ACBA Employment Law Symposium
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I. Overview

A. ERISA-Governed Plans

Under ERISA §2, 29 U.S.C. §1003, ERISA applies to *all* employee benefit plans (pension and welfare benefits) EXCEPT the following express exemptions:

1. Governmental Plans (ERISA §2(b)(1), 29 U.S.C. §1003(b)(1)), that is, plans established or maintained by the federal government, a state government or political subdivision, or any agency/instrumentality of these governments. This exclusion also extends to plans created under collective bargaining between the government and a union.

    a. This exception memorializes one of the driving intents behind ERISA – to curb abuse by *private* employee pensions.

2. Church Plans (ERISA §2(b)(2), 29 U.S.C. §1003(b)(2)), that is, plans established or maintained by a church/religious organization.

    a. This exception memorializes the separation between church and state.

    b. Church plans can elect to become subject to ERISA through a written election by the plan administrator, which is irrevocable.

    c. The determination of whether a plan is a "church plan" can be nuanced and fact-intensive, particularly when religious organizations are engaged in other business endeavors. *See Kaplan v. St. Peter's Healthcare System*, No. 13-2941, 2023 WL 2071725 (D. N.J. Feb. 24, 2023) (regarding whether a hospital system affiliated with the church is subject to ERISA).

3. Plans Maintained to Comply with Workers' Compensation/Unemployment Compensation/Disability Insurance Laws (ERISA §2(b)(3), 29 U.S.C. §1003(b)(3)

    a. These plans are already governed by other legal frameworks, rendering the protections of ERISA unnecessary and duplicative.

4. Benefit Plans Maintained Outside U.S. for Benefit of Non-Resident Aliens (ERISA §2(b)(4), 29 U.S.C. §1003(b)(4)).

    a. However, when an employer is subject to U.S. laws or maintains the plan in the U.S., the plan is generally subject to ERISA, even if it includes resident and non-resident employees.

5. Unfunded Excess Benefit Plans (ERISA §2(b)(5), 29 U.S.C. §1003(b)(5))..,

    a. Plans maintained by the employer for providing certain employees, generally high earners, with benefits in excess of certain IRS limitations. Any disputes under these plans resort back to general contract issues, not ERISA case law. Normally, these benefits are paid from the general assets of an organization – not plan funds.

B. Pension v. Welfare Benefits

There are two major categories of benefits provided by ERISA plans: "pension" and "welfare." ERISA treats the two types differently.

1. A "pension plan" is a plan that "provides retirement income to employees." ERISA § 3(2), 29 U.S.C. § 1002(2).

    a. Pension plans include both traditional "defined benefit" pensions (in which an employee's retirement income is determined by a formula and guaranteed by the plan) and 401(k) and other defined contribution plans (in where retirement income is determined only by the amount of the balance in the account).

    b. Employers are not required to offer pension benefits, but if they do, the pension plan must comply with certain requirements under ERISA and the tax code to ensure that employees will actually receive the promised benefits. These requirements include:

        i. Minimum vesting requirements. A pension plan must provide that an employee's right to their normal retirement benefit is nonforfeitable upon the attainment of normal retirement age. ERISA § 203, 29 U.S.C. § 1053.
        ii. In the case of a defined benefit plan, the accrued benefit generally must vest or be non-forfeitable over 5 years.
        iii. An employee's rights to the accrued benefit derived from their own contributions are non-forfeitable.

    c. Accrued benefits, including an early retirement benefit, cannot be cutback. ERISA § 204(g), 29 U.S.C. § 1054(g). *See Central Laborers' Pension Fund v. Heinz*, 541 U.S. 739 (2004).

2. A "welfare plan" is just about everything else.

   a. Welfare plans include: medical, surgical, or hospital care benefits; death, accident or disability benefits; sickness benefits. Some programs, such as vacation, sick pay and short-term disability, are provided through ERISA-exempt "payroll practices" and are governed by state law. *See* 29 C.F.R. § 2510.3-1(b)(2). In Pennsylvania, the right to short-term disability benefits may be enforced under the Wage Payment & Collection Law. *See Evans v. Capital Blue Cross*, 269 A.3d 569 (Pa. Super. 2022).

   b. Welfare plans are exempt from vesting rules for pension plans, ERISA § 201(1), 29 U.S.C. § 1051(1), and can be changed or eliminated at any time. However, the right to lifetime benefits may vest if the plan, construed under ordinary contract principles, so provides. *See M&G Polymers USA, LLC v. Tackett*, 574 U.S. 427 (2015). For example, if a plan promises retirees medical benefits "for life" without a reservation of rights, those rights "vest" and must be provided for the life of the retiree. *See, e.g., Kelly v. Honeywell Int'l, Inc.*, 933 F.3d 173, 179 (2d Cir. 2019); *Devlin v. Empire Blue Cross & Blue Shield*, 274 F.3d 76, 82 (2d Cir. 2001).

