

**CHUBB MANAGED CARE SEMINAR**

**ERISA Preemption and Breach of Fiduciary Duty Claims Under ERISA**

**Presented by:**

**Andrew W. Hull and Alice M. Morical**

## **ERISA PREEMPTION**

The Employee Retirement Income Security Act of 1974 (“ERISA”) establishes rules governing the conduct of plan sponsors and fiduciaries. An important aspect of ERISA is the preemption doctrine, which provides both a defense to state claims and a vehicle to remove to federal court a lawsuit that ostensibly asserts only state claims.

ERISA contains two separate statutory provisions regarding preemption. First, ERISA § 501 provides the civil enforcement mechanism for ERISA. 29 U.S.C. § 1132(a)(1)(B). It does not expressly state that ERISA preempts state law; however, courts have uniformly interpreted this provision to require the preemption of any state laws that conflict with the ERISA remedies or provide an alternative enforcement mechanism. This statutory section also provides a basis to remove to federal court any claim filed in state court that alleges state law claim only. The second, ERISA § 514, broadly (and explicitly) preempts, with certain exceptions, “any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.” 29 U.S.C. § 1144(a). A statutory or common law claim can be preempted under either provision independently.

The following organizes the nuanced case law of ERISA preemption and discusses preemption issues as they relate to managed care entities.

### **I. SECTION 502 PREEMPTION**

ERISA §502(a)(1)(B) provides a civil enforcement mechanism authorizing a participant or beneficiary “to recover benefits due ..., to enforce his rights under ..., or to clarify his rights to future benefits” under the terms of an ERISA plan. 29 U.S.C. §1132(a)(1)(B).

### **A. Early Supreme Court Authority**

In *Pilot Life*, the Supreme Court held that § 502(a)(1)(B) “provides an exclusive federal cause of action” for a resolution of “a suit by a beneficiary to recover benefits from a covered plan.” *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 62-63 (1987) (citing *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 56, 107 S. Ct. 1549 (1987)). The federal cause of action completely preempts any state law claim that seeks to provide different or additional remedies in connection with a benefit determination. This is so, the Court explained in *Pilot Life*, because §502(a)(1)(B) is part of a:

comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA. ‘The six carefully integrated civil enforcement provisions found in § 502(a) of the statute as finally enacted ... provide strong evidence that Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly.’

*Pilot Life*, 481 U.S. at 54 (quoting *Mass Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146 (1985)) (emphasis in original).

The Court in *Pilot Life* applied this rule to hold that § 502 (a)(1)(B) completely preempted state common law tort and contract actions asserting improper processing of a claim for benefits. The Court recognized that permitting such claims – which would have allowed the plaintiff to recover consequential damages not authorized under ERISA – would upset the careful remedial balance struck in ERISA § 502(a). *Id.* at 50, 54. The Court’s critical point was that ERISA § 502(a)(1)(B) must completely preempt state law claims and remedies that are different from the specific claims and remedies that

Congress included in ERISA because state law claims and remedies would disrupt ERISA's comprehensive and uniform system of benefit regulation.

Preemption under ERISA § 502 is also the basis for jurisdiction to remove a case from state court to federal court. In *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987), in a unanimous decision decided the same day as *Pilot Life*, the Supreme Court held that § 502(a)'s preemptive power is sufficient to confer federal jurisdiction over all claims within its scope, including claims plead exclusively under state law. The Court held that *Pilot Life* preemption was sufficient to confer removal jurisdiction. Section 502(a) preempts so completely that it has displaced any parallel state law cause of action, rendering such claims "necessarily federal in character" and sufficient to invoke federal jurisdiction. *Metropolitan Life*, 481 U.S. at 67. Removal under ERISA § 502 is routinely accepted in all federal courts. See, e.g., *Ducheck v. Blue Cross and Blue Shield*, 153 F.3d 648, 649 (8<sup>th</sup> Cir. 1998); see also *Mange v. Petrolite Corporation*, 135 F.3d 570, 571 (8<sup>th</sup> Cir. 1998) (plaintiffs' claims for compensation for unused vacation benefits are governed under ERISA and thus, removal was proper as the federal district had jurisdiction to hear the case); *Lister v. Stark*, 890 F.2d 941, 943-44 (7<sup>th</sup> Cir. 1989); *Sofa v. Pan-American Life Ins. Co.*, 13 F.3d 239, 241 (7<sup>th</sup> Cir. 1994) (plaintiff's claim for wrongful rescission of benefits was removable). As a matter of practice, ERISA cases filed in state court should be removed to federal court because federal courts are more familiar with the complicated issues that arise in most ERISA cases such as the standard of review, discovery issues and the like.

## **B. Recent Caselaw**

In *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002), the Supreme Court recently affirmed *Pilot Life's* holding that ERISA preempts state law causes of action that “add[] to the judicial remedies provided by ERISA.” *Id.* at 379. The Court emphasized such causes of action “patently violate ERISA’s policy of inducing employers to offer benefits by assuring a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards when a violation has occurred.” *Id.* Indeed, all members of the Court agreed that if the state independent review statute at issue in *Rush Prudential* had created an additional claim or an additional remedy, it would have been preempted under *Pilot Life* and its progeny. *Id.* at 379-80 (“[T]he state statute does not enlarge the claim for benefits beyond the benefits available in any action brought under [§ 502(a)]. This case therefore does not involve the sort of additional remedy exemplified in *Pilot Life*, ... and *Ingersoll-Rand* ...”; *Id.* at 388 (Thomas J., dissenting) (citing *Pilot Life* for the proposition that “as the Court concedes, ... even a state law that ‘regulates insurance’ may be preempted if it supplements the remedies provided by ERISA, despite ERISA’s savings clause ....”).<sup>1</sup>

Numerous federal circuit courts have had no difficulty applying the Court’s principles to recognize that state law claims related to alleged delay in the administration or determination of ERISA plan benefits are completely preempted under the scope of Section 502(a) of ERISA. *See, e.g., Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266, 273-75 (3<sup>rd</sup> Cir. 2001) (state law claims for alleged delay in approving benefits fall

---

<sup>1</sup> The Department of Labor’s claims procedure regulations underscore that the benefit determination process is an integral part of the claims administration for health and disability plans. *See* 29 C.F.R. § 2560.503-1 (2003). Imposing a patchwork of state law regulation and claims related to the manner and method of communicating benefit determinations would impede ERISA’s administrative and civil enforcement mechanisms.

squarely within ERISA's administrative function and are completely preempted. The plaintiff could have sought an injunction under Section 502(a), thereby using the provisions of the civil enforcement scheme provided by Congress); *Cico v. Does 1-8*, 385 F.3d 156 (2<sup>nd</sup> Cir. 2004) (state law claims against defendants who did not actually provide medical care to plaintiff are completely preempted under ERISA and within the scope of § 502(a).)

