

LEAVING WELL ENOUGH ALONE: REFLECTIONS ON THE CURRENT STATE OF ERISA REMEDIAL LAW¹

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Symposium: The Grand Irony? The Intersectionality of ERISA Preemption and Remedial Law.

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I. INTRODUCTION

As lawyers who represent employers and health plans in ERISA litigation, we have some strongly-held views on the topic of this symposium. The symposium title implies that ERISA's remedial scheme does not serve the interests of plan participants. Although the current state of the law (at least with respect to certain remedial issues) is undeniably complex, we believe the symposium title incorrectly suggests that there is something ironic about this corner of the law. We also believe it would be unwise to alter the balance articulated by Congress in the statute and applied (more or less) consistently by the Supreme Court. And we believe that any attempts to make incremental changes in the scope of ERISA remedies would be counter-productive and thus unwise as a matter of policy. From this perspective, we offer some thoughts on the current understanding of ERISA's two "preemption" provisions² and the courts' interpretation of

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ERISA's civil enforcement provisions in cases brought by plan participants and beneficiaries. Because of time and space constraints, this article will not address several other important issues involving the scope of ERISA's remedial provisions.³

II. Preliminary Observations

Much of the leading academic writing argues that ERISA provides inadequate remedies to plan participants.⁴ Because we assume other symposium participants are familiar with these arguments, they are not repeated here. Our experience, however, leads us to take issue with the

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² Section 514 of ERISA states that the statute "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" that is covered by ERISA. 29 U.S.C. § 1144(a). Section 502 of ERISA sets forth the statute's civil enforcement scheme, listing the remedies available under ERISA. 29 U.S.C. § 1132(a). As discussed *infra* Part V. preemption issues are often presented in cases implicating Section 502.

³ For example, the enforceability of subrogation provisions in plan documents remains an actively litigated subject notwithstanding (or perhaps because of, depending on one's point of view) the Court's decision in *Sereboff v. Mid Atl. Med. Servs., Inc.*, 547 U.S. 356 (2006). A second example involves the proper reading of Section 502(a)(2) as to whether employer plan sponsors have standing to bring actions seeking to clarify rights and obligations under ERISA plans. *E.g., Carl Colteryahn Dairy, Inc. v. Western Teamsters & Emp. Pension Fund*, 847 F.2d 113 (3d Cir. 1988), *cert. denied*, 488 U.S. 1041 (1989). Third, the article will not address preemption of specific state laws involving mandated benefits, such as the New Jersey Mental Health Parity Law, that have considerable importance to the managed care community. *E.g., Devito v. Aetna, Inc.*, 536 F. Supp. 2d 523 (D.N.J. 2008). Finally, this article does not address enforceability of defined benefit plans or the scope of remedies in claims brought under the Multiemployer Pension Plan Amendments Act.

⁴ See, e.g., John H. Langbein, *What ERISA Means By "Equitable:" The Supreme Court's Trail Of Error In Russell, Mertens, and Great-West*, 103 Colum. L. Rev. 1317 (2002); Colleen E. Medill, *Resolving the Judicial Paradox of "Equitable" Relief Under ERISA Section 502(a)(3)*, 39 John Marshall L. Rev. 827 (2006).

assumptions underlying some of the conclusions reached by scholars in this area.

For example, we think it is not particularly useful to think of ERISA in terms of primary v. secondary purposes.⁵ Such formulations look a lot like revisionist history. Recent scholarship reminds us that, in enacting ERISA, Congress was almost exclusively concerned about protecting defined benefit pension plan benefits, primarily in the unionized segment of the manufacturing industry.⁶ Indeed, the case has been made that the Studebaker bankruptcy was the principal impetus for ERISA.⁷ Whatever one might think of the role of organized labor in the passage of ERISA, we are reasonably certain that Congress did not enact ERISA out of concern for the remedies available to participants in health plans. After all, managed care was not commonplace in 1974, and there is nothing in the legislative history of ERISA to suggest that Congress enacted Section 502(a)(3) to provide compensatory damage remedies in welfare plan claims disputes. As Justice Marshall observed in *Central States*, the discussion of welfare plans in the ERISA legislative history was largely limited to the statute's reporting and disclosure requirements.⁸ Our review of the legislative history leads us to conclude that it is more accurate to acknowledge that the statute sets forth a series of "principal" objectives, one of which is the promotion of private

⁵ This is a view subscribed to, among others, by Professor Paul Secunda, associate professor of law at Marquette Law School and one of the organizers of this symposium. An abstract of the paper Professor Secunda will present at this symposium argues that employees too often have "no meaningful remedy for their claims" under ERISA. Paul M. Secunda, *Sorry, No Remedy: The Grand Irony of ERISA*, abstract available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1273840. Professor Secunda blames the "strict constructionist Justices" of the Supreme Court who have "accomplished this feat by elevating a secondary purpose of ERISA, to make sure employers voluntarily adopt employee benefit plans over the primary purpose of ERISA, to ensure employees and their beneficiaries are protected in their pension and welfare benefits." *Id.*

⁶ See, e.g., James A. Wooten, *A Legislative and Political History of ERISA, Part 1, J. of Pension Benefits*, at 32 (2006).

⁷ See, e.g., James A. Wooten, 'The Most Glorious Story of Failure in the Business:' *The Studebaker-Packard Corporation and the Origins of ERISA*, 49 *Buffalo L. Rev.* 683 (2001).

⁸ *Central States Pension Fund v. Central Transport, Inc.*, 472 U.S. 559, 569 n.9 (1985).

sector employer-sponsored retirement plans.⁹ As the Supreme Court famously observed in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987), ERISA “represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans.”

We think it is a mistake to minimize the importance of the voluntary formation principle in thinking about where to strike the balance as to the scope of ERISA’s remedial provisions under any particular set of facts. For better or worse, employer-provided benefits remain the cornerstone of the system. Medical benefits for private sector employees are still primarily delivered through plans, policies and practices largely funded by employers.¹⁰ Pension plans established by private sector employers, including 401k plans, remain the primary means by which employees covered by such plans save for retirement. Absent a massive overhaul of the U. S. health care system, there is no reasonable alternative to the existing arrangements for both pension and welfare benefits that have evolved over the last 25 years.¹¹

We believe the Supreme Court’s decisions on ERISA remedies have generally reflected an appropriate understanding of the importance of avoiding outcomes that would put additional pressure on the current system. Thus, in a variety of situations, the Court has recognized, sensibly in our

⁹ See Dana M. Muir, *Plant Closings and ERISA's Noninterference Provision*, 36 B.C. L. REV. 201, 204 n. 22 (1995) (listing ERISA’s five purposes, citing 29 U.S.C. §1001 (1988)); see also H.R. REP. NO. 533, 93d Cong., 1st Sess. 1-2 (1973), reprinted in 1974 U.S.C.C.A.N. 4639, 4640 (listing as one of Congress's goals the promotion of "a renewed expansion of private retirement plans").

¹⁰ A study published by the Employee Benefit Research Institute estimated that 161.7 million individuals were covered by employment-based health insurance in 2006, or roughly two-thirds of the non-elderly population. EBRI Issue Brief No 314, at 9 (Feb. 2008).

