I. What Constitutes an ERISA Plan?

The First Circuit has broken down ERISA’s statutory definition into the following five elements: (1) a plan, fund, or program (2) established or maintained (3) by an employer (4) for the purpose of providing medical, surgical, or hospital care, or sickness, accident, disability, death, or unemployment or vacation benefits (5) to participants or their beneficiaries. Wickman v. Nw. Nat’l Ins. Co., 908 F.2d 1077, 1082 (1st Cir.), cert. denied, 498 U.S. 1013 (1990) (quoting Donovan v. Dillingham, 688 F.2d 1367, 1371 (11th Cir. 1982) (en banc)).

A. Determining the Existence of an Employee Welfare Benefit Plan

A “plan, fund, or program” exists if “from the surrounding circumstances a reasonable person can ascertain the intended benefits, a class of beneficiaries, the source of financing, and the procedures for receiving benefits.” Wickman, 908 F.2d at 1082 (citing Donovan, 688 F.2d at 1373). “A plan need not be in writing to be covered by ERISA so long as the plan is a reality, meaning something more than a mere decision to extend benefits.” O’Leary v. Provident Life & Accident Ins. Co., 456 F. Supp. 2d 285, 293–94 (D. Mass. 2006). The First Circuit has held that a “plan” can be established or maintained through purchase of insurance; however, the purchase of insurance, standing alone, is not sufficient to establish a plan. Wickman, 908 F.2d at 1082. Where an employer purchases insurance for employees, “the crucial factor in determining if a ‘plan’ has been established is whether the purchase of the insurance policy constituted an expressed intention by the employer to provide benefits on a regular and long term basis.” Id. at 1083; Aguirre-Santos v. Pfizer Pharm., LLC, No. CIV. 12-1393 JAF, 2013 WL 5724061 (D.P.R. Oct. 21, 2013) (payment of severance benefits and insurance premiums for time specified in employment contract did not rise to level of an ongoing administrative scheme where there was nothing discretionary about timing, amount, or form of the payment). “Similarly, whether a reasonable employee would perceive an ongoing commitment by the employer to provide employee benefits is an important consideration.” New Eng. Mut. Life Ins. Co. v. Baig, 166 F.3d 1, 4 (1st Cir. 1999).

The purchase of “a group policy or multiple policies covering a class of employees offers substantial evidence that a plan . . . has been established.” Wickman, 908 F.2d at 1083; Baig, 166 F.3d at 4 (“[W]hen an employer deals directly with the insurer and actually purchases an insurance policy for an employee [as opposed to merely paying an employee enough to purchase his or her own insurance policy], there may be sufficient participation to meet the ‘established or maintained’ requirement under ERISA.”). A plan is unlikely to be established, however, where the purchase of insurance is an “isolated and aberrational incident.” Id. An employer’s distribution of a handbook or summary plan description (SPD) detailing ERISA rights is “strong evidence that the employer has adopted an ERISA regulated plan.” Id. However, “the absence of such documentation should not necessarily lead to a finding that there was no plan under ERISA.” Baig, 166 F.3d at 5 n.6. Any part of a benefits plan that addresses ERISA welfare benefits is governed by ERISA. See Balistracci v. NSTAR Elec. & Gas Corp., 449 F.3d 224, 229 (1st Cir. 2006).

As to the second element—whether the plan, fund or program is “established or maintained”—the issue is “whether from the surrounding circumstances a reasonable person can ascertain the intended benefits, a class of beneficiaries, the source of financing, and procedures for receiving benefits.” Gehrmann, 2016 WL 5816988, at *8 (quoting Wickman, 908 F.2d at 1082). The First Circuit will also consider Congress’s dual purpose of reducing the threat of abuse or mismanagement and eliminating the threat of conflicting and inconsistent state and local regulation. Demars v. Cigna Corp., 173 F.3d 443, 446 (1st Cir. 1999). In Gross v. Sun Life Assurance Co. of Can., 734 F.3d 1 (1st Cir. 2013), the plaintiff argued that employer’s long-term disability (LTD) policy, which was voluntary and employee-funded, was not an ERISA plan. Plaintiff sought to isolate the LTD policy from the remaining insurance
benefits available to separately evaluate whether ERISA applied to it. *Id.* at 5. The First Circuit refused to isolate the LTD policy from the employer’s entire insurance package for purposes of determining whether there was an employee welfare benefits plan. *Id.* at 8. The court reasoned that a “‘plan’ under ERISA may embrace one or more policies . . . and it strikes us as both impractical and illogical to segment insurance benefits that are treated as a single group and managed together, potentially placing some under ERISA and some outside the statute’s scope.” *Id.* Focusing on the facts demonstrating that the employer treated the life, accidental death, and disabilities policies as a unit, the court held that the LTD policy at issue was governed by ERISA. *Id.* at 8–9.

B. Definition of “Employee” for ERISA Purposes

In *Kwatcher v. Mass. Serv. Employees Pension Fund*, 879 F.2d 957, 959–60 (1st Cir. 1989), the court held that a sole shareholder of a closely held corporation was an “employer” and therefore could not be an “employee” and thereby a “participant” in an ERISA plan. The U.S. Supreme Court, however, overruled *Kwatcher*. See *Yates v. Hendon*, 541 U.S. 1 (2004). In *Yates*, the Court expressly rejected the *Kwatcher* court’s holding that a “working owner” is not a “participant” in the company’s ERISA benefits plan. *Id.* at 16. As the Court noted, affording “participant” status to working owners promotes ERISA’s purpose of establishing uniformity, by avoiding the anomaly of the same plan being governed by separate regimes. *Id.* at 17. *Yates* held that a working owner is a “participant” to the extent that the owner participates in a plan with other employees, but it leaves open the question of whether a plan that covers only the working owner is governed by ERISA.

Mere classification as a “common law” employee does not mandate coverage as a participant under an ERISA plan. *Edes v. Verizon Commc’n, Inc.*, 417 F.3d 133, 137 (1st Cir. 2005). Instead, courts should look to the explicit plan language to determine which employees qualify as “participants” under an ERISA plan. See *id.* (citing *Kolling v. Am. Power Conversion Corp.*, 347 F.3d 11, 14 (1st Cir. 2003)).

C. Interpretation of the Safe Harbor Regulation

In *Johnson v. Watts Regulator Co.*, 63 F.3d 1129 (1st Cir. 1995), the court held that an employer must satisfy all four “safe harbor” criteria in order to avoid ERISA. *Id.* at 1133. That is, to be exempt from ERISA, a plan must meet the following four criteria established by the U.S. Department of Labor (DOL) at 29 C.F.R. § 2510.3-1(j): (1) no contributions are made by the employer or employee organization; (2) participation in the plan is completely voluntary; (3) the employer permits the insurer to publicize the program to its employees and collects premiums through payroll deduction and remits them to the insurer, but the employer does not endorse the plan; and (4) the employer receives no consideration for its administrative services other than reasonable compensation. See also *Ferraro v. Unum Life Ins. Co. of Am.*, 765 F. Supp. 2d 53, 56 (D. Me. 2011). Although the court specifically addressed only the “endorsement” factor, it held more generally that employer “neutrality” is key to safe harbor protection, but that remaining neutrality does not require an employer to “build a moat around a program or to separate itself from all aspects of program administration.” *Johnson*, 63 F.3d at
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1134. The issue of “endorsement” depends on whether “in light of all the surrounding facts and circumstances, an objectively reasonable employee would conclude on the basis of the employer’s actions that the employer had not merely facilitated the program’s availability but had exercised control over it or made it appear to be part and parcel of the company’s own benefit package.” Id. at 1135.

The First Circuit also refused to examine an employer’s LTD policy, which was voluntary and employee-funded, independently from the rest of the employer’s insurance benefits plan. Gross, 734 F.3d at 10–11. Because the employer fully funded its life and accidental-death policies, the court found that the safe harbor exemption did not apply. Id. at 10. It also reasoned that the employer endorsed the LTD plan by determining which employees had access to the benefit. Id.

D. Amount of Employer Involvement Required to Sustain an Employee Welfare Benefit Plan

As long as the employer “merely advises employees of the availability of group insurance, accepts payroll deductions, passes them on to the insurer, and performs other ministerial tasks that assist the insurer in publicizing the program, it will not be deemed to have endorsed the program.” Johnson, 63 F.3d at 1134. In that case, the First Circuit held that an employer’s activities in terms of issuing certificates to covered employees, maintaining a list of insured persons, and assisting the insurer in securing appropriate claims documentation were merely “administrative tasks,” and that the employer had no “role in the substantive aspects of program design and operation” and therefore had not “endorsed” the accidental-death plan underwritten by the insurer. See id. at 1136. In Ferraro, the court found that the employer “endorsed” the plan where one of the employees was listed as the plan administrator and where the employer distributed a handbook to employees that described the LTD coverage in question in connection with other benefits the employer provided. 765 F. Supp. 2d 59. The court rejected plaintiff’s contention that safe harbor status existed because annual meetings were held by an insurance brokerage and because an agent of the insurer handled enrollment. Id.

E. Treatment of Multiple Employer Trusts and Welfare Agreements

First Circuit courts utilize the same criteria to establish whether an employee benefit plan exists without regard to the single or multiple employer context. See, e.g., Wickman, 908 F.2d at 1082; Jervis v. United Ass’n of Plumbers & Pipefitters Local Union No. 51 Pension Fund, No. 12-478 ML, 2013 WL 5704653, at *8 (D.R.I. Oct. 17, 2013).

F. De Facto Plan Administrators

“[T]he proper party defendant in an action concerning ERISA benefits is the party that controls administration of the plan.” Terry v. Bayer Corp., 145 F.3d 28, 36 (1st Cir. 1998) (internal quotation marks and citations omitted). “There is an exception to this general rule: If an entity or person other than the named plan administrator takes on the responsibilities of the administrator, that entity may also be liable for benefits.” Gomez-Gonzalez v. Rural Opportunities, Inc., 626 F.3d 654, 665 (1st Cir. 2010) (citing Law v. Ernst & Young, 956 F.2d 364, 372–73 (1st Cir. 1992)). See also
Golden Star, Inc. v. Mass Mut. Life Ins. Co., 22 F. Supp. 3d 72 (D. Mass. 2014) (service provider for 401(k) plans was a functional fiduciary when it had discretion to set the rate of its management fees in connection with its management of separate investment accounts). However, “the mere exercise of physical control or the performance of mechanical administrative tasks generally is insufficient to confer fiduciary status.” Tetreault v. Reliance Standard Life Ins. Co., 769 F.3d 49, 60 (1st Cir. 2014); Beddall v. State St. Bank & Trust Co., 137 F.3d 12, 18 (1st Cir. 1998). Accordingly, the First Circuit has determined that when the plan administrator retains discretion to decide disputes, a third-party service provider is not a fiduciary of the plan and thus is not amenable to a suit under § 1132(a)(1)(B). Terry, 145 F.3d at 35–36.

G. Cases Addressing Government Plans

Title I of ERISA does not apply to an employee benefit plan “if . . . such plan is a governmental plan . . .” 29 U.S.C. § 1003(b)(1). These plans include those “established or maintained” for employees by the government of the United States, by the government of any state or political subdivision thereof, or by any agency or instrumentality of any of the foregoing. Id. § 1002(32). Because ERISA does not define “political subdivision” or “agency or instrumentality,” this can lead to uncertainty as to whether ERISA applies. See, e.g., Caranci v. Blue Cross & Blue Shield of R.I., 194 F.R.D. 27, 33 (D.R.I. 2000). Yet most First Circuit district courts have easily disposed of the question. See, e.g., Grillo v. UniCare Life & Health Ins. Co., 109 F. Supp. 3d 377, 379 (D. Mass. 2015); Livingston v. Unum Provident, No. 2:14-cv-70-DBH, 2014 WL 4215433, at *3 (D. Me. Aug. 25, 2014); Hall v. Maine Mun. Employees Health Trust, 93 F. Supp. 2d 73, 80 (D. Me. 2000). The First Circuit has yet to address the governmental plan definition directly.

H. Cases Addressing Church Plans

The First Circuit has yet to directly address the contours of ERISA’s church plan definition. Consequently, courts have looked outside the First Circuit to analyze ERISA’s definition. See, e.g., Martinez-Gonzalez v. Catholic Sch. of Archdioceses of San Juan Pension Plan, No. 16-2077, 2017 WL 382711, at *1 (D.P.R. Jan. 27, 2017) (citing Rollins v. Dignity Health, 830 F.3d 900, 904–05 (9th Cir. 2016); Stapleton v. Advocate Health Care Network, 817 F.3d 517, 519 (7th Cir.), cert. granted, 137 S. Ct. 546 (2016); Kaplan v. Saint Peter’s Healthcare Sys., 810 F.3d 175, 177 (3d Cir. 2015)); Catholic Charities of Me., Inc. v. City of Portland, 304 F. Supp. 2d 77, 85 (D. Me. 2004) (citing Lown v. Cont’l Cas. Co., 238 F.3d 543, 547 (4th Cir. 2001)).

The Supreme Court clarified, in Advocate Health Care Network v. Stapleton, that a nonprofit church-affiliated organization may maintain a church plan, even if the plan was not originally established by a church. 137 S. Ct. 1652, 1663 (2017).

II. Preemption

A. Scope of ERISA Preemption

the Supreme Court held that ERISA preempts state law and provides exclusive federal remedies for disputes over the payment of benefits under ERISA-regulated employee benefit plans. Congress designed the statute in that manner in order “to promote uniformity in the nationwide regulation of employee benefit plans.” Carrasquillo v. Pharmacia Corp., 466 F.3d 13, 20 (1st Cir. 2006). In Pilot Life, the Supreme Court noted that ERISA contains a broad, general preemption clause that expressly “supersedes any and all state laws insofar as they may now or hereafter relate to any employee benefit plan.” 481 U.S. at 45 (quoting 29 U.S.C. § 1144(a)). Accordingly, the Court has held that ERISA implicates two separate types of preemption: “express preemption” and “complete” or “conflict preemption.” Id. at 47. See also Carrasquillo, 466 F.3d at 20 (“The Supreme Court has identified two instances where a state cause of action relates to an employee benefit plan: where the cause of action requires ‘the court’s inquiry [to] be directed to the plan,’ or where it conflicts directly with ERISA.”).

1. Express Preemption

When determining whether a state law “relates to” an ERISA plan, the term “state law” is expansively defined under ERISA to include “all laws, decisions, rules, regulations, or other State action having the effect of law, of any State.” 29 U.S.C. § 1144(c)(1). Moreover, Congress used the words “relate to” in their “broad common-sense meaning” of having “a connection with or reference to . . . a plan.” Pilot Life, 481 U.S. at 47; Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 96–97 (1983). Express preemption under ERISA “involves two central questions: (1) whether the plan at issue is an ‘employee benefit plan’ and (2) whether the cause of action ‘relates to’ this employee benefit plan.” McMahon v. Digital Equip. Corp., 162 F.3d 28, 36 (1st Cir. 1998). A state law claim “relates to” an ERISA plan if “it has a connection with or reference to such a plan,” Carlo v. Reed Rolled Thread Die Co., 49 F.3d 790, 793 (1st Cir. 1995), or if “the trier of fact necessarily would be required to consult the ERISA plan to resolve the plaintiff’s claims.” Harris v. Harvard Pilgrim Health Care, 208 F.3d 274, 281 (1st Cir. 2000) (“state-law claims for unfair and deceptive trade practices are preempted by ERISA” because the court necessarily would have to refer to the plan to determine whether the defendant breached its duties). See also Vartanian v. Monsanto Co., 14 F.3d 697, 700 (1st Cir. 1994) (state law expressly preempted if “in order to prevail, [plaintiff] must plead, and the court must find, that an ERISA plan exists”).

“Of course, not every conceivable connection will support preemption. For example, state laws that merely exert an indirect economic influence on a plan do not bind plan administrators to any particular choice and, thus, do not come within ERISA’s preemptive reach.” Merit Constr. Alliance v. City of Quincy, 759 F.3d 122, 128 (1st Cir. 2014) (internal quotations omitted) (concluding that city ordinance requiring contractors on public works projects to operate a state-approved apprentice training program was “too intrusive to withstand ERISA preemption” because it mandated the structure of the program, as well as how it needed to be administered). A state law has a “connection with” an ERISA plan if it impedes ERISA’s goal of achieving “nationally uniform administration of employee benefit plans.”
Pharm. Care Mgmt. Ass'n v. Rowe, 429 F.3d 294, 302 (1st Cir. 2005) (quoting N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 657 (1995)); see also Merit Constr. Alliance, 759 F.3d at 129. ERISA will not preempt a state law that allows plan administrators freedom to structure plans similarly from state to state. Rowe, 429 F.3d at 303. ERISA will preempt a law, however, that establishes an “alternative enforcement mechanism for ERISA plan benefits” as long as that alternative enforcement mechanism affects relationships between “the [ERISA] plan, administrators, fiduciaries, beneficiaries, and employer.” Carpenters Local Union No. 26 v. U.S. Fid. & Guar. Co., 215 F.3d 136, 140–41 (1st Cir. 2000).

A state law “references” an ERISA plan if the existence of an ERISA plan is “essential” to the operation of the law. See Rowe, 429 F.3d at 303. If deletion of the reference to an ERISA plan in the statute would render that law “inoperable,” the ERISA plan is “essential” to the law. See id. at 304. Therefore, ERISA will preempt state laws that either “single[] out ERISA plans for special treatment [or] depend[] on their existence as an essential part of its operation.” Carpenters Local, 215 F.3d at 145.

In both Carlo, 49 F.3d at 793–94, and Vartanian, 14 F.3d at 700, the First Circuit held that state law misrepresentation claims against employers/plan administrators concerning claimants’ entitlement to benefits were expressly preempted because the court would necessarily be required to consult the plan in order to analyze plaintiffs’ claims and/or compute the damages claimed by the plaintiffs. See also Carrasquillo, 466 F.3d at 20 (relying on Carlo to hold that state law claims are preempted where in order to decide those claims, “the court’s inquiry would necessarily ‘be directed to the Plan’”); Altshuler v. Animal Hosps., Ltd., 901 F. Supp. 2d 269 (D. Mass. 2012) (holding that state law claims were preempted by ERISA because they “arise from the same nucleus of related facts stemming from [plaintiff’s] disagreement with [administrator’s] loose administration of [ERISA retirement plan]”).

In Golas v. Homeview, Inc., 106 F.3d 1 (1st Cir. 1997), the court refused to decide whether misrepresentation claims brought against an insurance broker/agent, prior to the plaintiff’s enrollment in a plan, were preempted. In dicta, the majority stated that the claims would be preempted under Vartanian if the defendant was an agent of the plaintiff’s employer or the insurance company that issued and decided claims under the disability policy in question. Id. at 4 n.5. A concurrence would have found no preemption based on an assumption that the defendant was an independent broker and not an agent of an ERISA fiduciary. See id. at 9–10. In Toomajanian v. Insight Global, Inc., 32 F. Supp. 3d 80, 83 (D. Mass. 2014), the court distinguished Carlo, 49 F.3d 790, finding ERISA did not preempt misrepresentation and promissory estoppel claims against an employer, where the employee did not procure extended insurance coverage through the Consolidated Omnibus Budget Reconciliation Act (COBRA) based on the employer’s representation that employer-provided health insurance would provide ongoing coverage for his hospitalization. The court held the claims against his employer were not preempted because the employee was “not looking to recover benefits allegedly due to him under the ERISA Plan,” but was looking to recover “out-of-pocket medical bills [that were] neither defined by, nor limited to, the benefits he would have been entitled to under the Plan had he remained an employee.” Toomajanian, 32 F. Supp. 3d at 82.
2. Conflict or Complete Preemption

In addition to express preemption, which is subject to ERISA’s insurance savings clause, ERISA also implicates “conflict preemption” or “complete preemption,” which is not. Pursuant to the doctrine of “conflict preemption,” ERISA preempts state laws to the extent that they “conflict[] with the provisions of ERISA or operate[] to frustrate its objects,” irrespective of the savings clause. Boggs v. Boggs, 520 U.S. 833, 841 (1997); John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank, 510 U.S. 86, 99 (1993) (“‘where [that] law stands as an obstacle to the accomplishment of the full purposes and objectives of Congress,’ federal preemption occurs”) (quoting Silkwood v. Kerr-McGee Corp., 464 U.S. 238, 248 (1984)).

In Pilot Life, the Supreme Court noted that ERISA’s civil enforcement scheme “is one of the essential tools for accomplishing the stated purposes of ERISA,” 481 U.S. at 52, and the statute’s “civil enforcement remedies were intended to be exclusive.” Id. at 54. “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.” Id. Subsequent to Pilot Life, the Court held that state law claims that serve to “supplement or supplant” ERISA’s exclusive remedial scheme are necessarily preempted. Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 379–80 (2002). Two years later, the Court held that where the plaintiff’s claims are brought by an ERISA entity against an ERISA entity, where plaintiff, 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 the defendant’s actions, then the plaintiff’s cause of action is completely preempted. Aetna Health Inc. v. Davila, 542 U.S. 200, 221 (2004).

In Negron-Fuentes v. UPS Supply, 532 F.3d 1, 6–7 (1st Cir. 2008), the First Circuit stated that § 502(a)(1)(B) of ERISA “does displace related state law causes of action, triggering complete preemption and allowing for removal.... Removability thus turns on whether any of [plaintiff’s] claims .... are in substance duplicated or supplanted by the ERISA cause of action (in which case removal based on complete preemption is proper) or instead whether all are directed at violation of a ‘legal duty .... independent of ERISA or the plan terms.’ ....”; see also Coon-Retelle v. Verizon New Eng. Inc., No. 16–11530, 2017 WL 1234115, at *3 (D. Mass. Mar. 10, 2017) (confirming ERISA “converts an ordinary state common law complaint into one stating a federal claim for purposes of the well-pleaded complaint rule” but holding, in that case, that ERISA did not preempt claims concerning failure to pay wages, misclassification as an independent contractor, and failure to provide overtime compensation).

B. Preemption of State Antisubrogation Laws

A number of states have passed antisubrogation laws, which are statutes barring an insurance company from seeking reimbursement of benefits already paid to an insured. Under ERISA’s savings clause, 29 U.S.C. § 1144(b)(2)(A), state laws that regulate insurance are saved from preemption. These statutes have been challenged in the circuits, other than the First Circuit, with varying degrees of success. However, no states in the First Circuit have yet passed antisubrogation laws.
C. Preemption of Managed Care Claims

ERISA preempts state laws that constitute “alternative enforcement mechanisms” to ERISA or to ERISA plans. See Danca v. Private Health Care Sys., Inc., 185 F.3d 1, 5 (1st Cir. 1999) (holding that “state law tort suits that allege the improper processing of a claim for benefits under an ERISA covered plan . . . fall within the scope of [ERISA] § 502(a)” and are preempted, regardless of whether such claims otherwise might be “saved” under ERISA’s insurance savings clause). In Danca, the court held that plaintiff’s state law claims based on the defendant health maintenance organization’s (HMO’s) decision to deny plaintiff’s physician’s recommendation for in-patient treatment were preempted pursuant to the principles articulated in Pilot Life. Id. at 6. Although the allegedly negligent decision making could be characterized as medical in nature, “[w]hat matters, in our view, is that the conduct was indisputably part of the process used to assess a participant’s claim for a benefit payment under the plan. As such, any state-law based attack on this conduct would amount to an ‘alternative enforcement mechanism’ to ERISA’s civil enforcement provisions contained in ERISA § 502(a). . . .” Id. Similarly, in Hotz v. Blue Cross & Blue Shield of Mass., Inc., 292 F.3d 57, 61 (1st Cir. 2002), the court relied on Pilot Life to hold that plaintiff’s “bad faith” claims under Massachusetts General Laws chapters 93A and 176D were preempted. The court held that these state statutes offered remedies “at odds” with those available under ERISA. Id. The court rejected the argument that Unum Life Ins. Co. of Am. v. Ward, 526 U.S. 358 (1999), alters Pilot Life’s holdings. Hotz, 292 F.3d at 60–61. See also Brenner v. Metro. Life Ins. Co., No. 11-12096-GAO, 2013 WL 1337367, at *7 n.1 (D. Mass. Mar. 29, 2013) (state law claims based on unfair/deceptive trade practices preempted by ERISA).

These cases must be viewed in light of subsequent Supreme Court opinions regarding preemption of managed care claims in Moran, 536 U.S. at 373–74, and Davila, 542 U.S. at 209. In Moran, the Court held that an Illinois law requiring HMOs to provide services if a reviewing physician found such services medically necessary was not preempted under Pilot Life. 536 U.S. at 373–74. The Court held that the law did not provide a “new cause of action” or “new form of ultimate relief” and did not “enlarge the claim beyond the benefits available” in an action under ERISA. Id. at 379–80. In Davila, the Court rejected plaintiffs’ attempts to use state law to remedy damages they claimed to have suffered as a result of the defendants’ denial of plaintiffs’ health care claims. 542 U.S. at 209. The Court held that the claims were preempted because plaintiffs could have brought claims for benefits under ERISA and plaintiffs’ claims implicated no legal duties independent of ERISA. Id. at 213–14.

D. Preemption of Malpractice Claims

In McMahon v. Digital Equip. Corp., 162 F.3d 28 (1st Cir. 1998), the First Circuit held that ERISA preempted plaintiff’s characterization of her short-term disability benefit claim as a claim for malpractice. It reasoned that the plan administrator “was not a managed care provider; it was not responsible for providing McMahon with medical care, but rather for determining whether McMahon was eligible for short-term disability leave. Whether [the administrator] performed this responsibility
properly clearly ‘relates to’ the terms of Plan 502.” *Id.* But see *W.E. Aubuchon Co. v. BeneFirst, LLC*, 661 F. Supp. 2d 37, 46 (D. Mass. 2009) (noting that state law malpractice claims brought by the plan against the third-party administrator are generally not preempted).

**E. ERISA’s Insurance “Savings Clause”**

ERISA does not preempt state laws regulating insurance, specifically those that are (1) directed toward entities engaged in insurance; and (2) substantially affect risk-pooling. *Ky. Ass’n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 341–42 (2003). *See also Hotz v. Blue Cross & Blue Shield of Mass., Inc.*, 292 F.3d 57, 60 (1st Cir. 2002); *Summersgill v. E.I. du Pont de Nemours & Co.*, No. 13-CV-10279, 2014 WL 1032732, at *5 (D. Mass. Mar. 18, 2014). In *Hotz*, the First Circuit applied a two-pronged analysis, holding first that the state statutes in question did not come within the savings clause, and second that they were nonetheless preempted by conflict preemption principles, as discussed in Section D. 292 F.3d at 60–61. With respect to the savings clause analysis, the *Hotz* court found the clause inapplicable because the remedies provided by chapter 93A of the Massachusetts General Laws were not “unique” to the insurance industry but rather applied more generally to unfair commercial practices in any industry. *Id.* In so doing, the *Hotz* court applied the McCarran-Ferguson factors that have since been abandoned by the Supreme Court. *See Miller*, 538 U.S. at 339–40. Although the *Hotz* court’s savings clause analysis is subject to reexamination after *Miller*, the savings clause aspect of the case was rendered moot by the Supreme Court’s confirmation in *Moran*, 536 U.S. at 373–74, and *Davila*, 542 U.S. at 209, that ERISA preempts state law remedies that “supplement or supplant” ERISA’s exclusive enforcement regime, regardless of the savings clause. Since the *Hotz* court held that the state statutes in question offered remedies “at odds” with ERISA, its belt-and-suspenders savings clause discussion is dicta. *See also Summersgill*, 2014 WL 1032732 (holding ERISA preempted the beneficiary’s state law claims under state statutes allowing heath benefit plans to include coverage for religious non-medical care providers (Christian Science care facility); *Me. Educ. Ass’n Benefits Trust v. Cioppa*, 842 F. Supp. 2d 373, 380 (D. Me. 2012) (holding that ERISA’s savings clause preempted Maine statutes allowing school districts to obtain their own aggregate loss information from health insurers and requiring school districts to use this information to obtain competitive bids for employee health insurance every five years).

**F. Preemption of State Law Equitable Claims**

In *Zipperer v. Raytheon Co.*, 493 F.3d 50, 53 (1st Cir. 2007), *cert. denied*, 552 U.S. 1184 (2008), the plaintiff claimed that under state law principles of estoppel, he was entitled to a higher benefit than provided by the plan terms, due to incorrect benefit estimates distributed by the administrator. The First Circuit rejected that argument, holding that “even a narrow reading of section 514(a)’s ‘related to’ provision yields a conclusion that [plaintiff’s] claims are preempted, and that is because the claims can only be evaluated with respect to Raytheon’s recordkeeping responsibilities for the plan. Such responsibilities were part and parcel of Raytheon’s plan administration.”
The court added that “[s]ubjecting Raytheon’s plan administration to the state law scrutiny [plaintiff] seeks would conflict with ERISA’s proscription against state law ‘mandating plan administration’ and would also impermissibly create ‘an alternative enforcement scheme’ to ERISA’s own recordkeeping and reporting requirements.”

Id. at 54; see also Forristall v. Fed. Exp. Corp., 61 F. Supp. 3d 186, 191 (D. Mass. 2014) (finding that employee’s claims against employer for misrepresenting coverage under the plan were preempted because they touched on employer’s recordkeeping and disclosure duties as an ERISA plan administrator, which included providing participants with an accurate written description of the plan (citing Zipperer, 493 F.3d at 54)); cf. Toomajanian v. Insight Global, Inc., 32 F. Supp. 3d 80, 83 (D. Mass. 2014) (holding ERISA did not preempt promissory estoppel claims against an employer where the employee did not procure extended insurance coverage through COBRA based on employer’s representation that employer-provided health insurance would provide ongoing coverage for his hospitalization).

III. Exhaustion of Administrative Remedies

A. Is Exhaustion an Absolute Requirement?

A claimant seeking benefits under an ERISA plan must typically exhaust administrative remedies prior to filing suit. See Terry v. Bayer Corp., 145 F.3d 28, 36 (1st Cir. 1998). In Medina v. Metro. Life Ins. