

No. 08-810

**In The
Supreme Court of the United States**

—◆—
SALLY L. CONKRIGHT, PATRICIA M. NAZEMETZ,
LAWRENCE M. BECKER, AND XEROX CORPORATION
RETIREMENT INCOME GUARANTEE PLAN,

Petitioners,

v.

PAUL J. FROMMERT, ET AL.,

Respondents.

—◆—
**On Writ Of Certiorari To The
United States Court Of Appeals
For The Second Circuit**

—◆—
**BRIEF OF THE NATIONAL EMPLOYMENT
LAWYERS ASSOCIATION, AS *AMICUS CURIAE*
IN SUPPORT OF RESPONDENTS**

—◆—
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INTEREST OF THE AMICUS¹

The National Employment Lawyers Association (NELA) is the largest professional membership organization in the country comprised of lawyers who represent employees in labor, employment, and civil rights disputes. NELA and its 68 state and local affiliates have a membership of over 3,000 attorneys committed to working for those who have been illegally treated in the workplace. NELA strives to protect the rights of its members' clients, and regularly supports precedent-setting litigation affecting the rights of individuals in the workplace. For example, NELA filed or participated in filing *amicus curiae* briefs in this Court in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989); *Varsity Corp. v. Howe*, 516 U.S. 489 (1996); *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358 (1999); *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002); *Central Laborers' Pension Fund v. Heinz*, 541 U.S. 739 (2004); and *LaRue v. DeWolff, Boberg & Assocs.*, 552 U.S. 248 (2008).

Regarding the first question presented, in NELA's view, mandatory judicial deference is not warranted under the circumstances of this case for two reasons.

¹ Pursuant to Supreme Court Rule 37.6, *amicus* states that no person or entity other than *amicus curiae* and its undersigned counsel made a monetary contribution to the preparation or submission of this brief. No attorney for any party to this matter authored this brief in whole or in part. The parties have separately consented to the filing of this brief.

First, where the claim is one for benefits under 29 U.S.C. § 1132(a)(1)(B), requiring judicial deference to a plan interpretation articulated by the administrator for the first time outside the ERISA-mandated claim process would undermine both the protections afforded by that process to plan participants and the effectiveness of the process in promoting efficient resolution of benefit claims. Second, where a benefit claim arises from a statutory violation, mandatory judicial deference would undermine the statutory remedies for such violations and the discretion granted to district courts to implement statutory remedies.

For these reasons, *amicus* respectfully requests that the Court consider its views in support of Respondents.



SUMMARY OF ARGUMENT

This case comes before the Court in an unusual posture. Respondents originally filed claims under two subsections of ERISA's civil enforcement provision: ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), which authorizes, *inter alia*, a claim for appropriate equitable relief from a violation of the statute; and ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), which provides for, *inter alia*, a claim for benefits owing to a participant under the terms of a plan. *See Varsity Corp. v. Howe*, 516 U.S. 489, 512 (1996). The Second Circuit found that Respondents' employer, Xerox, had failed to comply with ERISA's requirement for advance

notice of plan amendments that reduce future pension benefit accruals and had violated ERISA's prohibition on retroactive pension benefit cutbacks. *Frommert v. Conkright*, 433 F.3d 254, 266-68 (2d Cir. 2006) ("*Frommert I*"); see ERISA § 204(g), (h), 29 U.S.C. § 1054(g), (h).

Notwithstanding that Section 1132(a)(3), by its terms, would seem to be the obvious choice to remedy a statutory violation – through appropriate equitable relief – the Second Circuit upheld the dismissal of Respondents' Section 1132(a)(3) claim and instead remanded for the district court to fashion relief under Section 1132(a)(1)(B). *Frommert I*, 433 F.3d at 268-70. In contrast, other courts addressing similar circumstances have held that equitable relief in the form of reformation or an injunction mandating that a plan term be given a specific meaning, to be followed by a Section 1132(a)(1)(B) claim for benefits under that plan term, is the proper course. See *Ross v. Rail Car America Group Disability Income Plan*, 285 F.3d 735, 740-41 (8th Cir. 2002). In this case, however, the Second Circuit chose to combine these two steps into one under Section 502(a)(1)(B). *Frommert I*, 433 F.3d at 269. As a result, this is not a typical Section 1132(a)(1)(B) case: it is not a claim for pension, disability, health, or severance benefits under the established terms of a plan. Cf. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989); *Metropolitan Life Ins. Co. v. Glenn*, 128 S. Ct. 2343 (2008).