¹¹ Notwithstanding President Obama’s ambitious plans to enact systemic reform of the nation’s health care system, it is unlikely that such overhaul will be enacted before the date of this symposium. We will leave for others the question of whether a systematic overhaul of the country’s health care delivery system can be achieved in the current political environment in a way that meets the needs and expectations of all stakeholders in the system.

view, that it is not a good idea to impose additional costs on employers and other plan sponsors.¹² The Court has likewise concluded that it is unwise to make it more difficult for large employers to administer plans in a consistent way across the country.¹³ Most recently, in *Kennedy v. Plan Administration for DuPont Savings & Investment Plan*,¹⁴ the Court unanimously reaffirmed the “plan documents” rule set forth in Section 404(a)(1) of ERISA. We think it is significant that Justice Souter’s opinion in *Kennedy* took as a given that it would be unwise to subject plan administrators to the additional cost of sorting out, through various types of collateral litigation, the question of whether plan beneficiaries had reflected an intent to change their retirement plan beneficiary designations in ways other than those expressly provided for in the plan documents.

Particularly in the current economic conditions, the imposition of substantial additional costs on the administration of employee benefit plans, including increased litigation costs, would have predictably perverse consequences. Outcomes that further compromise the ability of private sector employers to shoulder the financial burden of maintaining employee benefit plans will only increase the chances that fewer employees and retirees (and their dependants) will be covered by such plans.

For many of the same reasons, we believe it would be a mistake for courts to start treating ERISA as a traditional make-whole statute. Justice Scalia was surely correct in his observation in *Mertens v. Hewitt* that ERISA is a “complex and detailed statute that resolved innumerable disputes between powerful competing interests—not all in favor of potential plaintiffs.”¹⁵ It is clear enough from the text of the statute that Congress did not intend ERISA to provide make-whole relief in the same sense as that term is used in employee rights statutes such as the National Labor Relations Act or Title VII of the Civil Rights Act of 1964. The courts, in our

¹² See, e.g., *Egelhoff v. Egelhoff*, 532 U.S. 141, 149-150 (2000) (recognizing the congressional goal of ‘minimiz[ing] the administrative and financial burden[s]’ on plan administrators”). See, also, *Boggs v. Boggs*, 520 U.S. 833, 853 (1997); *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, -- (2002)[pinpoint should exist for a 2002 case].

¹³ See, e.g., *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 105 (1983) (“Congress minimized the need for interstate employers to administer their plans differently in each State in which they have employees”); *Ingersoll-Rand v. McClendon*, 498 U.S. 133 (1990).

¹⁴ 555 U.S. --- (Jan. 26, 2009).

¹⁵ *Mertens v. Hewitt Assoc.*, 508 U.S. 248, 262 (1993).

view, have properly rejected contrary arguments made by interest groups in a variety of situations.¹⁶

Finally, we take issue with the notion that employers are black-hearted villains eager to find ways to keep their employees from getting the benefits they deserve. We believe that Justice Scalia was also correct, in *Metropolitan Life v. Glenn*, when he rejected the respondent's request "to presume that all fiduciaries with a conflict act in their selfish interest, so that their decisions are automatically reviewed with less than total deference."¹⁷ Instead, Justice Scalia concluded, one should infer that a fiduciary "suppressed his selfish interest . . . in compliance with his duties of good faith and loyalty."¹⁸ Our practice involves helping sophisticated and well-meaning employers comply with both the letter and spirit of an extremely complex statute. In our experience, employers are not involved in a game of "gotcha" where they look for ways to keep their employees from receiving promised benefits. Sophisticated employers take their fiduciary responsibilities seriously, as well as the obligation to act in accordance with the terms of the plan. In some cases, that means giving people accurate but admittedly unhappy news about their entitlement to claimed benefits under a particular plan. Enforcing the rules doesn't make employers chintzy, let alone evil. Most U.S. employers are simply trying to do what it takes to maintain competitive employee benefit plans for their employees in the face of increasingly difficult economic conditions.

III. Preemption of State Common Law Claims

The watershed Supreme Court decision regarding the preemption of state common law claims is *Davila v. Aetna Health*.¹⁹ The Supreme Court

¹⁶ Insurance companies and others seeking to enforce subrogation provisions in ERISA plans are included in our definition of interest groups. We believe the views of the would-be enforcers of subrogation agreements are no more or less worthy than those expressed by participants and beneficiaries.

¹⁷ *Metropolitan Life Ins. Co. v. Glenn*, 554 U.S. ___, 128 S. Ct. 2343, 2360 (2008) (*Scalia, J., dissenting*).

¹⁸ *Id.*

¹⁹ 542 U.S. 200, 124 S.Ct. 2488 (2004). *Davila* was the culmination of a series of Supreme Court cases striking down various state laws providing a damages remedy outside of the scope of ERISA's civil enforcement

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ruled unanimously that the state law claim asserted there, based on the Texas Health Care Liability Act, was preempted by ERISA. The Texas statute imposed duties on managed health care entities to “exercise ordinary care when making health care treatment decisions,” and made HMOs liable for damages proximately caused by failure to exercise that ordinary care.²⁰ The plaintiffs in *Davila* alleged that their HMOs’ refusal to cover certain medications and hospital stays proximately caused them additional injury and therefore violated Texas law.

The Supreme Court found that the state law causes of action were preempted by Section 502(a)(1)(B) of ERISA, even though the state law causes of action were not identical to a claim for benefits under ERISA.²¹ The Court explained that the state law claims existed only because the HMOs administered ERISA-regulated benefit plans. Thus, the Court concluded, the claims did not “attempt to remedy any violation of a legal duty independent of ERISA.”²² Though the Texas statute authorized remedies unavailable in ERISA, this attempt to supplement ERISA remedies did not place the state statute outside of the scope of ERISA’s civil enforcement mechanism. As Justice Thomas explained, “Congress’ intent to make the ERISA civil enforcement mechanism exclusive would be undermined if state causes of action that supplement the ERISA § 502(a) remedies were permitted, even if the elements of the state cause of action did not precisely duplicate the elements of an ERISA claim.”²³

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mechanism. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987) (striking down state law providing remedies for consumers who had been subject to unfair claims practices by insurers); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 144 (1990) (a Texas wrongful termination statute at issue was preempted because it “purports to provide a remedy for the violation of a right expressly guaranteed by § 510 and exclusively enforced by § 502(a)”); *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 378 (2002) (“Congress had not intended causes of action under ERISA itself beyond those specified in” Section 502). See also *UNUMLife Ins. Co. of America v. Ward*, 526 U.S. 358 (1999); *Metropolitan Life Ins., Co. v. Massachusetts*, 471 U.S. 724 (1985).

²⁰ *Id.* at 2493.

²¹ *Id.* at 2499.

²² *Id.* at 2498.

²³ *Id.* at 2499-2500.

In reaching this result, the Court announced a clear rule in favor of preemption of state-law causes of action that attempted to supplement the remedies available under Section 502 of ERISA. As Justice Thomas put it, “any state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted. . . . The preemptive force of ERISA § 502(a) is still stronger.”²⁴

All nine Supreme Court justices agreed that the Texas statute was preempted by ERISA. In what has since become a famous concurrence (at least in the world of ERISA litigation), Justice Ginsburg wrote that the Court’s conclusion was consistent with the Court’s “governing case law.”²⁵ She lamented the fact Section 502 did not always provide the full range of remedies often sought by plaintiffs and urged Congress (or the Court) to “revisit” the ERISA regime to remedy the holes left by its remedial scheme.²⁶

Davila has largely resolved the question of ERISA preemption of state law claims. Lower courts have struck down as preempted various types of state law claims raised by plan participants and beneficiaries, even if the claim is not “completely duplicative” of an ERISA cause of action.²⁷ The law is less settled with respect to whether an action brought by other entities involved in plan administration should be seen as an assignment of a participant’s claim for benefits under Section 502(a)(1)(B) or a claim based on an independent legal claim of right.²⁸

²⁴ *Id.* at 2495.

²⁵ *Id.*, Ginsberg, J. concurring.

²⁶ *Id.*

²⁷ See, e.g., *Barber v. Unum Life Ins. Co.*, 383 F.3d 134 (3d Cir. 2004); *Hutchison v. Fifth Third Bancorp.*, 469 F.3d 583 (6th Cir. 2006); *Kilar v. Blue Cross Blue Shield Ass’n*, 195 Fed. Appx. 547 (9th Cir. 2006).

²⁸ Such cases often arise in disputes between health care providers and plans over payment of medical services. Courts have attempted to differentiate between “assigned” and “third party” claims, the latter of which are often not found preempted. See, e.g., *Memorial Hospital System v. Northbrook Life Insurance Co.*, 904 F.2d 236 (5th Cir. 1990)(ERISA does not preempt claim of health care provider alleging misrepresentation as to coverage of medical treatment). The distinction can be difficult to recognize in particular cases. Compare *Doctors Medical Center of Modesto Inc. v. Guardian Life Insurance Co. of America*, No. 1:08-CV-00903, 2009 WL

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In addition to correctly interpreting ERISA, the Court in *Davila* also struck the proper balance regarding ERISA's remedial scope as a matter of policy. Since *Pilot Life*, the Court has repeatedly acknowledged the importance of encouraging the formation of employer sponsored plans.²⁹ As noted above, the legislative history demonstrates Congress' concern about imposing excessive costs on employer plan sponsors.³⁰ It would be a profoundly bad idea to make the employee benefits world the plaintiffs' bar next dream come true by consigning every alleged error in benefit plan administration to the tender mercies of state tort law.³¹[GREAT POINT!] It is

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179681 (E.D. Cal. Jan. 26, 2009) (no preemption of a medical provider's claim of tortious interference with contract against a claims processing company in connection with a dispute over non-payment of the provider's medical expenses; plaintiff claimed that the insurance company had an independent legal obligation to reimburse the provider) *with In re Managed Care Litigation*, -- F. Supp. 2d --, No. 00-1334-MD, 2009 WL 210689 (S.D. Fla. Jan. 28, 2009) (complete preemption applies to claims brought by Missouri out-of-network physicians against health insurers that allegedly denied and delayed payment of claims on improper grounds).

²⁹ See, e.g., *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 376 (2002) (recognizing the "public interest in encouraging the formation of employee benefit plans") (*quoting Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987)); *Davila*, 524 U.S. at 208 (same). Congress recognized that high costs of maintaining voluntary employee benefit plans could deter employers from offering them, acknowledging the need to "strike a balance between providing meaningful reform and keeping costs within reasonable limits." H.R. Rep. No. 93-807, at 15 (1974).

³⁰ H.R. Rep. No. 93-779, at 2 (1974) (Congress "weighed carefully the additional costs to the employers and minimized these costs to the extent consistent with minimum standards" for benefits); 3 Legislative History of ERISA at 4673 (1976) (remarks of Senator Ullman) ("[P]ension plans cannot be expected to develop if costs are made overly burdensome, particularly for employers who generally foot most of the bill," explaining that such a burden would be "self defeating" and "unfavorable").

³¹ As *Davila* percolated through the lower courts, representatives of the plaintiffs' bar argued that tort claims brought under a variety of state law "bad faith" statutes should be immune from preemption. See, Donald T.

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by now well understood that litigation imposes increased costs across society, retarding job creation and ultimately harming consumers.³² One does not have to think too hard before concluding that it would be ruinous to the employer-based health care delivery system if health care goes the way of tobacco, asbestos and other species of repetitive tort litigation. After all, as the Court observed in *Egelhoff*, additional administrative burdens and costs will “ultimately [be] born by the beneficiaries” of the plan.³³

After more than twenty-five years of this aspect of ERISA preemption jurisprudence, we think the Court has got it about right. Read together, the Court’s decisions, culminating in *Davila*, have achieved what must be seen as an appropriate balance of the rights and obligations of all stakeholders involved in ERISA plan administration. Perhaps the best evidence that the current state of the law regarding the appropriate scope of Section 502 is not such a bad thing is the fact that Congress has found it unnecessary to make any changes to this part of the statute, including, most recently, in the Pension Plan Protection Act of 2006.³⁴

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Brogan, *Saving State Law Bad-Faith Claims From Preemption*, Trial Lawyers of America (2003) available at <http://www.harp.org/bogan.htm>. The Court wisely rejected that argument, obviously recognizing this as the exception that would swallow the preemption rule. There is no reason to believe that the plaintiffs’ bar has lost interest in the issue. Indeed, as described below, the rise in creative uses of Section 502(a)(3) can be traced to a recognition among plaintiffs lawyers that *Davila* was the end of the line as far as state law tort claims was concerned, and that they were more likely to be successful in getting big judgments and settlements by proceeding under a newly-minted interpretation of Section 502(a)(3) itself, arguing for an expansive interpretation of the term “equitable relief.” See pp. --- *infra*.

³² See, e.g., Richard A. Posner, *The Economics of Justice*, 4-5 (Harvard University Press, 1983).

³³ *Egelhoff v. Egelhoff*, 532 U.S. 141, 150 (2001). See also, *Pegram v. Herdrich*, 530 U.S. 211, 237 (2000) (rejecting the notion that state malpractice law should cover HMO decision-making, asking, “what would be gained by opening the federal courthouse doors for a fiduciary malpractice claim,” and concluding that there would be no benefit to the plan participant in “welcoming such unheard-of” litigation).

³⁴ Pub.L.No. 109-280.

Yet the current balance is tenuous. Developments in other areas of the law may signal a change in the Court's view of preemption. Recent decisions suggest a greater sympathy for a more aggressive interpretation of the presumption against preemption that applies in some areas of the law. The Court's recent decision in *Altria Group v. Good*³⁵ is illustrative. There, a group of cigarette smokers brought a civil action against a cigarette manufacturer alleging that the manufacturer's advertisements were misrepresentations that violated Maine's Unfair Trade Practices Act. The cigarette manufacturer argued that the state law claim was preempted by the Federal Cigarette Advertising and Labeling Act, which requires all cigarette packaging to contain the Solicitor General's warning and preempts state laws adding to the federally prescribed warning.³⁶ The Court concluded that the federal law did not encompass a general duty not to make fraudulent statements and thus did not preempt claims brought under state law.³⁷ Other cases working their way through the courts may cause a broader reassessment of the reach of federal law preemption. Because the tobacco wars are *sui generis*, the *Wyeth* case is the most likely next candidate.³⁸ However one might feel about preemption generally, a subsequent decision that reverses field in this area of ERISA preemption would be most unfortunate for the current private sector benefits delivery system.

IV. Preemption of state and local government legislative initiatives

Section 514 of ERISA is widely understood as one of the most expansive preemption provisions in federal statutory law. Specifically, Section 514(a) expressly preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . ." ³⁹ In *Shaw v. Delta Air Lines, Inc.*, the Supreme Court explained in broad terms that this language applies to any state mandate that "has a connection with or reference to such a plan."⁴⁰ In *Shaw*, the Supreme Court ruled that a New

³⁵ 555 U.S. ___, 129 S. Ct. 538 (2008).

³⁶ 15 U.S.C. § 1334(b).