## **II. SECTION 514 PREEMPTION AND THE SAVINGS TEST**

ERISA § 514 provides that ERISA “shall supercede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.” 29 U.S.C. § 1144(a). The Supreme Court has repeatedly noted that this preemption provision is “conspicuous for its breadth.” *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990); *see also Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 64-67 (1987); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 138-39, 111 S. Ct. 478 (1990); *see also Nagy v. Riblet Products Corp.* 79 F.3d 572, 574 (ERISA preempts all state law “relating to” pension plans—including tort and contract law).

### **A. Preemption of Claims that Relate to an Employee Benefit Plan**

As noted above, ERISA § 514 states in relevant part that ERISA “supercede[s] any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.” 29 U.S.C. § 1144(a). The Supreme Court has emphasized that Congress used the words “relate to” “in their broad sense, rejecting more limited pre-emption language that would have made the clause 'applicable only to state laws relating to specific subjects covered by ERISA.’” *Ingersoll-Rand*, 498 U.S. at 138 (quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 98 (1983)). Congress intended, through the enactment of ERISA, that

the field of employee benefit plans be “exclusively a federal concern.” *Alessi v. Raybestos - Manhattan, Inc.*, 451 U.S. 504, 523 (1981).

### **B. The Limits of “Relates to” Preemption**

The scope of preemption afforded by Section 514 is not, however, without limits. Initially, courts literally interpreted the “relates to” language. The sweeping preemption which resulted substantially weakened the rights of participants and beneficiaries. As a result, the Supreme Court began to constrict the breadth of ERISA preemption. In *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 98 (1983), for instance, the Supreme Court held that “some state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law ‘relates to’ the plan.” 463 U.S. at 100, n 21. Similarly, the Supreme Court has held that preemption does not apply to “run of the mill” state law claims. *Mackey v. Lanier Collections Agency & Service*, 486 U.S. 825 (1988). To determine whether a state statute of general application “relates to” an ERISA plan (and is therefore preempted), courts have considered numerous factors, including:

- whether the state law negates an ERISA plan provision;
- whether the state law affects relations between primary ERISA entities;
- whether the state law requires the establishment of a separate employee benefit plan to comply with the law;
- whether the state law regulates the type of benefits provided under plans or the terms of ERISA plans;
- whether the state law impacts the structure of ERISA plans;

- whether the state law provides an alternate cause of action to participants to collect benefits protected by ERISA;
- whether the state law impacts the administration of ERISA plans; and
- whether the preemption of the state law is consistent with other ERISA provisions.

JAYNE E. ZANGLEIN & SUSAN J. STABILE, *ERISA LITIGATION* 291-92 (2003) (internal citations omitted).

For example, in *Jass v. Prudential Health Care Plan, Inc.*, the Seventh Circuit recognized the following types of cases as “too tenuous” to be preempted by ERISA:

- state garnishment proceedings of pension income to enforce alimony;
- a defamation lawsuit against a plan by a doctor;
- a suit against an ERISA plan for unpaid rent;
- a suit against an ERISA plan for unpaid attorneys’ fees; and
- a tort action by a participant who slipped on a banana peel in a plan administrator's office.

*Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1494-95 (7<sup>th</sup> Cir. 1996) (internal citations omitted).

### **C. The Savings Clause**

The preemptive scope of ERISA § 514 is further limited by the savings clause found at 29 U.S.C. § 1144(b)(2)(A), which provides “nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking or securities.” The scope and application of the savings clause was

most recently addressed by the Supreme Court in *Kentucky Association of Health Plans, Inc. v. Miller*, 538 U.S. 329, 123 S. Ct. 1471 (2003).

In *Kentucky Association*, the Supreme Court ruled that in order to survive ERISA preemption under the savings clause, the state law must:

- “be specifically directed toward entities engaged in insurance”<sup>2</sup>; and
- “substantially affect the risk pooling arrangement between the insured and insurer.”<sup>3</sup>

123 S. Ct. at 1479. Each of these factors is discussed below.

### **1. Specifically Directed Toward Insurance Industry**

It is well established that a state law must be “specifically directed toward” the insurance industry in order to fall under ERISA’s savings clause; laws of general application that have some bearing on insurers do not qualify. *Pilot Life*, 481 U.S. at 50; *see also Rush Prudential*, 536 U.S. at 366; *FMC Corp.*, 498 U.S. at 61.

---

<sup>2</sup> In *Kentucky Association*, the Supreme Court discarded the three-factor McCarran-Ferguson test and developed a two-prong test. The new two-prong *Kentucky Association* test significantly borrows from the factors under the prior McCarran-Ferguson test. The Court transformed the McCarran-Ferguson factors into a new test in order to clarify what requirements must be met in order for the savings clause to apply. The Court made clear that the savings clause analysis was being changed to provide clear guidance to lower courts. 123 S. Ct. at 1478-79.

The first prong under the *Kentucky Association* test is substantially identical to the third factor under the McCarran-Ferguson test, which was “whether the practice is limited to entities within the insurance industry.” The first prong under *Kentucky Association* is whether the law is “specifically directed toward entities engaged in insurance . . .” *Id.* at 1479. Both inquiries focus on whether the law is directed toward entities in the insurance industry. Thus, cases interpreting the third factor in McCarran-Ferguson are instructive and provide guidance as to the first prong of the *Kentucky Association* test.

