



ERISA LITIGATION: BACK TO BASICS

**BY JENNIFER E. JOHNSEN,
NICOLE J. BUNTIN, AND
MARY A. GIORGI**

It has been more than 30 years since the Employee Retirement Income Security Act of 1974 (ERISA) was enacted by Congress. During this period of time, courts have interpreted and clarified (in some instances) the scope and application of the act and the remedies it affords. In 2008 alone, the U.S. Supreme Court decided two cases that may have far-reaching implications on ERISA litigation. It is impossible for one article to provide an analysis of all the potential issues that can arise in an ERISA-governed matter. Rather, this article is intended to provide non-ERISA practitioners with the nuts and bolts of ERISA litigation so that they are better prepared to identify ERISA-governed claims and to comply with the basic statutory and procedural requirements under ERISA.

Plans Covered by ERISA

ERISA was enacted to regulate “employee welfare benefit plans” established by employers to provide certain benefits to employees.¹ An employee welfare benefit plan is defined under ERISA as “any plan, fund, or program which was heretofore or is hereafter 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 or their beneficiary ... benefits.”² Two elements of this definition require explanation and discussion.

First, a plan, fund, or program must be “established or main-

tained by an employer.” Recently, the Fifth Circuit explained that an employer has not established or maintained a plan by merely “purchas[ing] insurance for its employees ... with no further involvement with the collection of premiums, administration of the policy, or submission of claims.”³ Second, the plan, fund, or program must provide benefits to “participants or their beneficiary(ies).” A participant is defined as “any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit ... or whose beneficiaries may be eligible to receive any such benefit.”⁴ Thus, by definition, a participant in an employee welfare benefit plan is an employee or former employee defined by ERISA as “any individual employed by an employer.”⁵ This begs the question of whether a working owner can be a plan participant. The U.S. Supreme Court has held that “a working owner can wear two hats, as an employer and employee,” and as long as “the plan covers one or more employees other than the business owner and his or her spouse, the working owner may participate on equal terms with other plan participants.”⁶

However, even if a plan initially qualifies as an employee welfare benefit plan, the statute exempts certain plans from the purview of ERISA. First, the act applies only to plans established and maintained by an employer or employee organization that is “engaged in commerce or in any industry or activity affecting commerce.”⁷ This requirement has been

interpreted broadly by courts. For example, the Ninth Circuit stated that “[w]hen Congress uses the term ‘activity affecting commerce,’ it is an expression of Congress’ intent to regulate ‘within the full sweep of its constitutional authority.’”⁸

In addition, the act exempts the following types of employee benefit plans: governmental plans,⁹ church plans,¹⁰ plans maintained solely for the purpose of complying with workers’ compensation requirements, unemployment or disability laws,¹¹ plans maintained outside the United States,¹² and excess benefits plans.¹³ These somewhat vague exemptions have required judicial interpretation. For example, “governmental plan means a plan established or maintained for its employees by the [g]overnment of the United States, by the government of any [s]tate or political subdivision thereof, or by any agency or instrumentality of any of the foregoing.”¹⁴ The phrase, “by any agency or instrumentality of any of the foregoing,” is at the root of the confusion. In *NLRB v. Natural Gas Utility Dist. of Hawkins County, Tenn.*,¹⁵ the Supreme Court, interpreting the meaning of a political subdivision under the National Labor Relations Act and the Labor Management Relations Act, stated that an entity is a political subdivision if (1) the entity was “created directly by the state, so as to constitute departments or administrative arms of the government” or (2) the entity is “administered by individuals who are responsible to public officials or the general electorate.”¹⁶ The Second Circuit, in *Rose v. Long Island R.R. Pension Plan*, explained that the Supreme Court’s analysis in *Natural Gas Utility* was generally applicable in interpreting ERISA’s governmental exemption “because ERISA, like the National Labor Relations Act, ‘represents an effort to strike an appropriate balance between the interests of employers and labor organizations.’”^{17,18}

ERISA’s Civil Enforcement Scheme

ERISA’s civil enforcement scheme, 29 U.S.C. § 1132, is specific as to who may bring a civil action under ERISA and the types of claims that those persons can bring. The act allows a “participant or beneficiary” to bring a civil action “to recover benefits due to him under the terms of the 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.”¹⁹ The act also permits a “participant, beneficiary, or fiduciary” to bring a civil action “(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.”²⁰