C. Employer's Duties to Disclose Benefit Information

Employers are not required to offer employee benefits to their employees. *See, e.g. Curtiss–Wright Corp. v. Schoonejongen,* 514 U.S. 73, 78 (1995) ("ERISA does not create any substantive entitlement to employer-provided health benefits or any other kind of welfare benefits. Employers or other plan sponsors are generally free under ERISA, for any reason at any time, to adopt, modify, or terminate welfare plans."). However, if they choose to do so, and the plan is subject to ERISA, ERISA §§ 102 and 104, 29 U.S.C. §§1022, 1024, impose certain obligations to disclose information about their benefit plans to participants and beneficiaries at the beginning of, and throughout, the employment relationship.

Even without a request for information, ERISA §102, 29 U.S.C. §1022, requires an employer to provide a ***summary plan description (SPD)*** and a ***summary of material modifications*** in the terms of the plan ***(SMM)*** to participants and beneficiaries.

1. Contents of the SPD and SMM

ERISA requires that the SPD "shall be written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan." Similarly, an SMM "shall be written in a manner calculated to be understood by the average plan participant." ERISA Section 102(a), 29 U.S.C. §1022(a).

An SPD must contain certain information including, i*nter alia*:

- the name and type of administration of the plan;
- in the case of a group health plan, information about the financing and the administration of claims;.
- the name and address of the person designated as agent for the service of legal process;
- the name and address of the administrator;
- a description of the relevant provisions of any applicable collective bargaining agreement;
- requirements for eligibility in the plan;
- circumstances which may result in loss of benefits;
- the source of financing of the plan, *i.e.*, insurance, a trust, self-funding;
- the identity of any organization through which benefits are provided;
- the procedures to be followed in presenting claims for benefits under the plan;
- HIPAA rights with respect to health benefits;
- the remedies available under the plan for the redress of denied claims.

SPDs are often stylized, including charts and other graphic aids, and otherwise are formatted in a way to help plan participants navigate benefits.

An SMM, as its name suggests, requires that an administrator must disclose "material" changes to the terms of the plan. Material revisions may include, for example, adding or removing benefits, changes to an insurance policy number, changes to an insurer or TPA, and the like. Most material changes must be noticed within 210-days of the end of the plan year when the change was adopted; but there is an accelerated notice requirement if a change results in a reduction of benefits (60-days after adoption).

2. Employer's Duty to Furnish SPD and SMMs

It is not enough for a benefit plan administrator to merely prepare SPDs and SMMs. Under ERISA §104(b)(1), 29 U.S.C. §1024(b)(1), the plan administrator is required to furnish to each participant and each beneficiary receiving benefits under the plan a copy of the SPD within 90 days after they become a participant. Thereafter, the plan administrator is required to furnish an updated SPD every 5 years if there are any plan amendments; otherwise, every 10 years.

In addition, plan documents, including SPDs, relevant bargaining agreements, insurance policies, and the like, must be made available for examination by participants and beneficiaries. Under ERISA § 104(b)(4), 29 U.S.C. §1024(b)(4), an administrator is required, ***upon written request of any participant or beneficiary***, to furnish "a copy of the latest updated summary, plan description, and the latest annual report, any terminal report, the bargaining agreement, trust agreement, contract, or other instruments under which the plan is established or operated." An administrator who fails to provide such documents within 30 days is subject to penalties of up to $110 per day under ERISA § 502(c), 29 U.S.C. § 1132(c).

3. Enforceability of SPDs

Although SPDs and similar documents may be the only information that an employee receives about a benefit plan, the language of an SPD does not necessarily govern the actual terms of a benefit plan. In *CIGNA Corp. v. Amara*, 563 U.S. 421 (2011), the Court held that statements in the summary documents do not themselves automatically constitute the terms of the plan for purposes of an action under ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), the provision which authorizes a participant or beneficiary to recover benefits due under the terms of the plan, to enforce the terms of a plan, or to clarify the right to future benefits under the terms of a plan.

Since *Amara*, there has been extensive litigation regarding when the SPD actually constitutes the terms of the plan, what happens when the language in the SPD and the plan document are inconsistent, and whether an SPD was properly adopted as embodying the terms of a plan. *See*, *e.g.*, *US Airways, Inc. v. McCutchen*, 569 U.S. 88 (2013), *on remand*, 2016 WL 1156778 (W.D. Pa. Mar. 16, 2016).

Even if the SPD may not necessarily control benefits, a violation of the disclosure obligations in ERISA such as potential misrepresentations in an SPD, may entitle a participant or beneficiary to equitable relief under ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3) (which authorizes a participant or beneficiary to obtain "other appropriate equitable relief"). *See Amara*, 563 U.S. at 444.

II. Continuing Rights to Benefits at Termination of Employment

A. General

Termination of employment affects various employee benefits differently.

1. Vested pension benefits are unaffected because they are non-forfeitable, as discussed above. Employee may be entitled to roll over vested portion of a pension benefit into a qualified retirement account.

2. Health Benefits and COBRA

A "qualifying event" such as a reduction in hours, termination, divorce or death triggers rights under the Consolidated Omnibus Budget Reconciliation Act (COBRA), 29 U.S.C. §§ 1161 et seq., which provides for the ability of employees and their families to continue employer-sponsored healthcare coverage when they would otherwise lose such coverage due to a "qualifying event."