<sup>3</sup> The second prong under the *Kentucky Association* test is substantially similar to the first factor of the McCarran-Ferguson test. The first factor under McCarran-Ferguson is “whether the practice has the effect of transferring or spreading a policyholder’s risk.” *Id.* at 1478. The second prong under *Kentucky Association* is whether the law “substantially affect[s] the risk pooling arrangement between the insurer and insured.” *Id.* at 1479. Due to this similarity, prior cases under the McCarran-Ferguson test provide guidance as to application of the second prong under the *Kentucky Association* test.

The Supreme Court in *Pilot Life* held that when a state bad faith law has developed from general principles of contract and tort law, it is not specifically directed at the insurance industry. The Court stated:

A common-sense view of the word “regulates” would lead to the conclusion that in order to regulate insurance, a law must not just have an impact on the insurance industry, but must be specifically directed toward that industry. Even though the Mississippi Supreme Court has identified its law of bad faith with the insurance industry, the roots of this law are firmly planted in the general principles of Mississippi tort and contract law. Any breach of contract, and not merely breach of an insurance contract, may lead to liability for punitive damages under Mississippi law.

481 U.S. at 51. Because all contracts were subject to bad faith claims, the law was not specifically directed at the insurance industry.

Since *Pilot Life*, lower courts have repeatedly recognized that state common law and statutory bad faith and negligence claims against insurers are not saved from preemption under ERISA as such laws are not specifically directed to the insurance industry. *See, e.g., Cannon v. Group Health Service of Okla., Inc.*, 77 F.3d 1270, 1275 (10<sup>th</sup> Cir.), *cert. denied*, 519 U.S. 816 (1996) (state law negligence claim does not specifically regulate insurance company within the meaning of ERISA’s savings clause); *Hogan v. Kraft Foods*, 969 F.2d 142, 144-45 (5<sup>th</sup> Cir. 1992) (state law claims for negligence and breach of duty of good faith and fair dealing do not specifically regulate insurance, banking, or securities and are thus not protected under ERISA’s savings clause); *Bast v. Prudential Ins. Co. of America*, 150 F.3d 1003, 1008 (9<sup>th</sup> Cir. 1998), *cert. denied*, 528 U.S. 870 (1999) (breach of good faith claim brought under the Washington Insurance Code is not exempt under ERISA’s savings clause); *Powell v. Chesapeake & Potomac Tel. Co. of Va.*, 780 F.2d 419, 423-24 (4<sup>th</sup> Cir. 1985), *cert. denied*, 476 U.S. 1170 (1986) (Virginia’s implied covenant of good faith and fair dealing does not bear

upon the “business of insurance” within contemplation of ERISA’s savings clause and thus is not saved from preemption); *Gilbert v. Alta Health & Life Ins. Co.*, 276 F. 3d 1292, 1296-98 (11<sup>th</sup> Cir. 2001) (Alabama statute governing insurer’s bad faith refusal to pay preempted under ERISA as statute had its roots in general principles of tort and contract law); *Walker v. Southern Co. Serv., Inc.*, 279 F. 3d 1289, 1292-94 (11<sup>th</sup> Cir), *cert. denied*, 123 S. Ct. 111 (2002); *see also Kelley v. Sears Roebuck & Co.*, 882 F.2d 453, 456 (10<sup>th</sup> Cir. 1989); *Caffey v. UNUM Life Ins. Co.*, 302 F.3d 576, 582 (6<sup>th</sup> Cir. 2002); *Howard v. Coventry Health Care of Iowa, Inc.*, 293 F.3d 442, 446-47 (8<sup>th</sup> Cir. 2002); *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266, 270 (3<sup>rd</sup> Cir. 2001).

## **2. Substantially Affect the Risk Pooling Arrangement**

The second factor under the *Miller* test considers whether the claim has the effect of transferring or spreading policyholder risk. *See Gilbert*, 276 F. 3d at 1298-99; *Walker*, 279 F. 3d at 1293; *compare Kelley v. Sears, Roebuck Co.*, 882 F.2d 453, 456 (10<sup>th</sup> Cir. 1989).

Since the ruling in *Kentucky Association*, other courts have found that bad faith and negligence claims do not substantially affect the risk pooling arrangement. *See Kidneigh v. UNUM Life Ins. Co of America*, 345 F.3d 1182, 1187-88 (10<sup>th</sup> Cir. 2003); *Ercole v. Conectiv and Coventry Health Care of Delaware, Inc.*, No. Civ. A. 03-186 GMS, 2003 WL 21104926 (D. De. May 15, 2003); and *McGuigan v. Reliance Standard Life Ins. Co.*, 256 F. Supp. 2d 345, 348. In *Ercole*, the court stated that:

There can be little dispute that the Delaware state bad faith cause of action does not substantially affect risk pooling between insurer and insured. Rather, it simply provides extra-contractual damages not permitted by ERISA.

Such common law claims, whether cast as bad faith, breach of implied duty or negligence merely seek to provide extra-contractual damages for an insurer's conduct in a benefit determination and do not substantially affect the risk pooling arrangement between the insurer and insured.

### **3. Self-Funded Plans**

Even if a law is one that regulates insurance within the meaning of ERISA, the law is not applicable to self-funded benefit plans because of the "Deemer clause," which states that neither employee benefit plans nor trusts established under such plans

shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

29 U.S.C. § 1144(b)(2)(B). This provision of ERISA exempts self-funded plans from state laws regulating insurance and therefore does not save state laws that regulate insurance as they relate to self-funded plans. *FMC v. Holliday*, 498 U.S. 52, 61 (1990); *American Medical Security, Inc. v. Auto Club Ass'n of Michigan*, 238 F.3d 743 (6<sup>th</sup> Cir. 2001); *Doe v. Blue Cross and Blue Shield*, 112 F.3d 869 (7<sup>th</sup> Cir. 1997).

### **III. TYPES OF CLAIMS PREEMPTED BY ERISA**

Lower courts have applied the preemption rules in a variety of contexts to numerous tort and contract claims. Courts have held that the following types of claims are preempted by ERISA:

- bad faith claims whether based on tort or statute . *See, e.g. Pitts v. American Security Life Ins. Co.*, 931 F.2d 351 (5<sup>th</sup> Cir. 1991); *In Re: Life Ins. Co. of Am.*, 857 F.2d 1190 (8<sup>th</sup> Cir. 1988); *Cantrell v. Great Republic Ins. Co.*, 873 F.2d 1249 (9<sup>th</sup> Cir. 1989).
- tortious breach of contract. *See, e.g., Fitzgerald v. Codex Corp.*, 882 F.2d 586 (1<sup>st</sup> Cir. 1989); *Shiffler v. Equitable Life Assurance Soc'y*. 838 F.2d 78 (3<sup>d</sup> Cir. 1988).