In addition, the act allows the secretary, a participant, a beneficiary, or a fiduciary to bring a civil action for “appropriate relief” under 29 U.S.C. § 1109.²¹ In February 2008, the Supreme Court interpreted § 1132(a)(2) in the context of a claim for breach of fiduciary duty arising out of alleged losses to a 401(k) plan.²² The Court held that although the statute “does not provide a remedy for individual injury distinct from plan injuries, [it] does authorize recovery for fiduciary breaches that impair the value of plan assets in a participant’s individual account.”²³ Prior to this decision, § 1132(a)(2) was interpreted to provide remedies only for entire plans, not for individuals.²⁴

ERISA’s Silent Procedural Characteristics: Exhaustion of Remedies

In order for a participant or beneficiary to bring an action under 29 U.S.C. § 1132(a)(1)(B), that person must first exhaust administrative remedies under the plan. This important requirement is not expressly stated within ERISA’s enforcement scheme but, if it is not satisfied, a plaintiff’s case may be dismissed. The purpose of the exhaustion requirement is “to help reduce the number of frivolous lawsuits under ERISA; to promote the consistent treatment of claims for benefits; to provide a nonadversarial method of claims settlement; and to minimize the costs of claims settlement for all concerned.”²⁵ Although exhaustion of administrative remedies is the general rule, courts have recognized exceptions in cases in which exhaustion would be futile or the remedy in the plan is inadequate.²⁶

ERISA’s Silent Procedural Characteristics: Statute of Limitations

In addition to complying with the exhaustion requirement, a plaintiff must bring his or her ERISA action within the applicable statute of limitations. Determining whether a claim under ERISA is barred by the statute of limitations depends on the type of claim asserted. If a plaintiff brings a claim for breach of fiduciary duty, the act provides that the claim is time barred if brought after the earlier of

- (1) six years after (A) the date of the last action which constituted a part of the breach or violation, or (B) in the case of an omission the latest date on which the fiduciary could have cured the breach or violation,
- or (2) three years after the earliest date on which the plaintiff had actual knowledge of the breach or violation.²⁷

Alternatively, if a plaintiff brings a claim for benefits or equitable relief, ERISA is silent on the applicable statute of limitations. In order to determine the applicable statute of limitations, courts “look to the most appropriate state statute of limitations,” which requires courts to “be cognizant of and examine the underlying nature of the federal claim as well as the federal policies involved.”²⁸ In doing so, courts often have found that, because a plaintiff’s alleged right to benefits arises from the written plan of benefits, these claims are “creatures of contract law” and the state statute governing breach of contract actions governs.²⁹ Furthermore, courts have held that a claim for benefits under ERISA accrues when “benefits are denied or when the claimant has reason to know his claim has been denied ... [or stated differently,] when the plan communicates a clear and continuing repudiation of a claimant’s rights under a plan.”³⁰

The above analysis for determining the applicable “state statute to borrow [may be] unnecessary” when the plan documents contain a limitations period. Courts have held that “contractual limitations periods on ERISA actions are enforceable, regardless of state law, provided they are rea-

sonable [because an] ERISA plan is nothing more than a contract, in which parties as a general rule are free to include whatever limitation they desire.”³¹

ERISA’s Silent Procedural Characteristics: Jury Trial

ERISA also does not speak to whether plaintiffs have the right to a jury trial. However, “[c]ourts addressing this issue have almost uniformly held that under the common law of trusts, proceedings to determine rights under employee benefits plans are equitable in character and thus a matter for a judge, not a jury.”³² This is true even though the plaintiff may seek damages in the form of monetary relief. The Eighth Circuit has explained that the “mere fact that [plaintiff asks] for monetary relief in part does not mandate that [the] action be characterized as legal rather than equitable. . . . Rather, because any monetary relief turns on a determination of entitlement to benefits, we consider such relief to be an integral part of an equitable action.”³³

