 96, 101](#) (2007). We explained before that § 206(d)(1) is much like a spendthrift trust provision barring assignment or alienation of a benefit, [see Boggs, supra, at 852](#), and the cognate trust law is highly suggestive here. Although the beneficiary of a spendthrift trust

traditionally lacked the means to transfer his beneficial interest to anyone else, he did have the power to disclaim prior to accepting it, so long as the disclaimer made no attempt to direct the interest to a beneficiary in his stead. . . .

We do not mean that the whole law of spendthrift trusts and disclaimers turns up in § 206(d)(1), but the general principle that a designated spendthrift can disclaim his trust interest magnifies the improbability that a statute written with an eye on the old law would effectively force a beneficiary to take an interest willy-nilly. Common sense and common law both say that “[t]he law certainly is not so absurd as to force a man to take an estate against his will.” *Townson v. Tickell*, 3 Barn. & Ald. 31, 36, 106 Eng. Rep. 575, 576-77 (K.B. 1819).

The Treasury is certainly comfortable with the state of the old law, for the way it reads its own regulation “no party ‘acquires from’ a beneficiary a ‘right or interest enforceable against the plan’ pursuant to a beneficiary’s waiver of rights where the beneficiary does not attempt to direct her interest in pension benefits to another person.” Brief for United States as *Amicus Curiae* 18. And, being neither “plainly erroneous [n]or inconsistent with the regulation,” the Treasury Department’s interpretation of its regulation is controlling. *Auer v. Robbins*, [519 U.S. 452, 461](#) (1997).

The Fifth Circuit found “significant support” for its contrary holding in the QDRO subsections, reasoning that “[i]n the marital-dissolution context, the QDRO provisions supply the *sole* exception to the anti-alienation provision,” [497 F.3d at 430](#), a point that echoes in DuPont’s argument here. But the negative implication of the QDRO language is not that simple. If a QDRO provided a way for a former spouse like Liv merely to waive benefits, this would be powerful evidence that the antialienation provision was meant to deny any effect to a waiver within a divorce decree but not a QDRO, else there would have been no need for the QDRO exception. But this is not so, and DuPont’s argument rests on a false premise. In fact, a beneficiary seeking only to relinquish her right to benefits cannot do this by a QDRO, for a QDRO by definition requires that it be the “creat[ion] or recogni[tion of] the existence of an alternate payee’s right to, or assign[ment] to an alternate payee [of] the right to, receive all or a portion of the benefits payable with respect to a participant under a plan.” ERISA § 206(d)(3)(B)(i)(I). There is no QDRO for a simple waiver; there must be some succeeding designation of an alternate payee. Not being a mechanism for simply renouncing a claim to benefits, then, the QDRO provisions shed no light on whether a beneficiary may waive by a non-QDRO.

In sum, Liv did not attempt to direct her interest in the SIP benefits to the Estate or any other potential beneficiary, and accordingly we think that the better view is that her waiver did not constitute an assignment or alienation rendered void under the terms of § 206(d)(1).

## B

DuPont has three other reasons for saying that Liv’s waiver was barred by ERISA. They are unavailing.

First, it argues that even if the waiver is not an assignment or alienation barred under the terms of § 206(d)(1), § 206(d)(3)(A) still prohibits it, in providing that § 206(d)(1) “shall apply to the creation, assignment, or recognition of a right to any benefit payable with respect to a participant pursuant to a domestic relations order [that is not a QDRO].” At the very least, DuPont reasons, Liv’s waiver included a “recognition” of William’s rights with respect to the SIP benefits. But DuPont overlooks the point that when subsection (d)(3)(A) provides that the bar to assignments or alienations extends to non-QDRO domestic relations orders, it does nothing to expand the scope of prohibited assignment and alienation under subsection (d)(1). Whether Liv’s action is seen as a waiver or as a domestic relations order that incorporated a waiver, subsection (d)(1) does not cover it and § 206(d)(3)(A) does not independently bar it.

Second, DuPont relies upon § 206(d)(3)(H)(iii)(II), providing that if a domestic relations order is not a QDRO, “the plan administrator shall pay the segregated amounts (including any interest thereon) to the person or persons who would have been entitled to such amounts if there had been no order.” According to DuPont, because the divorce decree was not a QDRO this provision calls for paying benefits as if there had been no order. But DuPont has wrenched this language out of its setting, reading clause (iii) of subparagraph (H) as if there were no clause (i):

During any period in which the issue of whether a domestic relations order is a qualified domestic relations order is being determined . . . the plan administrator shall separately account for the amounts (hereinafter in this subparagraph referred to as the “segregated amounts”) which would have been payable to the alternate payee during such period if the order had been determined to be a qualified domestic relations order. § 206(d)(3)(H)(i).

Thus it is clear that subparagraph (H) speaks of a domestic relations order that distributes certain benefits (the “segregated amounts”) to an alternate payee, when the question for the plan administrator is whether the order is effective as a QDRO. That is the circumstance in which, for want of a QDRO, clause (iii) tells the plan administrator not to pay the alternate, but to distribute the segregated amounts as if there had been no order. Clause (iii) does not, as DuPont suggests, state a general rule that a non-QDRO domestic relations order is a nullity in any proceeding that would affect the determination of a beneficiary. And of course clause (iii) says nothing here at all; the divorce decree names no alternate payee, and there are consequently no “segregated amounts.”

Third, DuPont claims that a plan cannot recognize a waiver of benefits in a non-QDRO divorce decree because ERISA preempts “any and all State laws insofar as they may now or hereafter relate to any employee benefit plan,” with “State law” being defined to include “decisions” or “other State action having the effect of law.” §§ 514(a), (c)(1). DuPont says that Liv’s waiver, expressed in a state-court decision and related to an employee benefit plan, is thus preempted. But recognizing a waiver in a divorce decree would not be giving effect to state law; the argument is that the waiver should be treated as a creature of federal common law, in which case its setting in a state divorce decree would be only happenstance. A court would merely be applying federal law to a document that might also have independent significance under state law.

### III

The waiver's escape from inevitable nullity under the express terms of the antialienation clause does not, however, control the decision of this case, and the question remains whether the plan administrator was required to honor Liv's waiver with the consequence of distributing the SIP balance to the Estate. We hold that it was not, and that the plan administrator did its statutory ERISA duty by paying the benefits to Liv in conformity with the plan documents.

ERISA requires "[e]very employee benefit plan [to] be established and maintained pursuant to a written instrument," § 402(a)(1), "specify[ing] the basis on which payments are made to and from the plan," § 402(b)(4). The plan administrator is obliged to act "in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of [Title I] and [Title IV] of [ERISA]," § 404(a)(1)(D), and the Act provides no exemption from this duty when it comes time to pay benefits. On the contrary, § 502(a)(1)(B) (which the Estate happens to invoke against DuPont here) reinforces the directive, with its provision that a participant or beneficiary may bring a cause of action "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan."

The Estate's claim therefore stands or falls by "the terms of the plan," § 502(a)(1)(B), a straightforward rule of hewing to the directives of the plan documents that lets employers "'establish a uniform administrative scheme, [with] a set of standard procedures to guide processing of claims and disbursement of benefits.'" *Egelhoff v. Egelhoff*, [532 U.S. 141, 148](#), (2001) . . . The point is that by giving a plan participant a clear set of instructions for making his own instructions clear, ERISA forecloses any justification for enquiries into nice expressions of intent, in favor of the virtues of adhering to an uncomplicated rule: "simple administration, avoid[ing] double liability, and ensur[ing] that beneficiaries get what's coming quickly, without the folderol essential under less-certain rules." *Fox Valley & Vicinity Const. Workers Pension Fund v. Brown*, [897 F.2d 275, 283](#) (C.A.7 1990) (Easterbrook, J., dissenting).

And the cost of less certain rules would be too plain. Plan administrators would be forced "to examine a multitude of external documents that might purport to affect the dispensation of benefits," *Altobelli v. IBM Corp.*, [77 F.3d 78, 82-83](#) (C.A.4 1996) (Wilkinson, C.J., dissenting), and be drawn into litigation like this over the meaning and enforceability of purported waivers. The Estate's suggestion that a plan administrator could resolve these sorts of disputes through interpleader actions merely restates the problem with the Estate's position: it would destroy a plan administrator's ability to look at the plan documents and records conforming to them to get clear distribution instructions, without going into court.

The Estate of course is right that this guarantee of simplicity is not absolute. The very enforceability of QDROs means that sometimes a plan administrator must look for the beneficiaries outside plan documents notwithstanding § 404(a)(1)(D); § 206(d)(3)(J) provides that a "person who is an alternate payee under a [QDRO] shall be considered for purposes of any provision of [ERISA]

a beneficiary under the plan.” But this in effect means that a plan administrator who enforces a QDRO must be said to enforce plan documents, not ignore them. In any case, a QDRO enquiry is relatively discrete, given the specific and objective criteria for a domestic relations order that qualifies as a QDRO, see §§ 206(d)(3)(C), (D), requirements that amount to a statutory checklist working to “spare [an administrator] from litigation-fomenting ambiguities,” *Metropolitan Life Ins. Co. v. Wheaton*, [42 F.3d 1080, 1084](#) (C.A.7 1994). This is a far cry from asking a plan administrator to figure out whether a claimed federal common law waiver was knowing and voluntary, whether its language addressed the particular benefits at issue, and so forth, on into factually complex and subjective determinations.

These are good and sufficient reasons for holding the line, just as we have done in cases of state laws that might blur the bright-line requirement to follow plan documents in distributing benefits. Two recent preemption cases are instructive here. *Boggs v. Boggs*, [520 U.S. 833](#), held that ERISA preempted a state law permitting the testamentary transfer of a nonparticipant spouse’s community property interest in undistributed pension plan benefits. We rejected the entreaty to create “through case law . . . a new class of persons for whom plan assets are to be held and administered,” explaining that “[t]he statute is not amenable to this sweeping extratextual extension.” *Id.* at 850. And in *Egelhoff* we held that ERISA preempted a state law providing that the designation of a spouse as the beneficiary of a nonprobate asset is revoked automatically upon divorce. [532 U.S. at 143](#). We said the law was at fault for standing in the way of making payments “simply by identifying the beneficiary specified by the plan documents,” *id.* at 148, and thus for purporting to “undermine the congressional goal of ‘minimiz[ing] the administrative and financial burden[s]’ on plan administrators,” *id.* at 149-50. . .

What goes for inconsistent state law goes for a federal common law of waiver that might obscure a plan administrator’s duty to act “in accordance with the documents and instruments.” See *Mertens v. Hewitt Associates*, [508 U.S. 248, 259](#), (1993) (“The authority of courts to develop a ‘federal common law’ under ERISA . . . is not the authority to revise the text of the statute.”). And this case does as well as any other in pointing out the wisdom of protecting the plan documents rule. Under the terms of the SIP Liv was William’s designated beneficiary. The plan provided an easy way for William to change the designation, but for whatever reason he did not. The plan provided a way to disclaim an interest in the SIP account, but Liv did not purport to follow it. The plan administrator therefore did exactly what § 404(a)(1)(D) required: “the documents control, and those name [the ex-wife].” *McMillan v. Parrott*, [913 F.2d 310, 312](#) (C.A.6 1990).

It is no answer, as the Estate argues, that William’s beneficiary-designation form should not control because it is not one of the “documents and instruments governing the plan” under § 404(a)(1)(D) and was not treated as a plan document by the plan administrator. That is beside the point. It is uncontested that the SIP and the summary plan description are “documents and instruments governing the plan.” See *Curtiss-Wright Corp.*, [514 U.S. at 84](#), (explaining that ERISA §§ 104(b)(2) and (b)(4) require a plan administrator to make available the “governing plan documents”). Those documents provide that the plan administrator will pay benefits to a

participant's designated beneficiary, with designations and changes to be made in a particular way. William's designation of Liv as his beneficiary was made in the way required; Liv's waiver was not.

#### IV

Although Liv's waiver was not rendered a nullity by the terms of § 206, the plan administrator properly distributed the SIP benefits to Liv in accordance with the plan documents. The judgment of the Court of Appeals is affirmed on the latter ground.

*It is so ordered.*

## Chapter 5 – Preemption

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### Add:

#### **GOLDEN GATE RESTAURANT ASSOCIATION v. CITY AND COUNTY OF SAN FRANCISCO**

[546 F.2d 639](#) (9th Cir. 2008)

WILLIAM A. FLETCHER, Circuit Judge:

Plaintiff Golden Gate Restaurant Association (“the Association”) challenges the employer spending requirements of the newly enacted San Francisco Health Care Security Ordinance (“the Ordinance”). The Association argues that the federal Employee Retirement Income Security Act of 1974 (“ERISA”) preempts the employer spending requirements of the Ordinance either because those requirements create a “plan” within the meaning of ERISA or because they “relate to” employers’ ERISA plans. On December 26, 2007, the district court granted the Association’s motion for summary judgment and enjoined the implementation of the employer spending requirements. On December 27, 2007, Defendant City and County of San Francisco (“the City”) and Defendant-Intervenor labor unions requested that this court stay the judgment of the district court pending appeal. In an order filed January 9, 2008, we granted the stay. We now reach the merits of the appeal. We hold that ERISA does not preempt the Ordinance.

#### I. Procedural History

In July 2006, the San Francisco Board of Supervisors unanimously passed the San Francisco Health Care Security Ordinance, and the mayor signed it into law. The Ordinance is codified at Sections 14.1 to 14.8 of the City and County of San Francisco Administrative Code. The Ordinance has two primary components: the Health Access Plan (“HAP”), and the employer spending requirements. The HAP is a City-administered health care program. It went into effect in the

summer of 2007. In funding the HAP, the City “prioritize[s] services for low and moderate income persons.” S.F. Admin. Code § 14.2(d) (2007). According to the City’s web page, as of August 9, 2008, 27,395 persons had enrolled in the HAP. Persons who already have health insurance or who live outside of San Francisco are not eligible for the HAP. Instead, such persons may be entitled to establish medical reimbursement accounts with the City. As we will explain in detail below, the Ordinance also requires all covered employers to make a certain level of health care expenditures on behalf of their covered employees. The Association does not challenge the HAP. It challenges only the employer spending requirements.

\* \* \*

### III. The Ordinance

The Ordinance mandates that covered employers make “required health care expenditures to or on behalf of” certain employees each quarter. S.F. Admin. Code § 14.3(a). “Covered employers” are employers engaging in business within the City that have an average of at least twenty employees performing work for compensation during a quarter, and nonprofit corporations with an average of at least fifty employees performing work for compensation during a quarter.