- state law claims of emotional distress. *See, e.g. Reilly v. Blue Cross*, 846 F.2d 416 (7<sup>th</sup> Cir. 1988); *Kuhl v. Lincoln Nat'l Health Plan of Kansas City*, 999 F.2d 298 (8<sup>th</sup> Cir. 1993).
- estoppel and oral representation claims. *See, e.g., Cleary v. Graphic Communication Int'l Union*, 841 F.2d 444 (1<sup>st</sup> Cir. 1988); *Smith v. Dunham-Bush*, 959 F.2d 6 (2d Cir. 1992); *Berger v. Edgewater Steel*, 911 F.2d 911 (3d Cir. 1990); *Nachwalter v. Christie*, 805 F.2d 956 (11<sup>th</sup> Cir. 1986).
- wrongful death claims. *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321 (5<sup>th</sup> Cir. 1992); *Parriro v. FHP, Inc.*, 146 F.3d 699 (9<sup>th</sup> Cir. 1998).
- fraud and detrimental reliance. *See, e.g. Memorial Hosp. Sys. v. Northbrook Life Ins. Co.*, 904 F.2d 236 (5<sup>th</sup> Cir. 1990); *Reilly v. Blue Cross*, 846 F.2d 416 (7<sup>th</sup> Cir. 1988); *Sanson v. General Motors Corp.*, 966 F.2d 618 (11<sup>th</sup> Cir. 1992).

#### **IV. PREEMPTION AS IT RELATES TO MANAGED CARE ENTITIES**

The Supreme Court's recent decision in *Aetna Health Inc. v. Davila*, 542 U.S. 200, 124 S. Ct. 2488 (2004) provides guidance in the application of ERISA preemption to managed care entities. In *Davila*, the Court held that when a managed care organization (HMO) denies coverage (and thereby denies treatment), that is not a "mixed" treatment/coverage decision to be remanded to state court. Instead, any challenge to that decision is within the purview of ERISA.

##### **A. The Davila Decision**

In *Davila*, two plaintiffs brought state law claims in state court against their HMOs for denial of benefits. The first plaintiff brought claims because the HMO refused to pay for Vioxx that was prescribed by the plaintiff's treating physician to treat arthritis pain. The second plaintiff underwent surgery and, although her treating physician recommended an extended hospital stay, the HMO discharge nurse determined that the plaintiff did not meet the plan's criteria for continued hospital stay and coverage for the extended hospital stay was denied. Both plaintiffs alleged failure to exercise ordering

care under the Texas Health Care Liability Act (“THCLA”), which the defendant HMOs then removed to federal district court arguing that claims were completely preempted by ERISA § 502(a).

The Supreme Court held that the claims were indeed preempted by Section 502 of ERISA:

If an individual, at some point in time, could have brought his claim under ERISA § 502(a)(1)(B), and where there is no other independent legal duty that is implicated by a defendant’s action, then the individual’s cause of action is completely preempted by ERISA § 502(a)(1)(B).

*Id.* at 210. While the plaintiffs alleged legal duties that arose independent of ERISA based upon the THCLA, the Court found that the duties imposed by the THCLA in the context of these cases did not actually arise independent of ERISA. The Court found that the HMOs were actually interpreting the terms of the relevant plans to determine coverage and therefore the harm arose because the plan did not cover the treatment.

The Court further held that because the claims were completely preempted under ERISA § 502, there was no need to consider whether the claims would also be preempted under ERISA § 514. The plaintiffs had argued that the cause of action would only be preempted if it would also be preempted under § 514. However, the Court clearly stated that if the claim was preempted under § 502, it does not matter whether it would also be preempted by express preemption under § 514.

The court also seemingly limited the scope of its earlier decision in *Pegram v. Herdrich*, 530 U.S. 211 (2000). In *Pegram*, the Plaintiff sued her physician owned and operated HMO and her treating physician for medical malpractice and for breach of ERISA fiduciary duty. In that case, the Court found that the treating physician’s decision

was not a fiduciary decision under ERISA, and therefore, the claim was not preempted by ERISA. In *Davila*, the Court stated the following:

it was essential to *Pegram's* conclusion that the decisions challenged there were truly 'mixed eligibility and treatment decisions,' 530 U.S. at 229, 120 S.Ct. 2143, *i.e.*, medical necessity decisions made by the plaintiff's treating physician *qua* treating physician and *qua* benefits administrator. Put another way, the reasoning of *Pegram* 'only make[s] sense where the underlying negligence also plausibly constitutes medical maltreatment by a party who can be deemed to be a treating physician or such a physician's employer.'

*Davila*, 542 U.S. at 214 (quoting *Cicio v. Does*, 321 F.3d 83, 109 (2d. Cir. 2003)).

Therefore, the Court in *Davila* noted that it was relevant that the defendants were neither respondent's treating physicians nor the employers of their treating physicians and therefore the coverage decisions were pure eligibility decisions. *Id.*

#### **B. Post *Davila* Managed Care Cases**

The *Davila* case provides more certainty for HMOs than existed in the past regarding state law claims that survive ERISA preemption. Following *Davila*, lower courts have found many similar claims against HMOs preempted by ERISA. *See, Land v. CIGNA Healthcare of Fla.*, 381 F.3d 1274 (11<sup>th</sup> Cir. 2004) (holding that claims against an HMO related to timing of discharge from hospital was preempted by ERISA); *Cicio v. Doe*, 385 F.3d 156 (2d Cir. 2004); *Calad v. CIGNA HealthCare of Tex.*, 388 F.3d 167 (5<sup>th</sup> Cir. 2004). It appears that plaintiffs' cases following *Davila* that attempted to allege state law liability will need to find an independent duty separate and apart from the defendants' ERISA duty.