Nonetheless, the first question presented to this Court, whether a district court must defer to an

ERISA plan administrator's interpretation of the terms of the plan arrived at outside the context of an administrative claim for benefits, is framed extremely broadly. As a result, this Court's answer to the first question potentially affects a wide-ranging class of garden-variety benefits claims, placing in jeopardy a well-established body of law respecting the question of deference.

Based on this settled body of law and the policy considerations supporting ERISA's claim process for benefit claims, the first question presented should be answered in the negative as to the type of claim at issue in this case: a claim for benefits pursuant to 29 U.S.C. § 1132(a)(1)(B).² The ERISA-mandated claim process plays a critical role in facilitating resolution of claims and – for those claims not resolved in the claim process – developing a record for efficient judicial review. The claim process achieves this goal by requiring that a plan administrator clearly articulate the rationale for a claim denial, permit the participant to review pertinent documents, and allow the participant to challenge the denial by an appeal. The lower courts have enforced these requirements, and thereby promoted the effective use of the claim process, by requiring that plan participants exhaust this process before seeking judicial review of their claims and by refusing to defer to plan administrator

² In the context of other claims authorized by ERISA's civil enforcement provision, this case presents no occasion for this Court to consider the availability of deference.

determinations arrived at outside the confines of this process. By declining to defer to plan interpretations reached outside this process when adjudicating benefits claims, courts promote the efficient use of the claim process and enable the claim process to perform these important functions. Thus, the Second Circuit correctly held that, on a claim for benefits under 29 U.S.C. § 1132(a)(1)(B), a court need not defer to a plan interpretation arrived at by a fiduciary outside this process. *Frommert v. Conkright*, 535 F.3d 111, 119 (2d Cir. 2008) (“*Frommert II*”). Additionally, mandatory judicial deference should play no role where, as here, a benefits claim arises from a violation of the statute that carries with it a statutory remedy. For these reasons, the judgment of the court of appeals should be affirmed.

◆

ARGUMENT

I. REQUIRING JUDICIAL DEFERENCE TO PLAN INTERPRETATIONS ARRIVED AT OUTSIDE THE CLAIM PROCESS WOULD UNDERMINE THE CLAIM PROCESS AND FRUSTRATE ERISA’S POLICY GOALS.

A. The Claim Process Promotes Efficient Resolution of Benefits Claims, Minimizing Administrative and Financial Burdens on Plans and Participants.

In the context of a claim for benefits, a plan administrator’s discretionary authority to interpret

the plan is exercised through the claim process mandated by 29 U.S.C. § 1133.³ This claims procedure provision and the Department of Labor regulations issued thereunder⁴ require that employee benefit plans establish and follow reasonable procedures for the adjudication of claims and appeals. The claim procedure must be set forth in the plan documents and reiterated in notices of adverse benefit determinations sent to participants. 29 C.F.R. § 2560-503.1(b)(2), (g)(1)(iv), (j)(4). First and foremost, the claim process requires that for every denied benefit claim, the plan administrator clearly communicate its reasons for denying the claim, afford the participant access to the documents and information that form the basis of the denial, permit the participant to appeal the denial to an appropriate named fiduciary and, if the denial is affirmed on appeal, clearly

³ ERISA § 503 provides as follows:

In accordance with regulations of the Secretary, every employee benefit plan shall –

(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and

(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

29 U.S.C. § 1133.

⁴ 29 C.F.R. § 2560.503-1.

explain the rationale for the affirmance. 29 U.S.C. § 1133; 29 C.F.R. § 2560.503-1(g), (h), (m).

The purpose of the claim process has been summarized as follows: “to minimize the number of frivolous ERISA lawsuits; promote the consistent treatment of benefit claims; promote a nonadversarial dispute resolution process; and decrease the cost and time of claims settlement.” *Makar v. Health Care Corp. of Mid-Atl.*, 872 F.2d 80, 83 (4th Cir. 1989) (citation omitted). To ensure that the claim process can effectively serve these functions, the circuits have unanimously held that a participant must exhaust these procedures before a claim for benefits can be brought under 29 U.S.C. § 1132(a)(1)(B).

