Review of Recent U.S. Supreme Court ERISA Cases and Looking to the Future

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I. Introduction

Since ERISA’s enactment in 1974, few terms of the U.S. Supreme Court have passed without the Court deciding at least one ERISA case. Posing complicated questions of statutory interpretation, background common-law principles, and administrative law, the statute offers fertile ground for disagreement among the federal courts in a heavily litigated and high-stakes field—precisely the types of issues that the Supreme Court views as most appropriate for its attention.

The Court’s most recent terms have been no exception. In recent years, the Court has revisited ongoing debates about the scope of ERISA remedies, the duty of prudence, and preemption of state law, while also addressing procedural issues on claims processing and litigation standards. This article reviews some of the Court’s most significant recent ERISA decisions and seeks to draw lessons about strategic challenges litigants might face and what the future might hold for ERISA in the Supreme Court.

II. Revisiting, Refining, and Readjusting on Important Recurring Issues

Some issues that reach the U.S. Supreme Court require little repeat treatment. They are amenable to a relatively clear answer, and once the Court announces that answer, litigants and lower courts operate under that decision with little need for further guidance. Indeed, the Court often declines to grant certiorari to review cases presenting issues that the Court has only recently addressed, preferring to allow time for its decisions to be applied and developed in the lower courts before returning to the issue. In other cases, however, a decision of the Supreme Court can raise as many questions as it answers, and the Court may be called upon to continually refine and shape previously announced principles. Many ERISA issues fall into that latter category, and the Supreme Court often finds itself repeatedly addressing questions that arise out of its own recent decisions. In the Court’s most recent terms, it has faced such issues in several areas of ERISA law: the availability and scope of equitable remedies, the content of fiduciary duties, the test for preemption of state law, and procedural issues in ERISA litigation.

A. ERISA Remedies

Leading into its most recent terms, the Court had issued two decisions that were perceived as making potentially significant changes to the landscape of ERISA remedies. In LaRue v. DeWolff, Boberg & Associates, Inc., 552 U.S. 248 (2008), the Court held that a participant in a defined-contribution pension plan could obtain a monetary recovery under Section 502(a)(2) of ERISA, 29 U.S.C. §1132(a)(2), for a breach of fiduciary duty that impaired the value of plan assets in the participant’s individual account, even if the fiduciary’s misconduct did not cause damage to the whole plan. Before LaRue, the Court had construed Section 502(a)(2) to provide for monetary relief only for losses to the plan as a whole, leaving it doubtful whether an individual participant could obtain a damages remedy for breach of fiduciary duty. LaRue altered that rule, arguably expanding the availability of individual damages remedies.

In CIGNA Corp. v. Amara, 563 U.S. 421 (2011), the Court appeared to take a corresponding turn with respect to Section 502(a)(3) of ERISA, 29 U.S.C. §1132(a)(3), which permits a plan participant or fiduciary to obtain “appropriate equitable relief” for violations of the statute or the plan. In a series of cases before CIGNA,
the Court had reaffirmed that “appropriate equitable relief” was limited to the categories of relief typically available in equity in the days of the divided bench. Because compensatory and punitive damages and similar forms of monetary relief had traditionally been a remedy at law rather than in equity, Section 502(a)(3) was generally viewed as precluding most forms of monetary relief except where the plaintiff sought recovery of specifically identifiable funds that rightfully belonged to the plaintiff—as, for example, when a plan fiduciary sought reimbursement of benefits paid to a participant who recovered from a third-party insurer or tortfeasor. In CIGNA, however, the Court suggested that other forms of monetary relief typically available in equity, such as a surcharge remedy, could be available under Section 502(a)(3).

Decisions like LaRue and CIGNA prompted speculation about the extent to which the Court intended to expand available remedies, encouraged the development of new theories of recovery, and helped fuel a stream of breach-of-fiduciary-duty litigation. The Court waded back into this arena in two significant recent decisions.

In US Airways v. McCutchen, 133 S. Ct. 1537 (2013), the Court considered a fiduciary’s suit under Section 502(a)(3) to enforce the reimbursement clause in a health benefits plan, under which the fiduciary sought reimbursement of the full amount of medical expenses the plan had paid to a plan participant who recovered payments for his injuries from a third-party tortfeasor and his insurer. The participant argued that full reimbursement would not be “appropriate equitable relief” because he had not recovered enough from the tortfeasor and insurer to constitute a double recovery, and because allowing full reimbursement would excuse the plan from contributing to the legal expenses he incurred in obtaining the third-party recovery, in violation of the equitable common-fund rule.