The Ordinance sets the required health care expenditure for employers based on the Ordinance’s “health care expenditure rate.” *Id.* §§ 14.1(b)(8), 14.3(a). For-profit employers with between twenty and ninety-nine employees and non-profit employers with fifty or more employees must make health care expenditures at a rate of \$1.17 per hour. For-profit employers with one hundred or more employees must make expenditures at a rate of \$1.76 per hour. . . .

. . . A “covered employer has discretion as to the type of health care expenditure it chooses to make for its covered employees.” ESR Reg. 4.2(A). Section 14.1(b)(7) of the Ordinance specifies that the definition of health care expenditure includ[es], but [is] not limited to

- (a) contributions by [a covered] employer on behalf of its covered employees to a health savings account as defined under section 223 of the United States Internal Revenue Code or to any other account having substantially the same purpose or effect without regard to whether such contributions qualify for a tax deduction or are excludable from employee income;
- (b) reimbursement by such covered employer to its covered employees for expenses incurred in the purchase of health care services;
- (c) payments by a covered employer to a third party for the purpose of providing health care services for covered employees;
- (d) costs incurred by a covered employer in the direct delivery of health care services to its covered employees; and

(e) payments by a covered employer to the City to be used on behalf of covered employees. The City may use these payments to:

(i) fund membership in the Health Access Program for uninsured San Francisco residents; and

(ii) establish and maintain reimbursement accounts for covered employees, whether or not those covered employees are San Francisco residents.

If an employer does not make required health care expenditures on behalf of employees in some other way, it may meet its spending requirement by making payments directly to the City under § 14.1(b)(7)(e). *See* ESR Reg. 4.2(A). We refer to this option as the City-payment option. If an employer elects the City-payment option, its covered employees who satisfy age and income requirements and are “uninsured San Francisco residents” may enroll in the HAP, and its other covered employees will be eligible for medical reimbursement accounts with the City. Covered employees may enroll in the HAP free of charge or at reduced rates. The HAP provides enrollees with “medical services with an emphasis on wellness, preventive care and innovative service delivery.”

An employer is exempt from making payments to the City if it makes health care expenditures under § 14.1(b)(7)(a)-(d) of at least \$1.17 or \$1.76 per hour (depending on the non-profit or for-profit status of the employer, and on the number of employees), and it is partially exempt to the extent that it makes lesser expenditures.

\* \*

The Ordinance includes a special provision for employers with self-insured health plans. An employer providing “health coverage to some or all of its covered employees through a self-funded/self-insured plan” will “comply with the spending requirement . . . if the preceding year’s average expenditure rate per employee meets or exceeds the applicable expenditure rate” for the employer. . . .

\* \* \*

We make two observations about the Ordinance. First, the Ordinance does not require employers to establish their own ERISA plans or to make any changes to any existing ERISA plans. Employers may choose to make up the difference between their existing health care expenditures and the minimum expenditures required by the Ordinance either by altering existing ERISA plans or by establishing new ERISA plans. However, they need not do so. The City-payment option allows employers to make payments directly to the City, if they so choose, without requiring them to establish, or to alter existing, ERISA plans. If employers choose to pay the City, the employees for whom those payments are made are entitled to receive either discounted enrollment in the HAP or medical reimbursement accounts with the City.

Second, the Ordinance is not concerned with the nature of the health care benefits an employer provides its employees. It is only concerned with the dollar amount of the payments an employer makes toward the provision of such benefits. An employer can satisfy its spending requirements by paying the City; it can satisfy those requirements by funding exclusively preventive care; it can satisfy those requirements by setting up an on-site clinic and reimbursing employees for the purchase of over-the-counter medications; or it can satisfy those requirements in some other manner, such as funding a traditional ERISA plan. The Ordinance does not look beyond the dollar amount spent, and it does not evaluate benefits derived from those dollars.

#### IV. Discussion

The Association argues that ERISA preempts the Ordinance either because it creates a “plan” within the meaning of ERISA or because it “relates to” employers’ ERISA plans within the meaning of ERISA. For the reasons that follow, we disagree.

\* \* \*

##### A. Presumption Against Preemption

We begin by noting that state and local laws enjoy a presumption against preemption when they “clearly operate[ ] in a field that has been traditionally occupied by the States.” . . . This presumption informs our preemption analysis. . . .

The field in which the Ordinance operates is the provision of health care services to persons with low or moderate incomes. State and local governments have traditionally provided health care services to such persons. The Ordinance uses a novel approach to the provision of health services to such persons, but operates in a field that has long been the province of state and local governments, thereby “implement[ing] policies and values lying within the traditional domain of the States.”

##### B. Preemption Under ERISA

\* \* \*

The Association and the amicus, the Secretary of Labor, make two central arguments. First, they argue that the City-payment option under the Ordinance creates an ERISA plan. This argument takes two forms. The Association argues in its brief that the Ordinance’s administrative obligations on employers, in combination with a reasonable person’s ability to ascertain “benefits, beneficiaries, source of financing, and procedures for receiving benefits,” creates an ERISA plan. The Secretary of Labor argues as amicus that the HAP itself is an ERISA plan. If either argument is correct, the Ordinance almost certainly makes an impermissible “reference to” an ERISA plan. Second, they argue that even if the City-payment option does not establish an ERISA plan, an employer’s obligation to make payments at a certain level—whether or not the payments are made to the City—“relates to” the ERISA plans of covered employers and is thus preempted. We address these arguments in turn.

## 1. The City-Payment Option Does Not Create an ERISA “Plan”

If the City-payment option does not create an “employee welfare benefit plan” within the meaning of ERISA, the first argument fails. The district court concluded that employers’ payments to the City do not create an ERISA plan. See *Golden Gate Rest. Ass’n*, [535 F. Supp. 2d at 976](#) (Ordinance does not “create [ ] a separate *de facto* ERISA plan”). For the reasons that follow, we agree with the district court and hold that the City-payment option does not create an ERISA plan, *de facto* or otherwise. We first address the Association’s argument. We then address the Secretary’s argument.

### a. Employers’ Administrative Obligations, and the Ability to Ascertain Benefits, Beneficiaries, Financing and Procedures

The first element of an employee welfare benefit plan is the existence of a “plan, fund or program.” *Patelco Credit Union v. Sabni*, [262 F.3d 897, 907](#) (9th Cir. 2001). In the context of ERISA, the phrase “plan, fund or program” is a term of art. As relevant to this case, an ERISA “plan” is an “employee welfare benefit plan,” defined as

[a]ny plan, fund, or program which . . . is . . . established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants . . . , through the purchase of insurance or otherwise, . . . medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment. . . .

ERISA § 3(1); see also ERISA § 3(3).

The Supreme Court has emphasized that ERISA is concerned with “benefit plans,” rather than simply “benefits,” because “[o]nly ‘plans’ involve administrative activity potentially subject to employer abuse.” *Fort Halifax Packing Co. v. Coyne*, [482 U.S. 1, 16](#) (1987). This focus on “benefit plans” is consistent with the first underlying purpose of ERISA—protecting employees against the abuse and mismanagement of funds. If an employee’s expectation of a “benefit” presents “a danger of defeated expectations [that] is no different from the danger of defeated expectations of wages for services performed,” then the employer’s actions giving rise to that expectation do not amount to a “benefit plan” because such danger is one “Congress chose not to regulate in ERISA.” *Morash*, [490 U.S. at 115](#).

Two Supreme Court cases tell us that an employer’s obligation to make monetary payments based on the amount of time worked by an employee, over and above ordinary wages, does not necessarily create an ERISA plan. This is so even if the payments are made by the employer directly to the employees who are the beneficiaries of the putative “plan.” First, in *Fort Halifax*, a Maine statute required an employer to pay employees one week’s pay for every year worked if the employees were terminated because of a plant closing. The Court held that the statute did not create a “plan” within the meaning of ERISA: “The Maine statute neither establishes, nor requires an employer to maintain, an employee benefit *plan*. The requirement of a one-time, lump-sum payment

triggered by a single event requires no administrative scheme whatsoever to meet the employer's obligation." [Id. at 12.](#)

Second, in *Massachusetts v. Morash*, [490 U.S. 107, 109](#) (1989), a Massachusetts statute required employers to pay discharged employees their "full wages, including holiday or vacation payments, on the date of discharge." The Court held that the statute was not preempted by ERISA. The Court wrote, "It is unlikely that Congress intended to subject to ERISA's reporting and disclosure requirements those vacation benefits which by their nature are payable on a regular basis from the general assets of the employer and are accumulated over time only at the election of the employee." [Id. at 116.](#) The Court in *Morash* emphasized the importance of the fact that the employer made the payments out of its general assets:

An entirely different situation would be presented if a separate fund had been created by a group of employers to guarantee the payment of vacation benefits to laborers who regularly shift their jobs from one employer to another. Employees who are beneficiaries of such a trust face far different risks and have far greater need for the reporting and disclosure requirements that the federal law imposes than those whose vacation benefits come from the same fund from which they receive their paychecks. [Id. at 120.](#)

The employer payments at issue under the San Francisco Ordinance, which the Association contends create an ERISA plan, are not made directly to employees. Rather, they are made to the City. But even if the employers made the payments directly to the employees, *Fort Halifax* and *Morash* indicate that those payments would not be enough to create an ERISA plan. Under the Ordinance, employers make the payments on a regular periodic basis and calculate those payments based on the number of hours worked by the employee. Further, as in *Morash*, employers make the payments "on a regular basis from [their] general assets." If employers made the payments directly to the employees, there would be little to differentiate those payments from wages paid to employees. . . .

The fact that an employer makes its payments to the City rather than to the employees confirms, if confirmation were needed, that the employer's administrative obligations under the City-payment option do not create an ERISA plan. Under the Ordinance, an employer has no responsibility other than to make the required payments for covered employees, and to retain records to show that it has done so. The payments are made for a specific purpose, but the employer has no responsibility for ensuring that the payments are actually used for that purpose. The Association points to the burden entailed in keeping track of which workers perform qualifying work in San Francisco, keeping track of the hours those employees work, and keeping track of the credit (if any) an employer should get for health care payments made to non-City entities. This burden is not enough, in itself, to make the payment obligation an ERISA plan. Many federal, state and local laws, such as income tax withholding, social security, and minimum wage laws, impose similar administrative obligations on employers; yet none of these obligations constitutes an ERISA plan.

We have emphasized that an employer’s administrative duties must involve the application of more than a modicum of discretion in order for those administrative duties to amount to an ERISA plan. It is within the exercise of that discretion that an employer has the opportunity to engage in the mismanagement of funds and other abuses with which Congress was concerned when it enacted ERISA. . . .

An employer’s administrative obligations under the City-payment option do not run the risk of mismanagement of funds or other abuse. . . .

\* \* \*

. . . For employers who choose to make payments to the City, their obligation ceases as soon as they make the required payments. If an employer has made such payments to the City under the Ordinance, covered employees may enroll in the HAP free of charge or at a discounted rate. But as we will explain in more detail in a moment, there is nothing in the Ordinance that guarantees that a certain level or kind of “intended benefits” will be provided by the HAP, or that a particular group of “intended . . . beneficiaries” will be included in the HAP.

#### b. The HAP as an ERISA Plan

The Association expressly stated in its complaint that it “wholeheartedly supports the San Francisco Health Access Program and its laudable goals.” It requested that the district court “issue declaratory and injunctive relief *without* disturbing all other lawful parts of the Ordinance unrelated to” the employer spending requirement. (Emphasis in original.) The Secretary of Labor, as *amicus curiae*, argues that the HAP itself is an ERISA plan. If the Secretary is right, ERISA preempts not merely the employer spending requirements, but the HAP itself. . . .

As described in greater detail above, the first element of an employee welfare benefit plan is the existence of a “plan, fund or program.” *Patelco Credit Union*, [262 F.3d at 907](#). The HAP, administered by the City, is not an ERISA plan. Rather, the HAP is a government entitlement program available to low- and moderate-income residents of San Francisco, regardless of employment status. It is funded primarily by taxpayer dollars. Employer payments under the Ordinance provide only a small portion of the HAP’s funding, and, although we do not know the precise numbers, employees covered under the Ordinance comprise substantially less than half of all HAP enrollees. The fact that a minority of HAP enrollees pay a discounted enrollment fee because their employers participate in the City-payment option is not enough to make the HAP a “plan, fund or program” within the meaning of ERISA.

The second element of an employee welfare benefit plan requires that the plan be “established or maintained by an employer through the purchase of insurance or otherwise.” *Patelco Credit Union*, [262 F.3d at 907](#). An employer electing the City-payment option does not “establish[] or maintain[]” the HAP through its payments. The HAP exists, and will continue to exist, whether or not any covered employer makes a payment to the City under the Ordinance. Further, the employer has no control over whether its employees are eligible for the HAP. Under the terms of

the ordinance, HAP eligibility is based on income level, age, uninsured status, and City residence, but the City is free to change the conditions of eligibility for HAP enrollment as it sees fit simply by amending the Ordinance. Finally, neither the employer nor the covered employee has any control over the kind and level of benefits provided by the HAP. The employer never negotiates or signs a contract with the City, and the employer has no control over the City's coverage decisions. When the City administers the HAP, it does not act as the employer's agent entrusted to fulfill the benefits promises the employer made to its employees. An employer can make no promises to its employees with regard to the HAP or its coverage. In short, the City, rather than the employer, establishes and maintains the HAP, and the City is free to change the kind and level of benefits as it sees fit.

## 2. "Relates to" Employers' ERISA Plans

The Association's and the Secretary of Labor's second argument is that, even if the City-payment option does not create an ERISA plan, the Ordinance is preempted because it "relates to" employers' ERISA plans. ERISA § 514(a).

Section 514(a) of ERISA states that ERISA preempts "any and all State laws insofar as they . . . relate to any employee benefit plan" governed by ERISA. ERISA § 514(a). The Supreme Court has established a two-part inquiry to interpret § 514(a): "A law 'relate[s] to' a covered employee benefit plan for purposes of § 514(a) if it [1] has a connection with or [2] reference to such a plan." *Dillingham*, [519 U.S. at 324](#). We consider these two inquiries in turn.

### a. "Connection with" a Plan

In *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, [514 U.S. 645, 655](#) (1995), the Court acknowledged the difficulty of interpreting § 514(a):

If "relate to" were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course . . . . But that, of course, would be to read Congress's words of limitation as mere sham, and to read the presumption against pre-emption out of the law whenever Congress speaks to the matter with generality.