³⁷ *Altria Grp*, 128 S. Ct. at 549.

³⁸ *E.g., Wyeth v. Levine*, No. 06-1249, *cert. granted* 128 S.Ct. 1118 (January 18, 2008)(raising question of whether FDA-approved warnings on prescription medications preempt various state failure-to-warn claims).

³⁹ 29 U.S.C. §1144(a).

⁴⁰ 463 U.S. 85, 97 (1982).

York state disability benefits law was preempted to the extent it required employers to provide pregnancy disability benefits in excess of what was then required by Title VII.⁴¹

In the years following *Shaw*, the Court struck down, as preempted under Section 514, a variety of state law initiatives that were held to “relate to” ERISA benefit plan administration. For example, in *Alessi v. Raybestos Manhattan, Inc.*, the Court held that a New Jersey statute that prohibited pension plans from offsetting benefits to plan participants who received workers compensation benefits under state law was preempted.⁴² In *Mackey v. Lanier Collection Agency*, the Court held that a provision of a Georgia garnishment statute that exempted ERISA plans from its coverage was preempted, irrespective of the fact that the intent of that statute was consistent with the purposes of ERISA.⁴³ And in *FMC Corp. v. Holliday*, the Court held preempted a Pennsylvania law prohibiting an ERISA plan to pursue a subrogation claim.⁴⁴

After *Shaw*, the Court also struck down state and local government legislation mandating employers to provide certain types of employee benefits. For example, in *District of Columbia v. Greater Washington Board of Trade*, the Supreme Court held that ERISA preempted a District of Columbia law that required employers who provided health insurance benefits to their employees to continue “equivalent” coverage to employees who become eligible for workers compensation benefits.⁴⁵ In *Metropolitan Life Insurance v. Massachusetts*, the Supreme Court concluded that state mandated benefits statutes “relate to” ERISA plans and are thus preempted unless within the scope of Section 514’s “savings clause.”⁴⁶ Lower courts reached similar outcomes.⁴⁷

⁴¹ *Id.*

⁴² 451 U.S. 504 (1981).

⁴³ 486 U.S. 825 (1988).

⁴⁴ 498 U.S. 57 (1990).

⁴⁵ 498 U.S. 57 (1990).

⁴⁶ 506 U.S. 125 (1992).

⁴⁷ See, e.g., *General Electric Co. v. New York State Dept of Labor*, 891 F.2d 25 (2d Cir. 1989) (New York prevailing wage statute preempted by obligating employers to provide certain level and type of fringe benefits); *Standard Oil Co. v. Agsalud*, 633 F.2d 760 (9th Cir. 1980) (Hawaii law mandating employee health coverage held preempted), *aff'd*, 454 U.S. 801 (1981).

In 1995, this feature of the preemption landscape began to change. In *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Inc.*, the Supreme Court upheld a New York state law that required patients of commercial insurers to pay a surcharge on hospital services not applicable to patients of other insurance providers.⁴⁸ In determining whether the state statute was preempted, the Supreme Court looked, not to the text of Section 514(a), but rather to the “structure and purpose” of ERISA. The Court found that “nothing in the language of the Act or the context of its passage indicates that Congress chose to displace general health care regulation.”⁴⁹ Thus, in *Travelers*, and two years later in *California Div. of Labor Stds. Enforcement v. Dillingham Constr., N.A., Inc.*,⁵⁰ the Court seemed to limit its decisions in earlier cases, at least with respect to the relationship between ERISA and state laws of general applicability.

Justice Scalia acknowledged the Court’s inconsistencies in approaches to interpreting Section 514 in his concurrence in *Dillingham*:

Since ERISA was enacted in 1974, this Court has accepted certiorari in, and decided, no less than 14 cases to resolve conflicts in the Courts of Appeals regarding ERISA pre-emption of various sorts of state law. The rate of acceptance, moreover, has not diminished (we have taken two more ERISA pre-emption cases so far this Term), suggesting that our prior decisions have not succeeded in bringing clarity to the law.⁵¹

Justice Scalia went on to suggest that the Court should acknowledge that its earlier broad interpretation of the text “relates to” was “wrong.”⁵²

⁴⁸ 514 U.S. 645 (1995).

⁴⁹ *Id.* at 654.

⁵⁰ 519 U.S. 316 (1997).

⁵¹ 519 U.S. at 334-35.

⁵² *Id.* at 335. In his concurrence, Justice Scalia recommended abandoning the “relates to” test in favor of conflict and field preemption principles used in other areas of the law. Those areas of preemption analysis often involve complex questions of both express and implied preemption that are beyond the scope of this article. See, e.g., *Riegel v. Medtronic*, 128 S.Ct. 999 (2008) (express preemption in federal statute precluded lawsuits against

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Decisions since *Dillingham* have largely failed to reconcile the competing interpretations of Section 514(a). While more recent decisions demonstrate that the Court has retreated from the purely textualist approach articulated in *Shaw*, the narrower interpretation of Section 514 suggested in *Travelers* has not taken hold (at least not completely). Indeed, in some cases the Court has explicitly adopted the broad reading of Section 514 articulated in *Shaw* in finding state initiatives preempted by Section 514(a).⁵³

The uncertainty in the scope of Section 514 preemption is problematic for employers as more and more states and localities attempt to enact various types of health care coverage mandates. Mandates increase the cost of coverage, decrease flexibility, and defeat one of ERISA's primary objectives--maintaining uniformity in plan administration.

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medical device manufacturers); *Geier v. American Honda Motor Co.*, 529 U.S. 861 (2000) (implied preemption in federal statute precluded common law tort claim).

⁵³ In *Boggs v. Boggs*, 520 U.S. 833 (1997), for example, the Court split 5-4 as to whether a provision of Louisiana's community property statute was subject to ERISA preemption. Justice Kennedy's majority opinion found the state law preempted on the basis of what he perceived as a direct conflict between the state law scheme and ERISA's rules governing joint and survivor annuities in ERISA retirement plans. The majority was explicit in stating that it need not address the question of the literal meaning of the "relate to" clause in Section 514. 520 U.S. at 841. Although *Boggs* plainly represents a different approach to the issue that seems closer to conflict preemption analysis, the outcome hardly suggests a more restrictive view of ERISA preemption in future cases. The four dissenting Justices lamented the majority's failure to acknowledge that state laws concerning family, property and probate issues are "all areas of traditional, and important, state concern." The dissenters concluded that the state law at issue did not concern a subject Congress intended to "place outside a State's legal reach." See also *Egelhoff v. Egelhoff*, 532 U.S. 141, 147-48 (2000) (finding that a state statute providing for automatic revocation of a spouse's rights upon divorce under certain ERISA benefit plans was preempted because of its "impermissible connection" to ERISA and its interference with the goal of "nationally uniform plan administration").