Adhering to precedent, the Court held that the plan’s suit sought “appropriate equitable relief” within the scope of Section 502(a)(3). In so holding, the Court emphasized that the written plan “is at the center of ERISA,” 133 S. Ct. at 1548, and that equitable unjust-enrichment defenses like the double-recovery rule or common-fund rule could not override clear plan terms allowing for full reimbursement. In other words, enforcing the plan as written is appropriate equitable relief, and giving the plaintiff the benefit of its bargain could not be unjust as an equitable matter. See id. at 1546-1548. That approach was consistent with ERISA’s focus on enforcing the plan as written and protecting contractually defined benefits. Id. at 1548.

Significantly, however, the Court went on to explain that, although equitable principles could not override clear plan terms, “they still might aid in properly construing” the plan. 133 S. Ct. at 1548. In particular, where a plan leaves a gap, the Court held that background equitable principles might apply. The plan at issue clearly addressed the apportionment of third-party payments between the beneficiary and the insurer, thereby precluding application of the equitable double-recovery rule. Id. at 1549. But the plan was silent on allocating the costs of recovering the third-party payment and therefore left space for the common-fund rule to apply—particularly given the strength and uniformity of that rule as a background principle. Id. at 1549-1550.

Like CIGNA, the McCutchen decision looked to equitable principles and suggested a somewhat broader view of which equitable rules might be relevant to ERISA remedial questions and what role those background rules play in the analysis. At the same time, however, McCutchen emphasized the superiority of plan terms over conflicting equitable rules and practices. In doing so, the Court opened the door for plan sponsors and fiduciaries to adopt language restricting the availability of particular equitable rules or defenses, while also inviting questions of whether and to what extent ERISA might constrain an employer or insurer from adopting such restrictions.

The Court returned again to ERISA remedies—and to subrogation in particular—in its most recent term. In Montanile v. Board of Trustees of the National Elevator Industry Health Benefits Plan, 136 S. Ct. 651
(2016), the Court considered a reimbursement claim, similar to the one in McCutchen, in which the plan participant had recovered a third-party settlement but then spent the settlement money on nontraceable items. The plan fiduciary attempted to enforce its reimbursement rights through an equitable lien against the defendant's general assets, but the Court held that such a remedy was not available under Section 502(a)(3). Although the reimbursement claim was equitable in nature, enforcing a remedy against general assets was not a remedy that was typically available in equity because, unlike in the Court's prior subrogation cases, the claim did not seek recovery of specifically identifiable funds. Id. at 658-659. Rather, the dissipation of the fund eliminated the equitable lien, leaving the plan with only a tort claim for wrongful disposal of the property. Id. at 659.

Although its holding arguably adhered more rigidly to the particulars of ancient equity practice than some prior decisions, the Court contended that its ruling followed directly from precedent. 136 S. Ct. at 657-658. And the Court specifically included CIGNA in that discussion, rejecting the plan's argument that CIGNA had “all but overru[ed]” the Court's prior decisions “in favor of [a] broad interpretation of ‘equitable relief’ under §502(a)(3).” Id. at 660 n.3. Rather, the Court described CIGNA as “reaffirm[ing] that tradition-ally speaking, relief that sought a lien or a constructive trust was legal relief, not equitable relief, unless the funds in question were particular funds or property in the defendant's possession.” Id. (internal quotation marks omitted). And the Court emphasized that its discussion of Section 502(a)(3) in CIGNA “was not essen-tial to resolving that case” and that the Court's interpretation of “appropriate equitable relief” under Section 502(a)(3) “remains unchanged.” Id. In revisiting the subrogation question in Montanile, then, the Court arguably sought and found an opportunity to minimize the consequences of CIGNA's broader language. Like McCutchen, though, the Court's attempt to settle that aspect of ERISA's remedial scheme will likely provoke further debate.

B. The Duty of Prudence

The Court has long understood ERISA's fiduciary duties, including the duty of prudence, as imposing a strict standard of conduct derived from the common law of trusts. As breach-of-fiduciary-duty litigation flourished in the wake of the financial crisis, the Court revisited ERISA's fiduciary duties in a series of unanimous decisions over the past three terms in which the Court refined its understanding of the duty of prudence and addressed the pleading standards a plaintiff must satisfy to state a claim for a violation of those duties.