- Covers employers with 20+ employees.
- Notice must be sent to qualified beneficiaries within 14 days of the COBRA administrator's notice of a qualifying event (which must be given with 30 days of the qualifying event).
- Employee generally has 60 days to elect coverage.

- Continuation coverage generally available for 18 or 36 months, depending on the qualifying event, e.g., 36 months for disability.
- Beneficiary may be responsible for paying COBRA premiums of up to 102% of full premium (150% if disability extension).
- Individual eligible for COBRA notice, but who is not given the notice may be awarded civil penalties of up to $110/day.
- If elected, coverage is retroactive to the date of the qualifying event.

3. Unless they are vested, as discussed in section I.B.2.b., welfare benefits generally terminate upon termination of employment. Thus, life, accident and disability benefit coverage terminates upon termination of employment.

4. Continuation or conversion coverage. Some employer-sponsored insurance covering life or disability benefits entitle an employee who is terminating employment to continue group coverage or to convert the group policy to an individual one. Conversion rights should be clearly spelled out in the SPD. An employer may have a fiduciary duty to explain conversion rights and to provide the necessary conversion materials at the time of employment termination. *See Erwood v. Life Ins. Co. of N. Am*., 2017 U.S. Dist. LEXIS 56348 (W.D. Pa. Apr. 13, 2017).

5. The Department of Labor Regulations have specifically carved out "payroll practices" from the definition of welfare benefit plans. *See* 29 C.F.R. § 2510.3-1(b). For example, "payment of an employee's normal compensation, out of the employer's general assets, on account of periods of time during which the employee is physically or mentally unable to perform his or her duties, or is otherwise absent for medical reasons (such as pregnancy, a physical examination or psychiatric treatment)." *Id.* at § (b)(2). Payment for overtime, shift premiums, and weekend and holiday premiums, and vacation pay, juror pay, training pay, and sabbatical pay out of the employer's general assets, also does not give rise to a welfare benefit plan under ERISA. *Id.* at § (b)(1), (3).

B. Severance

1. Not all severance plans are governed by ERISA. Like any other welfare benefit plan, a severance plan only constitutes an ERISA plan if it requires the establishment and maintenance of a separate and ongoing administrative scheme. *See Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 11 (1987); *Massachusetts v. Morash,* 490 U.S. 107, 116 (1989).

    a. The "crucial factor in determining whether a 'plan' has been established is whether [the employer has expressed an intention] to provide benefits on a *regular and long-term basis*." *Deibler v. United Food & Commercial Workers' Local Union 23*, 973 F.2d 206, 209 (3d Cir. 1992)(emphasis added).

    b. Under the right circumstances, even an informal severance arrangement can constitute an ERISA plan. *See Henglein v. Informal Plan for Plant Shutdown Benefits for Salaried Employees,* 974 F.2d 391, 400 (3d Cir. 1992).

c. Whether a plan exists under ERISA "is a question of fact, to be answered in light of all the surrounding facts and circumstances from the point of view of a reasonable person." *Deibler,* 973 F.2d at 209. While no one factor is dispositive, courts tend to examine the level of discretion involved; whether the plan involves simple calculations or lump sum payments; and whether it is funded through a dedicated, as opposed to general, account.

2. Discretion.

a. An administrative scheme "'may arise where the employer, to determine the employee's eligibility for and level of benefits, must analyze each employee's particular circumstances in light of the [policy's] criteria.'". *Shaver v. Siemans Corp*, 670 F. 462, 477 (3d Cir. 2012).

b. "Factors relevant to determining whether an employer's undertakings have created an ERISA plan also include whether the 'undertaking requires managerial discretion, that is, whether the undertaking could not be fulfilled without ongoing, particularized, administrative, analysis of each case' and whether 'a reasonable employee would perceive an ongoing commitment by the employer to provide some employee benefits.'" *Shaver*, 670 F.3d at 477.

c. In determining the level of discretion, "a court must look to the plan as a whole, not just how a plaintiff's specific circumstances play out under that plan." *Way v. Ohio Cas. Ins. Co.*, 346 F. Supp. 2d 711, 717 (D.N.J. 2004).

3. Lump Sum Versus Ongoing Payments

a. A severance plan that requires a single lump sum payment is typically not an ERISA plan. "The requirement of a one-time, lump-sum payment triggered by a single event requires no administrative scheme whatsoever to meet the employer's obligation . . . To do little more than write a check hardly constitutes the operation of a benefit plan. Once this single event is over, the employer has no further responsibility." *Fort Halifax*, 482 U.S. at 12 (emphasis added). *See also Girardot v. Chemours Company*, 731 Fed. App'x. 108 (3d Cir. 2018)(calculating one week of base pay for each full year of service with a minimum and maximum amount, lump sum equivalent to three-months of COBRA coverage, and prorated bonus did not implicate ERISA).

b. A plan which requires a simple lump sum payment plus continued benefits is also not an ERISA plan if the ongoing administration of benefits does not require the creation of a new administrative scheme. *Angst v. Mack Trucks, Inc.*, 969 F.2d 1530, 1538-39 (3d Cir. 1992). *Cf. Cureton v. Verizon Serv. Corp.,* No. 05-00213, 2005 WL 1785302, at *3 (E.D. Pa. July 25, 2005)(finding ERISA plan when the "obligation is ongoing and regular, triggered not by a

single, unique event, such as the closing of a plant, but by a variety of situations, with the potential to arise on a daily basis. . . .").