Likewise, the Court recognized that the two-part inquiry it had adopted to interpret § 514(a) did not provide much additional guidance in cases hinging on a law's "connection with" an employee benefit plan. "For the same reasons that infinite relations cannot be the measure of pre-emption, neither can infinite connections." *Id.* at [656](#).

We read *Travelers* as narrowing the Court's interpretation of the scope of § 514(a). . . .

As noted above, one "purpose of ERISA is to provide a uniform regulatory regime over employee benefit plans." *Davila*, [542 U.S. at 208](#). The purpose of ERISA's preemption provision is to "ensure [] that the administrative practices of a benefit plan will be governed by only a single set of regulations." *Fort Halifax Packing Co.*, [482 U.S. at 11](#).

\* \* \*

The Ordinance in this case stands in stark contrast to the laws struck down in *Egelhoff, Shaw* and *Agsalud*. The Ordinance does not require any employer to adopt an ERISA plan or other health plan. Nor does it require any employer to provide specific benefits through an existing ERISA plan or other health plan. Any employer covered by the Ordinance may fully discharge its expenditure obligations by making the required level of employee health care expenditures, whether those expenditures are made in whole or in part to an ERISA plan, or in whole or in part to the City. The Ordinance thus preserves ERISA’s “uniform regulatory regime.” *See Davila*, [542 U.S. at 208](#).

A covered employer may choose to adopt or to change an ERISA plan in lieu of making the required health care expenditures to the City. An employer may be influenced by the Ordinance to do so because, when faced with an unavoidable obligation to make a payment at a certain level, it may prefer to make that payment to an ERISA plan. However, as *Travelers* makes clear, such influence is entirely permissible.

In *Travelers*, a New York statute required hospitals to collect surcharges from patients covered by commercial insurance companies, including those administering ERISA plans, but not from patients covered by Blue Cross/Blue Shield plans. The difference in treatment was justified on the ground that “the Blues pay the hospitals promptly and efficiently and, more importantly, provide coverage for many subscribers whom the commercial insurers would reject as unacceptable risks.” *Travelers*, [514 U.S. at 658](#). The Court recognized that the surcharge might influence “choices made by insurance buyers, including ERISA plans.” *Id.* [at 659](#). But such an influence was not fatal to the New York statute: “An indirect economic influence . . . does not bind plan administrators to any particular choice and thus function as a regulation of an ERISA plan itself[.] . . . Nor does the indirect influence of the surcharges preclude uniform administrative practice [.]” *Id.* [at 659-60](#).

In this case, the influence exerted by the Ordinance is even less direct than the influence in *Travelers*. In *Travelers*, the required surcharge on benefits provided under ERISA plans administered by commercial insurers inescapably changed the cost structure for those plans’ health care benefits and thereby exerted economic pressure on the manner in which the plans would be administered. Here, by contrast, the Ordinance does not regulate benefits or charges for benefits provided by ERISA plans. Its only influence is on the employer who, because of the Ordinance, may choose to make its required health care expenditures to an ERISA plan rather than to the City.

\* \* \*

#### Conclusion

There may be better ways to provide health care than to require employers in the City of San Francisco to foot the bill. But our task is a narrow one, and it is beyond our province to evaluate the wisdom of the Ordinance now before us. We are asked only to decide whether § 514(a) of ERISA preempts the employer spending requirements of the Ordinance. We hold that it does not. The spending requirements do not establish an ERISA plan; nor do they have an impermissible connection with employers’ ERISA plans, or make an impermissible reference to such plans.

We therefore REVERSE the judgment of the district court and REMAND with instructions to enter summary judgment in favor of the City.

## Chapter 6 - Plan Administration

### P. 234

**Add:** after first full paragraph:

Plan fiduciaries and their functions are as follows:

Board of Directors	Duty to prudently appoint the plan administrator and plan trustee (or delegate appointment) and to monitor their performance.
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Plan Administrator Primary authority to manage and control the plan operation. May delegate fiduciary responsibility, but then has an ongoing duty to monitor appointed fiduciary.

Plan Trustee	Holds, invests and distributes plan assets. Maybe a directed trustee acting under direction of plan administrator.
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Plan Investment Committee	Acts within delegated authority and determines general plan investment of assets.
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Investment Manager	Specific investment responsibility granted by trustee or plan investment committee.
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Investment Advisor	Advises the plan administrator and plan investment committee as to the selection of investment options and investment managers.
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### P. 331

**Add:** before *Moench v. Robertson*

An ESOP is a qualified retirement plan governed by ERISA that is designed to invest primarily in the stock of the employer. It is a defined contribution plan with the value of the employee's retirement benefits tied to the market value of the employer's stock.

## Chapter 7 – Enforcement Issues

P. 347 A former employee who takes a lump-sum distribution from a 401(k) account may still qualify as a “participant” with standing to sue under ERISA § 502(a)(2). *Wangberger v Janus Capital Group, Inc.*, [529 F.3d 208](#) (4<sup>th</sup> Cir. 2008). The decision is in accord with similar holdings by the First, Third, Sixth, Seventh, and Eleventh Circuits.

P. 361

**Delete:**

p. 361 *Pinto v. Reliance Standard Life Insurance*

p. 366 *Denmark v. Liberty Life Company*

**Add:**

**METROPOLITAN LIFE INSURANCE COMPANY v. GLENN**

[128 S. Ct. 2343](#) (2008)

JUSTICE BREYER delivered the opinion of the Court.

The Employee Retirement Income Security Act of 1974 (ERISA) permits a person denied benefits under an employee benefit plan to challenge that denial in federal court. ERISA § 502(a)(1)(B). Often the entity that administers the plan, such as an employer or an insurance company, both determines whether an employee is eligible for benefits and pays benefits out of its own pocket. We here decide that this dual role creates a conflict of interest; that a reviewing court should consider that conflict as a factor in determining whether the plan administrator has abused its discretion in denying benefits; and that the significance of the factor will depend upon the circumstances of the particular case. See *Firestone Tire & Rubber Co. v. Bruch*, [489 U.S. 101, 115](#) (1989).

I

Petitioner Metropolitan Life Insurance Company (MetLife) serves as both an administrator and the insurer of Sears, Roebuck & Company’s long-term disability insurance plan, an ERISA-governed employee benefit plan. See App. 182a-183a; ERISA § 4. The plan grants MetLife (as administrator) discretionary authority to determine whether an employee’s claim for benefits is valid; it simultaneously provides that MetLife (as insurer) will itself pay valid benefit claims. App. 181a-182a.

Respondent Wanda Glenn, a Sears employee, was diagnosed with severe dilated cardiomyopathy, a heart condition whose symptoms include fatigue and shortness of breath. She applied for plan disability benefits in June 2000, and MetLife concluded that she met the plan’s standard for an initial 24 months of benefits, namely, that she could not “perform the material duties of [her] own job.” *Id.* at 159a-160a. MetLife also directed Glenn to a law firm that would assist her in applying for federal Social Security disability benefits (some of which MetLife itself would be

entitled to receive as an offset to the more generous plan benefits). In April 2002, an Administrative Law Judge found that Glenn’s illness prevented her not only from performing her own job but also “from performing any jobs [for which she could qualify] existing in significant numbers in the national economy.” App. to Pet. for Cert. 49a; see also [20 C.F.R. § 404.1520\(g\)](#) (2007). The Social Security Administration consequently granted Glenn permanent disability payments retroactive to April 2000. Glenn herself kept none of the backdated benefits: three-quarters went to MetLife, and the rest (plus some additional money) went to the lawyers.

To continue receiving Sears plan disability benefits after 24 months, Glenn had to meet a stricter, Social-Security-type standard, namely, that her medical condition rendered her incapable of performing not only her own job but of performing “the material duties of any gainful occupation for which” she was “reasonably qualified.” App. 160a. MetLife denied Glenn this extended benefit because it found that she was “capable of performing full time sedentary work.” *Id.* at 31a.

After exhausting her administrative remedies, Glenn brought this federal lawsuit, seeking judicial review of MetLife’s denial of benefits. See ERISA § 502(a)(1)(B); [461 F.3d 660, 665](#) (C.A.6 2006). The District Court denied relief. Glenn appealed to the Court of Appeals for the Sixth Circuit. Because the plan granted MetLife “discretionary authority to . . . determine benefits,” the Court of Appeals reviewed the administrative record under a deferential standard. *Id.* at 666. In doing so, it treated “as a relevant factor” a “conflict of interest” arising out of the fact that MetLife was “authorized both to decide whether an employee is eligible for benefits and to pay those benefits.” *Ibid.*

The Court of Appeals ultimately set aside MetLife’s denial of benefits in light of a combination of several circumstances: (1) the conflict of interest; (2) MetLife’s failure to reconcile its own conclusion that Glenn could work in other jobs with the Social Security Administration’s conclusion that she could not; (3) MetLife’s focus upon one treating physician report suggesting that Glenn could work in other jobs at the expense of other, more detailed treating physician reports indicating that she could not; (4) MetLife’s failure to provide all of the treating physician reports to its own hired experts; and (5) MetLife’s failure to take account of evidence indicating that stress aggravated Glenn’s condition. See *id.* at 674.

MetLife sought certiorari, asking us to determine whether a plan administrator that both evaluates and pays claims operates under a conflict of interest in making discretionary benefit determinations. The Solicitor General suggested that we also consider “how” any such conflict should “be taken into account on judicial review of a discretionary benefit determination.” Brief for United States as *Amicus Curiae* on Pet. for Cert. 22. We agreed to consider both questions. See [552 U.S.](#), 128 S. Ct. 1117, 169 L. Ed. 2d 845 (2008).

## II

In *Firestone Tire & Rubber Co. v. Bruch*, [489 U.S. 101](#), this Court addressed “the appropriate standard of judicial review of benefit determinations by fiduciaries or plan administrators under”

§ 502(a)(1)(B), the ERISA provision at issue here. [Id. at 105](#); see also [id. at 108](#). *Firestone* set forth four principles of review relevant here.

(1) In “determining the appropriate standard of review,” a court should be “guided by principles of trust law”; in doing so, it should analogize a plan administrator to the trustee of a common-law trust; and it should consider a benefit determination to be a fiduciary act (*i.e.*, an act in which the administrator owes a special duty of loyalty to the plan beneficiaries). [Id. at 111-113](#).

(2) Principles of trust law require courts to review a denial of plan benefits “under a *de novo* standard” unless the plan provides to the contrary. *Firestone*, [489 U.S. at 115](#).

(3) Where the plan provides to the contrary by granting “the administrator or fiduciary *discretionary authority* to determine eligibility for benefits,” *Firestone*, [489 U.S. at 115](#) (emphasis added), “[t]rust principles make a *deferential standard* of review appropriate,” [id. at 111 \(citing Restatement § 187 \(abuse-of-discretion standard\); Bogert § 560, at 193-208; emphasis added\)](#).

(4) If “a benefit plan gives discretion to an administrator or fiduciary who *is operating under a conflict of interest*, that conflict must be *weighed as a factor* in determining whether there is an abuse of discretion.” [Firestone, supra, at 115 \(quoting Restatement § 187, Comment d; emphasis added; alteration omitted\)](#).

The questions before us, while implicating the first three principles, directly focus upon the application and the meaning of the fourth.

### III

The first question asks whether the fact that a plan administrator both evaluates claims for benefits and pays benefits claims creates the kind of “conflict of interest” to which *Firestone*’s fourth principle refers. In our view, it does.

That answer is clear where it is the employer that both funds the plan and evaluates the claims. In such a circumstance, “every dollar provided in benefits is a dollar spent by . . . the employer; and every dollar saved . . . is a dollar in [the employer’s] pocket.” *Bruch v. Firestone Tire & Rubber Co.*, [828 F.2d 134, 144](#) (C.A.3 1987). The employer’s fiduciary interest may counsel in favor of granting a borderline claim while its immediate financial interest counsels to the contrary. Thus, the employer has an “interest . . . conflicting with that of the beneficiaries,” the type of conflict that judges must take into account when they review the discretionary acts of a trustee of a common-law trust. Restatement § 187, Comment *d*; [see also Firestone, supra at 115 \(citing that Restatement comment\)](#); *cf.* Black’s Law Dictionary 319 (8th ed. 2004) (“conflict of interest” is a “real or seeming incompatibility between one’s private interests and one’s public or fiduciary duties”).

Indeed, *Firestone* itself involved an employer who administered an ERISA benefit plan and who both evaluated claims and paid for benefits. See [489 U.S. at 105](#). And thus that circumstance quite possibly was what the Court had in mind when it mentioned conflicted administrators. See [id.](#)

[at 115](#). The *Firestone* parties, while disagreeing about other matters, agreed that the dual role created a conflict of interest of some kind in the employer.

MetLife points out that an employer who creates a plan that it will both fund and administer foresees, and implicitly approves, the resulting conflict. But that fact cannot change our conclusion. At trust law, the fact that a settlor (the person establishing the trust) approves a trustee's conflict does not change the legal need for a judge later to take account of that conflict in reviewing the trustee's discretionary decisionmaking. See Restatement § 107, Comment *f* (discretionary acts of trustee with settlor-approved conflict subject to "careful scrutiny"); [id.](#) § 107, Comment *f*, Illustration 1 (conflict is "a factor to be considered by the court in determining later whether" there has been an "abuse of discretion"); [id.](#) § 187, Comment *d* (same); 3 A. SCOTT, W. FRATCHER, & M. ASCHER, SCOTT AND ASCHER ON TRUSTS § 18.2, pp. 1342-43 (5th ed. 2007) [hereinafter SCOTT] (same). See also, e.g., Bogert § 543, at 264 (rev. 2d ed. 1993) (settlor approval simply permits conflicted individual to act as a trustee); [id.](#) § 543(U), at 422-431 (same); Scott § 17.2.11, at 1136-1139 (same).

MetLife also points out that we need not follow trust law principles where trust law is "inconsistent with the language of the statute, its structure, or its purposes." *Hughes Aircraft Co. v. Jacobson*, [525 U.S. 432, 447](#) (1999) (internal quotation marks omitted). MetLife adds that to find a conflict here is inconsistent (1) with ERISA's efforts to avoid complex review proceedings, see *Variety Corp. v. Howe*, [516 U.S. 489, 497](#) (1996); (2) with Congress' efforts not to deter employers from setting up benefit plans, see [ibid.](#), and (3) with an ERISA provision specifically allowing employers to administer their own plans, see ERISA § 408(c)(3).