Appropriate Equitable Relief

Much litigation has ensued regarding the meaning of “appropriate equitable relief” under 29 U.S.C. § 1132(a)(3) when an insurer seeks to recover monies from a participant or beneficiary. Most often, this situation arises when the plan at issue contains a reimbursement provision and (1) the insured is receiving disability benefits and subsequently receives other income benefits, be it through an award of Social Security Disability Income, workers’ compensation benefits, or other forms of payment described in the plan, or (2) the insured is receiving or has received medical benefits and subsequently recovers damages from a third-party tortfeasor for the same accident. The U.S. Supreme Court has addressed this issue in two noteworthy opinions. First, in *Great-West Life & Annuity Ins. Co. v. Knudson*, the Court was presented with a situation in which a plan participant sustained injuries as a result of an auto accident with a third party and received medical benefits under the plan. The participant recovered damages for the same accident from the third-party tortfeasor, and the insurer under the group plan sought reimbursement of the benefits it had paid from the third-party funds pursuant to a reimbursement provision in the plan.³⁴ The Supreme Court held that, because the settlement funds were placed into a special needs trust, the claim was characterized as legal, rather than equitable, and no recovery was permitted under 29 U.S.C. § 1132(a)(3).³⁵ The Court focused on the fact that the participant did not have the funds in her possession, and, therefore, such a claim merely imposed personal liability upon the participant.³⁶

After *Knudson*, circuit courts split over whether fiduciaries could ever use 29 U.S.C. § 1132(a)(3) to pursue reimbursements from plan participants. In 2006, the Supreme Court again addressed the issue in *Sereboff v. Mid Atlantic Medical Services Inc.*³⁷ The facts in *Sereboff* were similar to those in *Knudson* but, in *Sereboff*, the third-party funds were preserved in an investment account “until the [District] Court rule[d] on the merits of [the] case and all appeals, if any, were exhausted.”³⁸ The *Sereboff* Court found that, because the funds were specifically identifiable and in the possession

of the participant, a reimbursement action under 29 U.S.C. § 1132(a)(3) was appropriate.³⁹ Courts have applied the *Sereboff* rubric similarly to claims involving the recovery of an overpayment of benefits under long-term disability plans. For example, in *Gilcbrest v. Unum Life Ins. Co. of Am.*, the participant sued the fiduciary after his long-term disability benefits were terminated and the fiduciary counterclaimed to recover overpayment of benefits as a result of the participant’s receipt of Social Security Disability Income (SSDI).⁴⁰ The court found that the reimbursement provision in the plan specifically identified a particular fund—recovery of “other income” such as SSDI—and a particular share of that fund to which the plan was entitled—the portion of benefits paid that should have been offset by SSDI.⁴¹ Therefore, a reimbursement action under 29 U.S.C. § 1132(a)(3) is generally maintainable when the funds at issue are specifically identifiable and in the possession of the participant.

Remedies

Another litigated issue in the ERISA arena is whether a plaintiff may seek to recover extracontractual damages under ERISA’s civil enforcement scheme. The Supreme Court first addressed this issue in 1985 in *Mass. Mut. Life Ins. Co. v. Russell*,⁴² holding that the plaintiff could not recover extracontractual damages under 29 U.S.C. § 1132(a)(2).⁴³ The Court did not speak to whether extracontractual damages were available under either 29 U.S.C. § 1132(a)(1)(B) or 29 U.S.C. § 1132(a)(3). However, in 1993, the Supreme Court addressed this issue in the context of 29 U.S.C. § 1132(a)(3) and held that an action for “appropriate equitable relief” is for “remedies traditionally viewed as equitable, such as injunction or restitution” and not for money damages.⁴⁴

Although it did not address 29 U.S.C. § 1132(a)(1)(B), the *Russell* Court noted that the statute “says nothing about the recovery of extracontractual damages” and that the “six carefully integrated civil enforcement provisions found in [29 U.S.C. § 1132] provide strong evidence that Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly.”⁴⁵ Courts have relied on this language in refusing to permit claims for extracontractual damages, holding that to do so would “appear to be at odds with the plain meaning of the Supreme Court’s statements in *Russell* . . . [and] seem to do some violence to the language [of the statute], which appears to limit beneficiaries to contractual claims by providing only for action based upon or arising ‘under the terms of the plan.’”⁴⁶ Thus, extracontractual damages are generally not recoverable under 29 U.S.C. §§ 1132(a)(1)(B), (a)(2) or (a)(3).

The act does provide, however, that a court has the discretion to award attorneys’ fees and costs to either party.⁴⁷ Courts apply multifactor tests to determine whether a party is entitled to attorneys’ fees under ERISA, and these tests often vary.⁴⁸ Regardless of the test applied, courts have held that “[n]o single factor is determinative, and thus, the district court must consider each factor before exercising its discretion.”⁴⁹ Therefore, determining the amount to be awarded for attorneys’ fees most often depends on the court and the applicable facts of the case.