4. Source of funding

   a. "The 'source of financing' implication has become a critical factor in determining whether a plan is, as a matter of law, governed by ERISA." *Schwartz v. Liberty Life Assur. Co. of Boston*, 470 F. Supp. 2d 511, 515 (E.D. Pa. 2007).

   b. "[W]here the source of financing is the general assets of the employer, as opposed to a trust fund, insurance fund, or some other independent third party source, courts have interpreted these plans as excluded from the governance of ERISA." *Id.* Instead, "[i]f the source of funding is from the general assets of the employer . . . , then the benefit is properly regarded as a payroll practice." *Id.* at 517. *See Massachusetts v. Morash*, 490 U.S. 107, 120 (1989).

C. Long Term Disability

Upon termination of employment, certain considerations for LTD arise:

- Policy/plan controls
- Normally, life, disability, and AD&D plans end coverage upon termination.
- If loss/disability occurs *before* termination, benefits normally continue (including related benefits – *e.g.,*. waiver of premium of life insurance benefits).
- If loss/disability occurs *after* termination, there is generally no coverage.
- Sometimes, it is possible to convert or "port" coverage to an individual plan.
- Generally, in order to qualify for LTD benefits, employee must be "actively at work" when disability arises.
- Generally, no payments for LTD are made until employee satisfies an "elimination period" of 3 to 6 months. The employer may have a short term disability plan or payroll practice that provides income during this period. Also, the employee is eligible for FMLA or other job-protected leave during this period.
- Note difference between disability under the ADA and under the typical terms of an LTD plan, which generally defines disability as the inability to perform the material duties of the employee's occupation with or without an accommodation.
- Sometimes an employer's long term disability plan will entitle an employee on disability to continue to receive benefits under the employer's health plan.

III. Employers' Fiduciary Responsibilities

A. Employer Obligations When Benefit Plans are Offered

1. Employers are responsible for maintaining records with respect to each employee sufficient to determine the benefits due or which may become due to employee under 29 U.S.C. § 1059.

2. Employers have disclosure obligations, described in Part II, under ERISA §§ 102, 104, 29 U.S.C. §§ 1022, 1024.

3. In routinely conveying information about benefits throughout the employment relationship, such as information about benefits offered during the hiring process, the need to apply for, obtain benefits or maintain benefits during the employment relationship, the available benefits upon termination of employment, or answering questions about benefits, the employer is acting as a fiduciary, and has certain duties established by statute and trust law.

B. What is a Fiduciary?

1. Employers appoint fiduciaries, such as plan administrators, to administer employee benefits plans.

2. However, the definition of a fiduciary under ERISA is broader than appointed fiduciaries.

    a. Under ERISA § 3(21), 29 U.S.C. § 1002(21):

    A person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, … , or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan.

    b. An employer acts as a fiduciary when explaining plan benefits to its employees. *In re Unisys Corp. Retiree Med. Benefits ERISA Litig.,* 579 F.3d 220, 228 (3d Cir. 2009).

    c. An employer acts as a fiduciary when it misrepresents the status of pension benefits to a participant or beneficiary. *Deschamps v. Bridgestone Americas, Inc. Salaried Employees Ret. Plan*, 840 F.3d 267, 277 (6th Cir. 2016).

d. When an employer arranges for an agent to communicate with participants about their benefits, the employer performs a fiduciary function and the actions of the agent can be imputed to the employer. *Sullivan-Mestecky v. Verizon Communications Inc.*, 961 F.3d 91, 104 (2d Cir. 2020).

C. The Responsibilities of a Fiduciary

1. Under ERISA 404, 29 U.S.C. § 1104, a fiduciary must act "solely in the interest of the participants and beneficiaries and—(A) for the exclusive purpose of: (i) providing benefits to participants and their beneficiaries; and … (d) in accordance with the documents and instruments governing the plan."

   The statute thus imposes high standards of fiduciary duty on plan administrators:

   > The prudent person standard, in combination with the duty of loyalty, "imposes an unwavering duty on an ERISA trustee to make decisions with single-minded devotion to a plan's participants and beneficiaries and, in so doing, to act as a prudent person would act in a similar situation. … ERISA requires that a fiduciary "act 'for the exclusive purpose' of providing benefits to plan beneficiaries."

   Krohn v. Huron Mem'l Hosp.¸ 173 F.3d 542, 547 (6th Cir. 1999).

2. In addition, the common law of trusts can be used to "'define the general scope of [trustees' and other fiduciaries'] authority and responsibility.'" *In re Unisys Corp. Retiree Med. Benefits ERISA Litig.,* 579 F.3d 220, 227 (3d Cir. 2009) (*Unisys IV*).

