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TOPIC: Do Your 401(k) and Deferred Compensation Plan Dispute Resolution Provisions Protect Your Company to Their Fullest? Four Questions to Ask in Light of Recent Legal Developments

MARKET TREND: Claims for benefits and fiduciary breach claims under the Employee Retirement Income Security Act of 1974 ("ERISA") in connection with qualified and nonqualified retirement plans can result in serious liabilities. The long-running ERISA fiduciary case of *Tussey v. ABB Inc.* recently settled with a $55 million award to the participants and $20 million in legal fees to the plaintiffs' lawyers. In recent years, ERISA dispute resolution procedures have been impacted by case law and Department of Labor ("DOL") guidance. These developments lead to new best practices for employers and provide planning opportunities to better protect companies from legal actions.

SYNOPSIS: Disputes under qualified and nonqualified retirement plans can take several forms. Some claims, especially for qualified retirement plans, may assert breaches of ERISA fiduciary duties. See, for example, our Marketplace article from earlier this year, "401(k) Fiduciary Litigation: Morals from the Story." Other disputes may relate to individual claims for benefits under plan terms that must be decided through ERISA claims procedures. Legal actions by participants should follow only after claims procedures have been exhausted. Dispute resolution provisions and claims procedures contained in qualified and nonqualified retirement plans related to all these types of disputes can significantly impact a company's level of exposure to these claims. This article reviews four areas where recent case law and DOL guidance suggest dispute resolution best practices for plans, including mandatory arbitration provisions (such as the one recently enforced by the recent Ninth Circuit), plan-level statutes of limitation, and other claims procedure enhancements.

TAKEAWAYS: Employers should review their qualified and nonqualified retirement plans' dispute resolution and claims procedures considering these recent developments to see whether they provide all the protections that recent cases and guidance suggest.

ERISA Protections for Participants

One basic principle of ERISA is that participants' promised benefits must be protected. One form of protection is the requirement that ERISA fiduciaries act prudently and in the exclusive best interest of participants and their beneficiaries. ERISA authorizes a private right of action for participants to sue on behalf of the plan to enforce those fiduciary duties if breached. The claims often take the form of class action lawsuits filed by groups of participants on behalf of the plan against the plan sponsor and various plan fiduciaries.

ERISA also provides a forum for participants to resolve individual disagreements with the plan regarding claims for plan benefits. The DOL has detailed regulations that require ERISA plans to establish and maintain procedures through which participants can file claims for benefits and seek review of denied claims for benefits (referred to throughout this summary as "ERISA claims procedures").

This summary generally focuses on the ERISA claims procedures and other dispute resolution provisions applicable to qualified and nonqualified retirement plans and does not attempt to address the ERISA claims procedures applicable to group health plans. This summary also does not detail the technical ERISA claims procedure requirements. Rather, the summary focuses on the importance of following the ERISA claims procedures and legal developments affecting best practices.

Note that while nonqualified deferred compensation plans are generally exempt from ERISA's substantive provisions (including fiduciary duties), they are still subject to ERISA's enforcement provisions, including the claims procedure regulations of ERISA. Therefore, both qualified and nonqualified plans are affected by this article.

ERISA Claims Procedure Background

The first ERISA claims procedures were issued in 1977.[1] New DOL claims procedure regulations were issued in 2000 for any claims filed on or after January 1, 2002.[2] The DOL claims procedure regulations were further amended in December 2016 to add new disability claims procedures, which are further described below and which were effective for disability claims filed after April 1, 2018.[3] See our Marketplace article from earlier this year, "New DOL Rules on Disability Claims May Impact Retirement and Deferred Compensation Plans."