Jurisdiction

ERISA's civil enforcement scheme contains a jurisdictional clause that grants district courts of the United States "exclusive jurisdiction of civil actions under this subchapter brought by the secretary or by a participant, beneficiary, fiduciary, or any person referred to in section 1021(f)(1) of this title."⁵⁰ Moreover, the statute provides that "[s]tate courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under paragraphs (1) (B) and (7) of subsection (a) of this section"⁵¹ which include claims by a participant or beneficiary for benefits, to enforce rights under the plan or to clarify rights to future benefits and claims by "a [s]tate to enforce compliance with a qualified medical child support order. . . ."⁵²

When a claim for benefits pursuant to 29 U.S.C. § 1132(a) (1)(B) is brought in state court, the action may be removed to federal court under 28 U.S.C. § 1331 as a federal question. The more difficult question comes up when common law causes of action are included in the state court action and such claims are, or may be, pre-empted by ERISA. Pre-emption and removal are two separate issues.

Pre-emption

There are three interrelated clauses in 29 U.S.C. § 1144 that are used to evaluate whether state law claims are preempted by ERISA—the pre-emption clause, savings clause, and deemer clause. The pre-emption clause provides that ERISA "supersedes any and all State laws insofar as they may now or hereafter *relate to* any employee benefit plan described in section 1003(a) . . . and [are] not exempt under section 1003(b)."⁵³ The savings clause provides that "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which *regulates insurance, banking, or securities*."⁵⁴ Finally, the deemer clause states that

[n]either an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.⁵⁵

A wealth of litigation has been brought regarding the meaning and interrelationship of the above provisions. The most litigated provision is the pre-emption clause and the phrase "relate to any employee benefit plan" contained therein. The Supreme Court has interpreted this language broadly by stating that the "breadth [of the pre-emption clause's] reach is apparent from that section's language [and a] law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan."⁵⁶ However, this broad interpretation is not limitless. In *Mackey v. Lanier Collections Agency & Service Inc.*, the Supreme Court again addressed the meaning of "relate to" and held that "lawsuits against ERISA plans for run-of-the-mill state-law claims such as unpaid rent, failure to pay creditors, or even torts committed by an ERISA

plan are relatively commonplace," and even though these claims affect ERISA plans, they "are not preempted."⁵⁷ To clarify its interpretation further, in 1995, the Supreme Court stated that "Congress intended to preempt at least three categories of state law: (1) laws that 'mandate[] employee benefit structures or their administration'; (2) laws that bind employers or plan administrators to particular choices or preclude uniform administrative practice; and (3) 'laws providing alternate enforcement mechanisms' for employees to obtain ERISA plan benefits."⁵⁸

The savings and deemer clauses are implicated once it is determined that a state law claim "relates to" an ERISA-governed benefit plan and is pre-empted under the pre-emption clause. The savings clause operates as an exception to pre-emption, returning to the states the authority to enforce those state laws that regulate insurance—except as provided in the deemer clause.⁵⁹ As explained above, "[u]nder the deemer clause, an employee benefit plan governed by ERISA shall not be 'deemed' an insurance company, an insurer, or engaged in business of insurance for purposes of state laws 'purporting to regulate' insurance companies or insurance contracts."⁶⁰ The deemer clause has been interpreted by the Supreme Court to "exempt self-funded ERISA plans from state laws that 'regulate insurance' within the meaning of the savings clause."⁶¹ However, "employee benefit plans that are insured are subject to indirect state insurance regulation."⁶² In *FMC Corp. v. Holliday*, the Supreme Court explained that "[a]n insurance company that insures a plan remains an insurer for purposes of state laws 'purporting to regulate insurance' after application of the deemer clause."⁶³ As a result, "[t]he ERISA plan is consequently bound by state insurance regulations insofar as they apply to the plan's insurer."⁶⁴

Removal

Pursuant to 28 U.S.C. § 1441(a), "any civil action brought in a [s]tate court of which the district courts of the United States have original jurisdiction, may be removed by the defendant or the defendants, to the district court of the United States for the district and division embracing the place where such action is pending." District courts have original jurisdiction over cases "arising under the Constitution, laws, or treaties of the United States,"⁶⁵ and "[i]t is long settled law that a cause of action arises under federal law only when the plaintiff's well-pleaded complaint raises issues of federal law."⁶⁶ Because "[f]ederal preemption is ordinarily a federal defense to the plaintiff's suit[,] . . . it does not appear on the face of the well-pleaded complaint, and therefore, does not authorize removal to federal court."⁶⁷ However, there is an exception to this rule—that is, when the federal statute completely pre-empts the state law cause of action. The Supreme Court has determined that ERISA is one of those statutes and has explained that "Congress has clearly manifested an intent to make causes of action within the scope of the civil enforcement provisions [of ERISA] removable to federal court."⁶⁸ Thus, if a cause of action falls within the scope of 29 U.S.C. § 1132(a), it is removable notwithstanding the well-pleaded complaint rule and notwithstanding how the claim is characterized in the complaint.