   When an ERISA participant or beneficiary requests information from an ERISA fiduciary who is aware of the status and situation of that participant and beneficiary, the fiduciary has an obligation to convey complete and accurate information material to the beneficiary's circumstance, even if that information comprises elements about which the beneficiary has not specifically inquired. *Bixler v. Cent. Pennsylvania Teamsters Health & Welfare Fund,* 12 F.3d 1292, 1300 (3d Cir. 1993). The duty to inform is a constant thread in the relationship between beneficiary and trustee. *Krohn*, 173 F.3d at 548; *Bixler*, 12 F.3d at 1300.

   An ERISA "fiduciary may not, in the performance of [its] duties, 'materially mislead those to whom the duties of loyalty and prudence are owed.'" *Adams v. Freedom Forge Corp.,* 204 F.3d 475, 492 (3d Cir.2000). This responsibility encompasses "not only a negative duty not to misinform, but also an affirmative duty to inform when the trustee knows that silence might be harmful." *Unisys IV*, 579 at 227 (quoting *Bixler,* 12 F.3d at 1300).

D. Remedies for Breach of Fiduciary Duty

A breach of fiduciary duty claim may be premised on a misrepresentation ***or*** an omission. To establish such a breach, a plaintiff must demonstrate that:

> (1) the defendant was "acting in a fiduciary capacity"; (2) the defendant made "affirmative misrepresentations or failed to adequately inform plan participants and beneficiaries"; (3) the misrepresentation or inadequate disclosure was material; and (4) the plaintiff detrimentally relied on the misrepresentation or inadequate disclosure.

Unisys IV, 579 F.3d at 228 (citations omitted); *James v. Pirelli Armstrong Tire Corp.*, 305 F.3d 439, 452 (6th Cir. 2002).

Under ERISA §502(a)(3), 29 U.S.C. §1132(a)(3), a court may award "*appropriate equitable relief"* to redress violations of ERISA or the terms of the Plan, including breach of fiduciary duty. *Varity Corp. v. Howe*, 516 U.S. 489, 510 (1996). Thus, even when a plaintiff is not entitled to relief under the terms of the plan as written, ERISA §502(a)(3), 29 U.S.C. §1132(a)(3), allows a participant or beneficiary to obtain other categories of equitable relief, including: reformation of the terms of the plan to remedy false or misleading information the defendant provided; equitable estoppel, "to place the person entitled to its benefit in the same position in which he would have been had the representations been true;" and a surcharge remedy "extended to a breach of trust committed by a fiduciary encompassing any violation of a duty imposed upon that fiduciary." *CIGNA Corp. v. Amara*, 563 U.S. 421, 440-42 (2011).

Many courts also recognize an equitable estoppel claim by a participant who has received inaccurate information regarding their benefits. While most courts require a showing of "extraordinary circumstances" such as fraud on the employer's part to recover on an equitable estoppel theory, the Sixth Circuit recently concluded that there is constructive fraud in the ERISA context when there is:

> (1) an information asymmetry, such that the defendant is the only one who knows the true facts and the plaintiff cannot ascertain the true facts; (2) the defendant misrepresents the benefits to which the plaintiff is entitled; and (3) the plaintiff investigated her benefits and drew a reasonable conclusion about them on the basis of the defendant's misrepresentations, ***even when the documents the plaintiff relied upon contained a disclaimer*** that the plan would govern in the event of a conflict.… [W]hether the defendant took actions to mitigate its misrepresentations and correct the plaintiff's misunderstanding is also relevant. Thus when an employer made an "honest mistake" and misinformed a beneficiary of her benefits, but then repeatedly sent correction letters in the ensuing months, the employer is not grossly negligent and therefore has not committed constructive fraud.

Pearce v. Chrysler Grp. LLC Pension Plan, 893 F.3d 339, 348-49 (6th Cir. 2018).

It is not necessary to exhaust administrative remedies to bring action to redress a fiduciary breach or other statutory violation, although it is sometimes prudent to do so.

IV. ERISA Benefits Litigation Issues

Litigation in federal court following an adverse benefit decision has several unique characteristics compared to more traditional civil litigation. For example, the types of causes of action are limited, there is limited (or sometimes no) discovery, the standard of review can be a determinative factor, and cases that do not settle are resolved on summary judgment (not trial).

A. Standard of Review

ERISA does not set forth a standard of review statutorily. Instead, case law has developed with two possible standards of review depending on the underlying plan documents. *See Est. of Schwing v. The Lilly Health Plan*, 562 F.3d 522, 525 (3d Cir. 2009) (citing *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989) and *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008)).

First, the default standard is *de novo* – the court gives no weight to the administrator's decision during the claims process and can make its own decision. *Fleisher v. Standard Ins. Co.*, 679 F.3d 116, 120 (3d Cir. 2012).

Second, if the plan documents memorialize a grant of discretionary authority to the administrator, the discretionary or arbitrary and capricious standard of review applies. Under this scenario, an administrator's decision is only overturned if it is unreasonable, unsupported by substantial evidence, or erroneous as a matter of law. *Fleisher*, 679 F.3d at 121.

Some jurisdictions, such as Texas, have enacted bans on discretionary provisions in insurance policies, which generally negates the arbitrary and capricious standard of review in cases involving fully-insured plans governed by such law.