The lack of clarity regarding Section 514 surely contributed to the Ninth Circuit's recent decision in *Golden Gate Restaurant Assn.*, upholding the San Francisco Health Care Security Ordinance.⁵⁴ An association of restaurant operators challenged the ordinance, arguing that ERISA preempted the mandate. [CAN WE ADD 1 SENTENCE DESCRIBING THE ORDINANCE?]The Ninth Circuit panel rejected this argument, concluding that the San Francisco ordinance does not regulate the terms of any employers' ERISA plans. This conclusion was based primarily on a feature of the ordinance giving employers the option of making a contribution to the city that would be used to fund health care benefits through a city-sponsored program. The court decided that this option did not constitute an "ERISA plan" and, accordingly, that the ordinance was not preempted under Section 514.⁵⁵ The court also concluded that the San Francisco ordinance was materially different from a Maryland statute that was held preempted by the Fourth Circuit.⁵⁶

We share the view of others who have found this conclusion unpersuasive. Professor Edward Zelinsky seems correct in concluding that the employers' ongoing payment for their employees' health care at least arguably constitutes an employee health benefit plan, irrespective of whether the program is sponsored by the city or the employers.⁵⁷ As he explains, courts have been reasonably consistent in interpreting the statutory text and implementing regulations to conclude that "employers' ongoing outlays for their employees' medical coverage constitute 'plans' for ERISA purposes."⁵⁸ Under the ordinance, employers are required to make continuing payments that are analytically "indistinguishable" from employers' payments to traditional insurers which automatically give rise to ERISA treatment.⁵⁹

⁵⁴ *Golden Gate Restaurant Association v. San Francisco*, 546 F.3d 639 (9th Cir. 2008)

⁵⁵ *Id.*

⁵⁶ *Retail Leaders Indus. Ass'n v. Fielder*, 475 F.3d 180 (4th Cir. 2006)(striking down as preempted the Maryland "Fair Share Health Care Fund Act").

⁵⁷ Edward A. Zelinsky, *Employer Mandates and ERISA Preemption: A Critique of Golden Gate Restaurant Association v. San Francisco*, Working Paper No. 245, at 9 (Nov. 2008) available at <http://ssrn.com/abstract=1299128>.

⁵⁸ *Id.* at 9.

⁵⁹ *Id.* at 12.

However well-intentioned, benefit mandate requirements such as the San Francisco ordinance are contrary to fundamental objectives of ERISA. First, such requirements obviously disrupt ERISA's goal of encouraging uniform administration of benefit plans nation-wide. As the Court noted in *Egelhoff*:

One of the principal goals of ERISA is to enable employers 'to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits.' Uniformity is impossible, however, if plans are subject to different legal obligations in different States.⁶⁰

Similarly, local mandates increase costs for employers. According to the Employee Benefit Research Institute, "mandated benefits cause reductions in coverage owing to small firms' greater sensitivity to price."⁶¹ For some, particularly smaller, employers, mandates provide the tipping point on whether to provide benefits in the first instance."⁶²

At an intellectual level, settled principles of federalism surely justify many of these efforts.⁶³ There is often much to be said for having state governments act as laboratories for experiments on new solutions to economic and social issues. In the world of health care, experiments like

⁶⁰ *Egelhoff*, 532 U.S. at 147 (quoting *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987)).

⁶¹ EBRI Issue Brief No 314, at 11 (Feb. 2008).

⁶² *Id.* at 12 (finding that "roughly 18 percent of businesses that are currently without coverage would likely sponsor coverage but for mandates").

⁶³ Yet other initiatives cannot be justified on federalism grounds. The motive behind a particular initiative is often properly considered in determining the scope of Section 514 preemption. For example, the Maryland statute overturned in *Felder*, was an unsubtle attempt by supporters of organized labor to strike a blow against Wal-Mart. See Thomas P. Gies, *The Maryland 'Wal-Mart Bill' – Is It Preempted By ERISA?*, *Employee Relations Law Journal*, (Sept. 22, 2006).

that underway in Massachusetts may yield promising solutions.⁶⁴ Yet it seems that the health care delivery system may be too complex to hope that meaningful reform can percolate up from the statehouses. Scholars including Andrew Fichter have questioned whether the various state healthcare coverage laws passed to date have, in fact, shown much innovation.⁶⁵ There are surely many reasons for this, including the fact that, as written, ERISA broadly limits the ability of states and local governments to tinker with the health care delivery system. From where we sit, the problem is far too complex to be solved in any manner short of Congressional action.⁶⁶ Any legislative change that would include an amendment to Section 514 of ERISA should be part of a comprehensive approach to the benefit delivery system that would not frustrate the important goals of encouraging plan formation and the promotion of uniformity in plan administration.

V. The Scope of Section 502

A. Section 502(a)(3) and Welfare Plan Claims

i. Introduction

The Court's decision in *Davila* has led to a flood of litigation in which plaintiffs have sought an expansive reading of Section 502(a)(3). This development is not surprising in light of Justice Ginsburg's concurring opinion. Yet, in our view, if there is any irony in ERISA remedial jurisdiction,

⁶⁴ In 2006, Massachusetts enacted comprehensive health care reform legislation. See 2006 Mass. Acts Chp. 58. Among other things, the statute provides subsidized health care to lower-income employees through a device called the Commonwealth Health Insurance Connector Authority. Through a variety of means, the statute requires all citizens to obtain health insurance coverage. The law imposes a variety of taxes on employers doing business in Massachusetts to help fund the increased coverage. The law has not yet faced a legal challenge based on ERISA preemption.

⁶⁵ See Fichter, "State Healthcare Coverage Reform: Where is Federalism Leading Us?," 17 Temp. Pol. & Civ. Rts. L. Rev. 629 (2008).

⁶⁶ Professor Fichter seems to agree with this view. He observes that health care reform should be done at the federal level in part because ERISA serves a valid interstate purpose in encouraging multi-state employers to offer benefits. Fichter, *supra* n. 64 at p. 6.

it is here. Notwithstanding their unending creativity, plaintiffs' lawyers appear not to have understood that Section 502(a)(3) could be interpreted to support a claim for damages until the doors to the courthouse began to close. It was only then that advocates realized they might be able to open a door to the federal courthouse (and stay there) if they could conjure up a way to characterize various legal theories in terms cognizable under Section 502(a)(3). Of course the Court's decision in *Mertens*, with its observation that 502(a)(3) must be limited to equitable claims "typically available" in equity, stood in the way.⁶⁷ Few areas of ERISA remedial litigation have been more hotly contested in the last ten years than the meaning of the term "appropriate equitable relief." In our judgment, this is one of the most important issues on which the courts have generally reached the right result.

ii. Claims for Compensatory Damages

The Supreme Court decided, first in *Mertens*, and then in *Great-West Insurance v. Knudson*,⁶⁸ that a claim for money damages is not available under Section 502(a)(3). The majority opinion in *Great-West* clearly states that money damages, the classic form of legal relief, is not contemplated by the language of Section 502(a)(3).⁶⁹

In response to *Davila*, plaintiffs have advanced numerous arguments in support of the notion that compensatory damages are available under Section 502(a)(3), notwithstanding the Courts' unambiguous holding in *Great-West* and the settled modern understanding that a claim for damages is the classic form of legal (and not equitable) relief. Plaintiffs often base such claims on the equitable theory of "surcharge."⁷⁰ Advocates assert that,

⁶⁷ 508 U.S. at 256.

⁶⁸ 534 U.S. 204, 209 (2002)

⁶⁹ *Id.*

⁷⁰ For example, the Department of Labor has regularly argued that money damages were typically available in equity and therefore should be available under 502(a)(3). See, e.g., Brief for the Sec'y of Labor as *Amicus Curiae* supporting Appellant's Petition for Panel and En Banc Rehearing, *Pereira v. Farace*, 413 F.3d 330 (2nd Cir. 2005), *cert denied* (No. 03-11087); Brief for the Sec'y of Labor as *Amicus Curiae* supporting Appellant and Requesting Reversal, *Goeres v. Charles Schwab & Co.*, 2007 WL 495191 (9th Cir. Feb. 14, 2007) (No. 05-15282); Brief for the Sec'y of Labor as *Amicus Curiae* Supporting Appellant and Requesting Reversal, *Callery v. U.S. Life Ins. Co.*, 392 F.3d 401 (10th Cir. 2004), *cert denied* (No. 03-4097), 2003 WL

(continued...)

in 18th century England, a common law trustee could be “surcharged” so that a plaintiff could receive money damages in a proceeding brought in a court of equity. Because ERISA is based on principles of trust law, the ability of the chancellor to impose a “surcharge,” they say, means that compensatory damages should be seen as a form of equitable relief “typically available” in equity within the meaning of *Mertens*.