In Fifth Third Bancorp v. Dudenhoeffer, 134 S. Ct. 2459 (2014), the Court considered ERISA's fiduciary duties in the context of an employee stock ownership plan (ESOP). On behalf of a putative class, the plaintiff plan participants—whose retirement savings had been eliminated in large part when their employer's stock price crashed—claimed that their employer's stock was overvalued and excessively risky on the eve of the housing crisis because of the employer's involvement in subprime lending and because, as nonpublic information indicated, officers of the firm had made misstatements about the company's financial prospects. The plaintiffs accordingly argued that a prudent investor would have either sold the ESOP's holdings of employer stock before the value declined, refrained from buying any more employer stock, canceled the ESOP option in the employee retirement plan, or disclosed the inside information so the stock's market price would adjust to correct value.

Rejecting the approach adopted by many courts of appeals, the Supreme Court held that no special “presumption of prudence” applied to ESOP fiduciaries. The Court derived this result largely from the text of ERISA's fiduciary-duty provisions, which it viewed as establishing the content of the relevant duties and the extent to which those duties are loosened to permit and encourage ESOPs. 134 S. Ct. at 2467. Under that text, the Court held, ERISA's ordinary fiduciary duties apply to ESOP fiduciaries except for the duty to diversify.
At the same time, however, the Court recognized unique litigation threats in the ESOP context and the potential conflict between ERISA's fiduciary obligations and the constraints imposed by the securities laws on ESOP fiduciaries accused of imprudently failing to act on insider information. 134 S. Ct. at 2469-2470. To address those concerns, the Court underscored the role of a motion to dismiss for failure to state a claim as an “important mechanism for weeding out meritless claims.” Id. at 2471. The Court emphasized that the pleading standards governing such a motion require careful and context-specific examination of the complaint to determine whether the plaintiff has plausibly alleged that the fiduciary acted imprudently. Id. In particular, the Court held that to state a plausible claim against an ESOP fiduciary for breach of the duty of prudence, an ERISA plaintiff must plead facts and allegations showing some alternative course of action the fiduciary could have taken consistent with the securities laws and that a prudent fiduciary could not have rejected the proposed alternative course as doing more harm than good. Id. at 2472-2473.

Less than a year later, after thus confining the scope of claims accusing ESOP fiduciaries of improperly retaining imprudent investments, the Court returned to the fiduciary standard to make clear that a fiduciary—at least outside the ESOP context—must nonetheless regularly monitor investment options in a plan and remove imprudent options. Applying the common law of trusts, the Court held in Tibble v. Edison International, 135 S. Ct. 1823 (2015), that the fiduciary of a retirement plan has a continuing duty to monitor investments included in the plan and to remove imprudent investment options, even if those options were not imprudent when they were first selected. Id. at 1827-1829.

Finally, in its 2016 decision in Amgen Inc. v. Harris, 136 S. Ct. 758 (2016), the Court took the unusual step of summarily reversing a court of appeals decision that had allowed a claim for breach of fiduciary duty to proceed past a motion to dismiss. After a drop in stock price, the plaintiffs in Amgen, who held individual accounts in plans similar to an ESOP, sued for breach of fiduciary duty, and the court of appeals found the complaint sufficient to state a claim under Fifth Third. Perhaps seeking to demonstrate the efficacy of its decision in Fifth Third, the Court summarily held that the complaint failed to meet the Fifth Third standard. In particular, it failed to include facts and allegations sufficient to plausibly allege that a prudent fiduciary in the same position could not have concluded that the proposed alternative course of action would do more harm than good. Id. at 759-760.

C. Preemption

In its most recent ERISA decision, the Supreme Court waded again into the thicket of ERISA preemption—an area in which the Court has continually revised its approach in an attempt to balance the expansive language of ERISA’s express preemption clause with the interest of States in enacting laws of general applicability that relate in some way to ERISA plans.

In Gobeille v. Liberty Mutual Insurance Co., 136 S. Ct. 936 (2016), the Court considered the validity of a Vermont law requiring entities that pay for and provide healthcare services to report certain information to a state agency. ERISA’s express preemption clause broadly preempts “any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.” 29 U.S.C. §1144(a). Recognizing that the scope of preemption under that language, if applied literally, “would never run its course,” Gobeille, 136 S. Ct. at 943, the Court has developed a series of approaches to applying the express preemption clause. In Gobeille, the Court adhered to its most recent decisions in holding that state law is preempted under ERISA where (1) the state law makes immediate reference to ERISA plans, or (2) the state law has an impermissible connection with ERISA plans—for example, by governing a central matter of plan administration or interfering with nationally uniform plan administration. Id.
Applying that standard, the Court held that the Vermont law was preempted as having an impermissible connection with ERISA plans. The Court considered ERISA’s objectives of making promised benefits more secure through a system of oversight that was intended to be uniform so as to minimize the costs and uncertainty of litigation and other administrative burdens. 136 S. Ct. at 943-944. And the Court emphasized ERISA’s existing requirements for reporting, disclosure, and recordkeeping—requirements that the Court deemed central to ERISA’s uniform system of plan administration. Id. at 944-945. In an arguable expansion of its preemption precedent, the Court held that the possibility that differing or parallel reporting regimes in multiple jurisdictions could prove burdensome to plan administrators was sufficient to warrant preemption, which would prevent the proliferation of novel, inconsistent, or burdensome requirements. Id. at 945. Indeed, the Court underscored that “the possibility of a body of disuniform state reporting laws and, even if uniform, the necessary to accommodate multiple governmental agencies” sufficed to result in preemption even if plans were not yet actually confronted with multiple inconsistent regimes, because imposing those requirements directly regulated a fundamental ERISA function. Id. (emphasis added). As in other areas of ERISA law, the Court thus took a further step on well-worn ground that is likely to generate new questions for the Court to resolve.

D. Claims Processing and Litigation

After issuing important decisions addressing the deference courts owe to a plan administrator or insurer in reviewing a denial of benefits, see Metropolitan Life Ins. Co. v. Glenn, 554 U.S. 105 (2008); Conkright v. Frommert, 559 U.S. 506 (2010)—as well as the standard governing an award of attorney fees under ERISA, see Hardt v. Reliance Standard Life Ins. Co., 560 U.S. 242 (2010)—the Court returned to a procedural issue, this time concerning the intersection of ERISA’s internal review provisions and judicial review under Section 502(a)(1)(B), 29 U.S.C. §1132(a)(1)(B). In Heimeshoff v. Hartford Life & Accident Insurance Co., 134 S. Ct. 604 (2013), the Court considered the enforceability of a contractual limitations provision requiring that any suit for denial of benefits be brought within three years after proof of loss was due on the claim. In so holding, the Court applied a general contract principle that contracting parties may agree to a limitations provision for claims under the contract, provided that the period is reasonable and is not prohibited by statute. 134 S. Ct. at 611. Applying that principle made particular sense in an ERISA case, the Court explained, because of the primacy of the plan: ERISA’s focus is on the plan as written, and a suit for benefits under Section 502(a)(1)(B) is a suit to enforce the terms of the plan. Id. at 611-612. The Court found that even though the requirement to exhaust administrative remedies meant that the clock began to run on the three-year period before the plaintiff’s claim had accrued, the three-year limitations provision was not unreasonable on its face and did not undermine ERISA’s remedial scheme. Building on its prior decision in Glenn, the Court noted that plan participants would have no incentive to shortchange the internal review process in favor of a rush to the courthouse, since courts would usually review the plan’s decision only for an abuse of discretion. Id. at 614. To the extent bad faith on the administrator’s part or other extraordinary circumstances prevented a diligent claimant from seeking judicial review, the Court held that traditional doctrines such as waiver, estoppel, and equitable tolling could protect the claimant. Id. at 615.

III. Synthesizing Recent Trends and Looking to the Future

In each of these areas, the Court’s recent decisions have continued to develop and refine the doctrine on important recurring questions and clarify the import of prior decisions. Although these recent decisions have covered a range of different ERISA questions, several lessons can be drawn that cut across those decisions and suggest some directions for ERISA’s future before the Supreme Court.
A. Attracting the Court's Attention

The Supreme Court grants certiorari in a vanishingly small percentage of cases that are presented to it, typically deciding fewer than eighty cases per year out of the thousands of petitions it receives. Yet ERISA issues regularly earn a place on the limited docket. What do the Court's most recent cases tell us about why these cases gain the Court's attention?

In many recent cases, the Court has granted review of ERISA issues for the same reason it grants review of other issues—to resolve disagreements among the lower courts on important issues of federal law. McCutchen, Montanile, Fifth Third, and Heimeshoff, for example, all came to the Court after the lower courts had taken conflicting approaches to the questions presented. Although the Court has affirmed the decision below in several recent cases, the Court's recent ERISA decisions have more often vacated or reversed the decision below—another similarity to other cases outside the ERISA context.

One factor that might be somewhat unique in the ERISA context has been the Court's willingness to consider related issues without significant passage of time between cases. Ordinarily, when the Court issues a decision, it prefers to let that decision “percolate”—i.e., to give the lower courts an opportunity to construe and apply the decision and to resolve open questions on their own—before revisiting the issue. As discussed above, the Court has not always followed that practice in ERISA cases. As the subrogation and fiduciary-duty cases illustrate, the Court sometimes returns to issues in short order—perhaps to clarify language in a prior opinion, or to further explain or emphasize a prior holding that lower courts did not appear to apply correctly. Practitioners seeking to gain a coveted spot on the Court's docket—or to oppose an adversary's petition for certiorari—should therefore consider the extent to which an issue can be said to require further percolation and development or whether an argument can be made that the Court needs to revisit the issue to clarify or enforce its prior decisions.

B. ERISA Ideology?

One notable pattern across the Court's recent ERISA cases is the degree of unanimity or near-unanimity the Court has frequently achieved. In the fiduciary-duty area, Fifth Third, Tibble, and Amgen were all unanimously decided, as was Heimeshoff on contractual limitations provisions. Montanile was decided 8-to-1, and Gobelle, issued after the passing of Justice Scalia, was decided 6-to-2. Although the Justices have divided along more traditionally “ideological” voting lines in some cases—including, for example, decisions about the deference courts owe to plan administrators' discretionary denial of benefits—the Court has often left ideological lines behind in deciding ERISA issues. The replacement of Justice Scalia thus may have less of an impact on outcomes in some ERISA cases than in other areas.

In contrast, the Office of the Solicitor General within the U.S. Department of Justice, which represents the interests of the United States in all cases before the Supreme Court, has often followed notably partisan lines in its advocacy on ERISA issues. The Solicitor General plays an important role in ERISA litigation before the Court, regularly participating in ERISA cases even where the United States is not a party—either as an amicus curiae at the merits stage or in response to an invitation from the Court to provide the views of the United States on whether the Court should grant a particular petition. Whereas the Justice Department under President Bush often took positions in support of ERISA plans, the Obama Administration fairly consistently advocated for the plan participant or beneficiary. Under the Trump Administration, one can fairly expect that the Justice Department might well revert to a more plan-oriented perspective. The Court notices when the United States switches its position. Practitioners and litigants whose cases might be headed to the Supreme Court should thus always consider what position the United States is likely to take and how the government’s advocacy is likely to affect the outcome.
C. Factors Guiding the Court’s Decisions

Finally, the Court’s recent decisions demonstrate that, across a wide variety of ERISA issues, the same sets of factors tend to guide the Court’s analysis. Among the considerations that appear repeatedly in the Court’s opinions are ERISA’s text; its broader statutory purposes; the primacy of the ERISA plan as written; background principles of equity or trust law; and the views of the U.S. government. The relative weight accorded to those factors varies widely, however, and the Court often treats those factors inconsistently across different decisions.

In its subrogation decisions, for example, the Court has often emphasized ERISA’s statutory text as opening the door for consideration of background equitable principles—see, for example, CIGNA and Montanile—but in McCutchen, the Court privileged the primacy of the plan’s written terms over background equitable rules, on the theory that doing so better served ERISA’s underlying purposes. But the Court has also rejected “vague notions of purpose” as incompetent to overcome text that requires resort to equity. Montanile, 136 S. Ct. at 661.

In its decisions on claims processing and litigation procedures, the Court has at times put trust law at the center of the analysis (Glenn), while at other times elevating ERISA’s policies over trust law (Conkright), and still other times allowing the plan terms to control (Heimeshoff). In the fiduciary-duty space, Fifth Third was largely a textual analysis, while Tibble looked mainly to trust law. And in preemption cases, the Court has struggled to reconcile the statute’s text with policy concerns that may conflict with the preemption clause’s broad reach.

Given that the same factors that carried the day in one case might be relegated to a subordinate role in the next, litigants whose cases might one day end up before the Court should consider from the outset of any case what the most persuasive framing is likely to be: Is the Court more likely to be persuaded if the case is presented as a substantive case about ERISA’s purposes? A procedural case about the efficacy of the Rule 12(b)(6) pleading standards? A deference case about the competence of federal regulators to police issues that plaintiffs are asking the courts to address? With so many arrows in the quiver, litigants should consider strategic issues up front to determine which of those tools are most likely to be effective.

IV. Conclusion

Given ERISA’s complexity and the frequency of ERISA litigation, there is every reason to believe that the Court will continue to engage regularly with ERISA issues, as the Court continues its efforts to clarify and enforce its prior decisions, resolve newly arising disagreements, and respond to trends and developments in the lower courts. The Court’s pending decision in the “church plans” cases will likely have significant implications, as could other brewing issues that might soon make their way to the Court—whether on questions of standing, allegedly excessive investment fees in fiduciary-duty cases, or the validity and viability of recent Department of Labor regulations. However these or other issues are decided, these decisions will most likely become part of an ongoing conversation that we can expect the Court to regularly revisit.