Plaintiffs continue to seek to find new ways to hold insurers liable under state laws. *See, e.g., Dishman v. Unum Life Ins. Co.*, 269 F.3d 974 (9<sup>th</sup> Cir. 2001) (finding that state law invasion of privacy claim based upon investigation done in connection with

disability claim was not preempted by ERISA); *Erlandson v. Liberty Life Assurance Co.*, 320 F. Supp. 2d 501 (N.D. Tex. 2004) (same).

It is also certainly likely that the state legislature will continue to regulate the conduct of HMOs and further, that the resulting statutes will be challenged on the basis of ERISA preemption. *See, Pharmaceutical Care Management Ass'n. v. Rowe*, 307 F.Supp.2d 164 (D.M.E. 2004) (holding that Maine's Unfair Prescription Drug Practice Act is likely preempted by ERISA and for that and other reasons granted injunction). Therefore, the issues that may arise in managed care litigation will likely continue to be diverse as state laws change and as plaintiffs' counsel continue to seek to find new ways to bring claims against managed care entities.

## **BREACH OF FIDUCIARY CLAIMS UNDER ERISA**

These materials focus on fiduciary claims under ERISA. They examine the persons who are fiduciaries under the statute, what conduct may constitute a breach of fiduciary duty, and the potential remedies available for such breaches.

### **I. FIDUCIARY STATUS UNDER ERISA**

#### **A. The Statutory Definition**

ERISA defines the term “fiduciary” as any person “to the extent” he/she (1) “exercises any discretionary authority or discretionary control respecting management of [a] plan or exercises any authority or control regarding management or disposition of its assets,” (2) “renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of a plan or has authority or responsibility to do so,” or (3) “has any discretionary authority or discretionary responsibility in the administration of [a] plan.” ERISA § 3(21)(A), 29 U.S.C. § 1002(21)(A).

#### **B. Fiduciary Positions and Functions**

Under ERISA, certain positions are specifically defined as fiduciary positions. For example, ERISA § 402(a), 29 U.S.C. § 1102(a), states that a plan must appoint a “named fiduciary” who has overall fiduciary responsibility for the plan. This “named fiduciary” must either be named in the plan document, under a procedure specified in the plan, or by an employer, a union, or an employer and a union acting together. *See* 29 C.F.R. § 2509.75-5 at FR-3. ERISA also allows a plan document to name a fiduciary who only holds that status for a particular function. *See* 29 C.F.R. § 75-8 at D-4.

Likewise, ERISA § 3(38), 29 U.S.C. § 1002(38), requires that an “investment manager” acknowledge his fiduciary status.

In general, however, courts have stressed that the test for determining an individual’s fiduciary status under ERISA is a “functional” one. Accordingly, courts do not simply focus on the titles and duties set forth in the plan documents but, instead, examine whether the person or firm actually exercises any of the discretionary functions set forth in ERISA § 3(21)(A). *See, e.g., Health Cost Controls of Ill., Inc. v. Washington*, 187 F.3d 703, 709 (7<sup>th</sup> Cir. 1999)(“ERISA makes the existence of discretion a *sine qua non* of fiduciary status”). As a result, courts routinely hold that persons who carry out the basic fiduciary functions concerning asset management, plan administration, and providing investment advice are fiduciaries under the statute.

The authority to appoint plan fiduciaries is by itself a fiduciary function. 29 C.F.R. § 2509.75-8 at D-4. Moreover, if the plan instrument provides a fiduciary with the right to select and remove other fiduciaries, that person has a continuing duty to monitor those fiduciaries who he/she may remove. 29 C.F.R. § 2509.75-8 at FR-17.

Critically, a person who holds no actual position with a plan may become a fiduciary if he or she exercises *de facto* control over a fiduciary function. Courts have determined that individuals have become *de facto* fiduciaries in numerous different settings. For example, in *Lopresti v. Terwilliger*, 126 F.3d 34 (2d Cir. 1997), the Second Circuit Court of Appeals considered the ERISA fiduciary status of a company’s president. The trial court had determined that the president was not a fiduciary because the plan documents did not provide him with any authority in administering the plan. The Court of Appeals reversed the trial court’s determination and held the president was

a *de facto* ERISA fiduciary because the undisputed evidence demonstrated that the president had commingled plan assets with his company's general assets and used plan assets to pay company creditors. According to the Court of Appeals, these facts established that the president “exercise[d] ... authority or control respecting ... disposition of [plan] assets’ and hence [was] a fiduciary for purposes of imposing personal liability under ERISA.” *Id.*

Likewise, the Seventh Circuit Court of Appeals in *Health Controls of Ill., Inc. v. Washington*, 187 F.3d 703 (7<sup>th</sup> Cir. 1999), found that a third party service provider hired by the plan administrator was a *de facto* fiduciary. In that case, the plan administrator had hired the service provider to oversee the plan's claims reimbursement from participants under its subrogation clause. In determining that the service provider was an ERISA fiduciary, the Court of Appeals noted that after it received assignment of the plan's subrogation claims, the service provider did not consult with the plan administrator when deciding what legal actions to take against the participants to obtain reimbursement for the subrogated claims.

Finally, an employer that acts both as the plan sponsor and the plan administrator may be considered an ERISA fiduciary in certain circumstances. For example, in *Varity Corp. v. Howe*, 516 U.S. 489 (1996), an employer, which also administered its employee welfare benefit plan, distributed materials and held a meeting with its employees during which it convinced approximately 1,500 of the employees to voluntarily transfer to a new subsidiary based upon misrepresentations concerning the subsidiary's financial viability and the security of the employees' future benefits. The U.S. Supreme Court found that the employer's representatives were acting in a fiduciary capacity when they made these

misrepresentations because transmitting information to help plan participants make an informed decision concerning their benefits was a plan-related activity, the persons who made the misrepresentations had authority to communicate as plan fiduciaries, and in the context within which these statements were made, it was reasonable for employees to conclude that the employer was communicating in its capacity as plan administrator.