B. Discovery Limited

Generally, particularly when the arbitrary and capricious standard of review applies, the court's review is limited to the so-called administrative record as it existed before the administrator during the claims process. *Hilbert v. Lincoln Nat'l Life Ins. Co.*, No. 15-0471, 2016 WL 727584, at *1 (M.D. Pa. Feb. 24, 2016). Focusing only on the administrative record, and not extra-record evidence through discovery or other means, is critical to ensure ERISA's goal of an expeditious review of a benefit decision, and "to keep district courts from becoming substitute plan administrators." *Crosswhite v. Reliance Standard Life Ins. Co*., 259 F. Supp. 2d 911, 917 (E.D. Mo. 2003) (citing *Donatelli v. Home Ins. Co*., 992 F.2d 763, 765 (8th Cir. 1993)).

Some circuits expressly allow discovery into issues concerning the completeness of the administrative record, how plan administrators or fiduciaries have interpreted the plan terms in previous instances, whether the plan administrator has complied with procedural regulations, and any conflicts of interest of plan administrators or other decisionmakers. *See Crosby v. La. Health*

Serv. & Indem. Co., 647 F.3d 258, 263 (5th Cir. 2011). *See also Atkins v. UPMC Healthcare Benefits Trust*, 2013 U.S. Dist. LEXIS 175684 (W.D. Pa. Dec. 16, 2013) (discovery related to all plan documents, including those reflecting the delegation of discretion to the administrator, and to procedural conflicts was permitted); Haisley v. Sedgwick Claims Mgmt. Servs., 776 F. Supp. 2d 33, 53 (W.D. Pa. 2011) (reflecting discovery into whether a medical report was submitted by the plaintiff).

This means that the claimant cannot introduce new evidence during litigation and likewise cannot seek any discovery from the administrator. At the same time, the administrator is likewise constrained to rely on evidence of record from the administrative process and cannot introduce new evidence or new arguments. *Noga v. Fulton Fin. Corp. Employee Benefit Plan*, 19 F. 4th 264 (3d Cir. 2021). Even for opinions on medical evidence, which are more akin to expert reviews and reports, the written report is the only evidence before the court from that professional – there is no deposition, supplementation, or testimony.

Even if the *de novo* standard applied, discovery is not guaranteed. Courts have more leeway to permit discovery in *de novo* cases, as long as the court also believes that the evidence would be helpful to its decision. *See Luby v. Teamsters Health, Welfare & Pen. Trust Funds*, 944 F.2d 1176, 1184 (3d Cir. 1991); *Quesinberry v. Life Ins. Co. of N. Am.*, 987 F.2d 1017, 1025 (4th Cir. 1993). Courts often weigh the potential benefit of discovery versus the burden and expense in light of ERISA's goal to preserve efficient reviews of benefits decisions. *See Musser v. Harleysville Life Ins. Co*., No. 14-2041, 2015 WL 4730091, at *9 (M.D. Pa. Aug. 10, 2015) (where the Court explained that the potential benefit of the aid of discovery "is speculative and would come at the price of increased litigation costs for both parties.").

One "hot topic" of discovery is frequently the potential bias of medical reviewers used by the administrator during the claims process, including financial incentives, prior findings of bias, rate of denials, rate of retention, and similar topics.

C. Asserting Both a Benefits Claim and § 502(a)(3) Claim in Same Complaint

Normally, the only claim allowable following an adverse decision on a benefits claim in the administrative process is a claim for benefits (plus fee shifting and costs under ERISA) under ERISA §502(a)(1)(b), 29 U.S.C. 1132(a)(1)(B). As noted below, all state court causes of action (breach of contract, unjust enrichment, bad faith, consumer protection laws, and similar) are generally preempted by ERISA.

However, ERISA §502(a)(3), 29 U.S.C. §1132(a)(3), allows "appropriate equitable relief" in certain circumstances, particularly to act as a catch-all when other remedial provisions of Section 502 might not provide relief. Courts are split as to whether a Section 502(a)(3) claim may be pleaded in the alternative to a denial of benefits claim – some allow the pleading of both claims, but not ultimate recovery under both theories when overlapping ERISA violations are at issue. *See New York State Psychiatric Ass'n v. UnitedHealth Grp*., 798 F.3d 125, 134 (2d Cir. 2015). Other courts will dismiss the Section 502(a)(3) claim under Rule 12, despite Fed. R. Civ. P. 8(d), which permits pleading alternative claims, regardless of consistency. *See Rochow v. Life Ins. Co. of N. America*, 780 F.3d 364 (6th Cir. 2015).

Section 502(a)(3) allows a participant or beneficiary to obtain various equitable relief, including reformation of the terms of the plan to remedy false or misleading information the defendant provided; equitable estoppel, "to place the person entitled to its benefit in the same position in which he would have been had the representations been true"; and a surcharge remedy "extended to a breach of trust committed by a fiduciary encompassing any violation of a duty imposed upon that fiduciary." *CIGNA Corp. v. Amara*, 563 U.S. 421, 440-42 (2011).