Although many of ERISA's vast requirements (including the ERISA claims procedures) impose additional administrative and operational compliance burdens on employers and plan administrators, ERISA also offers various legal protections for employers. The ERISA claims procedures provide one of those key protections. Specifically, participants generally are not permitted to bring a claim for benefits in court unless and until the plan's internal claims and

[1] *See* 42 Fed. Reg. 27426 (May 27, 1977).
[2] DOL Reg. §2560.503-1(p).
[3] DOL Reg. §2560.503-1(p)(3).

appeals procedures are fully exhausted. In addition, in the event a claim is eventually brought in court, courts apply a deferential standard of review to the plan's decisionmaker (assuming the plan document includes a grant of discretion to that decisionmaker) and the plan's decisions will be overturned only if they are arbitrary and capricious or constitute an abuse of discretion.[4] The application of such a standard of review can make or break an ERISA claim for benefits that proceeds to litigation.

Consequences of Failure to Comply with the ERISA Claims Procedures

If a plan fails to follow the ERISA claims procedures (e.g., it fails to meet the required deadline or include ERISA-required content), there are several legal consequences. First, the participant may be allowed to go to court without exhausting the plan's internal claims and appeals procedures[5] and the deferential standard of review may not apply once the participant is in court.[6] In particular, for disability claims, a plan's failure to *strictly* comply with the ERISA claims procedures will result in the claim being deemed denied without the exercise of discretion by the plan's decisionmaker, which means a court will not grant deference to the plan decisionmaker's determination.[7]

In a claim determination not involving disability, the consequences of failing to strictly comply with the ERISA claims procedures are not as clear. A plan's internal claims procedures must only be "consistent with" the ERISA claims procedures.[8] Most courts have treated substantial compliance with the ERISA claims procedures as sufficient to require exhaustion of internal claims procedures and to apply the deferential standard of review.[9]

In addition to the consequences described above, if a plan fails to adequately notify a participant of a denial of an initial claim for benefits, that could toll the deadline to appeal the denial. If the appeals period never begins to run, the claimant can avoid an otherwise applicable statute of limitations that would have placed an outside limit on when the participant could file a claim in court.

Finally, several courts have held that the proper remedy for an inadequate *disability* claims determination was the reinstatement of terminated disability benefits.[10] In other words, a procedural violation of the ERISA claims procedures can require a substantive remedy (at least in a narrow subset of cases).

The protections afforded by ERISA are valuable, and a company is wise to ensure procedural compliance with the ERISA claims procedures to ensure that those protections apply to its determinations on participants claims and appeals. In addition, plan sponsors should take another look at their internal claims and appeals procedures to make sure that the plans include all the language permitted by ERISA in order to ensure maximum protection under the law. Below are four questions employers should ask themselves when reviewing their plans' claims procedures and other dispute resolution provisions.

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[4] *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989) (establishing the principle that the amount of deference to be paid to a decision to deny benefits depends on a grant of discretion under the plan).
[5] *See, e.g., Greifenberger v. Hartford Life Ins. Co.*, 131 Fed. Appx. 756 (2d Cir. 2005).
[6] *See, e.g., Rasenack v. AIG Life Ins.*, 585 F.3d 1311 (10th Cir. 2009)
[7] *See* DOL Reg. §2560.503-1(l)(2).
[8] DOL Reg. §2560.503-1(l).
[9] See, e.g., *Lafleur v. La. Health Serv. & Indemnity Co.*, 563 F.3d 148, 46 EBC 1593, (5th Cir. 2009).
[10] *See, e.g., Wenner v. Sun Life Assur. Co. of Can.*, 482 F.3d 878 (6th Cir. 2007).

Four Questions to Ask Regarding Your Qualified Retirement Plan's Dispute Resolutions and ERISA Claims Procedures

I. *Should We Add an Individual Mandatory Arbitration Provision to the Plan?*

Employers are always looking for ways to minimize the cost and publicity of litigation. One way to accomplish that goal is through arbitration, where disputes are resolved before an arbitrator (or a group of arbitrators) rather than a judge. A mandatory individual arbitration provision may also preclude participants from banding together in a class action lawsuit. A recent decision out of the Ninth Circuit – *Dorman v. Charles Schwab Corp*, No. 18-15281 (9th Cir. 2019) – holds that ERISA plans may include mandatory arbitration provisions that require individual arbitration, and preclude class action litigation, for claims asserting breach of fiduciary duties under ERISA Section 502(a).