But we cannot find in these considerations any significant inconsistency. As to the first, we note that trust law functions well with a similar standard. As to the second, we have no reason, empirical or otherwise, to believe that our decision will seriously discourage the creation of benefit plans. As to the third, we have just explained why approval of a conflicted trustee differs from review of that trustee's conflicted decisionmaking. As to all three taken together, we believe them outweighed by "Congress' desire to offer employees enhanced protection for their benefits." *Variety*, *supra*, at 497 (discussing "competing congressional purposes" in enacting ERISA).

The answer to the conflict question is less clear where (as here) the plan administrator is not the employer itself but rather a professional insurance company. Such a company, MetLife would argue, likely has a much greater incentive than a self-insuring employer to provide accurate claims processing. That is because the insurance company typically charges a fee that attempts to account for the cost of claims payouts, with the result that paying an individual claim does not come to the same extent from the company's own pocket. It is also because the marketplace (and regulators) may well punish an insurance company when its products, or ingredients of its products, fall below par. And claims processing, an ingredient of the insurance company's product, falls below par when it seeks a biased result, rather than an accurate one. Why, MetLife might ask, should one consider an insurance company *inherently* more conflicted than any other market participant, say, a manufacturer who might earn more money in the short run by producing a product with poor

quality steel or a lawyer with an incentive to work more slowly than necessary, thereby accumulating more billable hours?

Conceding these differences, we nonetheless continue to believe that for ERISA purposes a conflict exists. For one thing, the employer's own conflict may extend to its selection of an insurance company to administer its plan. An employer choosing an administrator in effect buys insurance for others and consequently (when compared to the marketplace customer who buys for himself) may be more interested in an insurance company with low rates than in one with accurate claims processing. *Cf.* Langbein, *Trust Law as Regulatory Law*, [101 NW. U.L. REV. 1315, 1323-24](#) (2007) (observing that employees are rarely involved in plan negotiations).

For another, ERISA imposes higher-than-marketplace quality standards on insurers. It sets forth a special standard of care upon a plan administrator, namely, that the administrator “discharge [its] duties” in respect to discretionary claims processing “solely in the interests of the participants and beneficiaries” of the plan, § 404(a)(1); it simultaneously underscores the particular importance of accurate claims processing by insisting that administrators “provide a ‘full and fair review’ of claim denials,” *Firestone*, [489 U.S. at 113](#) (quoting § 503(2)); and it supplements marketplace and regulatory controls with judicial review of individual claim denials, see § 502(a)(1)(B).

Finally, a legal rule that treats insurance company administrators and employers alike in respect to the *existence* of a conflict can nonetheless take account of the circumstances to which MetLife points so far as it treats those, or similar, circumstances as diminishing the *significance* or *severity* of the conflict in individual cases. See Part IV, *infra*.

#### IV

We turn to the question of “how” the conflict we have just identified should “be taken into account on judicial review of a discretionary benefit determination.” [552 U.S.](#), 128 S. Ct. 1117 (2008). In doing so, we elucidate what this Court set forth in *Firestone*, namely, that a conflict should “be weighed as a ‘factor in determining whether there is an abuse of discretion.’” [489 U.S. at 115](#) (quoting Restatement § 187, Comment *d*; alteration omitted).

We do not believe that *Firestone*'s statement implies a change in the *standard* of review, say, from deferential to *de novo* review. Trust law continues to apply a deferential standard of review to the discretionary decisionmaking of a conflicted trustee, while at the same time requiring the reviewing judge to take account of the conflict when determining whether the trustee, substantively or procedurally, has abused his discretion. See Restatement § 187, Comments *d-j*; [id.](#) § 107, Comment *f*; Scott § 18.2, at 1342-1344. We see no reason to forsake *Firestone*'s reliance upon trust law in this respect.

Nor would we overturn *Firestone* by adopting a rule that in practice could bring about near universal review by judges *de novo*—*i.e.*, without deference—of the lion's share of ERISA plan claims denials. See Brief for America's Health Insurance Plans et al. as *Amici Curiae* 3-4 (many ERISA plans grant discretionary authority to administrators that combine evaluation and payment

functions). Had Congress intended such a system of review, we believe it would not have left to the courts the development of review standards but would have said more on the subject. See *Firestone*, *supra*, at 109, [109 S. Ct. 948](#) (“ERISA does not set out the appropriate standard of review for actions under § 502(a)(1)(B)”).

Neither do we believe it necessary or desirable for courts to create special burden-of-proof rules, or other special procedural or evidentiary rules, focused narrowly upon the evaluator/payor conflict. In principle, as we have said, conflicts are but one factor among many that a reviewing judge must take into account. Benefits decisions arise in too many contexts, concern too many circumstances, and can relate in too many different ways to conflicts—which themselves vary in kind and in degree of seriousness—for us to come up with a one-size-fits-all procedural system that is likely to promote fair and accurate review. Indeed, special procedural rules would create further complexity, adding time and expense to a process that may already be too costly for many of those who seek redress.

We believe that *Firestone* means what the word “factor” implies, namely, that when judges review the lawfulness of benefit denials, they will often take account of several different considerations of which a conflict of interest is one. This kind of review is no stranger to the judicial system. Not only trust law, but also administrative law, can ask judges to determine lawfulness by taking account of several different, often case-specific, factors, reaching a result by weighing all together.

In such instances, any one factor will act as a tiebreaker when the other factors are closely balanced, the degree of closeness necessary depending upon the tiebreaking factor’s inherent or case-specific importance. 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 1317-21 (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. See Herzel & Colling, *The Chinese Wall and Conflict of Interest in Banks*, [34 BUS. LAW 73, 114](#) (1978) (recommending interdepartmental information walls to reduce bank conflicts); Brief for Blue Cross and Blue Shield Association as *Amicus Curiae* 15 (suggesting that insurers have incentives to reward claims processors for their accuracy); *cf. generally* J. MASHAW, *BUREAUCRATIC JUSTICE* (1983) (discussing internal controls as a sound method of producing administrative accuracy).

The Court of Appeals’ opinion in the present case illustrates the combination-of-factors method of review. The record says little about MetLife’s efforts to assure accurate claims assessment. The Court of Appeals gave the conflict weight to some degree; its opinion suggests that, in context, the court would not have found the conflict alone determinative. See [461 F.3d at](#)

[666, 674](#). The court instead focused more heavily on other factors. In particular, the court found questionable the fact that MetLife had encouraged Glenn to argue to the Social Security Administration that she could do no work, received the bulk of the benefits of her success in doing so (the remainder going to the lawyers it recommended), and then ignored the agency's finding in concluding that Glenn could in fact do sedentary work. *See id. at 666-69*. This course of events was not only an important factor in its own right (because it suggested procedural unreasonableness), but also would have justified the court in giving more weight to the conflict (because MetLife's seemingly inconsistent positions were both financially advantageous). And the court furthermore observed that MetLife had emphasized a certain medical report that favored a denial of benefits, had deemphasized certain other reports that suggested a contrary conclusion, and had failed to provide its independent vocational and medical experts with all of the relevant evidence. *See id. at 669-74*. All these serious concerns, taken together with some degree of conflicting interests on MetLife's part, led the court to set aside MetLife's discretionary decision. *See id. at 674-75*. We can find nothing improper in the way in which the court conducted its review.

Finally, we note that our elucidation of *Firestone's* standard does not consist of a detailed set of instructions. In this respect, we find pertinent this Court's comments made in a somewhat different context, the context of court review of agency factfinding. *See Universal Camera Corp., supra*. In explaining how a reviewing court should take account of the agency's reversal of its own examiner's factual findings, this Court did not lay down a detailed set of instructions. It simply held that the reviewing judge should take account of that circumstance as a factor in determining the ultimate adequacy of the record's support for the agency's own factual conclusion. *Id. at 492-97*. In so holding, the Court noted that it had not enunciated a precise standard. *See, e.g., id. at 493*. But it warned against creating formulas that will "falsify] the actual process of judging" or serve as "instrument[s] of futile casuistry." *Id. at 489*. The Court added that there "are no talismanic words that can avoid the process of judgment." *Ibid.* It concluded then, as we do now, that the "[w]ant of certainty" in judicial standards "partly reflects the intractability of any formula to furnish definiteness of content for all the impalpable factors involved in judicial review." *Id. at 477*.

We affirm the decision of the Court of Appeals.

*It is so ordered.*

CHIEF JUSTICE ROBERTS, concurring in part and concurring in the judgment.

I join all but Part IV of the Court's opinion. I agree that a third-party insurer's dual role as a claims administrator and plan funder gives rise to a conflict of interest that is pertinent in reviewing claims decisions. I part ways with the majority, however, when it comes to *how* such a conflict should matter. *See ante*, at 2349-52. The majority would accord weight, of varying and indeterminate amount, to the existence of such a conflict in every case where it is present. *See ante*, at 2351-52. The majority's approach would allow the bare existence of a conflict to enhance the significance of other factors already considered by reviewing courts, even if the conflict is not shown to have played any role in the denial of benefits. The end result is to increase the level of scrutiny in

every case in which there is a conflict—that is, in many if not most ERISA cases—thereby undermining the deference owed to plan administrators when the plan vests discretion in them.

I would instead consider the conflict of interest on review only where there is evidence that the benefits denial was motivated or affected by the administrator’s conflict. No such evidence was presented in this case. I would nonetheless affirm the judgment of the Sixth Circuit, because that court was justified in finding an abuse of discretion on the facts of this case—conflict or not.

\* \* \*

The conflict of interest at issue here is a common feature of ERISA plans. The majority acknowledges that the “lion’s share of ERISA plan claims denials” are made by administrators that both evaluate and pay claims. . . . For this reason, the majority is surely correct in concluding that it is important to retain deferential review for decisions made by conflicted administrators, in order to avoid “near universal review by judges *de novo*.” *Ante*, at 2350.

But the majority’s approach does not do so. Saying that courts should consider the mere existence of a conflict in every case, without focusing that consideration in any way, invites the substitution of judicial discretion for the discretion of the plan administrator. Judicial review under the majority’s opinion is less constrained, because courts can look to the bare presence of a conflict as authorizing more exacting scrutiny.

This problem is exacerbated because the majority is so imprecise about how the existence of a conflict should be treated in a reviewing court’s analysis. . . .

Pursuant to the majority’s strained analogy, *Universal Camera Corp. v. NLRB*, [340 U.S. 474](#) (1951), makes an unexpected appearance on stage. . . .

\* \* \*

It is the actual motivation that matters in reviewing benefits decisions for an abuse of discretion, not the bare presence of the conflict itself. Consonant with this understanding, a conflict of interest can support a finding that an administrator abused its discretion only where the evidence demonstrates that the conflict actually motivated or influenced the claims decision. . . . The mere existence of a conflict, however, is not justification for heightening the level of scrutiny, either on its own or by enhancing the significance of other factors.

\* \* \*

JUSTICE SCALIA, with whom JUSTICE THOMAS joins, dissenting.

I agree with the Court that petitioner Metropolitan Life Insurance Company [hereinafter petitioner] has a conflict of interest. A third-party insurance company that administers an ERISA-governed disability plan and that pays for benefits out of its own coffers profits with each benefits claim it rejects. I see no reason why the Court must volunteer, however, that *an employer* who

administers its own ERISA-governed plan “clear[ly]” has a conflict of interest. See *ante*, at 2348. At least one Court of Appeals has thought that while the insurance-company administrator has a conflict, the employer-administrator does not. See *Colucci v. Agfa Corp. Severance Pay Plan*, [431 F.3d 170, 179](#) (C.A.4 2005). I would not resolve this question until it has been presented and argued, and the Court’s unnecessary and uninvited resolution must be regarded as dictum.

The more important question is how the existence of a conflict should bear upon judicial review of the administrator’s decision, and on that score I am in fundamental disagreement with the Court. Even if the choice were mine as a policy matter, I would not adopt the Court’s totality-of-the-circumstances (so-called) “test,” in which the existence of a conflict is to be put into the mix and given some (unspecified) “weight.” This makes each case unique, and hence the outcome of each case unpredictable—not a reasonable position in which to place the administrator that has been explicitly given discretion by the creator of the plan, despite the existence of a conflict. See *ante*, at 2353-54 (Roberts, C.J., concurring in part and concurring in judgment). More importantly, however, this is not a question to be solved by this Court’s policy views; our cases make clear that it is to be governed by the law of trusts. Under that law, a fiduciary with a conflict does not abuse its discretion unless the conflict *actually* and *improperly motivates* the decision. There is no evidence of that here.

I

\* \* \*

Looking to the common law of trusts (which is, after all, what the *holding* of *Firestone* binds us to do), I would adopt the entirety of the Restatement’s clear guidelines for judicial review. In trust law, a court reviewing a trustee’s decision would substitute its own *de novo* judgment for a trustee’s only if it found either that the trustee had no discretion in making the decision, see *Firestone, supra*, at [111-12](#), or that the trustee had discretion but abused it, see RESTATEMENT (SECOND) OF TRUSTS § 187. Otherwise, the court would defer to the trustee. Cf. *Shelton v. King*, [229 U.S. 90, 94-95](#) (1913). “Abuse of discretion,” as the Restatement uses the term, refers specifically to four distinct failures: the trustee acted dishonestly; he acted with some other improper motive; he failed to use judgment; or he acted beyond the bounds of a reasonable judgment. See RESTATEMENT (SECOND) OF TRUSTS § 187, Comment *e*.

\* \* \*

Common sense confirms that a trustee’s conflict of interest is irrelevant to determining the substantive reasonableness of his decision. A reasonable decision is reasonable whether or not the person who makes it has a conflict. If it were otherwise, the consequences would be perverse: A trustee without a conflict could take either of two reasonable courses of action, but a trustee with a conflict, facing the same two choices, would be compelled to take the course that avoids the appearance of self-dealing. He would have to do that even if he thought the other one would better serve the beneficiary’s interest, lest his determination be set aside as unreasonable. . . .

## II

Applying the Restatement's guidelines to this case, I conclude that the only possible basis for finding an abuse of discretion in this case would be unreasonableness of petitioner's determination of no disability. The principal factor suggesting that is the finding of disability by the Social Security Administration (SSA). But ERISA fiduciaries need not always reconcile their determinations with the SSA's, nor is the SSA's conclusion entitled to any special weight. *Cf. Black & Decker Disability Plan v. Nord*, [538 U.S. 822, 834](#) (2003). The SSA's determination may have been wrong, and it was contradicted by other medical opinion.