Standard of Review of ERISA Claims

The applicable standard under which a court reviews a benefits claim decision has been one of the most disputed issues in ERISA litigation. Depending on the applicable plan language, the court either reviews a claim decision de novo or for abuse of discretion. This principle was established in *Firestone Tire and Rubber Co. v. Bruch*,⁶⁹ in which the Supreme Court was asked to determine the appropriate standard of review in actions challenging denial of benefits based on plan interpretations.⁷⁰ Because ERISA is silent as to the appropriate standard of review, federal courts first adopted the “arbitrary and capricious standard” developed under a provision of the Labor Management Relations Act.⁷¹ In *Firestone*, the Supreme Court noted that this “wholesale importation of the arbitrary and capricious standard into ERISA [was] unwarranted.”⁷² Guided by trust law principles, the Court held that “a denial of benefits challenged under § 1132(a)(1)(B) is to be reviewed under a de novo standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan.”⁷³

Despite the direction provided by *Firestone*, the ruling failed to provide factors or a standard to determine when a plan provides sufficient discretionary authority to remove it from a de novo review to a more deferential standard of review. Generally, when the plan specifically confers discretion on the fiduciary or administrator to make a determination about benefits and to construe the provisions of the plan, there is sufficient discretion for an abuse of discretion standard. However, language such as “a claimant is eligible for benefits ‘when Prudential determines’ that eligibility exists and that disabilities are ‘determined by Prudential’” is not sufficient to confer discretion.⁷⁴ In contrast, language giving the insurer “full and exclusive authority to control and manage ... interpret [and] resolve all questions arising in its administration, interpretation, and application” does confer sufficient discretion to apply an abuse of discretion standard of review because, even though it does not use the word discretion, the “language unambiguously communicates the message that payment of benefits is subject to [the insurer’s] discretion.”⁷⁵

If sufficient discretion is conferred, the next question is whether there has been an abuse of discretion. Circuit courts may use different language in describing how the determination is reached, but generally an insurer has not abused its discretion if it has acted reasonably. For example, the Eighth Circuit has stated that, under the abuse of discretion standard, a court “will not disturb the administrator’s decision if it was reasonable [and they] measure reasonableness by whether substantial evidence exists to support the decision, meaning ‘more than a scintilla but less than a preponderance.’”⁷⁶ Similarly, the Fourth Circuit has stated that an “administrator’s decision will not be disturbed if it is the result of a deliberate, principled reasoning process and if it is supported by substantial evidence [and] [s]ubstantial evidence consists of less than a preponderance but more than a scintilla of relevant evidence that a reasoning mind would accept as sufficient to support a particular conclusion.”⁷⁷ The Fourth Circuit has gone even further,

providing that, in assessing a claims decision, the reviewing court should consider factors such as—

- (1) the language of the plan; (2) the purposes and goals of the plan; (3) the adequacy of the materials considered to make the decision and the degree to which they support it; (4) whether the fiduciary’s interpretation was consistent with other provisions in the plan and with earlier interpretations of the plan; (5) whether the decision-making process was reasoned and principled; (6) whether the decision was consistent with the procedural and substantive requirements of ERISA; (7) any external standard relevant to the exercise of discretion; and (8) the fiduciary’s motives and any conflict of interest it may have.⁷⁸

This last factor has spurred much debate, specifically over what weight should be given to the fact that a conflict of interest may exist. In *Metropolitan Life Ins. Co. v. Glenn*, the Supreme Court recently confirmed that a conflict of interest is presumed when the administrator of the plan both makes the eligibility decision and pays the benefits from its own funds.⁷⁹ The *Firestone* court stated that, “if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a factor in determining whether there is an abuse of discretion.”⁸⁰ The Supreme Court recently revisited the rule from *Firestone* and attempted to create uniformity in the way a conflict of interest is considered. Previously, when a conflict was present, the Third, Fourth, Fifth, and Eighth Circuits applied a modified abuse of discretion standard—a sliding-scale approach based on the extent of the conflict—whereas the Second, Tenth, and Eleventh Circuits applied a burden-shifting test where, if a conflict was present, the burden shifted to the defendant to prove its decision was not improper. The Court’s recent decision in *Glenn* effectively did away with these differing approaches in favor of a method using a combination of factors to review decisions made by conflicted fiduciaries.