### **C. Limits to Fiduciary Status**

The Department of Labor regulations implementing ERISA state that an entity which performs “purely ministerial functions . . . within a framework of policies, interpretations, rules, practices and procedures made by other persons is not a fiduciary.” 29 C.F.R. § 2509.75-8 D-2. Such ministerial, non-fiduciary functions include: (1) application of rules for determining an individual’s eligibility for plan participation or benefits; (2) calculation of service and compensation credits for benefits; (3) preparation of employee communications material; (4) preparation of government required reports; (5) maintenance of participants’ service and employment records; (6) calculation of an individual’s benefits; (7) orientation of new participants and advising participants of their rights and options under the plan; (8) collection of contributions and application of contributions as provided in the plan; (9) preparation of reports concerning participants’ benefits; (10) processing of claims; and (11) making recommendations to others for decisions with respect to plan administration. *Id.*; *see also Bollenbacher v. Helena Chemical Co.*, 934 F. Supp. 1015, 1024-25 (N.D. Ind. 1996).

In *Bollenbacher*, the court applied these factors when considering the ERISA fiduciary status of an employer. Under the plan at issue, the employer’s responsibilities in administering it were limited to: executing employee enrollment forms; sending out

claim forms to employees; disseminating information to employees about their benefits under the plan; and providing the insurer with certain personnel information pertaining to employees who applied for benefits. Accordingly, the court held that the employer was not a fiduciary under ERISA because its responsibilities under the plan were simply ministerial in nature and lacked any discretionary authority.

It is also important to keep in mind that a person is an ERISA fiduciary only “to the extent” that he/she performs one of the defined fiduciary functions. Applying this language, courts have repeatedly held that someone who takes on limited fiduciary duties does not become an ERISA fiduciary for all purposes. For example, a number of courts have noted that ERISA fiduciary status is not “an all or nothing concept” and have held that insurers which acquire fiduciary status through adjudicating benefit claims do not thereby assume fiduciary responsibilities for other aspects of plan administration.

In addition, courts have labeled certain decisions which affect ERISA plans, such as plan amendments or termination, as “employer” or “settlor” functions to which fiduciary responsibilities do not apply. In *Curtis-Wright Corp. v. Schoonejongen*, 514 U.S. 73 (1995), the U.S. Supreme Court held that even though an employer may act as a fiduciary when it is administering its employee welfare benefit plan, it is not engaged in plan administration, and therefore not acting as a plan fiduciary, when it decides to create, amend, or terminate an ERISA plan.

In certain circumstances, courts have held that individuals or entities whose titles would suggest fiduciary status are not ERISA fiduciaries because they lack any actual discretionary authority. For example, in *Beddall v. State Street Bank and Trust Co.*, 137 F.3d 12(1<sup>st</sup> Cir. 1998), the court considered whether a “custodial trustee” was an ERISA

fiduciary. The court determined that the custodial trustee was not an ERISA fiduciary because he was only authorized to perform limited administrative and ministerial functions with respect to specific plan investments.

Similarly, individuals who provide professional services or act as advisors to plans, such as attorneys, are generally not considered to be fiduciaries under ERISA unless they assume *de facto* control over specific fiduciary functions. For example, in *Custer v. Sweeny*, 89 F.3d 1156 (4<sup>th</sup> Cir. 1996), the Fourth Circuit Court of Appeals rejected the argument that an attorney who simply provided legal services to a pension fund was an ERISA fiduciary. According to the court, performing professional services which were customary to his profession did “not make the attorney an ERISA fiduciary because legal representation of an ERISA plan rarely involves the discretionary authority or control required by the statute’s definition of ‘fiduciary.’”

However, in *Health Controls of Ill., Inc. v. Washington*, 187 F.3d 703 (7<sup>th</sup> Cir. 1999), the Seventh Circuit Court of Appeals held that a third party service provider hired by the plan administrator to oversee the plan’s claims reimbursement from participants under its subrogation clause was a plan fiduciary. The court reached this conclusion because the service provider did not consult with the plan administrator when deciding what legal actions to take against plan participants when seeking reimbursement for the subrogated claims.

## II. WHAT CONSTITUTES A POTENTIAL BREACH OF FIDUCIARY DUTY

ERISA § 404(a)(1), 29 U.S.C. § 1104(a)(1), imposes four specific statutory duties upon fiduciaries. Under this provision, a fiduciary must act solely in the interests of participants and beneficiaries:

- (a) for the exclusive purpose of:
  - (i) providing benefits to participants and beneficiaries; and
  - (ii) defraying reasonable expenses of administering the plan;
- (b) with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of enterprises of a like character and with like aims;
- (c) by diversifying the investments of the plan so as to minimize risks of large losses; and
- (d) by acting in accordance with plan documents.

Applying this provision, courts have consistently held that ERISA fiduciaries have a duty not to mislead plan participants or misrepresent the terms or administration of the plan. For example, in *Varity Corp. v. Howe*, 516 U.S. 489 (1996), the U.S. Supreme Court held that an employer, which administered its employee welfare benefit plan, breached its ERISA fiduciary duties when it intentionally misrepresented the security of the future benefits for employees who voluntarily agreed to transfer to a new subsidiary. In reaching this decision, the Supreme Court found that transmitting information to help plan participants make an informed decision about plan benefits was a plan-related activity, the persons who made the misrepresentations possessed the authority to act as plan fiduciaries, and in the context within which these statements were made, the

employees could reasonably conclude that the communications were being made in employer's capacity as plan administrator.

In the context of managed care plans, most recent breach of fiduciary litigation has focused on the plan's duty to affirmatively disclose information affecting plan participants. However, courts have reached different conclusions with respect to the duty of a managed care plan to affirmatively disclose information. For example, in *Horvath v. Keystone Health Plan East, Inc.*, 333 F.3d 450 (3d Cir. 2003), a participant in an HMO brought a breach of fiduciary claim under ERISA § 502(a)(3), alleging that the HMO had breached its fiduciary duties by failing to disclose details of cost-control incentives offered to participating physicians. The Third Circuit Court of Appeals rejected this claim. It determined that the HMO had no fiduciary duty to disclose the details of the cost control incentives offered to participating physicians absent evidence that: (1) the participant requested such information; (2) the HMO was on notice that the participant needed such information to prevent her from making a harmful decision; and (3) the participant was actually harmed by not having such information. *See also Ehlmann v. Kaiser Found. Health Plan of Ex.*, 198 F.3d 552 (5<sup>th</sup> Cir.), *cert. denied*, 530 U.S. 1291 (2000)(ERISA does not impose a fiduciary duty on HMOs to disclose physician compensation and reimbursement schemes to plan members).