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The Supreme Court reaffirmed its holding in *Firestone* in the following case that addressed what standard of review should apply to a plan administrator's decision after the administrator's prior decision was rejected as unreasonable:

**CONKRIGHT v. FROMMERT**  
[130 S. Ct. 1640](#) (2010)

CHIEF JUSTICE ROBERTS delivered the opinion of the Court.

People make mistakes. Even administrators of ERISA plans. That should come as no surprise, given that the Employee Retirement Income Security Act of 1974 is "an enormously complex and detailed statute," *Mertens v. Hewitt Associates*, [508 U.S.248, 262](#) (1993), and the plans that administrators must construe can be lengthy and complicated. (The one at issue here runs to 81 pages, with 139 sections.) We held in *Firestone Tire & Rubber Co. v. Bruch*, [489 U.S. 101](#) (1989), that an ERISA plan administrator with discretionary authority to interpret a plan is entitled to deference in exercising that discretion. The question here is whether a single honest mistake in plan interpretation justifies stripping the administrator of that deference for subsequent related interpretations of the plan. We hold that it does not.

## I

As in many ERISA matters, the facts of this case are exceedingly complicated. Fortunately, most of the factual details are unnecessary to the legal issues before us, so we cover them only in broad strokes. This case concerns Xerox Corporation's pension plan, which is covered by ERISA. Petitioners are the plan itself (hereinafter Plan), and the Plan's current and former administrators (hereinafter Plan Administrator). See ERISA Sec. 3(16)(A)(i); App. 32a. Respondents are Xerox employees who left the company in the 1980's, received lump-sum distributions of retirement benefits they had earned up to that point, and were later rehired. See [328 F.Supp.2d 420, 424](#) (W.D.N.Y.2004); Brief for Respondents 9-10. The dispute giving rise to this case concerns how to

account for respondents' past distributions when calculating their current benefits-that is, how to avoid paying respondents the same benefits twice.

The Plan Administrator initially interpreted the Plan to call for an approach that has come to be known as the "phantom account" method. [328 F.Supp.2d, at 424](#). Essentially, that method calculated the hypothetical growth that respondents' past distributions would have experienced if the money had remained in Xerox's investment funds, and reduced respondents' present benefits accordingly. See [id., at 426-428](#); App. to Pet. for Cert. 146a. After the Plan Administrator denied respondents' administrative challenges to that method, respondents filed suit in federal court under ERISA Sec. 502(a)(1)(B). See [328 F.Supp.2d, at 428-429](#). The District Court granted summary judgment for the Plan, applying a deferential standard of review to the Plan Administrator's interpretation. See [id., at 430-431, 439](#). The Second Circuit vacated and remanded, holding that the Plan Administrator's interpretation was unreasonable and that respondents had not been adequately notified that the phantom account method would be used to calculate their benefits. See [433 F.3d 254, 257, 265-269](#) (2006).

The phantom account method having been exorcised from the Plan, the District Court on remand considered other approaches for adjusting respondents' present benefits in light of their past distributions. See [472 F.Supp.2d 452, 456-458](#) (W.D.N.Y.2007). The Plan Administrator submitted an affidavit proposing an approach that, like the phantom account method, accounted for the time value of the money that respondents had previously received. But unlike the phantom account method, the Plan Administrator's new approach did not calculate the present value of a past distribution based on events that occurred after the distribution was made. Instead, the new approach used an interest rate that was fixed at the time of the distribution, thereby calculating the current value of the distribution based on information that was known at the time of the distribution. See App. to Pet. for Cert. 147a-153a. Petitioners argued that the District Court should apply a deferential standard of review to this approach, and accept it as a reasonable interpretation of the Plan.

The District Court did not apply a deferential standard of review. Nor did it accept the Plan Administrator's interpretation. Instead, after finding the Plan to be ambiguous, the District Court adopted an approach proposed by respondents that did not account for the time value of money. Under that approach, respondents' present benefits were reduced only by the nominal amount of their past distributions-thereby treating a dollar distributed to respondents in the 1980's as equal in value to a dollar distributed today. See [472 F.Supp.2d, at 457-458](#). The Second Circuit affirmed in relevant part, holding that the District Court was correct not to apply a deferential standard on remand, and that the District Court's decision on the merits was not an abuse of discretion. See [535 F.3d 111, 119](#) (2008).

Petitioners asked us to grant certiorari on two questions: (1) whether the District Court owed deference to the Plan Administrator's interpretation of the Plan on remand, and (2) whether the Court of Appeals properly granted deference to the District Court on the merits. We granted certiorari on both, but find it necessary to decide only the first.

## II

### A

This Court addressed the standard for reviewing the decisions of ERISA plan administrators in *Firestone*, [489 U.S. 101](#). Because ERISA's text does not directly resolve the matter, we looked to "principles of trust law" for guidance. [Id.](#), at 109, 111. We recognized that, under trust law, the proper standard of review of a trustee's decision depends on the language of the instrument creating the trust. See [id.](#), at 111-112. If the trust documents give the trustee "power to construe disputed or doubtful terms, ... the trustee's interpretation will not be disturbed if reasonable." [Id.](#), at 111. Based on these considerations, we held that "a denial of benefits challenged under section 502(a)(1)(B) is to be reviewed under a de novo standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." [Id.](#), at 115.

We expanded *Firestone's* approach in *Metropolitan Life Ins. Co. v. Glenn*, [554 U.S. 105](#) (2008). In determining the proper standard of review when a plan administrator operates under a conflict of interest, we again looked to trust law, the terms of the plan at issue, and the principles of ERISA—plus, of course, our precedent in *Firestone*. We held that, when the terms of a plan grant discretionary authority to the plan administrator, a deferential standard of review remains appropriate even in the face of a conflict.

It is undisputed that, under *Firestone* and the terms of the Plan, the Plan Administrator here would normally be entitled to deference when interpreting the Plan. See [328 F.Supp.2d, at 430-431](#) (observing that the Plan grants the Plan Administrator "broad discretion in making decisions relative to the Plan"). The Court of Appeals, however, crafted an exception to *Firestone* deference. Specifically, the Second Circuit held that a court need not apply a deferential standard "where the administrator ha[s] previously construed the same [plan] terms and we found such a construction to have violated ERISA." [535 F.3d, at 119](#). Under that view, the District Court here was entitled to reject a reasonable interpretation of the Plan offered by the Plan Administrator, solely because the Court of Appeals had overturned a previous interpretation by the Administrator. Cf. [ibid.](#) ([accepting the District Court's chosen method as one of "several reasonable alternatives"](#)).

### B

We reject this "one-strike-and-you're-out" approach. Brief for Petitioners 51. As an initial matter, it has no basis in the Court's holding in *Firestone*, which set out a broad standard of deference without any suggestion that the standard was susceptible to ad hoc exceptions like the one adopted by the Court of Appeals. See [489 U.S., at 111, 115](#). Indeed, we refused to create such an exception to *Firestone* deference in *Glenn*, recognizing that ERISA law was already complicated enough without adding "special procedural or evidentiary rules" to the mix. [128 S.Ct., at 2351](#). If, as we held in *Glenn*, a systemic conflict of interest does not strip a plan administrator of deference, it is difficult to see why a single honest mistake would require a different result.

Nor is the Court of Appeals' decision supported by the considerations on which our holdings in *Firestone* and *Glenn* were based—namely, the terms of the plan, principles of trust law, and the purposes of ERISA. See *supra*, at 1646-1647. First, the Plan here grants the Plan Administrator general authority to "[c]onstrue the Plan." App. to Pet. for Cert. 141a-142a. Nothing in that provision suggests that the grant of authority is limited to first efforts to construe the Plan.

Second, the Court of Appeals' exception to *Firestone* deference is not required by principles of trust law. Trust law is unclear on the narrow question before us. A leading treatise states that a court will strip a trustee of his discretion when there is reason to believe that he will not exercise that discretion fairly—for example, upon a showing that the trustee has already acted in bad faith:

If the trustee's failure to pay a reasonable amount [to the beneficiary of the trust] is due to a failure to exercise [the trustee's] discretion honestly and fairly, the court may well fix the amount [to be paid] itself. On the other hand, if the trustee's failure to provide reasonably for the beneficiary is due to a mistake as to the trustee's duties or powers, and there is no reason to believe the trustee will not fairly exercise the discretion once the court has determined the extent of the trustee's duties and powers, the court ordinarily will not fix the amount but will instead direct the trustee to make reasonable provision for the beneficiary's support. 3 A. Scott, W. Fratcher, & M. Ascher, *Scott and Ascher on Trusts* § 18.2.1, pp. 1348-1349 (5th ed. 2007) (hereinafter *Scott and Ascher*) (footnote omitted) (citing cases).

This is not surprising—if the settlor who creates a trust grants discretion to the trustee, it seems doubtful that the settlor would want the trustee divested entirely of that discretion simply because of one good-faith mistake.

Here the lower courts made no finding that the Plan Administrator had acted in bad faith or would not fairly exercise his discretion to interpret the terms of the Plan. Thus, if the District Court had followed the trust law principles set out in *Scott and Ascher*, it should not have "act[ed] as a substitute trustee," *Eaton v. Eaton*, [82 N.H. 216, 218](#), 132 A. 10, 11 (1926), and stripped the Plan Administrator of the deference he would otherwise enjoy under *Firestone* and the terms of the Plan.

Other trust law sources, however, point the other way. For example, the Restatement (Second) of Trusts states that "the court will control the trustee in the exercise of a power where he acts beyond the bounds of a reasonable judgment." Restatement (Second) of Trusts s 187, Comment i, p. 406 (1957). Another treatise states that, after a trustee has abused his discretion, "[s]ometimes the court decides for the trustee how he should act, either by stating the exact result it desires to achieve, or by fixing some limits on the trustee's action and giving him leeway within those limits." G. Bogert & G. Bogert, *Law of Trusts and Trustees* § 560, p. 223 (2d rev. ed.1980).

The unclear state of trust law on the question was perhaps best captured by the Texas Supreme Court:

There is authority for ordering a dismissal of the case to afford the trustee an opportunity to exercise a reasonable discretion in arriving at the amount of payments to be made in the light of our discussion of the problem and after a proper consideration of the many factors involved. On the other hand, there is authority for remanding the case to the trial court to hear evidence and in the exercise of its supervisory jurisdiction to fix the amount of such payments. There is still other authority for remanding the case to the trial court to hear evidence and fix the boundaries of a reasonable discretion to be exercised by the trustee within maximum and minimum limits. *State v. Rubion*, [158 Tex. 43, 54-55](#), 308 S.W.2d 4, 11 (1957) (citations omitted).

While we are "guided by principles of trust law" in ERISA cases, *Firestone*, [489 U.S., at 111](#), we have recognized before that "trust law does not tell the entire story," *Varity Corp. v. Howe*, [516 U.S. 489, 497](#) (1996); see *ibid.* ("In some instances, trust law will offer only a starting point, after which courts must go on to ask whether, or to what extent, the language of the statute, its structure, or its purposes require departing from common-law trust requirements"); Brief for Respondents 50 (pressing same view as the dissent but concluding that the dispute over trust law "need not be resolved"). Here trust law does not resolve the specific issue before us, but the guiding principles we have identified underlying ERISA do.

Congress enacted ERISA to ensure that employees would receive the benefits they had earned, but Congress did not require employers to establish benefit plans in the first place. *Lockheed Corp. v. Spink*, [517 U.S. 882, 887](#) (1996). We have therefore recognized that ERISA represents a "'careful balancing' between ensuring fair and prompt enforcement of rights under a plan and the encouragement of the creation of such plans." *Aetna Health Inc. v. Davila*, [542 U.S. 200, 215](#) (2004) (quoting *Pilot Life Ins. Co. v. Dedeaux*, [481 U.S. 41, 54](#) (1987)). Congress sought "to create a system that is [not] so complex that administrative costs, or litigation expenses, unduly discourage employers from offering [ERISA] plans in the first place." *Varity Corp., supra*, at 497. ERISA "induc[es] employers to offer benefits by assuring a predictable set of liabilities, under uniform

standards of primary conduct and a uniform regime of ultimate remedial orders and awards when a violation has occurred." *Rush Prudential HMO, Inc. v. Moran*, [536 U.S. 355](#) (2002).

Firestone deference protects these interests and, by permitting an employer to grant primary interpretive authority over an ERISA plan to the plan administrator, preserves the "careful balancing" on which ERISA is based. Deference promotes efficiency by encouraging resolution of benefits disputes through internal administrative proceedings rather than costly litigation. It also promotes predictability, as an employer can rely on the expertise of the plan administrator rather than worry about unexpected and inaccurate plan interpretations that might result from de novo judicial review. Moreover, Firestone deference serves the interest of uniformity, helping to avoid a patchwork of different interpretations of a plan, like the one here, that covers employees in different jurisdictions—a result that "would introduce considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them." *Fort Halifax Packing Co. v. Coyne*, [482 U.S. 1, 11](#) (1987). Indeed, a group of prominent actuaries tells us that it is impossible even to determine whether an ERISA plan is solvent (a duty imposed on actuaries by federal law, see ERISA § § 103(a)(4), (d)) if the plan is interpreted to mean different things in different places.

Respondents and the United States as amicus curiae do not question that deference to plan administrators serves these important purposes. Rather, they argue that deference is less important once a plan administrator has issued an interpretation of a plan found to be unreasonable. But the interests in efficiency, predictability, and uniformity—and the manner in which they are promoted by deference to reasonable plan construction by administrators—do not suddenly disappear simply because a plan administrator has made a single honest mistake.

This case illustrates the point. Consider first the interest in efficiency, an interest that Xerox has pursued by granting the Plan Administrator authority to construe the Plan. On remand from the Court of Appeals, if the District Court had applied a deferential standard of review under *Firestone*, the question before it would have been whether the Plan Administrator's interpretation of the Plan was reasonable. After answering that question, the case might well have been over. Instead, the District Court declined to defer, and therefore had to answer the more complicated question of how best to interpret the Plan.

The prospect of increased litigation costs inherent in respondents' approach does not end there. Under respondents' and the Government's view, the question whether a deferential standard of review was required in this case turns on whether the Plan Administrator was interpreting the "same terms" or deciding the "same issue" on remand. Whether that condition is satisfied will not always be clear. Indeed, petitioners dispute that question here, arguing that the Plan Administrator confronted an entirely new issue on remand—how to interpret the Plan, knowing that specific

provisions requiring use of the phantom account method could not be applied to respondents due to a lack of notice. Respondents would force the parties to litigate this potentially complicated "same issue" or "same terms" question before a district court could even decide whether deference is owed to a plan administrator's view. As we recognized in *Glenn*, there is little place in the ERISA context for these sorts of "special procedural rules [that] would create further complexity, adding time and expense to a process that may already be too costly for many of those who seek redress." [128 S.Ct., at 2351](#).