D. Right to Jury Trial

Because remedies under ERISA are considered equitable, there is no right to a jury trial in ERISA cases. *Turner v. CF & I Steel Corp*., 770 F.2d 43 (3d Cir. 1985).

E. Remedies

1. State Law Claims Preempted

ERISA preempts any state law claim that "relates to" an ERISA plan. *See* 29 U.S.C. § 1144(a).[1] The term 'relate to' has been construed broadly." *Pane* v. *RCA Corp.,* 868 F.2d 631, 635 (3d Cir. 1989). "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." *Shaw* v. *Delta Air Lines, Inc.,* 463 U.S. 85, 96-97 (1983).

As such, a plan participant cannot bring both an ERISA claim and a state law wage payment or breach of contract claim. *See McMahon v. McDowell*, 794 F.2d 100, 106 (3d Cir. 1986). State law will only apply if the plan at issue is not governed by ERISA. Severance policies and short-term disability policies are examples of plans that are sometimes ERISA plans, and sometimes are not.

2. ERISA's Remedial Scheme

To recover benefits, a participant or beneficiary must bring a claim under ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), which authorizes an action "to recover benefits due to [a participant or beneficiary] under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." The remedies authorized by this section are limited to enforcement of the plan as written. *CIGNA Corp. v. Amara*, 563 U.S. 421, 435-436 (2011).

Any equitable relief beyond enforcement of the terms of the plan must be brought under ERISA § 502(a)(3), 29 U.S.C. §1132(a)(3), which authorizes a participant, beneficiary or fiduciary to bring an action:

[1] However, state laws regulating insurance, banking, or securities, and generally applicable state criminal laws, are exempt from this preemption provision, as are generally applicable state criminal laws. *See* 29 U.S.C. § 1144(b)(2)(A) and (b)(4).

(A) to enjoin any act or practice which violates any provision of this title or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan

3. Attorneys' Fees and Costs

ERISA § 502(g), 29 U.S.C. § 1132(g), gives the court discretion to award of attorneys' fees and costs to the prevailing party, including to a claimant who achieves some degree of success on the merits. *Hardt v. Reliance Standard Life Insurance Co.*, 560 S. Ct. 242, 255 (2010).

A fee is not automatic. In the Third Circuit, the court must apply the following factors: (1) the offending parties' culpability or bad faith; (2) the ability of the offending parties to satisfy an award of attorneys' fees; (3) the deterrent effect on an award of attorneys' fees against the offending parties; (4) the benefit conferred on members of the pension plan as a whole; and (5) the relative merits of the parties' position. *See Ursic v. Bethlehem Mines*, 719 F.2d 670, 673 (3d Cir. 1983); *see also Ellison v. Shenango Inc. Pension Bd.*, 956 F.2d 1268, 1273 (3d Cir. 1992)(applying the *Ursic* factors).

V. ERISA interference and retaliation claims under Section 510

ERISA §510, 29 U.S.C. § 1140, makes it an unlawful employment practice to discriminate against a plan participant or beneficiary "for exercising any right to which he is entitled under the provisions of an employee benefit plan … or for the purpose of interfering with the attainment of any right to which such participant may become entitled under the plan." The statute therefore recognizes two different claims under Section 510: interference with the right to future benefits, and retaliation for the use of past benefits.

A. Proving a Section 510 Violation

1. To prevail on an interference claim, an employee must show "(1) prohibited employer conduct (2) taken for the purpose of interfering (3) with the attainment of any right to which the employee may become entitled." *Berger v. Edgewater Steel Co.*, 911 F.2d 911, 922 (3d Cir. 1990).

2. The Third Circuit has not articulated the precise elements of a *prima facie* case of ERISA retaliation, but has recognized that the *McDonnell Douglas* burden-shifting framework applicable to other employment discrimination and retaliation claims also applies to ERISA retaliation claims. *See Kowalski v. L&F Prods., Inc.*, 82 F.2d 1283, 1289 (3d Cir. 1996). A retaliation claim under *McDonnell Douglas* requires a showing of (1) protected activity; (2) an adverse employment action; and (3) and a causal connection between the two. *See Farrell v. Planters Lifesavers Co.*, 206 F.3d 271, 279 (3d Cir. 2000)(setting forth the elements of a Title VII retaliation claim); *Lichtenstein v. UPMC*, 691 F.3d 294, 302 (3d Cir. 2012)(setting forth the elements of an *FMLA* retaliation claim).

3. With respect to both claims, once the plaintiff establishes a *prima facie* case, the burden shifts to the employer to state a legitimate, non-discriminatory reason for taking the adverse action. Then, the burden shifts back to the employee to show that the employer's proffered reason was pretextual, either by showing that a "discriminatory reason more likely motivated the employer or … that the employer's proffered explanation is unworthy of credence." *Kairys v. Southern Pines Trucking*, 75 F.4th 153, 163 (3d Cir. 2023).

4. An employee need not show that his/her past use benefits, or intended use of future benefits, was the sole reason for his termination. *Dewitt v. Penn-Del Directory Corp.*, 106 F.3d 514, 522 (3d Cir. 1997). Rather, the employee need only show that that the employer's "intent to interfere with rights secured under ERISA played a determinative role in the decision to take [an adverse] action." *Turner v. Schering-Plough Corp.*, 901 F.2d 335, 348 (3d Cir. 1990).