At the same time, the claim process is designed to foster a “meaningful dialogue” between plan administrators and participants regarding benefits claims. *See Gilbertson v. Allied Signal, Inc.*, 328 F.3d 625, 635 (10th Cir. 2003) (“ERISA’s procedural regulations are meant to promote accurate, cooperative, and reasonably speedy decision-making, not to generate an endless stream of business for employment lawyers.”). The requirement that plan administrators clearly inform participants of the basis for a claim denial ensures that participants can adequately “prepare for any further administrative review, as well as an appeal to the federal courts.” *Richardson v. Cent. States Se. & Sw. Areas Pension Fund*, 645 F.2d 660, 665 (8th Cir. 1981). The claim process also assists courts by defining and refining contested issues and establishing a claim record, facilitating

efficient judicial review of claims not resolved in the claim process. In this way, the claim process advances two of the core public policy goals of ERISA and the federal common law created thereunder: to facilitate the provision of benefits to employees by minimizing the administrative and financial burdens of benefit plans, and to establish the minimum procedural and substantive safeguards. *See Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990); *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 148 (1985); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983). As discussed below, the effectiveness of the claim process in achieving these goals would be severely undermined were courts adjudicating benefits claims required to defer to plan interpretations arrived at by plan administrators outside of this process.

B. The Department of Labor Recognizes That Deferential Review Should Not Be Required for Benefit Decisions Reached Outside the Claim Process.

In promulgating its claim procedure regulation under 29 U.S.C. § 1133, the Secretary of Labor has explained that no deference is due to a plan administrator's discretionary decision unless the decision is reached in compliance with the claim process. The regulations specify that if a plan fails to establish or follow claim procedures consistent with the regulations, a participant "shall be deemed to have exhausted the administrative remedies available under the plan and shall be entitled to pursue any available

remedies under section 502(a).” 29 C.F.R. § 2560.503-1(l). The Secretary’s preamble to the regulations explains that this provision is intended “to clarify that the procedural minimums of the regulation are essential to procedural fairness and that a decision made in the absence of the mandated procedural protections should not be entitled to any judicial deference.” (65 Fed. Reg. 70246, 70255 n. 39 (Nov. 21, 2000)). Thus, the Secretary of Labor recognizes that in relation to claims for benefits, deferential review should not be required for plan interpretations reached outside the claim process.⁵

C. The Lower Courts Repeatedly Hold That in Adjudicating 29 U.S.C. § 1132(a)(1)(B) Claims, Judicial Deference Is Not Required Where a Plan Interpretation Is Reached for the First Time Outside the Claim Process.

Recognizing the importance of maintaining the integrity of the claim process, the circuit courts have

⁵ Regulations enacted pursuant to the Department’s rule-making authority “have the force of law . . . and are to be given controlling weight unless they are found to be arbitrary, capricious, or manifestly contrary to the statute.” *Freeman v. Nat’l Broad. Co.*, 80 F.3d 78, 82 (2d Cir. 1996) (citing *United States v. Nixon*, 418 U.S. 683, 695 (1974)); *Chevron v. Natural Res. Def. Council, Inc.*, 476 U.S. 837, 843-44 (1984). The Department’s interpretations of its own regulations are generally entitled to deference as well. *Auer v. Robbins*, 519 U.S. 452, 461 (1997).

repeatedly held that judicial deference is not required where a plan interpretation was reached for the first time outside the claim process. See *Matuszak v. Torrington Co.*, 927 F.2d 320, 323 (7th Cir. 1991) (“This Court would emasculate ERISA’s disclosure requirement if it were to defer to reasons that the Board first identified on appeal in the District Court, years after the decision at issue. No plan can authorize such a result, so *Firestone* requires that we review the Board’s decision *de novo*.”); *Marolt v. Alliant Techsystems, Inc.*, 146 F.3d 617, 620 (8th Cir. 1998) (“We will not permit ERISA claimants denied the timely and specific explanation to which the law entitles them to be sandbagged by after-the-fact plan interpretations devised for purposes of litigation.”); see also *Univ. Hosps. of Cleveland v. Emerson Elec. Co.*, 202 F.3d 839, 849 n. 7 (6th Cir. 2000) (“[I]t strikes us as problematic to, on one hand, recognize an administrator’s discretion to interpret a plan by applying a deferential ‘arbitrary and capricious’ standard of review, yet, on the other hand, allow the administrator to ‘shore up’ a decision after-the-fact by testifying as to the ‘true’ basis for the decision after the matter is in litigation”).⁶