The position of respondents and the Government could interject other additional issues into ERISA litigation. For example, even under their view, the District Court here could have granted deference to the Plan Administrator; the court merely was not required to do so. That raises the question of how a court is to decide between the two options; respondents' answer is to weigh an indeterminate number of factors, which would only further complicate ERISA proceedings.

This case also demonstrates the harm to the interest in predictability that would result from stripping a plan administrator of Firestone deference. After declining to apply a deferential standard here, the District Court adopted an interpretation of the Plan that does not account for the time value of money. In the actuarial world, this is heresy, and highly unforeseeable. Indeed, the actuaries tell us that they have never encountered an ERISA plan resembling this one that did not include some adjustment for the time value of money.

Respondents' own actuarial expert testified before the District Court that fairness would require recognizing the time value of money in some fashion. And respondents and the Government do not dispute that the District Court's approach, which does not account for the fact that respondents were able to use their past distributions as they saw fit for over 20 years, would place respondents in a better position than employees who never left the company. Deference to plan administrators, who have a duty to all beneficiaries to preserve limited plan assets, see *Varity Corp.*, [516 U.S., at 514](#), helps prevent such windfalls for particular employees.

Finally, this case demonstrates the uniformity problems that arise from creating ad hoc exceptions to Firestone deference. If other courts were to adopt an interpretation of the Plan that does account for the time value of money, Xerox could be placed in an impossible situation. Similar Xerox employees could be entitled to different benefits depending on where they live, or perhaps where they bring a legal action. Cf. ERISA § 502(e)(2) (permitting suit "where the plan is administered, where the breach took place, or where a defendant resides or may be found"). In fact, that may already be the case. In similar litigation over the Plan, the Ninth Circuit also rejected the use of the phantom account method, but held that the Plan Administrator should utilize actuarial principles in accounting for rehired employees' past distributions-which would presumably include taking some cognizance of the time value of money. See *Miller v. Xerox Corp. Retirement Income Guarantee Plan*, [464](#)

[E.3d 871, 875-876](#) (2006); Brief for ERISA Industry Committee and American Benefits Council as Amici Curiae 8-9. Thus, failing to defer to the Plan Administrator here could well cause the Plan to be subject to different interpretations in California and New York. "Uniformity is impossible, however, if plans are subject to different legal obligations in different States." *Egelhoff v. Egelhoff*, [532 U.S. 141, 148](#)(2001). *Firestone* deference serves to avoid that result and to preserve the "careful balancing" of interests that ERISA represents. *Pilot Life Ins. Co.*, [481 U.S., at 54](#).

## C

In spite of all this, respondents and the Government argue that requiring the District Court to apply *Firestone* deference in this case would actually disserve the purposes of ERISA. They argue that continued deference would encourage plan administrators to adopt unreasonable interpretations of plans in the first instance, as administrators would anticipate a second chance to interpret their plans if their first interpretations were rejected. And they argue that plan administrators would be able to proceed seriatim through several interpretations of their plans, each time receiving deference, thereby undermining the prompt resolution of disputes over benefits, driving up litigation costs, and discouraging employees from challenging the decisions of plan administrators at all.

All this is overblown. There is no reason to think that deference would be required in the extreme circumstances that respondents foresee. Under trust law, a trustee may be stripped of deference when he does not exercise his discretion "honestly and fairly." 3 Scott and Ascher 1348. Multiple erroneous interpretations of the same plan provision, even if issued in good faith, might well support a finding that a plan administrator is too incompetent to exercise his discretion fairly, cutting short the rounds of costly litigation that respondents fear.

Applying a deferential standard of review does not mean that the plan administrator will prevail on the merits. It means only that the plan administrator's interpretation of the plan "will not be disturbed if reasonable." *Firestone*, [489 U.S., at 111](#); see also *ibid.* ("Where 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" (quoting Restatement (Second) of Trusts s 187)). Thus, far from "impos[ing] [a] rigid and inflexible requirement" that courts must defer to plan administrators, post, at 1655, we simply hold that the lower courts should have applied the standard established in *Firestone* and *Glenn*.

## III

The Court of Appeals erred in holding that the District Court could refuse to defer to the Plan Administrator's interpretation of the Plan on remand, simply because the Court of Appeals had found a previous related interpretation by the Administrator to be invalid. Because we reverse on

that ground, we do not reach the question whether the Court of Appeals also erred in applying a deferential standard of review to the decision of the District Court on the merits.

The judgment of the Court of Appeals for the Second Circuit is reversed, and the case is remanded for further proceedings consistent with this opinion.

It is so ordered.

P. 401

**Add** after Question 4

In a much anticipated decision, the Supreme Court offered dicta that abruptly shifts course and embraces wide-ranging equitable remedies for plan participants seeking relief against plan fiduciaries who breach their duties under ERISA.

### **CIGNA CORPORATION v. AMARA (PART III)**

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

Justice BREYER delivered the opinion of the Court.

[In 1998 CIGNA converted its final average pay defined benefit plan into a cash balance plan. The accrued benefits of participants under the final average pay plan were converted into cash balance benefits with participants being provided the greater of their final average pay benefit or their cash balance benefit, sometimes referred to as a “greater of A and B” benefit. As a result, some plan participants did not accrue any additional benefits for a period of time – until their cash balance benefit exceeded their final average pay benefit. The district court found that CIGNA’s descriptions of the new plan were incomplete and misleading and that plan participants who read the descriptions believed that their benefit under the converted plan was equal to the value of their final average pay benefit plus additional accruals under the cash balance plan, sometimes referred to as an “A plus B” benefit.]

I

\* \* \*

The District Court concluded, as a matter of law, that CIGNA's representations (and omissions) about the plan, made between November 1997 (when it announced the plan) and December 1998 (when it put the plan into effect) violated:

(a) ERISA § 204(h), implemented by [Treas. Reg. § 1.411\(d\)-6](#), which (as it existed at the relevant time) forbade an amendment of a pension plan that would "provide for a significant reduction in the rate of future benefit accrual" unless the plan administrator also sent a "written notice" that provided either the text of the amendment or summarized its likely effects.

and

(b) ERISA §§ 102(a) and 104(b), which require a plan administrator to provide beneficiaries with summary plan descriptions and with summaries of material modifications, "written in a manner calculated to be understood by the average plan participant," that are "sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan."

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The District Court then turned to the remedy.

\* \* \*

Third, the court reformed the terms of the new plan's guarantee. It erased the portion that assured participants who retired the greater of "A" (that which they had already earned as of December 31, 1997, under the old plan, \$11,667 in our example) or "B" (that which they would earn via CIGNA's annual deposits under the new plan, including CIGNA's initial deposit). And it substituted a provision that would guarantee each employee "A" (that which they had already earned, as of December 31, 1997, under the old plan) plus "B" (that which they would earn via CIGNA's annual deposits under the new plan, excluding CIGNA's initial deposit). In our example, the District Court's remedy would no longer force our employee to choose upon retirement either an \$11,667 annuity or his new plan benefits (including both CIGNA's annual deposits and CIGNA's initial deposit). It would give him an \$11,667 annuity plus his new plan benefits (with CIGNA's annual deposits but without CIGNA's initial deposit).

Fourth, the court "order[ed] and enjoin[ed] the CIGNA Plan to reform its records to reflect that all class members ... now receive [the just described] 'A + B' benefits," and that it pay appropriate benefits to those class members who had already retired. [Id.](#), at 222.

Fifth, the court held that ERISA § 502(a)(1)(B) provided the legal authority to enter this relief. That provision states that a "civil action may be brought" by a plan "participant or beneficiary ... to recover benefits due to him under the terms of his plan." The court wrote that its orders in effect awarded "benefits under the terms of the plan" as reformed. [559 F.Supp.2d, at 212](#).

At the same time the court considered whether ERISA § 502(a)(3) also provided legal authority to enter this relief. That provision states that a civil action may be brought

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

The District Court decided not to answer this question because (1) it had just decided that the same relief was available under § 502(a)(1)(B), regardless, cf. *Varity Corp. v. Howe*, [516 U.S. 489, 515](#) (1996); and (2) the Supreme Court has "issued several opinions ... that have severely curtailed the kinds of relief that are available under § 502(a)(3)," [559 F.Supp.2d, at 205](#) (citing *Sereboff v. Mid Atlantic Medical Services, Inc.*, [547 U.S. 356](#) (2006); *Great-West Life & Annuity Ins. Co. v. Knudson*, [534 U.S. 204](#) (2002); and *Mertens v. Hewitt Associates*, [508 U.S. 248](#) (1993)).

3

The parties cross-appealed the District Court's judgment. The Court of Appeals for the Second Circuit issued a brief summary order, rejecting all their claims, and affirming "the judgment of the district court for substantially the reasons stated" in the District Court's "well-reasoned and scholarly opinions." [348 Fed.Appx. 627](#) (2009). The parties filed cross-petitions for writs of certiorari in this Court. We granted the request in CIGNA's petition to consider whether a showing of "likely harm" is sufficient to entitle plan participants to recover benefits based on faulty disclosures.

II

CIGNA in the merits briefing raises a preliminary question. Brief for Petitioners 13-20. It argues first and foremost that the statutory provision upon which the District Court rested its orders, namely, the provision for recovery of plan benefits, § 502(a)(1)(B), does not in fact authorize the District Court to enter the kind of relief it entered here. And for that reason, CIGNA argues, whether the District Court did or did not use a proper standard for determining harm is beside the point. We believe that this preliminary question is closely enough related to the question presented that we shall consider it at the outset.

\* \* \*

B

If § 502(a)(1)(B) does not authorize entry of the relief here at issue, what about nearby § 502(a)(3)? That provision allows a participant, beneficiary, or fiduciary "to obtain other appropriate equitable relief" to redress violations of (here relevant) parts of ERISA "or the terms of the plan." The District Court strongly implied, but did not directly hold, that it would base its relief upon this subsection were it not for (1) the fact that the preceding "plan benefits due" provision, § 502(a)(1)(B), provided sufficient authority; and (2) certain cases from this Court that narrowed the application of the term "appropriate equitable relief," see, e.g., *Mertens*, [508 U.S. 248](#); *Great-West*, [534 U.S. 204](#). Our holding in Part II-A, *supra*, removes the District Court's first obstacle. And

given the likelihood that, on remand, the District Court will turn to and rely upon this alternative subsection, we consider the court's second concern. We find that concern misplaced.

We have interpreted the term "appropriate equitable relief" in § 502(a)(3) as referring to "'those categories of relief' " that, traditionally speaking (i.e., prior to the merger of law and equity) " 'were typically available in equity.' " Sereboff, [547 U.S., at 361](#) (quoting Mertens, [508 U.S., at 256](#)). In Mertens, we applied this principle to a claim seeking money damages brought by a beneficiary against a private firm that provided a trustee with actuarial services. We found that the plaintiff sought "nothing other than compensatory damages" against a nonfiduciary. [Id., at 253, 255 \(emphasis deleted\)](#). And we held that such a claim, traditionally speaking, was legal, not equitable, in nature. [Id., at 255](#).

In Great-West, we considered a claim brought by a fiduciary against a tort-award-winning beneficiary seeking monetary reimbursement for medical outlays that the plan had previously made on the beneficiary's behalf. We noted that the fiduciary sought to obtain a lien attaching to (or a constructive trust imposed upon) money that the beneficiary had received from the tort-case defendant. But we noted that the money in question was not the "particular" money that the tort defendant had paid. And, traditionally speaking, relief that sought a lien or a constructive trust was legal relief, not equitable relief, unless the funds in question were "particular funds or property in the defendant's possession." [534 U.S., at 213](#) (emphasis added).

The case before us concerns a suit by a beneficiary against a plan fiduciary (whom ERISA typically treats as a trustee) about the terms of a plan (which ERISA typically treats as a trust). See *LaRue v. DeWolff, Boberg & Associates, Inc.*, [552 U.S. 248, 253, n. 4](#) (2008); *Varity Corp.*, [516 U.S., at 496-497](#). It is the kind of lawsuit that, before the merger of law and equity, respondents could have brought only in a court of equity, not a court of law. 4 A. Scott, W. Fratcher, & M. Ascher, *Trusts* § 24.1, p. 1654 (5th ed. 2007) (hereinafter *Scott & Ascher*) ("Trusts are, and always have been, the bailiwick of the courts of equity"); *Duvall v. Craig*, [2 Wheat. 45, 56](#) (1817) (a trustee was "only suable in equity").

With the exception of the relief now provided by § 502(a)(1)(B), Restatement (Second) of Trusts §§ 198(1)-(2) (1957) (hereinafter *Second Restatement*); 4 *Scott & Ascher* § 24.2.1, the remedies available to those courts of equity were traditionally considered equitable remedies, see *Second Restatement* § 199; J. Adams, *Doctrine of Equity: A Commentary on the Law as Administered by the Court of Chancery* 61 (7th Am. ed. 1881) (hereinafter *Adams*); 4 *Scott & Ascher* § 24.2.

The District Court's affirmative and negative injunctions obviously fall within this category. [Mertens, supra, at 256 \(identifying injunctions, mandamus, and restitution as equitable relief\)](#). And other relief ordered by the District Court resembles forms of traditional equitable relief. That is because equity chancellors developed a host of other "distinctively equitable" remedies—remedies that were "fitted to the nature of the primary right" they were intended to protect. 1 S. Symons, *Pomeroy's Equity Jurisprudence* § 108, pp. 139-140 (5th ed. 1941) (hereinafter *Pomeroy*). See generally 1 J. Story, *Commentaries on Equity Jurisprudence* § 692 (12th ed. 1877) (hereinafter *Story*).

Indeed, a maxim of equity states that "[e]quity suffers not a right to be without a remedy." R. Francis, *Maxims of Equity* 29 (1st Am. ed. 1823). And the relief entered here, insofar as it does not consist of injunctive relief, closely resembles three other traditional equitable remedies.