5. Because "smoking gun" evidence of an employer's specific intent to violate ERISA is rare, intent can be shown through circumstantial evidence. *Dewitt*, 106 F.3d at 523. ERISA Section 510 claims are analyzed under the familiar burden-shifting framework set forth in *McDonnell-Douglas Corp. v. Green*, 411 U.S. 792, 802 (1973). *See DeFederico v. Rolm Co.*, 201 F.3d 200, 205 (3d Cir. 2000).

6. If an employee shows that the employer's proffered reason is a pretext, the court may infer that the employer was motivated by the specific intent to interfere with the attainment, or retaliate against the use of, of ERISA benefits. *Id.* at 205-07.

7. A court can determine that an employer's proffered reason is pretextual by identifying "weaknesses, implausibilities, inconsistencies, incoherencies, or contradiction." *Kowalski*, 80 F.3d at 1289. For example, testimony from the decision-maker about the reason for termination in a manner that is "evasive" and "lacking in credibility;" a termination under unusual circumstances; and replacement of some, but not all, of an employee's duties all can be evidence of pretext. *See Kairys*, 75 F.4th at 164.

8. "One way for the employee to satisfy the burden [of proving that the employer targeted ERISA rights] is to show that his termination resulted in a substantial savings in benefit expenses." *Clark v. Coats & Clark, Inc.*, 990 F.2d 1217, 1224 (11th Cir. 1993). If a self-insured employer is concerned about rising health insurance premiums and attributes rising costs to an employee or beneficiary, this may suggest a specific intent to violate ERISA. *See Stein v. Atlas Indus., Inc.*, 730 Fed. Appx. 313, 322-23 (6th Cir. 2018); *Trujillo v. PacifiCorp,* 524 F.3d 1149, 1156, 1160 (10th Cir. 2008); *Hirsch v. National Mall & Service, Inc.,* 989 F. Supp. 977, 984 (N.D. Ill. 1997). For example, evidence that a self-insured employer highlighted an employee's health insurance expenses is evidence from which a fact-finder can determine that the use and anticipated future use of benefits motivated the employer's decision. *See Kairys*, 75 F.4th at 164-65.

9. Moreover, if an employee can show a close temporal proximity between his employer's awareness of his health insurance costs and his termination, the Court can infer intent/causation. *See Kowalski v. L&F Prods.*, 82 F.2d 1283, 1290 (3d Cir. 1996)(timing of discharge shortly after taking ERISA-protected leave was evidence of pretext); *Kairys*, 75 F.4th at 165 (firing employee approximately one week before the end of the benefits year was "proximity … probative of the Company's discriminatory intent"); *Trujillo*, 524 F.3d at 1157-58 (in ERISA 510 and ADA association case, causation could be inferred from 11-day gap between when employer learned of employees' son's cancer relapse and when employer started investigation into employees).

B. Remedies

1. As with other ERISA claims, there is no right to a jury trial for Section 510 claims. *See Cox v. Keystone Carbon Co.*, 894 F.2d 647, 649-50 (3d Cir. 1990); *Eichorn v. AT&T Corp.*, 484 F.3d 644, 652 (3d Cir. 2007).

2. Remedies are also limited under ERISA Section 510, given that the statute only provides for equitable remedies. *See Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 210 (2002). In the Third Circuit, equitable remedies exclude compensatory damages, punitive damages, and back pay. *Eichorn*, 484 F.3d at 658. However, in limited circumstances, equitable relief can include the payment of money. *Id.* at 655 n. 6.

3. Reinstatement is the "typical remedy" for a Section 510 violation. *Id.* at 658. While the Third Circuit has not directly spoken on whether front pay is available in a Section 510 claim when reinstatement is not feasible, Judge Ranjan recently held that front pay was available, in *Kairys v. Southern Pines Trucking, Inc.*, 595 F. Supp. 3d 376, 388-90 (W.D. Pa. 2022), *affirmed on other grounds*, 75 F.4th 153 (3d Cir. 2023).[2] *See also Schwartz v. Gregori*, 45 F.3d 1017, 1021 (6th Cir. 1995); *DeLapaz v. Magnifique Parfumes and Cosmetics, Inc.*, 2012 WL 4498878 at *5 (N.D. Ind. Sep. 26, 2012); *Folz v. Marriott Corp.*, 597 F. Supp. 1007, 1018-19 (W.D. Mo. 1984). *Cf. Teutscher v. Woodson*, 835 F.3d 936, 946 & n.3 (9th Cir. 2016)(assuming, without deciding, that front pay is available under ERISA).

[2] This holding is consistent with the Supreme Court's and Third Circuit's treatment of front pay under other employment discrimination statutes. *See Pollard v. E.I. du Pont de Nours & Co.*, 532 U.S. 843, 853 (2001); *Maxfield v. Sinclair Intern.*, 766 F.2d 788, 796 (3d Cir. 1985); *Donlin v. Philips Lighting North Am. Corp.*, 581 F.3d 73, 86 (3d Cir. 2009).