⁶ Indeed, some circuit courts have refused to even consider – much less defer to – rationales for claim denials that do not appear in the administrative record. *King v. Hartford Life & Accident Ins. Co.*, 414 F.3d 994, 999-1000 (8th Cir. 2005) (“When reviewing a denial of benefits by an administrator who has discretion under an ERISA-regulated plan, a reviewing court ‘must focus on the evidence available to the plan administrators

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Where an administrator with discretion attempts to adopt in litigation a rationale articulated in the claim process by another entity, the courts of appeal have held that deference is not required because the administrator failed to exercise its discretion during the claim process. See *Shelby County Health Care Corp. v. Majestic Star Casino, LLC*, 581 F.3d 355, 365 (6th Cir. 2009) (“Where a plan administrator does not make the benefits decision, the plan administrator has not exercised its discretionary authority, and therefore a deferential standard of review is not justified.”).⁷

at the time of their decision and may not admit new evidence or consider *post hoc* rationales.”); *Glista v. Unum Life Ins. Co. of Am.*, 378 F.3d 113, 132 (1st Cir. 2004) (“Under these circumstances, we think the ‘appropriate equitable relief’ is to hold Unum to the basis that it articulated in its internal claims review process for denying benefits. . . . In addition to driving up the cost of proceedings, Unum’s failure [to raise additional rationales in the claims process] may well have prevented a more efficient resolution of this case.”); *Dishman v. Unum Life Ins. Co. of Am.*, 269 F.3d 974, 986-87 (9th Cir. 2001) (“[T]he fact that UNUM may be able, post-hoc, to offer a legally plausible justification for its termination of Dishman’s benefits is irrelevant.”); *Conley v. Pitney Bowes*, 176 F.3d 1044, 1048-49 (8th Cir. 1999) (“It is true that in reviewing a denial of benefits under an employee welfare plan subject to ERISA, a court must focus on the evidence available to the plan administrators at the time of their decision and may not admit new evidence or consider *post hoc* rationales.”).

⁷ See also *Sanford v. Harvard Indus., Inc.*, 262 F.3d 590, 597 (6th Cir. 2001); *Sharkey v. Ultramar Energy Ltd.*, 70 F.3d 226, 229 (2d Cir. 1995); *Nelson v. EG&G Energy Measurements Group, Inc.*, 37 F.3d 1384, 1389 (9th Cir. 1994); *Rodriguez-Abreu*

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Likewise, courts have declined to defer to benefit decisions reached outside claim process deadlines imposed by plan or the regulations, again because the purportedly discretionary plan interpretation was not reached during the claim process. *See Gritzer v. CBS, Inc.*, 275 F.3d 291, 296 (3d Cir. 2002) (“Where a trustee fails to act or to exercise his or her discretion, de novo review is appropriate because the trustee has forfeited the privilege to apply his or her discretion; it is the trustee’s analysis, not his or her right to use discretion or a mere arbitrary denial, to which a court should defer.”).⁸

To be sure, some courts have accorded deference where a plan administrator, although technically out of compliance with claim procedure requirements, has nonetheless acted in such a way as to promote the goals of the claim process. *See Gilbertson v. Allied Signal, Inc.*, 328 F.3d 625, 634 (10th Cir. 2003)

v. Chase Manhattan Bank, N.A., 986 F.2d 580, 584 (1st Cir. 1993); *Baker v. Big Star Div. of the Grand Union Co.*, 893 F.2d 288, 290-91 (11th Cir. 1989) (as amended Jan. 29, 1990).