The use of arbitration in ERISA plans has not always been clear. ERISA claims procedure regulations expressly approve the use of arbitration and other dispute resolution mechanisms as part of a plan's internal claims and appeals procedures if the participant still retains the right to bring a claim under ERISA Section 502 in court after the internal procedures are exhausted.[11]

The *Dorman* decision, however, looks at the use of a mandatory arbitration provision as applied to a claim regarding breach of ERISA fiduciary duties, not a claim for individual benefits under the claims procedures.

The decision balances the requirements and protections of the Federal Arbitration Act ("FAA") against ERISA's participant protections and enforcement regime. The FAA governs arbitration agreements in contracts involving transactions in interstate commerce and generally provides that arbitration agreements shall be "valid, irrevocable, and enforceable. . . ."[12] The Supreme Court was generally hesitant to enforce the FAA where there was uneven bargaining power between the parties (e.g., in contracts between employers and employees) and where federal statutory rights were implicated.[13] Similarly, the Ninth Circuit held that ERISA claims are not arbitrable in *Amaro v. Continental Can Co*., 724 F.2d 747 (9th Cir. 1984).

More recently, courts have been willing to rely on the FAA and accept arbitration provisions. Notably, the Supreme Court held that federal statutory claims are generally arbitrable and arbitrators can competently interpret and apply federal statues in *Am. Express Co. v. Italian Colors Restaurant*, 570 U.S. 228 (2013). In similar fashion, the Supreme Court held in *Epic Systems Corp. v. Lewis*, 138 S. Ct. 1612 (2018) that individual mandatory arbitration provisions in employment agreements are enforceable based on the FAA and despite potentially conflicting provisions in the National Labor Relations Act.

In *Dorman*, a former participant in the Schwab 401(k) plan filed a class action suit in district court alleging that the defendants violated ERISA and breached their fiduciary duties by including poor performing Schwab-affiliated investment funds in the plan.[14] The plan included an arbitration provision, which also waived participants' rights to bring any class or collective action. Therefore, the defendants moved to compel arbitration. The district court held that the Ninth

[11] DOL Reg. §§2560.503-1(c)(3) and 2560.503-1(c)(4).
[12] 9 U.S.C. §§ 1 and 2.
[13] See *Wilko v. Swan*, 346 U.S. 427 (1953).
[14] *Dorman v. Charles Schwab Corp*, D.C. No. 4:17-cv-00285-CW (9th Cir. 2019).

Circuit precedent in *Amaro* precluded arbitration in an ERISA plan. A three-judge panel of the Ninth Circuit held that the Supreme Court's 2013 *American Express* decision required the Ninth Circuit to overturn its prior ruling in *Amaro* and the Ninth Circuit remanded the case back to district court.[15]

In addition to the published decision in *Dorman*, the Ninth Circuit panel submitted a supplemental memorandum, which more clearly indicates that plan fiduciaries can bind a plan to mandatory arbitration of disputes, and waivers of class action, arising under the plan.[16] The court noted that any participant who continues to participate in the plan after the effective date of an amendment, including an arbitration provision, is agreeing to be bound by the arbitration clause.[17] Therefore, an employer can amend its plan now and bind all current and future participants to binding arbitration (i.e., the provision is not limited to new participants after the effective date of the amendment).

Note that the decision in *Dorman* has limitations. For instance, the case involved a claim for breach of fiduciary duty, and it likely would not apply in a case regarding a denied claim for benefits. The DOL takes the position that ERISA always allows participants to bring a suit in Federal court regarding their claims for benefits after the plan's internal claims and appeals procedures are exhausted[18] and at least one court has agreed.[19]

Dorman also likely does not help in the event a defendant is attempting to rely on an arbitration provision in a contract with an individual employee, such as an employment agreement. The Ninth Circuit held in 2018 that an arbitration provision in an individual's employment agreement did not bind the plaintiffs to arbitration in a breach of fiduciary duty case because such a claim belonged to the plan and not to any individual.[20] Therefore, the plan document itself must contain the arbitration provision.

Finally, there are practical considerations to consider when determining whether arbitration is right for a particular plan and employer. Arbitration may not make sense for everyone.

Despite the limitations, *Dorman* may prove to be an important decision because it provides planning opportunities for employers to avoid the massive litigation expenses that are attendant to ERISA fiduciary class action litigation.

II. *Does the Plan Include the Requirement that Claims Procedures be Exhausted before a Lawsuit?*

Many employers take it for granted that a participant must exhaust the plan's internal claims and appeals procedures before filing a lawsuit over disputed benefits. However, ERISA itself does not actually contain an exhaustion requirement. Most courts do require participants to exhaust available administrative procedures before bringing a suit in court.[21] This is beneficial for

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[15] *Id.*
[16] *Dorman v. Charles Schwab Corp*, D.C. No. 4:17-cv-00285-CW (9th Cir. 2019) (unpublished memorandum).
[17] *Id.*
[18] See Preamble to 2000 Claims Regulations, 65 Fed. Reg. 70246, 70253 (Nov. 21, 2000).
[19] Sosa v. PARCO Oilfields Servs., Ltd., No. 2:05-cv-153 (E.D. Tex. Sep. 27, 2006).
[20] *Munro v. Univ. of S. Cal.*, 896 F.3d 1088, 1092 (9th Cir. 2018).
[21] *See, e.g., Kinkead v. Sw. Bell Corp. Sickness & Accident Disability Plan*, 111 F.3d 67 (8th Cir. 1997) ("[f]ederal courts applying ERISA have uniformly concluded that benefit claimants must exhaust the review procedures mandated by 29 U.S.C. § 1133(2) before bringing claims for wrongful denial to court").

employers because requiring a participant to go through the plan's internal claims and appeals procedures allows the plan administrator to compile an administrative record and have a good basis for denial, which will be given deference if the claim ever proceeds to trial. In addition, there is a chance that the dispute can be resolved without a lawsuit.

Although many courts routinely require exhaustion, a recent decision out of the United States District Court of Arizona cautions that employers must have language requiring exhaustion for some courts to require the exhaustion of the plan's administrative remedies before suing. In *Greiff v. Life Ins. Co. of N. Am.*, the district court held that the Ninth Circuit's ERISA court-created exhaustion requirement applies only if the relevant plan document requires such exhaustion.[22] The plan document in that case had information required by the ERISA claims procedures, which includes language that all denial letters will include a statement of the right to bring a civil action under Section 502(a) of ERISA, but the plan document did not indicate that internal administrative remedies must first be exhausted. Therefore, the court denied the motion to dismiss based on a failure to exhaust.

This decision highlights the importance of including an express exhaustion requirement in the plan document and summary plan description ("SPD"). Note that ERISA SPD content requirements require the inclusion of a model statement of ERISA rights, which provides that a participant "may file suit in Federal court" (without any reference to the exhaustion requirement). At least one court found that a participant was not required to exhaust the plan's internal claims procedures when the SPD included this legally required language and the SPD's other language regarding exhaustion seemed permissive rather than mandatory.[23] In light of this case, cautious plan sponsors will include strong, mandatory exhaustion language and caveat the model statement of ERISA rights to provide that participants "may file suit in Federal court" *after* exhausting the plan's internal claims and appeals procedures.

III. *Does the Plan Include a Statute of Limitations for Claims for Benefits?*

ERISA claims for fiduciary breach generally must be filed within a certain time prescribed by ERISA, but ERISA does not prescribe an outside deadline by which a claim for benefits must be filed in court after the claim has been denied by the plan. Instead, courts typically apply the statute of limitations for a state-law claim that is most analogous to ERISA when determining the applicable statute of limitations for a claim for benefits, often (but not always) based on statutes of limitations for contract claims.[24] Therefore, statutes of limitations for claims for benefits vary by state and choice of law becomes important. In order to ensure consistency, employers have sought to implement plan-imposed deadlines for filing lawsuits by adding a plan-level statute of limitations for those claims. In 2013, the Supreme Court blessed this approach and held that parties may contract around a default state-level statute of limitations unless the limitation is unreasonable.[25]

It's not entirely clear what a "reasonable" statute of limitations entails, but it is a facts and circumstances determination. A three-year period is generally reasonable. Some courts have enforced one-year statute of limitations.[26]

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[22] *Greiff v. Life Ins. Co. of N. Am.*, 2019 WL 2912757 (July 5, 2019 D. AZ) (citing *Vaught v. Scottsdale Healthcare Corp. Health Plan*, 546 F.3d 620, 626 (9th Cir. 2008)).
[23] *Watts v. Bellsouth Telecomms., Inc.*, 316 F.3d 1203 (11th Cir. 2003).
[24] See, e.g., *Redmon v. Sud-Chemie Inc. Ret. Plan for Union Employees*, 547 F.3d 531, (6th Cir. 2008)
[25] *Heimeshoff v. Hartford Life & Acc. Ins. Co.*, 134 S. Ct. 604 (2013).
[26] *See e.g., Scharff v. Raytheon Co. Short Term Disability Plan*, 2007 WL 2947566 (C.D. Cal. 2007).

Regardless of the timeline imposed, employers should ensure that the plan-level statute of limitations is included in all plan documents and in benefit denial letters. The First, Third, and Sixth Circuits have all held that a benefit denial letter must state a plan-imposed time limit for filing suit for the limit to be enforced against a participant, and the District Court of South Carolina recently followed those circuits.[27]

IV. *Does the Plan Include a Clear Reservation of Discretionary Authority to Make Eligibility Determinations and Construe Plan Terms*?

If a plan document does not convey decision-making discretion on the plan administrator (or other fiduciary decisionmaker), the denial of a claim for benefits is reviewed *de novo*.[28] This means that the court will apply its own judgment without deference to the plan administrator's decision and that the favorable standard of review generally applicable to ERISA claims for benefits does not apply. At least one court has also held that an SPD's grant of discretionary authority to the plan administrator is unenforceable when the plan document itself is silent.[29] Therefore, plan sponsors should review their plans to ensure that the plan itself gives the administrator or fiduciary decisionmaker discretionary authority to determine plan eligibility and construe plan terms.

Courts have also held that the discretionary authority must be appropriately delegated to the actual decisionmaker (e.g., a benefits committee).[30] Therefore, if a claim denial is made by an unauthorized party, a de novo review applies. This is problematic for some plans, who name the company as the "plan administrator" in the plan document. In this case, the company should ensure that, unless the governing body of the company is making benefit determinations, a proper delegation of authority is in place to the person or entity actually making the claims determinations.

Conclusion

Disputes impacting qualified and nonqualified retirement plans are virtually inevitable. Employers should take advantage of the protections under ERISA and applicable case law to ensure that those disputes are resolved fairly and efficiently. The recent decisions noted above should provide a reason for employers to take a fresh look at the claims procedures and other dispute resolution provisions in their plans. Employers should also continue to monitor developments in the *Dorman* case to see if its decision about mandatory individual arbitration provisions in ERISA plans holds up and is adopted by other circuits.

[27] *Starnes v. Universal Fidelity Adm'r Co., CA No.* 6:17-3073 (DSC 2017).
[28] *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989).
[29] *Prichard v. Metro. Life Ins. Co.*, 783 F.3d 1166 (9th Cir. 2015).
[30] See, e.g., *Jebian v. Hewlett-Packard Co. Employee Benefits Org. Income Protection*, 349 F.3d 1095 (9th Cir. 2003).