The Supreme Court explained that courts reviewing the reasonableness of a benefits determination should “take account of several different considerations of which a conflict of interest is one.”⁸¹ Significantly, the Court explained that “any one factor will act as a tiebreaker when the other factors are closely balanced, the degree of closeness necessary depending on the tiebreaking factor’s inherent or case-specific importance.”⁸² As the Court further explained,

The conflict of interest ... 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 [and 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 interest in firm finances, or by imposing management

checks that penalize inaccurate decision-making irrespective of whom the inaccuracy benefits.⁸³

Although *Glenn* was not a discovery case, the ruling has resulted in much debate over how—if at all—the case changed the landscape of ERISA litigation with respect to the scope of discovery, specifically with respect to the scope of an insurer’s conflict of interest and the effect, if any, that it may have had over a claims decision. In most circuits, the scope of discovery in ERISA cases has traditionally been limited to the administrative record or to those materials that were presented to the claims fiduciary during the administrative review of the claim, absent extraordinary circumstances. The *Glenn* Court declined to adopt “special burden-of-proof rules, or other special procedural or evidentiary rules, focused narrowly upon the evaluation/payor conflict” because “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.”⁸⁴ Still, the question of whether *Glenn* has changed the scope of discovery persists. Some courts have ruled that *Glenn* did not change the scope and they continue to look to pre-*Glenn* precedent to determine what discovery should be allowed;⁸⁵ other courts have ruled that discovery beyond the administrative record is necessary in order to determine the significance or weight of an insurer’s conflict of interest.⁸⁶ This issue will continue to be addressed by the circuits as practitioners bring discovery issues to the forefront in ERISA cases.

Conclusion

The issues and topics discussed in this article are meant to provide the reader with a basic understanding of ERISA litigation. Like many other areas of the law, the Employee Retirement Income Security Act is continuously evolving. With the number of ERISA opinions in 2008 alone, there is no doubt that the landscape will continue to shift as courts interpret and clarify the scope and application of the act as well as the remedies it provides. **TFL**



Jennifer E. Johnsen, Nicole J. Buntin, and Mary A. Giorgi are with Gallivan, White & Boyd, P.A. in Greenville, S.C. Johnsen is a shareholder of the firm, and her litigation practice focuses on business and commercial litigation, life, health, and disability benefits, insurance coverage, and intellectual property litigation.



Buntin and Giorgi, both associates at the firm, focus on business and commercial litigation with an emphasis on health care and benefits, disputes arising under ERISA and insurance coverage matters. Giorgi also handles construction litigation matters

and represents contractors and subcontractors in a variety of disputes involving design and construction issues.

Endnotes

¹ERISA plans can provide, among other things, medical, surgical, hospital care, sickness, accident, disability, death, unemployment, or vacation benefits.

²29 U.S.C. § 1002(1).

³*Shearer v. Southwest Serv. Life Ins. Co.*, 516 F.3d 276, 279 (5th Cir. 2008).

⁴29 U.S.C. § 1002(7).

⁵29 U.S.C. § 1002(6).

⁶*Raymond B. Yates, M.D., P.C. Profit Sharing Plan v. Hendon*, 541 U.S. 1, 6, 16 (2004).

⁷29 U.S.C. § 1003(a).

⁸*Winterrowd v. David Freedman and Co., Inc.*, 724 F.2d 823, 825 (9th Cir. 1984) (citing *Polish Nat'l Alliance v. NLRB*, 322 U.S. 643, 647 (1944)).

⁹29 U.S.C. § 1003(b)(1).

¹⁰29 U.S.C. § 1003(b)(2).

¹¹29 U.S.C. § 1003(b)(3).

¹²29 U.S.C. § 1003(b)(4).

¹³29 U.S.C. § 1003(b)(5).

¹⁴29 U.S.C. § 1002(32).

¹⁵402 U.S. 600, 604–605 (1971).

¹⁶*Id.*

¹⁷*Rose v. Long Island R.R. Pension Plan*, 828 F.2d 910, 916 (2d Cir. 1987) (quoting H.R. Rep. No. 533, 1974 U.S. Code Cong. & Ad. News at 4647).

¹⁸In *Alley v. Resolution Trust Corp.*, 984 F.2d 1201, 1206 (D.C. Cir. 1993), the District of Columbia Circuit concluded that while the *Natural Gas Utility* test may be appropriate in determining whether an entity is affiliated with a state government, the test is less useful in determining whether an entity is affiliated with the federal government, because the primary consideration is the “nature of an entity’s relationship to and governance of its employees.”

¹⁹29 U.S.C. § 1132(a)(1)(B).

²⁰29 U.S.C. § 1132(a)(3).

²¹29 U.S.C. § 1132(a)(2).

²²*LaRue v. DeWolff, Boberg & Associates Inc.*, 128 S. Ct. 1020, 1022–1023 (2008).

²³*Id.* at 1026.

²⁴*Id.* at 1023.

²⁵*Harrow v. Prudential Ins. Co. of America*, 279 F.3d 244, 249 (3d Cir. 2002) (quoting *Amato v. Bernard*, 618 F.2d 559, 567 (9th Cir. 1980)). See also *Lane v. Sunoco Inc.*, 260 Fed. Appx. 64, 66 (10th Cir. 2008) (stating that not requiring exhaustion would permit premature judicial interference and would impede those internal processes that result in a completed record of decision-making for a court to review) (internal citations omitted).

²⁶*Lane*, 260 Fed. Appx. at 66. (holding that a “district court may waive exhaustion ... when (1) the administrative process would be futile, or (2) the remedy in the benefit plan is inadequate.”). See also *Harrow*, 279 F.3d at 250 (stating that excuse of exhaustion on futility grounds depends on a number of factors); *Ravencraft v. Unum Life Ins. Co. of Am.*, 212 F.3d 341, 344 (6th Cir. 2000) (stating that futility can be shown if “the review procedures are insufficient or unfair, or [the] available remedy is inadequate”); *Smith v. Blue Cross & Blue Shield United of Wisc.*, 956 F.2d 655, 659

(7th Cir. 1992) (stating that one exception to the exhaustion requirement is where there is a “lack of meaningful access to the review procedures.”).

²⁷29 U.S.C. § 1113.

²⁸*Jenkins v. Local 705 Intern. Broth. of Teamsters Pension Plan*, 713 F.2d 247, 251 (7th Cir. 1983).

²⁹*Id.* at 252–253; see also *Damerson v. Sinai Hosp. of Baltimore Inc.*, 815 F.2d 975, 981 (4th Cir. 1987) (an ERISA claim alleging breach of duty is analogous to a breach of contract action).

³⁰*Johnson v. Georgia-Pacific Corp.*, 260 Fed. Appx. 994, 997 (9th Cir. 2007) (internal citations omitted).

³¹*Northlake Regional Medical Center v. Waffle House System Employee Benefit Plan*, 160 F.3d 1301, 1303 (11th Cir. 1998) (citing *Doe v. Blue Cross & Blue Shield United of Wisc.*, 112 F.3d 869, 874–875 (7th Cir. 1997)).

³²*Berry v. Ciba-Geigy Corp.*, 761 F.2d 1003, 1007 (4th Cir. 1985).

³³*In re Vorpabl*, 695 F.2d 318, 322 (8th Cir. 1982); see also *Calamia v. Spivey*, 632 F.2d 1235, 1236–1237 (5th Cir. 1980).

³⁴*Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002).

³⁵*Id.* at 220–221.

³⁶*Id.*

³⁷*Sereboff v. Mid Atlantic Medical Services Inc.*, 547 U.S. 356 (2006).

³⁸*Id.* at 360.

³⁹*Id.* at 369.

⁴⁰*Gilcbrest v. Unum Life Ins. Co. of Am.*, 255 Fed. Appx 38, 39–40 (6th Cir. 2007).

⁴¹*Id.* at 44–45.

⁴²*Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134 (1985).

⁴³*Id.* at 148.

⁴⁴*Mertens v. Hewitt Associates*, 508 U.S. 248 (1993).

⁴⁵*Russell*, 473 U.S. at 144, 146.

⁴⁶*Harsh v. Eisenberg*, 956 F.2d 651, 655 (7th Cir. 1992).

⁴⁷29 U.S.C. § 1132(g)(1) (“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.”)

⁴⁸See *Gaeth v. Hartford Life Ins. Co.*, No. 06-6490, 2008 WL 3833879, at *3 (6th Cir. Aug. 19, 2008) (noting that the test used by the Sixth Circuit is different from the test used by the Second Circuit).

⁴⁹*Id.* (quoting *Moon v. Unum Provident Corp.*, 461 F.3d 639, 643 (6th Cir. 2006)).

⁵⁰29 U.S.C. § 1132(e)(1).

⁵¹*Id.*

⁵²29 U.S.C. §§ 1132(a)(1)(B), (a)(7).

⁵³29 U.S.C. § 1144(a) (emphasis added).

⁵⁴29 U.S.C. § 1144(b)(2)(A) (emphasis added).

⁵⁵29 U.S.C. § 1144(b)(2)(B).

⁵⁶*Shaw v. Delta Air Lines Inc.*, 463 U.S. 85, 96–97 (1983).

⁵⁷*Mackey v. Lanier Collections Agency & Service Inc.*, 486 U.S. 825, 833 (1988).

⁵⁸*Wilmington Shipping Co. v. New England Life Ins. Co.*,

496 F.3d 326, 343 (4th Cir. 2007) (quoting *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 658–59 (1995)).

⁵⁹*FMC Corp. v. Holliday*, 498 U.S. 58, 55 (1990).

⁶⁰*Id.*

⁶¹*Id.* at 61.

⁶²*Id.*

⁶³*Id.*

⁶⁴*Id.*

⁶⁵28 U.S.C. § 1331.

⁶⁶*Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 63 (1987).

⁶⁷*Id.*

⁶⁸*Id.* at 66.

⁶⁹*Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101 (1989).

⁷⁰*Id.* at 108.

⁷¹*Id.* at 109.

⁷²*Id.*

⁷³*Id.* at 115.

⁷⁴*Woods v. Prudential Ins. Co. of America*, 528 F.3d 320, 322–323 (4th Cir. 2008).

⁷⁵*Gutta v. Standard Select Trust Ins. Plan*, 530 F.3d 614, 619–620 (7th Cir. 2008).

⁷⁶*Wakkinen v. Unum Life Ins. Co. of America*, No. 06-3054, 2008 WL 2597088, at *8 (8th Cir. July 2, 2008) (quoting *Woo v. Deluxe Corp.*, 144 F.3d 1157, 1162 (8th Cir. 1998)).

⁷⁷*Whitley v. Hartford Life & Acc. Ins. Co.*, 262 Fed. Appx. 546, 551 (4th Cir. 2008).

⁷⁸*Id.*

⁷⁹*Metropolitan Life Ins. Co. v. Glenn*, 128 S. Ct. 2343, 2348 (2008).

⁸⁰*Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989).

⁸¹*Glenn*, 128 S. Ct. at 2351.

⁸²*Id.*

⁸³*Id.* at 2351–2352.

⁸⁴*Id.* at 2351.

⁸⁵See, for example, *Wakkinen v. Unum Life Ins. Co. of Amer.*, 531 F.3d 575 (8th Cir. 2008); *Dubois v. Unum Life Ins. Co. of Amer.*, No. CIV. 08-163-P-S, 2008 WL 2783283 (D. Me. July 14, 2008); *Eppler v. Hartford Life and Accident Ins. Co.*, No. C. 07-04696-WHA, 2008 WL 3266469 (N.D. Cal. Aug. 7, 2008); *Singleton v. Hartford Life & Accident Ins. Co.*, No. 4:08-CV-00361-WRW, 2008 WL 3978680 (E.D. Ark. July 29, 2008); *Samuel v. Citibank, N.A., Long Term Disability Plan*, No. CIV. 07-4051, 2008 WL 4138174 (D.S.D. Sept. 3, 2008).

⁸⁶See, for example, *Wilcox v. Wells Fargo and Co. Long Term Disability Plan*, No. 06-16140, 2008 WL 2873735 (9th Cir. July 23, 2008); *Burke v. Pitney Bowes Inc. Long-Term Disability Plan*, No. 06-15341, 2008 WL 4276910 (9th Cir. Sept. 19, 2008); *Hogan-Cross v. Metropolitan Life Ins. Co.*, 568 F.Supp.2d 410 (S.D.N.Y. 2008); *Paul v. Hartford*, Civil Action No. 08-cv-00890-REB-MEH, 2008 WL 2945607 (D. Colo. July 28, 2008).