⁸ *See also Rasenack ex rel. Tribolet v. AIG Life Ins. Co.*, ___ F.3d ___, 2009 WL 3526490, *3, *5 (10th Cir. Nov. 2, 2009); *Burke v. PriceWaterHouseCoopers LLP Long Term Disability Plan*, 572 F.3d 76, 80 (2d Cir. 2009); *Strom v. Siegel Fenchel & Peddy P.C. Profit Sharing Plan*, 497 F.3d 234, 243-44 (2d Cir. 2007); *Nichols v. Prudential Ins. Co. of Am.*, 406 F.3d 98, 109 (2d Cir. 2005); *Jebian v. Hewlett-Packard Employee Benefits Org. Income Protection Plan*, 349 F.3d 1098, 1104, 1108 (9th Cir. 2003); *Gilbertson*, 328 F.3d at 631-32; *Univ. Hosps. of Cleveland*, 202 F.3d at 846 n. 3; *Mansker v. TMG Life Ins. Co.*, 54 F.3d 1322, 1328 (8th Cir. 1995).

“Courts have also been willing to overlook administrators’ failure to meet certain procedural requirements when the administrator has substantially complied with the regulations and the process as a whole fulfills the broader purposes of ERISA and its accompanying regulations.”⁹ But all of these courts recognize the paramount importance of fostering effective use of the claim process by participants and plan administrators by limiting judicial deference in circumstances where discretion has not been exercised during the claim process. *See Jebian v. Hewlett-Packard Employee Benefits Org. Income Protection Plan*, 349 F.3d 1098, 1108 (9th Cir. 2003) (“The prospect of de novo review of untimely decisions should therefore only spur administrators into producing timely, reasoned decisions – exactly what ERISA aims to achieve.”)¹⁰

⁹ *See also LaMantia v. Voluntary Plan Admins., Inc.*, 401 F.3d 1114, 1123-24 (9th Cir. 2005); *Seman v. FMC Corp. Ret. Plan for Hourly Employees*, 334 F.3d 728, 733 (8th Cir. 2003); *McGarrah v. Hartford Life Ins. Co.*, 234 F.3d 1026, 1031 (8th Cir. 2000), *abrogated on other grounds by Chronister v. Unum Life Ins. Co. of Am.*, 563 F.3d 773, 775 (8th Cir. 2009).

¹⁰ The existence of the claim process defeats analogies to trust law in answering the first question presented. Petitioners admit that the trust law authorities on which they rely arise from a system that lacks ERISA’s pre-litigation claim process for benefit claims. “Indeed, under the law of trusts, there is no analogue to the administrative claims process in which ERISA benefits are originally determined.” (Pet. Br., at 33.) As a result, trust law principles that contemplate that a trustee’s discretion to interpret will be exercised for the first time in litigation have no relevance to this case. ERISA benefit claims arise under a

(Continued on following page)

In sum, “deferential review under the ‘arbitrary and capricious’ standard is merited for decisions regarding benefits *when they are made in compliance with the plan procedures.*” *Sanford*, 262 F.3d at 597 (emphasis added). To promote the effective use of the claim procedures, this Court should decline to hold that in the benefit claim context, courts must always defer to a plan administrator’s determination without regard to whether it was reached in the claim process.

D. An Affirmative Answer to the First Question Presented Would Render the Claim Process Ineffective, Defeat the Purposes of Exhaustion, Increase Litigation, Drive Up Plan Costs, and Deprive Participants of ERISA-Mandated Protections.

As the cases cited above recognize, the claim process cannot serve its salutary purposes if courts, in deciding claims under 29 U.S.C. § 1132(a)(1)(B), must disregard the results of the claim process and instead defer to an interpretation by a plan administrator with discretion regardless of the circumstances under which the interpretation was rendered. Requiring deference in the situation contemplated by the first question presented would frustrate rather

regime that contemplates the opposite: that plan interpretations relating to benefit claims will be arrived at and articulated in the claim process.

than further the salutary effect of the claim process. A requirement that courts adjudicating benefit claims defer to plan interpretations arrived at for the first time in litigation would reduce the incentive for plan administrators to reach a reasoned decision in the claim process. Such a rule would encourage sloppy decisionmaking and inadequate notice to participants, promoting litigation. *See Richardson*, 645 F.2d at 664 (“While we have no desire to complicate the lives of the Trustees, or to require a lengthy reasoned opinion in every case, we do feel that the Trustees are obligated to briefly state the facts of the case and the rationale for their decision. In this way, the Trustees may begin to build a body of precedent that will ultimately bring about a form of consistency otherwise lacking in the administration of the Fund.”).

Requiring deference to plan interpretations raised for the first time in litigation would also undermine ERISA’s goal to provide for procedural fairness and consistent plan application. Plan administrators would be encouraged to take extreme or experimental positions during the claim process, confident that if these positions are ultimately found to be arbitrary and capricious, the court will be required to defer to a subsequent interpretation. Nor would mandatory deference sought by Petitioners further consistent plan interpretations, at least at the claim level, because plan administrators would have no need to ensure that their interpretations were consistent and

complete prior to litigation.¹¹ The claim process simply cannot serve its salutary purpose if it is effectively optional for plan administrators, in that they are not bound by plan interpretations they reach in the claim process.

E. This Court’s Decisions Do Not Require Deference Under the Circumstances of This Case.

As the cases cited above demonstrate, this Court’s decisions do not require judicial deference in the context of a 29 U.S.C. § 1132(a)(1)(B) claim where a plan interpretation has been rendered outside the claim process. *Glenn* addresses discretionary determinations on benefits claims that were the product of pre-litigation decision-making. *See* ERISA § 503, 29 U.S.C. § 1133 (prescribing claim process for benefits claims); *Glenn*, 128 S. Ct. at 2350 (discussing how conflict of interest should be weighed as a factor “on judicial review of a discretionary benefit determination”); *see also Firestone*, 489 U.S. at 1115 (holding that the default standard of review for benefit claim denials is de novo review). *Firestone* and

¹¹ The claims process is intended to ensure consistent plan interpretations and the regulations require that “a plan’s claims procedures must include administrative safeguards and processes designed to ensure and to verify . . . that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants.” 65 Fed. Reg. 70246-01, 70251.

Glenn have nothing to say on the question whether, in applying a plan term, a court is obligated to afford deference to an administrator's newly-minted determination reached outside the claim process. Likewise, *Central States, Southeast & Southwest Areas Pension Fund v. Central Transport, Inc.*, 472 U.S. 559 (1985), cited by Petitioners, where this Court accorded "significant weight" to a trustee's interpretation of plan terms as conferring a right to conduct an audit, does not involve a benefit claim subject to the claim process or judicial review under ERISA § 502(a)(1)(B). *Id.* at 568. For the same reason, cases in the lower courts that extend *Firestone* deference to certain non-benefits determinations have no application here. See, e.g., *Moench v. Robertson*, 62 F.3d 553, 564-66 (3d Cir. 1995) (holding that under certain circumstances, deferential review may apply to plan investment decisions alleged to be breaches of fiduciary duty). Conversely, the question in this case, which is before the Court as a benefit claim case, is whether deferential review is required for plan interpretations reached outside the claim process. Thus, *Moench* and similar case law also relied upon by Petitioners have no bearing on the question of whether deferential review is appropriate to non-benefit determinations.

F. Remand to the Plan Administrator Is Only Appropriate When It Will Preserve the Integrity of the Claims Process.

In order to preserve the integrity of the claims process, courts should not be required to remand issues to the plan administrator that have already been subject to that process. The lower courts have developed a body of law addressing when remand to the administrator is an appropriate remedy following an arbitrary and capricious claim decision: remand is appropriate to ensure that participants receive a full and fair review process or to fully develop factual issues, but it is not appropriate to resolve legal issues or where the evidence compels only one reasonable conclusion. In the present case, after the Court of Appeals rejected Petitioners' original plan interpretation as arbitrary and capricious and its attempted amendment as a violation of ERISA §§ 204(h) and 204(g), something had to be done to determine the proper interpretation of the plan so as to provide the participants with the correct benefits, and the district court was instructed to craft an appropriate remedy. *Frommert I*, 433 F.3d at 268. *Amici* for Petitioners have suggested that the proper course of action was to remand the issue to the plan administrator. Brief for *Amicus Curiae* ERISA Industry Committee at 17-18. But this solution is inefficient, undermines the court's ability to bring finality to the litigation, and is contrary to well-established law under ERISA § 502(a)(1)(B). Courts remand matters to the plan to

preserve the integrity of the claims process and promote efficient claims resolution, not to rehash issues that have already been subject to that process.

Section 502(a)(1)(B) itself provides the basic remedy for an arbitrary and capricious plan decision because it explicitly empowers courts to directly enforce the terms of the plan by ordering that benefits be paid according to the terms of the plan. 29 U.S.C. § 1132(a)(1)(B). But, in some situations, ordering benefit payments is premature or otherwise inefficient without first remanding undecided issues back to the plan administrator. For example, in *Saffle v. Sierra Pacific Power Co. Bargaining Unit Long Term Disability Plan*, the Ninth Circuit found that the plan administrator had abused its discretion by imposing a benefits eligibility requirement that could not be squared with the plain language of the plan terms. 85 F.3d 455, 460-61 (9th Cir. 1996). But because the claims process and subsequent litigation had been premised on a faulty understanding of the plan, the court instructed that the claim should be remanded to the plan administrator for further claims procedures consistent with the court's interpretation of the plan. *Id.* Importantly, the *Saffle* court did not remand the issue on which the plan had already reached an arbitrary interpretation – whether the plan incorporated reasonable accommodations into the standard of disability – rather, it decided that issue and remanded so that the participant could pursue her claim based on the correct interpretation. *Id.* Similarly, the Third Circuit held that where a plan

abused its discretion and violated ERISA by failing to have an adequate review process for adverse benefits determinations, the underlying question of the participant's eligibility should be determined by the plan in the first instance, but only *after* the district court had approved the adoption of appropriate claim procedures. *Grossmuller v. Int'l Union*, 715 F.2d 853, 859 (3d Cir. 1983). The court did not leave the development of claim review procedures to the discretion of the plan administrator. *Id.*

Preserving the integrity of the claims process is the unifying principle of the federal common law that courts have developed on whether remand to the plan is appropriate following a finding that the plan administrator made an arbitrary and capricious decision. For example, courts will remand if it is necessary for the plan administrator to review evidence not before the administrator on the original determination. *See, e.g., Miller v. United Welfare Fund*, 72 F.3d 1066, 1071 (2d Cir. 1995). Or, like the *Saffle* case, courts can remand when the plan administrator has applied the wrong standard of disability to the claim, after the court has clarified the correct standard of disability. *See, e.g., Patterson v. Hughes Aircraft Co.*, 11 F.3d 948, 951 (9th Cir. 1993) (rejecting plan administrator's interpretation of term "mental disorder" and remanding to the plan for reevaluation in light of court's interpretation of the term); *King v. Hartford Life & Acc. Ins. Co.*, 414 F.3d 994, 1005-06 (8th Cir. 2005) (remanding to administrator after determining the correct standard of accidental death). In some

situations, where it is not clear from the record that an adverse decision was wrong, courts will remand if the plan administrator has failed to adequately explain the grounds of its decision or otherwise did not provide an adequate claims process, thereby denying the participant an opportunity to prepare a complete record. *See, e.g., DeGrado v. Jefferson Pilot Financial Ins. Co.*, 451 F.3d 1161, 1176 (10th Cir. 2006); *Quinn v. Blue Cross & Blue Shield Ass'n*, 161 F.3d 472, 477 (7th Cir. 1998) (remand appropriate where administrator “fails to make adequate findings or fails to provide adequate reasoning”); *Buffonage v. Prudential Ins. Co. of America*, 426 F.3d 20, 31-32 (1st Cir. 2005) (remanding to administrator so that participant could “have the benefit of an untainted process”). In all of these situations, remand is appropriate because it will enable the claims process to perform the salutary function for which it was designed: to provide a low-cost nonadversarial means for resolving claims and establishing the record for subsequent litigation.

In situations where remand to the plan will not facilitate a better claims process and more efficient resolution of the dispute, courts have overturned arbitrary and capricious decisions and directly awarded benefits. For example, in *Hackett v. Xerox Corp. Long-Term Disability Income Plan*, the Seventh Circuit held that it was inappropriate to remand an arbitrary and capricious decision back to the administrator for further procedures where benefits had been paid for years and the administrator lacked credible evidence

to discontinue the claim. 315 F.3d 771, 776 (7th Cir. 2003). The court reasoned that in such a situation courts should restore the status quo – payment of benefits – whereas remand for more claims procedures might be appropriate where benefits had never been paid in the first instance. *Id.* Similarly, in *Zervos v. Verizon New York, Inc.*, the Second Circuit held that remand to the administrator is not appropriate where the claim record was complete, but the administrator’s decision to deny benefits was unreasonable on that record. 277 F.3d 635, 648 (2d Cir. 2002). In this situation, requiring further claims procedures will do nothing but prolong the case, raising rather than lessening the costs of claims resolution. If the record clearly establishes that the participant is entitled to benefits, the most efficient resolution is for the court to simply exercise its power to award benefits under ERISA section 502(a)(1)(B).

Under this body of law, the present case does not warrant remand to decide the contested issue of plan interpretation. Petitioners had the opportunity to, and in fact did, develop an interpretation of the disputed plan provisions during the claims process and there is no suggestion by any party that this claims process was inadequate. The circumstances of the case do not require any additional evidentiary development, and remand to the administrator for a do-over on the interpretation issue will not yield any benefits for subsequent litigation. Instead, the district court should be free to determine the correct interpretation of the plan in its own sound discretion,

as the Second Circuit held it was. Then, as happened in *Saffle*, *King* and *Grossmuller*, the claims should be remanded to the administrator to determine the amount of benefits each participant is entitled to in light of that interpretation.

II. THE DISTRICT COURT SHOULD NOT BE REQUIRED TO DEFER TO THE PLAN ADMINISTRATOR'S PROPOSED REMEDY FOR ITS OWN STATUTORY VIOLATION.

The Second Circuit's second decision in *Frommert v. Conkright* also affirmed the district court's remedy for the plan administrator's violation of ERISA § 204(h), 29 U.S.C. § 1054(h). The Second Circuit had recommended in its earlier opinion that "[o]n remand, the remedy crafted by the district court for those employees rehired prior to 1998 should utilize an appropriate pre-amendment calculation to determine their benefits." *Frommert II*, 535 F.3d at 116 (citing *Frommert I*, 433 F.3d at 268). It also recognized "the difficulty that this task poses because of the ambiguous manner in which the pre-amendment terms of the Plan described how prior distributions were to be treated" and "suggest[ed] that it may wish to employ equitable principles when determining the appropriate calculation and fashioning an appropriate remedy."¹² *Id.*

¹² As discussed earlier, the issue of appropriate remedies could and should be avoided entirely by properly casting this case as a claim for breach of fiduciary duty, pursuant to ERISA
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ERISA § 204(h) contains a built-in remedy: it requires that the improper amendment be deemed void, and the plan enforced according to its pre-amendment terms. But here, as noted by the Second Circuit in *Frommert II*, the prior plan “addresses the situation of a discharged-and-then-rehired employee with what can only be described as ambiguity, contradiction or silence” and, thus, the district court was required to remedy the statutory violation by crafting its own interpretation of the exiting plan terms. The Second Circuit affirmed the district court’s solution as the “selection of one reasonable approach among several reasonable alternatives.” *Frommert II*, 535 F.3d at 119 (citing *Lifson v. INA Life Ins. Co. of N.Y.*, 333 F.3d 349, 353 (2d Cir. 2003) (per curiam)). Petitioners argue that the court should have looked to the plan administrator itself to craft a remedy for its own violation of ERISA § 204(h). But generally, where the remedy for a statutory violation requires analysis beyond the automatic implementation of a remedy prescribed by the statute itself, “these choices are, of course, left in the first instance to the district courts. However, such discretionary choices are not left to the court’s inclination, but to its judgment; and its judgment is to be guided by sound legal principles.” *See Albermarle Paper Co. v. Moody*, 422 U.S. 405, 416 (1975) (citation omitted). In addition, any equitable remedy crafted by a district court is subject to review

§ 502(a)(3), 29 U.S.C. § 1132(a)(3), for which the statute prescribes remedy by “appropriate equitable relief.”

by a court of appeal. *See, e.g., Downie v. Independent Drivers Ass'n Pension Plan*, 934 F.2d 1168, 1170 (10th Cir. 1991).

By arguing that the Court is required to defer to the remedy proposed by the plan administrators, rather than accepting the remedy ordered by the district court, Petitioners seek to place the plan administrator in the shoes of the district court and expand the deference given to plan administrators far beyond the scope of plan interpretations within the claim process. The district court should not be required to defer to the plan administrator's proposed remedy, where it is based on a *post hoc* interpretation of ambiguous plan provisions.



CONCLUSION

For the foregoing reasons, the National Employment Lawyers Association urges the Court to affirm the Second Circuit's decision in *Frommert v. Conkright*, 535 F.3d 111 (2d Cir. 2008).

Respectfully submitted,

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