However, the Eighth Circuit Court of Appeals held in *Shea v. Esensten*, 107 F.3d 625 (8<sup>th</sup> Cir.), *cert. denied*, 118 S.Ct. 297 (1997), that an HMO fiduciary possessed an obligation to affirmatively disclose its financial incentive system with physicians, which the participant alleged had discouraged the physician from referring his patients to specialists. The court found that the participant "had the right to know [the HMO] was

offering financial incentives that could have colored [the] doctor's medical judgment about the urgency for a [referral to a specialist] .... Indeed, in this case the danger of the plan participant's well being was created by the fiduciary itself." According to the court, "[w]hen an HMO's financial incentives discourage a treating doctor from providing essential health care referrals for conditions covered under the plan benefit structure, the incentives must be disclosed and the failure to do so is a breach of ERISA's fiduciary duties." Regardless of whether an HMO has a fiduciary duty to disclose such an incentive program, the program's mere existence should not give rise to an ERISA breach of fiduciary claim. *See, e.g., Weiss v. CIGNA HealthCare of New York, Inc.*, 968 F. Supp. 757 (S.D. N.Y. 1997) (managed care plan did not breach its fiduciary duty to participant by providing financial incentives to physicians to limit referrals to specialists since such incentives were expressly encouraged by federal and state law).

Participants in HMOs have also asserted claims for breach of fiduciary duty based upon certain common plan features. For example, in *Maltz v. Aetna Health Plans of New York, Inc.*, 114 F.3d 9 (2d Cir. 1997), a participant alleged that Aetna's conversion to a capitation-based compensation scheme for participating primary care physicians constituted a breach of fiduciary duty because it interfered with her existing physician-patient relationships, and she sought a preliminary injunction to prohibit Aetna from instituting this compensation structure or taking other steps that would threaten her existing doctor-patient relationships. The Second Circuit Court of Appeals affirmed the trial court's denial of the preliminary injunction. According to the Court of Appeals, Aetna did not breach its fiduciary duty by switching to the capitation-based compensation scheme, even if it resulted in the participant's existing doctors terminating their

relationships with her, as long as other competent physicians were available under the plan.

### **III. CLAIMS FOR BREACH OF FIDUCIARY DUTY**

Fiduciaries may incur liability under ERISA through three different statutory provisions. Liability may arise under: ERISA § 409, 29 U.S.C. § 1109, (which is enforced through ERISA § 502(a)(2), 29 U.S.C. § 1132(a)(2)); ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3); or as a co-fiduciary under ERISA § 405, 29 U.S.C. § 1105.

#### **A. Liability under ERISA §§ 409 and 502(a)(2)**

ERISA § 502(a)(2), 29 U.S.C. § 1132(a)(2), allows for breach of fiduciary duty claims. The provision provides that a “civil action may be brought ... by the Secretary [of Labor], or by a participant or fiduciary for appropriate relief under Section 409 [ 29 U.S.C. § 1109].” In turn, ERISA § 409(a), 29 U.S.C. § 1109(a) states:

Any person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations or duties imposed upon plan fiduciaries by this title shall be personally liable to make good to such plan any losses to the plan resulting from each such breach, and to restore to such plan any profits of such fiduciary which have been made through use of assets of the plan by the fiduciary, and shall be subject to such other equitable or remedial relief as the court may deem appropriate, including removal of such fiduciary ....

ERISA § 409, as enforced through ERISA § 502(a)(2), allows for the recovery of both equitable and legal relief. However, an action under these provisions may only be brought on behalf of the plan itself. They do not provide individual participants with a private cause of action to recover for the recovery of compensatory or punitive damages. *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 136-48 (1985). Instead, the measure of

loss under ERISA § 409 is the restoration of the plan to the position it would have achieved but for the breach.

**B. Liability under ERISA § 502(a)(3)**

ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), allows a participant or beneficiary to bring a cause of action to either enjoin an act or practice which violates either ERISA or a plan's terms or to obtain "other appropriate equitable relief" to redress such violations or to enforce any provisions of ERISA or a plan's terms. In *Varity Corporation v. Howe*, 516 U.S. 489 (1996), the U.S. Supreme Court held that ERISA § 502(a)(3) provides individual participants and beneficiaries with a private cause of action for "appropriate equitable relief" to remedy a breach of fiduciary duty. However, a breach of fiduciary duty claim cannot be brought under ERISA § 502(a)(3) when a participant may obtain an adequate remedy by asserting a claim for wrongful denial of benefits under ERISA Section 502(a)(1)(B). As the Supreme Court explained in *Varity Corporation*, "where Congress elsewhere provided adequate relief for a beneficiary's injury, there will likely be no need for further equitable relief, in which case such relief normally would not be 'appropriate'."

Accordingly, trial courts routinely disposed of breach of fiduciary duty claims when the plaintiff has also asserted a denial of benefits claim under ERISA Section 502(a)(1)(B). *See, e.g., Hyde v. Benicorp Ins. Co.*, \_\_ F. Supp. 2d \_\_, 2005 WL 712480 (D. Kan. 2005)(dismissing plaintiffs' breach of fiduciary claim under ERISA Section 502(a)(3) because they had also brought a claim for wrongful denial of benefits); *Swearingen v. Honeywell, Inc.*, 189 F. Supp. 2d 1189, 1197(D. Kan. 2002)(since plaintiff's allegations related to the processing and denial of her benefit claims, she had

an “adequate remedy” under ERISA Section 502(a)(1)(B) and could not seek equitable relief under ERISA Section 502(a)(3)); *Peach v. Ultramar Diamond Shamrock*, 229 F. Supp.2d 759, 771 (E.D. Mich. 2002)(“[i]f the plaintiff seeks a payment of benefits, then his sole remedy is under 29 U.S.C. § 1132(a)(1)(B)”); *Chiroff v. Life Insurance Company of North America*, 142 F. Supp.2d 1360, 1365-66 (S.D. Fla. 2000) (motion to dismiss breach of fiduciary duty claim granted when plaintiffs also brought a claim for disability benefits under § 1132(a)(1)(B)); *Wilson v. Globe Specialty Products, Inc.*, 117 F. Supp.2d 92, 98 (D. Mass. 2000) (motion to amend to add breach of fiduciary duty claim denied because plaintiffs also sought remedy for denial of benefits under 29 U.S.C. § 1132(a)(1)(B)); *Jones v. American Airlines, Inc.*, 57 F. Supp.2d 1224, 1236 (breach of fiduciary duty claim dismissed where premised on wrongful denial of benefits).

The U.S. Supreme Court most recently considered what constitutes “appropriate equitable relief” for purposes of obtaining a remedy under ERISA § 502(a)(3) in *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 122 S.Ct. 708 (2002). In *Great-West*, the Supreme Court held that the term “equitable relief,” as used in ERISA § 502(a)(3), means something less than “all relief,” and refers to those categories of relief which were typically available in equity. Accordingly, the Court determined that ERISA § 502(a)(3) does not authorize actions for specific performance of ERISA plan provisions if such an action would require the payment of money and would impose personal liability on a party based upon its contractual duties under an ERISA plan. In contrast, the Supreme Court held that a plaintiff could seek restitution under ERISA § 502(a)(3) in the form of a constructive trust or an equitable lien, where money or property identified

as belonging in good conscience to the plaintiff could clearly be traced to particular funds or property in the other party's possession.

Applying *Great-West*, several courts have held that a plan participant or beneficiary cannot seek to recover the value of benefits which would have been paid to them but for the alleged breach of fiduciary duty. For example, in *Clark v. Hewitt Assocs.*, 294 F. Supp. 2d 946 (N.D. Ill. 2003), a beneficiary brought a breach of fiduciary claim against an insurer, claiming that it breached its fiduciary duty by failing to provide her husband (the insured) with an explanation of benefits informing him that it would not pay any benefits if he committed suicide within the first two years of coverage, which unfortunately he had done. However, her prayer for relief requested payment of \$165,000, the amount which would have been payable under the policy. The beneficiary contended that she was “seeking equitable relief – asking the court to ‘estop Defendant from denying coverage based on policy language that neither she nor her husband had ever seen.’” *Id.* The court rejected the beneficiary's argument because she sought payment of the money allegedly owed under the policy, noting that “[a]lmost any legal claim can be given the form of an equitable claim.”

Similarly, in *Kishtner v. Principal Life Ins. Co.*, 186 F. Supp. 438 (S.D. N.Y. 2002), the court rejected a plaintiff's attempt to receive the value of the life insurance benefits he allegedly would have received but for the employer-fiduciary's breach in miscommunicating the policy's terms. The court held that “such an action cannot be considered an action for restitution or one implicating a constructive trust because, under *Great-West*, such remedies are appropriate only where the specific property sought is identifiable and in the hands of the defendant.” As the court noted, “[t]he money

[plaintiff] seeks from [the employer] is the damage he has suffered because [the insurer] will not pay the money it has.”

In *Horvath v. Keystone Health Plan East, Inc.*, 333 F.3d 450 (3d Cir. 2003), a plan participant in an HMO brought a breach of fiduciary claim under ERISA § 502(a)(3) based upon the HMO’s failure to disclose cost-incentives offered to physicians and sought recovery in the form of restitution and disgorgement. In dictum, the court noted that the participant’s “claims for restitution and disgorgement are likely barred by the Supreme Court’s recent decision in *Great-West*” because the defendant possessed “no funds readily traceable to [the participant] over which a constructive trust or other equitable remedy may be imposed.”

### **C. Co-Fiduciary Liability**

ERISA holds co-fiduciaries liable for any breaches of fiduciary duty committed by other fiduciaries, so long as the co-fiduciary: (1) “participates knowingly in, or knowingly undertakes to conceal, an act or omission of such other fiduciary, knowing such act or omission is a breach,” (2) “enabled such other fiduciary to commit a breach,” or (3) “has knowledge of a breach by such other fiduciary, unless he makes reasonable efforts under the circumstances to remedy the breach.” ERISA § 405(a), 29 U.S.C. § 1105. With respect to such liability, the ability of a co-fiduciary to obtain contribution or indemnification from other fiduciaries has been the subject of conflicting decisions. *See, e.g., Free v. Briody*, 732 F.2d 1331, 1337 (7<sup>th</sup> Cir. 1984) (“An award of indemnification within the limited circumstances of this case appears to us to be properly within the court’s equitable powers.”); *but see, Lumpkin v. Envirodyne Indus. Inc.*, 933 F.2d 449, 464 N.10 (7<sup>th</sup> Cir. 1991)(recognizing that the issue of contribution under ERISA “is still

unsettled”); *Mutual Life Ins. Co. v. Yampol*, 706 F. Supp. 596, 597-600 (N.D. Ill. 1989) (holding that ERISA does not expressly address the issue of contribution and that Supreme Court cases have limited available remedies to those expressly set forth in the statute).

The question of whether a non-fiduciary can be held liable under ERISA when acting with a fiduciary that breaches his or her fiduciary responsibilities has also been the subject of significant litigation and uncertainty. The Seventh Circuit Court of Appeals initially held that non-fiduciaries could be found liable. *See Thorton v. Evans*, 692 F.2d 1064, 1078 (7<sup>th</sup> Cir. 1982)(finding that a non-fiduciary who conspires with fiduciaries can be held liable under ERISA). Relying on *dicta* in the Supreme Court’s opinion for *Mertens v. Hewitt Associates*, 508 U.S. 248 (1993), the Seventh Circuit subsequently reversed itself and held that non-fiduciaries could not be found liable. *See Florin v. Nationsbank*, 60 F.3d 1245, 1248 (7<sup>th</sup> Cir. 1996). Finally, the Supreme Court addressed this issue in *Harris Trust & Savings Bank v. Saloman Smith Barney, Inc.*, 530 U.S. 238, 244-54 (2000), holding that non-fiduciaries can be held liable in the context of a prohibited transaction.