First, what the District Court did here may be regarded as the reformation of the terms of the plan, in order to remedy the false or misleading information CIGNA provided. The power to reform contracts (as contrasted with the power to enforce contracts as written) is a traditional power of an equity court, not a court of law, and was used to prevent fraud. See *Baltzer v. Raleigh & Augusta R. Co.*, [115 U.S. 634, 645](#) (1885) ("[I]t is well settled that equity would reform the contract, and enforce it, as reformed, if the mistake or fraud were shown"); *Hearne v. Marine Ins. Co.*, [20 Wall. 488, 490](#) (1874) ("The reformation of written contracts for fraud or mistake is an ordinary head of equity jurisdiction"); *Bradford v. Union Bank of Tenn.*, [13 How. 57, 66](#) (1852); J. Eaton, *Handbook of Equity Jurisprudence* § 306, p. 618 (1901) (hereinafter Eaton) (courts of common law could only void or enforce, but not reform, a contract); 4 Pomeroy § 1375, at 1000 (reformation "chiefly occasioned by fraud or mistake," which were themselves concerns of equity courts); 1 Story §§ 152-154; see also 4 Pomeroy § 1375, at 999 (equity often considered reformation a "preparatory step" that "establishes the real contract").

Second, the District Court's remedy essentially held CIGNA to what it had promised, namely, that the new plan would not take from its employees benefits they had already accrued. This aspect of the remedy resembles estoppel, a traditional equitable remedy. See, e.g., E. Merwin, *Principles of Equity and Equity Pleading* § 910 (H. Merwin ed. 1895); 3 Pomeroy § 804. Equitable estoppel "operates to place the person entitled to its benefit in the same position he would have been in had the representations been true." [Eaton § 62, at 176](#). And, as Justice Story long ago pointed out, equitable estoppel "forms a very essential element in ... fair dealing, and rebuke of all fraudulent misrepresentation, which it is the boast of courts of equity constantly to promote." 2 Story § 1533, at 776.

Third, the District Court injunctions require the plan administrator to pay to already retired beneficiaries money owed them under the plan as reformed. But the fact that this relief takes the form of a money payment does not remove it from the category of traditionally equitable relief. Equity courts possessed the power to provide relief in the form of monetary "compensation" for a loss resulting from a trustee's breach of duty, or to prevent the trustee's unjust enrichment. Restatement (Third) of Trusts § 95, and Comment a (Tent. Draft No. 5, Mar. 2, 2009) (hereinafter Third Restatement); [Eaton §§ 211-212, at 440](#). Indeed, prior to the merger of law and equity this kind of monetary remedy against a trustee, sometimes called a "surcharge," was "exclusively equitable." *Princess Lida of Thurn and Taxis v. Thompson*, [305 U.S. 456, 464](#) (1939); Third Restatement § 95, and Comment a; G. Bogert & G. Bogert, *Trusts and Trustees* § 862 (rev.2d ed.1995) (hereinafter Bogert); 4 Scott & Ascher §§ 24.2, 24.9, at 1659-1660, 1686; Second Restatement § 197; see also *Manhattan Bank of Memphis v. Walker*, [130 U.S. 267, 271](#) (1889) ("The suit is plainly one of equitable cognizance, the bill being filed to charge the defendant, as a trustee, for a breach of trust"); 1 J. Perry, *A Treatise on the Law of Trusts and Trustees* § 17, p. 13

(2d ed. 1874) (common-law attempts "to punish trustees for a breach of trust in damages, ... w[ere] soon abandoned").

The surcharge remedy extended to a breach of trust committed by a fiduciary encompassing any violation of a duty imposed upon that fiduciary. See Second Restatement § 201; Adams 59; 4 Pomeroy § 1079; 2 Story §§ 1261, 1268. Thus, insofar as an award of make-whole relief is concerned, the fact that the defendant in this case, unlike the defendant in *Mertens*, is analogous to a trustee makes a critical difference. See [508 U.S., at 262-263](#). In sum, contrary to the District Court's fears, the types of remedies the court entered here fall within the scope of the term "appropriate equitable relief" in § 502(a)(3).

\* \* \*

#### IV

We have premised our discussion in Part III on the need for the District Court to revisit its determination of an appropriate remedy for the violations of ERISA it identified. Whether or not the general principles we have discussed above are properly applicable in this case is for it or the Court of Appeals to determine in the first instance. Because the District Court has not determined if an appropriate remedy may be imposed under § 502(a)(3), we must vacate the judgment below and remand this case for further proceedings consistent with this opinion.

It is so ordered.

Justice SOTOMAYOR took no part in the consideration or decision of this case.

Justice SCALIA, with whom Justice THOMAS joins, concurring in the judgment.

I agree with the Court that § 502(a)(1)(B) of ERISA, does not authorize relief for misrepresentations in a summary plan description (SPD). I do not join the Court's opinion because I see no need and no justification for saying anything more than that.

\* \* \*

#### **G. Attorney Fees**

P. 420

Add before "H. Right to Jury Trial"

#### **HARDT v. RELIANCE STANDARD LIFE INSURANCE CO.**

[130 S.Ct. 2149](#) (2010)

Justice THOMAS.

In most lawsuits seeking relief under the Employee Retirement Income Security Act of 1974 (ERISA) "a reasonable attorney's fee and costs" are available "to either party" at the court's

“discretion.” ERISA § 502(g)(1). The Court of Appeals for the Fourth Circuit has interpreted § 502(g)(1) to require that a fee claimant be a “prevailing party” before he may seek a fees award. We reject this interpretation as contrary to § 502(g)(1)’s plain text. We hold instead that a court “in its discretion” may award fees and costs “to either party,” *ibid.*, as long as the fee claimant has achieved “some degree of success on the merits,” *Ruckelshaus v. Sierra Club*, [463 U.S. 680, 694](#) (1983).

## I

In 2000, while working as an executive assistant to the president of textile manufacturer Dan River, Inc., petitioner Bridget Hardt began experiencing neck and shoulder pain. Her doctors eventually diagnosed her with carpal tunnel syndrome. Because surgeries on both her wrists failed to alleviate her pain, Hardt stopped working in January 2003.

In August 2003, Hardt sought long-term disability benefits from Dan River’s Group Long-Term Disability Insurance Program Plan (Plan). Dan River administers the Plan, which is subject to ERISA, but respondent Reliance Standard Life Insurance Company decides whether a claimant qualifies for benefits under the Plan and underwrites any benefits awarded. Reliance provisionally approved Hardt’s claim, telling her that final approval hinged on her performance in a functional capacities evaluation intended to assess the impact of her carpal tunnel syndrome and neck pain on her ability to work.

Hardt completed the functional capacities evaluation in October 2003. The evaluator summarized Hardt’s medical history, observed her resulting physical limitations, and ultimately found that Hardt could perform some amount of sedentary work. Based on this finding, Reliance concluded that Hardt was not totally disabled within the meaning of the Plan and denied her claim for disability benefits. Hardt filed an administrative appeal. Reliance reversed itself in part, finding that Hardt was totally disabled from her regular occupation, and was therefore entitled to temporary disability benefits for 24 months.

While her administrative appeal was pending, Hardt began experiencing new symptoms in her feet and calves, including tingling, pain, and numbness. One of her physicians diagnosed her with small-fiber neuropathy, a condition that increased her pain and decreased her physical capabilities over the ensuing months.

Hardt eventually applied to the Social Security Administration for disability benefits under the Social Security Act. Her application included questionnaires completed by two of her treating physicians, which described Hardt’s symptoms and stated the doctors’ conclusion that Hardt could not return to full gainful employment because of her neuropathy and other ailments. In February 2005, the Social Security Administration granted Hardt’s application and awarded her disability benefits.

About two months later, Reliance told Hardt that her Plan benefits would expire at the end of the 24-month period. Reliance explained that under the Plan's terms, only individuals who are "totally disabled from all occupations" were eligible for benefits beyond that period, and adhered to its conclusion that, based on its review of Hardt's records, Hardt was not "totally disabled" as defined by the Plan. Reliance also demanded that Hardt pay Reliance \$14,913.23 to offset the disability benefits she had received from the Social Security Administration. (The Plan contains a provision coordinating benefits with Social Security payments.) Hardt paid Reliance the offset.

Hardt then filed another administrative appeal. She gave Reliance all of her medical records, the questionnaires she had submitted to the Social Security Administration, and an updated questionnaire from one of her physicians. Reliance asked Hardt to supplement this material with another functional capacities evaluation. When Reliance referred Hardt for the updated evaluation, it did not ask the evaluator to review Hardt for neuropathic pain, even though it knew that Hardt had been diagnosed with neuropathy after her first evaluation.

Hardt appeared for the updated evaluation in December 2005, and appeared for another evaluation in January 2006. The evaluators deemed both evaluations invalid because Hardt's efforts were "submaximal."

Lacking an updated functional capacities evaluation, Reliance hired a physician and a vocation rehabilitation counselor to help it resolve Hardt's administrative appeal. The physician did not examine Hardt; instead, he reviewed some, but not all, of Hardt's medical records. Based on that review, the physician produced a report in which he opined that Hardt's health was expected to improve. His report, however, did not mention Hardt's pain medications or the questionnaires that Hardt's attending physicians had completed as part of her application for Social Security benefits. The vocational rehabilitation counselor, in turn, performed a labor market study (based on Hardt's health in 2003) that identified eight employment opportunities suitable for Hardt. After reviewing the physician's report, the labor market study, and the results of the 2003 functional capacities evaluation, Reliance concluded that its decision to terminate Hardt's benefits was correct. It advised Hardt of this decision in March 2006.

After exhausting her administrative remedies, Hardt sued Reliance in the United States District Court for the Eastern District of Virginia. She alleged that Reliance violated ERISA by wrongfully denying her claim for long-term disability benefits. See § 502(a)(1)(B). The parties filed cross-motions for summary judgment, both of which the District Court denied.

The court first rejected Reliance's request for summary judgment affirming the denial of benefits, finding that "Reliance's decision to deny benefits was based on incomplete information." . . . The court also found that Reliance had "improperly rejected much of the evidence that Ms. Hardt submitted," *id.* at 45a, and had "further ignored the substantial amount of pain medication Ms. Hardt's treating physicians had prescribed to her." Accordingly, the court thought it "clear that Reliance's decision to deny Ms. Hardt long-term disability benefits was not based on substantial evidence."

The District Court then denied Hardt’s motion for summary judgment, which contended that Reliance’s decision to deny benefits was unreasonable as a matter of law. In so doing, however, the court found “compelling evidence” in the record that “Ms. Hardt [wa]s totally disabled due to her neuropathy.” Although it was “inclined to rule in Ms. Hardt’s favor,” the court concluded that “it would be unwise to take this step without first giving Reliance the chance to address the deficiencies in its approach.” In the District Court’s view, a remand to Reliance was warranted because “[t]his case presents one of those scenarios where the plan administrator has failed to comply with the ERISA guidelines,” meaning “Ms. Hardt did not get the kind of review to which she was entitled under applicable law.” Accordingly, the court instructed “Reliance to act on Ms. Hardt’s application by adequately considering all the evidence” within 30 days; “[o]therwise,” it warned, “judgment will be issued in favor of Ms. Hardt.”

Reliance did as instructed. After conducting that review, Reliance found Hardt eligible for long-term disability benefits and paid her \$55,250 in accrued, past-due benefits.

Hardt then moved for attorney’s fees and costs under § 502(g)(1). The District Court assessed her motion under the three-step framework that governed fee requests in ERISA cases under Circuit precedent. At step one of that framework, a district court asks whether the fee claimant is a “‘prevailing party.’” If the fee claimant qualifies as a prevailing party, the court proceeds to step two and “determin[es] whether an award of attorneys’ fees is appropriate” by examining “five factors.” Finally, if those five factors suggest that a fees award is appropriate, the court “must review the attorneys’ fees and costs requested and limit them to a reasonable amount.”

Applying that framework, the District Court granted Hardt’s motion. . . .

Reliance appealed the fees award, and the Court of Appeals vacated the District Court’s order. According to the Court of Appeals, Hardt failed to satisfy the step-one inquiry—*i.e.*, she failed to establish that she was a “prevailing party.” In reaching that conclusion, the Court of Appeals relied on this Court’s decision in *Buckhannon*, under which a fee claimant qualifies as a “prevailing party” only if he has obtained an “‘enforceable judgment[t] on the merits’” or a “‘court-ordered consent decre[e].’” The Court of Appeals reasoned that because the remand order “did not require Reliance to award benefits to Hardt,” it did “not constitute an ‘enforceable judgment on the merits’ as *Buckhannon* requires,” thus precluding Hardt from establishing prevailing party status.

## II

Whether § 502(g)(1) limits the availability of attorney’s fees to a “prevailing party” is a question of statutory construction. As in all such cases, we begin by analyzing the statutory language, “assum[ing] that the ordinary meaning of that language accurately expresses the legislative purpose.” *Gross v. FBL Financial Services, Inc.*, 557 U.S. \_\_\_, \_\_\_ (2009).

Section 502(g)(1) provides:

“In any action under this subchapter (other than an action described in paragraph (2)) by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney’s fee and costs of action to either party.”

The words “prevailing party” do not appear in this provision. Nor does anything else in § 502(g)(1)’s text purport to limit the availability of attorney’s fees to a “prevailing party.” Instead, § 502(g)(1) expressly grants district courts “discretion” to award attorney’s fees “to *either* party.” (Emphasis added.)

That language contrasts sharply with § 502(g)(2), which governs the availability of attorney’s fees in ERISA actions under § 515 (actions to recover delinquent employer contributions to a multiemployer plan). In such cases, only plaintiffs who obtain “a judgment in favor of the plan” may seek attorney’s fees. § 502(g)(2)(D). The contrast between these two paragraphs makes clear that Congress knows how to impose express limits on the availability of attorney’s fees in ERISA cases. Because Congress failed to include in § 502(g)(1) an express “prevailing party” limit on the availability of attorney’s fees, the Court of Appeals’ decision adding that term of art to a fee-shifting statute from which it is conspicuously absent more closely resembles “invent[ing] a statute rather than interpret[ing] one.”

We see no reason to dwell any longer on this question. We therefore hold that a fee claimant need not be a “prevailing party” to be eligible for an attorney’s fees award under § 502(g)(1).

### III

We next consider the circumstances under which a court may award attorney’s fees pursuant to § 502(g)(1). “Our basic point of reference” when considering the award of attorney’s fees is the bedrock principle known as the “ ‘American Rule’ ”: Each litigant pays his own attorney’s fees, win or lose, unless a statute or contract provides otherwise. Statutory changes to this rule take various forms. Most fee-shifting provisions permit a court to award attorney’s fees only to a “prevailing party.” Others permit a “substantially prevailing” party or a “successful” litigant to obtain fees. Still others authorize district courts to award attorney’s fees where “appropriate,” or simply vest district courts with “discretion” to award fees.

Of those statutory deviations from the American Rule, we have most often considered statutes containing an express “prevailing party” requirement. Our “prevailing party” precedents, however, do not govern the availability of fees awards under § 502(g)(1), because this provision does not limit the availability of attorney’s fees to the “prevailing party.”

. . . [w]e first look to “the language of the section,” *id.* at 682, which unambiguously allows a court to award attorney’s fees “in its discretion . . . to either party,” § 502(g)(1). Statutes vesting judges with such broad discretion are well known in the law, particularly in the attorney’s fees context.

*Ruckelshaus* lays down the proper markers to guide a court in exercising the discretion that § 502(g)(1) grants. As in the statute at issue in *Ruckelshaus*, Congress failed to indicate clearly in § 502(g)(1) that it “meant to abandon historic fee-shifting principles and intuitive notions of fairness.” [463 U.S. at 686](#). Accordingly, a fees claimant must show “some degree of success on the merits” before a court may award attorney’s fees under § 502(g)(1), [id. at 694](#). A claimant does not satisfy that requirement by achieving “trivial success on the merits” or a “purely procedural victor[y],” but does satisfy it if the court can fairly call the outcome of the litigation some success on the merits without conducting a “lengthy inquir[y] into the question whether a particular party’s success was ‘substantial’ or occurred on a ‘central issue.’” [Id. at 688](#).

Reliance essentially agrees that this standard should govern fee requests under § 502(g)(1), but argues that Hardt has not satisfied it. Specifically, Reliance contends that a court order remanding an ERISA claim for further consideration can never constitute “some success on the merits,” even if such a remand results in an award of benefits. See [id. at 34-50](#).

Reliance’s argument misses the point, given the facts of this case. Hardt persuaded the District Court to find that “the plan administrator has failed to comply with the ERISA guidelines” and “that Ms. Hardt did not get the kind of review to which she was entitled under applicable law.” Although Hardt failed to win summary judgment on her benefits claim, the District Court nevertheless found “compelling evidence that Ms. Hardt is totally disabled due to her neuropathy,” and stated that it was “inclined to rule in Ms. Hardt’s favor” on her benefits claim, but declined to do so before “first giving Reliance the chance to address the deficiencies in its” statutorily mandated “full and fair review” of that claim. Hardt thus obtained a judicial order instructing Reliance “to act on Ms. Hardt’s application by adequately considering all the evidence” within 30 days; “[o]therwise, judgment will be issued in favor of Ms. Hardt.” After Reliance conducted that court-ordered review, and consistent with the District Court’s appraisal, Reliance reversed its decision and awarded Hardt the benefits she sought.

These facts establish that Hardt has achieved far more than “trivial success on the merits” or a “purely procedural victory.” Accordingly, she has achieved “some success on the merits,” and the District Court properly exercised its discretion to award Hardt attorney’s fees in this case. Because these conclusions resolve this case, we need not decide today whether a remand order, without more, constitutes “some success on the merits” sufficient to make a party eligible for attorney’s fees under § 502(g)(1).

We reverse the judgment of the Court of Appeals for the Fourth Circuit and remand this case for proceedings consistent with this opinion. . . .

## Chapter 8 – Nondiscrimination Rules

P. 435

**Add** to end of second full paragraph under [I.R.C. Section 414](#)

As of 2011, the [I.R.C. Section 414\(q\)\(1\)\(B\)](#) limit, as adjusted for the cost of living, is \$110,000.

P. 437

**Add** to end of last full paragraph on page 437

In 2011, the maximum taxable wage base for Social Security is \$106,800.

P. 460

**Add** to end of first full paragraph

In 2011, the maximum taxable wage base for Social Security is \$106,800.

## Chapter 9 – Plan Operation

P. 466

**Add** to end of first full paragraph

In 2011, the [I.R.C. § 401\(a\)\(17\)\(A\)](#) limit, as adjusted, is \$245,000.

**Add** to end of paragraph under [I.R.C. § 415\(c\)](#)

In 2011, the [I.R.C. § 415\(c\)\(1\)\(A\)](#) limit, as adjusted, is \$49,000.

P. 467

**Add** to end of first full paragraph

In 2011, the [I.R.C. § 415\(b\)\(1\)\(A\)](#) limit, as adjusted, is \$195,000.

P. 468

**Add** to end of paragraph under [I.R.C. § 402\(g\)](#)

In 2011, the [I.R.C. § 402\(g\)](#) limit, as adjusted, is \$16,500.

P. 470

**Add** to end of first paragraph under [I.R.C. § 414\(v\)](#)

In 2011, the [I.R.C. § 414\(v\)](#) limit, as adjusted, is \$5,500.

P. 479

**Add** after last line in first carryover paragraph:

The Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010, Pub. L. No. 111-192, extended the amortization period for funding shortfalls. ERISA § 303(c)(2)(d) and [I.R.C. § 430\(c\)\(2\)\(D\)](#) now permit a plan sponsor to choose between two amortization schedules: a “two plus seven” schedule or a 15-year schedule.

P. 489

**Replace** second sentence in third paragraph with following:

First, the income ceiling for individuals with an employer-sponsored plan was raised so that in 2011, single taxpayers with an adjusted gross income of no more than \$56,000 and married taxpayers with an adjusted gross income of no more than \$90,000 are eligible to participate in an employer-sponsored retirement plan. [I.R.C. § 219\(g\)\(3\)\(B\)](#).

**Replace** the second sentence in the fourth paragraph with the following:

Finally, both an individual participating in an employer-sponsored retirement plan and the participant’s spouse can set up a variant of the IRA, called a Roth IRA, as long as the couple’s adjusted gross income in 2011 does not exceed \$179,000 (or \$122,000 for single taxpayers). [I.R.C. § 408A\(c\)\(3\)\(C\)\(ii\)](#).

**Replace** the fourth sentence in the sixth paragraph with the following:

In 2011, the traditional IRA limit is phased out for single taxpayers who earn between \$56,000 and \$66,000 and for married taxpayers who earn between \$90,000 and \$110,000, and the Roth IRA limit is phased out for single taxpayers who earn between \$107,000 and \$122,000 and for married taxpayers who earn between \$169,000 and \$179,000.

P. 494

**Add** following new paragraph before 9-12 Questions and Problems

The Worker, Retiree, and Employer Recovery Act of 2008, signed by President Bush on December 23, 2008, suspended the minimum distribution requirements for 2009, so individuals age 70 ½ and older were not required to take a minimum distribution for 2009.

**Add:** after 10-1 Questions and Answers

**IN RE BATONI**

[594 F.3d 230](#) (3d Cir. 2010)

SMITH, *Circuit Judge*.

This appeal requires us to consider the scope of the Employee Retirement Income Security Act’s (“ERISA”) Anti-Cutback rule, ERISA § 302(d). Certain current and retired members of a union (the “Battoni Plaintiffs”) challenged an amendment to their welfare plan (the “Disputed Amendment”) as an unlawful cutback of their accrued benefits under their pension plan. We must determine whether the Disputed Amendment, which conditions receipt of healthcare benefits under a welfare plan on non-receipt of an accrued benefit under a pension plan, violates the Anti-Cutback rule. In light of ERISA’s statutory text and our precedent, we conclude that the Disputed Amendment violated the Anti-Cutback rule by constructively amending the pension plan in a manner that decreased an accrued benefit under that plan. Accordingly, we will affirm the District Court’s judgment in favor of the Battoni Plaintiffs.

I.

A.

In November 1999, the Local 675 and the Local 102 chapters of the International Brotherhood of Electrical Workers (“IBEW”) merged. As a result of the merger, the Local 675 chapter was dissolved and its members were transferred to the Local 102 chapter. The chapters’ pension and welfare plans were also combined.

Before the merger, the Local 675 Pension Plan permitted plan participants to choose between a lump sum pension benefit or a periodic monthly benefit. The Local 102 Pension Plan, on the other hand, provided only a periodic monthly benefit to its participants. After the merger, the two pension plans were combined into one—the Local 102 Pension Plan. To accommodate the lump sum pension benefit option that was included in the Local 675 Pension Plan, the Local 102 Pension Plan was amended to provide former Local 675 members the right to receive a lump sum benefit for pre-merger accruals. Post-merger accruals, however, could be applied only towards a periodic monthly benefit.

The chapters’ welfare plans were combined by transferring the Local 675 members to the Local 102 Welfare Plan. That plan provided eligible retirees healthcare benefits for themselves and their spouses. To receive these benefits, a retiree was required to satisfy certain conditions outlined in the plan. Shortly after the merger, the Local 102 Welfare Plan was amended to include a new condition on the receipt of healthcare benefits. This amendment, the Disputed Amendment, conditioned a retiree’s receipt of healthcare benefits on the retiree’s not choosing the lump sum

pension benefit offered under the Local 102 Pension Plan. The Disputed Amendment stated, in relevant part, that:

Retired employees who elect a lump sum pension benefit in lieu of periodic monthly benefits from [the] IBEW Local 102 Pension Plan and/or from another Local Union IBEW Pension Plan shall not be eligible for continued [healthcare] coverage.

Before the addition of the Disputed Amendment, a former Local 675 member could elect to receive the lump sum pension benefit provided under the Local 102 Pension Plan and still receive healthcare benefits under the Local 102 Welfare Plan.

B.

A group of current and retired members of the Local 102 chapter who were formerly members of the Local 675 chapter, the Battoni Plaintiffs, challenged the Disputed Amendment, alleging, among other things, that it violated the Anti-Cutback rule. The Battoni Plaintiffs filed suit in the United States District Court for the District of New Jersey, naming the Local 102 Pension and Welfare Plans and the current and former trustees of those plans (collectively, the “Union”) as defendants.

After a bench trial, the District Court concluded that the Disputed Amendment violated the Anti-Cutback rule and entered judgment in favor of the Battoni Plaintiffs. The Union then filed this timely appeal.

II.

The Union appeals from the District Court’s judgment entered after a bench trial. . . .

III.

The Anti-Cutback rule states: “The accrued benefit of a participant under a plan may not be decreased by an amendment of the plan, other than an amendment described in section 302(d)(2) or 4281.” ERISA § 204(g)(1). To state a claim for violation of ERISA’s Anti-Cutback rule one must show (1) that a plan was amended and (2) that the amendment decreased an accrued benefit. *See id.*

\* \* \*

A.

The first question that must be resolved is whether the Disputed Amendment, by conditioning the receipt of welfare benefits on a retiree not exercising her right to receive a lump sum pension benefit under the Local 102 Pension Plan, constituted an amendment to the Local 102 Pension Plan. *See* ERISA § 302(d)(1). Because the Disputed Amendment constructively amended the right to receive a lump sum pension benefit under the Local 102 Pension Plan, we conclude that the first requirement of an Anti-Cutback claim was satisfied.

1.

Our view of what constitutes an “amendment” to a pension plan has been construed broadly to protect pension recipients. . . . According to the Union, the Disputed Amendment amended the welfare plan and thus was exempted from the Anti-Cutback rule. ERISA § 201(1). The Anti-Cutback rule, however, cannot be employed in such an overly simplistic, robotic fashion.

We must examine the Disputed Amendment closely to determine its true character before we declare it solely a welfare plan amendment and exempt from the Anti-Cutback rule. An evaluation of the amendment’s benefit characteristics, which are independent of the formal placement of the amendment, is necessary. “The type of benefit provided, not other considerations, determines whether a plan [amendment amends a] pension plan or a welfare plan.” *Id.*; see *Rombach v. Nestle USA, Inc.*, [211 F.3d 190, 193-94](#) (2d Cir. 2000).

As a general rule, an amendment amends a pension plan “to the extent that by its express terms or as a result of surrounding circumstances . . . [it] provide[s] retirement income to employees, or . . . results in a deferral of income by employees for periods extending to the termination of covered employment or beyond[.]” ERISA § 3(2)(A) (defining “pension plan”). “[T]he words ‘to the extent that’ rather than ‘solely’ clearly indicate that Congress intended to allow any plan or part of a plan,” *McBarron*, [771 F.2d at 98](#), to be considered a pension plan or a welfare plan. As such, the “meaning and function” of the amendment determines whether it modifies a pension plan, a welfare plan, or both.

2.

The Disputed Amendment is part of the Local 102 Welfare Plan “to the extent” that it pertains to welfare benefits, ERISA § 3(1), and part of the Local 102 Pension Plan “to the extent” that it pertains to pension benefits. The Disputed Amendment constructively amended the pension plan by adding a condition to the receipt of a benefit accrued under that plan. If a retiree elects to receive the lump sum pension benefit under the Local 102 Pension Plan she loses healthcare benefits under the Local 102 Welfare Plan. Thus, the Disputed Amendment necessarily, “by its express terms or as a result of surrounding circumstances.” . . .

B.

Having determined that the Disputed Amendment amended the Local 102 Pension Plan, the next inquiry is whether the amendment decreased an accrued benefit. See ERISA § 302(d)(1). The Union argues that the Disputed Amendment merely restricts access to healthcare benefits and does not decrease any accrued benefit. But because the Disputed Amendment imposed a condition on the receipt of the lump sum benefit under the Local 102 Pension Plan, it decreased an accrued benefit. “[A]t the moment [a] new condition is imposed, the accrued benefit becomes less valuable[.]” *Cent. Laborers’ Pension Fund v. Heinz*, [541 U.S. 739, 746](#) (2004). . . .

In *Central Laborers' Pension Fund*, the Supreme Court considered “whether the [Anti-Cutback] rule prohibits an amendment expanding the categories of postretirement employment that triggers suspension of payment of early retirement benefits already accrued.” [541 U.S. at 741](#). It held that such an amendment was prohibited in part because the imposition of a new condition on an accrued benefit decreased the value of that accrued benefit. [Id. at 746](#).

\* \* \*

The same reasoning applies here. The Local 102 Pension Plan, like Heinz’s pension plan, imposed a new condition on the receipt of an accrued benefit. The Battoni Plaintiffs’ lump sum pension benefits accrued before the Disputed Amendment was added to the Local 102 Welfare Plan. Yet the Disputed Amendment conditioned the receipt of those accrued benefits on forfeiting healthcare benefits. This “new condition,” [id.](#), in and of itself, decreased the value of the lump sum pension benefit, *see id.*

\* \* \*

#### IV.

The Disputed Amendment constructively amended the pension plan because it conditioned receipt of the lump sum pension benefit, an accrued benefit, on surrendering healthcare benefits provided by the welfare plan. This condition on the receipt of the lump sum pension benefit decreased the value of that benefit in violation of the Anti-Cutback rule. Thus, we will affirm the District Court’s judgment that the Disputed Amendment violated ERISA’s Anti-Cutback rule.