The argument has yet to succeed. Most courts have concluded that a plaintiff’s decision to rephrase a claim for damages as “surcharge” does not alter the fundamental nature of a claim for compensatory damages as being legal rather than equitable.⁷¹ Courts have, rightly in our view, rejected this argument as an inappropriate extension of trust law. As the Tenth Circuit put it, “[W]hile it is obvious that ERISA is informed by trust law, the statute is, in its contours, meaningfully distinct from the body of the common law of trusts. A method of interpretation consonant with this realization will reject the unselective incorporation of trust law rules into ERISA.”⁷² And, as Professor Muir has recognized, the Congressional intent to encourage employers to sponsor employee benefit plans is a “unique aspect of ERISA” that is central to a correct understanding in applying the common law of trusts to ERISA’s remedial provisions.⁷³

(continued)

24309395; Brief for the Sec’y of Labor as *Amicus Curiae* supporting Plaintiff-Appellant and Urging Reversal, *Coan v. Kaufman*, 457 F.3d 250 (2d Cir. 2006) (No. 04-5173), 2005 WL 5071038.

⁷¹ See *Coan v. Kaufman*, 457 F.3d 250 (2d Cir. 2006) (rejecting the notion that “artful pleading” will permit the transformation of freestanding claim for money damages into one for equitable relief); *Knieriem v. Group Health Plan, Inc.*, 434 F.3d 1058, 1064 (8th Cir. 2006) (“Merely re-labeling the relief sought as ‘restitution’ or ‘surcharge’ does not alter the nature of a remedy from monetary to equitable).

⁷² *Callery v. U.S. Life*, 392 F.3d 401, 405-06 (10th Cir. 2004) *cert. denied*, 546 U.S. 812 (2005); *Moore v. Amer. Fed. of Television & Radio Artists*, 216 F.3d 1236, 1244 n.17 (11th Cir. 2000). The First Circuit has made the same observation: “[o]rdinary trust principles cannot be transferred wholesale, and, where ERISA itself specifies [the requirement], courts must be especially cautious in creating additional ones.” *Barrs v. Lockheed Martin Corp.*, 287 F.3d 202, 207 (1st Cir. 2002).

⁷³ Dana M. Muir, *ERISA Remedies: Chimera or Congressional Compromise?*, 81 Iowa L. Rev. 1, 52 (1995)

The issue of appropriate equitable relief, including the surcharge doctrine, was fully briefed in last year's most important Supreme Court ERISA remedies case, *LaRue v. DeWolff Boberg & Associates*, 128 S.Ct. 1020 (2008). Yet the Court explicitly declined to address the issue. 128 S.Ct. at 1023.

A close review of the issue suggests that surcharge is a poor fit for inclusion in the list of remedies "typically available" in equity within the meaning of *Mertens*. Trust law authorities cited in support of the surcharge argument typically involved a trustee who benefited personally from conduct that was found to be a breach of fiduciary duty. Those cases, of course, amount to the same thing as a claim for equitable restitution, a remedy that has long been understood to be available under ERISA.⁷⁴ Other trust law authorities appear to limit surcharge to cases in which a trustee acted in bad faith.⁷⁵ ERISA's fiduciary duty rules, of course, are not limited to such allegations. Section 409 of ERISA makes ERISA fiduciaries personally liable for any losses to the plan caused by a breach of fiduciary duty, irrespective of intent. Moreover, an unthinking transfer of trust law principles to ERISA fails to recognize another "unique aspect" of ERISA, *viz.*, the well-settled notion that employers who sponsor ERISA plans can wear "two hats."⁷⁶

The Court conducted a lengthy examination of traditional equitable remedies in *Chauffeurs, Teamsters & Helpers, Local 391 v. Terry*, 494 U.S. 588 (1990), as part of deciding whether a claim for back pay under Section 301 of the Labor Management Relations Act, 29 U.S.C. § 185, should be considered a legal or equitable claim for purposes of the Seventh Amendment right to a jury trial. The *Terry* Court concluded that the historical reason the chancellor entertained claims that we now think of as legal claims for damages is that courts of equity had exclusive jurisdiction over actions involve a trustee's breach of fiduciary duty.⁷⁷ The Court also noted that a monetary recovery was often available in courts of equity only where it was accompanied by a conventional equitable claim. The Court thus recognized that a monetary award may be characterized as an

⁷⁴ See, e.g., *Sereboff v. Mid Atl. Med. Servs., Inc*, 547 U.S. 356 (2006).

⁷⁵ See, e.g., *Mosser v. Darrow*, 341 U.S. 267, 272 (1951) (Court found that the trustee's self-dealing was "willful and deliberate"). Accord Restatement of Trusts § 205 cmt g.

⁷⁶ See *Donovan v. Bierworth*, 680 F.2d 263, 272 n.8 (2d Cir.), *cert. denied*, 459 U.S. 1069 (1982).

⁷⁷ 494 U.S. at 571 n.8.

equitable remedy if it is found to be an action for disgorgement of improper profits or "incidental to or intertwined with injunctive relief."⁷⁸

Justice Brennan famously observed in *Terry* that he had become weary of "rattling through dusty attics of ancient writs" in determining whether a particular remedy was legal or equitable.⁷⁹ Whether the current Justices reached a similar conclusion after reading the briefs in *LaRue* is unknowable. In any event, *LaRue* suggests that a majority of the current Justices are unwilling to undertake another examination of these issues. This assumption is confirmed by the Court's subsequent refusal to grant *certiorari* in *Amschwand v. Spherion Corp.*⁸⁰

Results in cases like *Amschwand* are, at the end of the day, the unavoidable consequence of an accurate reading of the statute. Unlike employee rights statutes such as Title VII, the remedial purpose of ERISA is simply "not to make the aggrieved employee whole."⁸¹ That the remedies provided by ERISA are insufficient to provide a traditional make-whole remedy or compensatory damages in every situation is a simple reflection of the political compromises and policy judgments made by Congress. These policy judgments plainly include the encouragement of plan formation.⁸²

⁷⁸ 494 U.S. at 571.

⁷⁹ 494 U.S. at 574-75.

⁸⁰ 505 F.3d 342, 348 (5th Cir. 2007), *cert. denied*, 128 S.Ct. 2995 (2008). *Amschwand* presented compelling facts from a participant's perspective. There, a terminally ill employee was incorrectly informed that his life insurance policy would carry over despite a change in insurance companies. After his death, the new carrier informed his widow that the life insurance policy had, in fact, expired due to a clerical mistake on the part of the insurer. The Fifth Circuit concluded that Section 502(a)(3) did not authorize a claim by the widow. The court reasoned that the remedy that the widow sought, the proceeds of the lost policy, was "simply a form of make-whole damages" and the allegation of a breach of trust did not convert the restitutionary remedy to an equitable one.

⁸¹ *Millsap v. McDonnell Douglas*, 368 F.3d 1246, 1260 (10th Cir. 2004) (citing *Mertens*, 508 U.S. at 253, 261-62 and *Russell*, 473 U.S. at 138, 142, 148).

⁸² It bears repeating that this is not a new problem. The Court made it clear twenty years ago that ERISA does not provide a complete package of remedies. *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825, 836 (1988) (observing that Congress decided to limit state law garnishment claims against ERISA pension plans and not welfare plans).

Others will doubtless argue that the statute should be amended to make it a traditional “make whole” statute, at least for claims brought by participants and beneficiaries. Apart from the asymmetrical nature of such a claim (why, after all, shouldn’t everyone involved in any aspect of plan administration be entitled to “make whole” relief), the ultimate question posed by those arguments is whether such a regime could be imposed without a collapse of the current system. We are skeptical.

There is, after all, another piece to the puzzle. Malingering happens. Last fall, the State of New York launched an investigation into the Long Island Rail Road when it was discovered that over ninety percent of L.I.R.R. employees retire and apply successfully for disability pensions. Some of those receiving disability pensions were famously described as being avid golfers, often playing on a state-owned golf course fewer than 20 miles from the Hofstra campus⁸³ To be sure, the benefit program at issue there is administered by the Railroad Retirement Board and is not an ERISA plan. Yet, there is little reason to believe that making ERISA a “make whole” statute would change human nature. And without a change in human nature, one should be sensible about how we decide benefit eligibility questions. Without rules, strictly enforced, the system will collapse.

Advocates of an expanded interpretation of Section 502(a)(3) inevitably fall back on the ultimately unpersuasive rationale that it is unfair for people not to get fully compensated for all the bad things that can happen to them. To be sure, it’s unfortunate that some people cannot afford health insurance; it’s also unfortunate when people lose their jobs and their coverage. And one might say that it’s unfair that insurance policies don’t cover anything and everything.⁸⁴ But it’s too late in the day to say that ERISA is supposed to be all things to all people. The health care issue is so complex that it would be a mistake to do anything about the current situation except as part of a comprehensive review by Congress.

⁸³<http://www.nytimes.com/2008/10/30/nyregion/30lirr.html?scp=1&sq=l.i.r.r.&st=cse>

⁸⁴ This article is plainly not a defense of the insurance industry. [TOM. NOT SURE YOU NEED THE LAST SENTENCE] it bears mention that the current benefit delivery system depends in large extent on a financially healthy insurance industry. And, as in other areas of insurance, the continued health of insurers requires rejection of claims not covered by the policy. This same economic reality should inform one’s approach to the self-insured world in which many large employers operate.

Incremental changes to the statute will only result in confusion, inconsistencies, lack of uniformity of administration and enforcement, higher costs to employers as well as plan members, and, ultimately, fewer employee benefits plans.

B. Section 502(a)(2) - Fiduciary Breach Claims involving 401k Plan after *LaRue*

The Supreme Court's decision last year in *LaRue v. DeWolff, Boberg, & Associates*⁸⁵ changed the rules regarding claims for damages in individual account plans. In *LaRue*, the Court concluded that participants in such plans have the right under ERISA to sue for monetary damages caused by fiduciary breaches with respect to their individual accounts. The majority opinion found that the Fourth Circuit had correctly applied language in *Massachusetts Mutual Life Ins. Co. v. Russell*,⁸⁶ that was widely understood to prohibit individual claims for breach of fiduciary duty under Section 502(a)(2) and that such actions could only be brought "on behalf of the plan."⁸⁷ The Court modified the rule articulated in *Russell*, concluding that significant changes in the employee benefit plan industry since the 1980s compelled a different result in this case. The Court noted the rising importance of individual account based retirement plans and the fact that, in the case of such plans, fiduciary breaches threatening the financial soundness of such plans would directly impact the benefit security of the individual plan participants. In the Court's view, ERISA's fundamental remedial purposes could be fulfilled only by permitting individual participants in such plans to sue to recover damages resulting from breaches of fiduciary duty under Section 502(a)(2), regardless of whether such damages accrued to the benefit of one or all of the plan's participants.⁸⁸

Chief Justice Roberts issued a concurring opinion joined by Justice Kennedy. The Chief Justice observed that because plaintiff's right to direct

⁸⁵ 128 S. Ct. 1020 (2008).

⁸⁶ 473 U.S. 134 (1985)

⁸⁷ *Id.* at 142 n.9. See, also, *Fox v. Herzog Heine Geduld Inc.*, 232 Fed. Appx. 104, 105 (3d Cir. 2007); *Coan v. Kaufman*, 457 F.3d 250 (2d Cir. 2006); *Magin v. Monsanto Co.*, 420 F.3d 679 (7th Cir. 2005); *McDonald v. Provident Indem. Life Ins. Co.*, 60 F.3d 234 (5th Cir. 1995); *Kuper v. Iovenko*, 66 F.3d 1447, 1452-53 (6th Cir. 1995); *McDonald v. Household Int'l, Inc.*, 425 F.3d 424 (7th Cir. 2005); *Izzarelli v. Rexene Products Co.*, 24 F.3d 1506, 1523 (5th Cir. 1994).

⁸⁸ 128 S. Ct. at 1025.

his investment allocations was a right “granted and governed by the plan,” his claim was properly viewed as a claim for benefits that turns on the “application and interpretation of the plan terms, specifically those governing investment options and how to exercise them.”⁸⁹ He then wrote that it is “at least arguable” that Section 502(a)(1)(B) provides the only proper remedy for such claims.⁹⁰ The Chief Justice then observed that it is “not clear” that plaintiff could also bring a claim under Section 502(a)(2). Because ERISA is a “comprehensive and reticulated statute,” and relying on *Varity Corp. v. Howe*⁹¹, the Roberts’ opinion argues that the sort of claim brought by plaintiff might not be “appropriate” under Section 502(a)(2). The Chief Justice noted with approval the decisions of lower courts refusing to permit plaintiffs “from recasting” benefit claims as actions for breach of fiduciary duty under Section 502(a)(2).⁹² The Chief Justice concluded that these were unsettled questions not properly presented in *LaRue*, suggesting both that they could be taken up on remand and that “other courts in other cases remain free to consider what we have not – what effect the availability of relief under § 502(a)(1)(B) may have on a plan participant’s ability to proceed under § 502(a)(2).”⁹³

The Court’s decision creates a new cause of action for ERISA plan participants. Participants may now bring individual claims for losses to a participant’s plan account, irrespective of whether any other plan participant, let alone a class of participants, can allege the same type of loss. Such litigation can be brought by individuals alleging any sort of mishandling of their plan accounts, including clerical errors and other innocent mistakes made by plan fiduciaries that allegedly caused a “depletion” in the value of an individual’s 401k account balance.

There is nothing in the Court’s opinion to limit *LaRue* type actions to 401k plans; the Court’s opinion suggests that the cause of action now authorized under Section 502(a)(2) would extend to any ERISA-regulated plan, including welfare plans. One can imagine *LaRue* type claims brought by participants in plans, e.g., Health Savings Accounts, which also contain

⁸⁹ 128 S.Ct. at 1026.

⁹⁰ *Id.*

⁹¹ 516 U.S. 489 (1996).

⁹² 128 S.Ct. at 1027.

⁹³ *Id.* at 1028. The plaintiff in *LaRue* ended up with no recovery. Following remand and after discovery, he dismissed his complaint with prejudice in October, 2008.

individual account features. More broadly, because ERISA's fiduciary duty rules apply to welfare plans to the same extent they regulate retirement plans, there exists the possibility of a wide range of claims against plan sponsors and their party service providers focusing on whether losses sustained can be argued as constituting a plan "benefit." The characterization of what constitutes a plan "benefit," in light of consequential damages principles, will be increasingly important in such litigation.⁹⁴

The Court's decision in *LaRue* is likely to have the most immediate impact on 401k plan "stock drop" litigation.⁹⁵ There[need to identify the case, not just in the fn] the court held, following *LaRue*, that group plan participants suing in their individual capacities who chose to invest in company stock (the value of which was allegedly inflated by misleading statements made by company executives) could bring a claim under Section 502(a)(2) even if other participants of the plan were uninjured by the breach. There is no reason to believe there will be a different outcome in the 401k plan "excessive fee" cases.

Litigation after *LaRue* will sort out a number of issues either implicated or left open by the Court's decision. These include: the right of plan participants who have "cashed out" of the plan to recover damages;⁹⁶ the

⁹⁴ See, e.g., *Phaler v. National Latex*, 2007 WL 4395155 (6th Cir. 2007)(plaintiffs claims included a demand for unpaid medical claims submitted to providers, on a "make whole" relief theory).

⁹⁵ See, e.g., *Rogers v. Baxter Int'l Inc.*, 521 F.3d 702 (7th Cir. 2008).

⁹⁶ This issue of statutory standing is governed by *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989). Lower courts have taken divergent approaches to the issue of what can be called "former participant" standing. Compare: *Sommers Drug Stores Co. Employee Profit Sharing Trust v. Corrigan Enters., Inc.*, 793 F.2d 1456 (5th Cir. 1986) (recognizing the distinction between "benefits" v. "damages" in claims brought by former employees); *Kuntz v. Reese*, 785 F.2d 1410 (9th Cir. 1986); *Graden v. Conexant Systems, Inc.*, 496 F.3d 291 (3d Cir. 2007). *Harzewski v. Guidant Corp.*, 489 F.3d 799 (7th Cir. 2007) is thought by some to have resolved the issue in favor of finding former participants have standing in Section 502(a)(2) cases. The Court's opinion did not resolve this question, however (either under Article III or the statute itself) of such individuals to bring damages claims. See, e.g., *Bendaoud v. Hodgson, et al.*, 2008 WL 4335884 (D. Mass., September 24, 2008) (analyzing standing of plaintiff who cashed out of plan prior to alleged backdating scheme at issue in the section 502(a)(2) claim and finding that plaintiff lacked Article III standing on the

(continued...)

measure of such damages⁹⁷ identification of the proper defendant(s) in such cases;⁹⁸ and whether jury trials will be made available.⁹⁹

(continued)

502(a)(2) claim because he sought recovery on behalf of other plan participants). [CHANGE FONT TO MATCH THE REST OF THE ARTICLE]

⁹⁷ The proper measure of damages in ERISA “lost profits” cases can be a complex question. Several circuits measure a “loss” by comparing what the plan actually earned on the investment at issue with what would have been earned if the assets had been invested in other alternatives available under the plan. *E.g.* *GIW Indus. v. Trevor, Stewart, Burton & Jacobsen, Inc.*, 895 F.2d, 729, 733 (11th Cir. 1990); *Dardaganis v. Grace Capital, Inc.*, 889 F.2d 1237, 1243-4 (2d Cir. 1989). Some courts have compared the loss on the investment at issue with other measures of investment return as surrogates, such as prevailing interest rates or the return originally anticipated on the investment. *E.g.*, *Katsaros v. Cody*, 744 F.2d 270, 281 (2d Cir. 1984); *Donovan v. Mazzola*, 716 F.2d 1226, 1232-33 (9th Cir. 1983).

⁹⁸ The Court did not address whether either of the defendants was in fact an ERISA fiduciary. The question of fiduciary status turns on whether the entity manages plan assets, and/or has discretionary authority or control over plan administration with respect to disputed events. *See, e.g.*, *Confer v. Custom Engineering Co.*, 952 F.2d 34 (3d Cir. 1991); *In re WorldCom, Inc., ERISA Litigation*, 263 F. Supp. 2d 745, 760-61 (S.D.N.Y. 2003). Certain conduct, such as clerical mistakes, may not be actionable as fiduciary breaches. *Livick v. The Gillette Co.*, 524 F.3d 24 (1st Cir. 2008) (inaccurate estimate of plaintiff’s benefit not actionable as breach of fiduciary duty); *Kannapien v. Quaker Oats Co.*, 507 F.3d 629 (7th Cir. 2007), *reh. en banc denied*, (7th Cir. Dec. 21, 2007) (neither plant manager nor human resources manager acted as a fiduciary when they discussed pension benefits with plan participants).

⁹⁹ Although most courts hold that jury trials are not available in ERISA litigation, some courts have held or suggested otherwise, based on the reasoning that a claim for damages for breach of fiduciary duty under Section 502 seeks legal relief that will support a jury demand. *See, e.g.*, *Ellis v. Rycenga Homes, Inc.*, 2007 WL 1032367 (W.D. Mich. 2007) (citing *Great-West* and concluding that plaintiff’s breach of fiduciary claim, seeking monetary damages, involved claims for legal relief); *Minnesota Power and Affiliated Companies Retirement Plan v. Capital Guardian Trust Co.*, *supra*

(continued...)

The Chief Justice's concurring opinion may be the most durable feature of the Court's opinion in *LaRue*. It seems to recognize the practical problems associated with permitting individual claims for breach of fiduciary duty in disputes that are, in the end, hard to distinguish from traditional benefit claims. The Chief Justice's opinion reflects an understanding of the importance, at least to plan sponsors, of being able to require exhaustion of benefit claims and eligibility disputes through procedures established in the plan. The Chief Justice is surely correct in observing that these safeguards "encourage employers and others to undertake the voluntary step of providing plans."¹⁰⁰

To be sure, the Roberts' concurrence will continue to engender debate. For instance, the Chief Justice was not specific in suggesting which subsection of Section 502(a)(1)(B) would apply in a case of this sort. In some fact patterns, there may be significant outcome-determinative differences in the treatment of claims seeking enforcement of rights under the terms of the plan, or clarification of rights to future benefits, compared to a claim for "recovery of benefits." His opinion likewise does not address the question of how one would measure "benefits" in a claim for benefits brought under Section 502(a)(1)(B) against "lost profits" that appear to be recoverable under Section 502(a)(2) according to the majority opinion. And the Roberts concurrence does not address the growing body of ERISA benefits claims cases in which employees who are not plan participants are held unable to bring an action under Section 502(a)(1)(B) seeking to recover benefits under the terms of the plan.¹⁰¹

VI. CONCLUSION

The current debate about the scope of ERISA remedies reminds us of the old Chinese proverb: "Be careful what you wish for." The courts have properly recognized that ERISA's preemption provisions were crafted to protect both employers who shoulder the growing costs of employee benefit plans and the participants who benefit from them. A change in the current balance of rights and remedies available under the statute would create

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(court authorized plaintiff to proceed on a jury trial in claim against financial manager).

¹⁰⁰ 128 S.Ct. at 1027.

¹⁰¹ See, e.g., *Todisco v. Verizon Communications, Inc.*, 497 F.3d 95 (1st Cir. 2007).

uncertainty in plan administration, higher costs to employers, increased litigation, and, ultimately, fewer plans offered by employers. Now, **that** would be ironic.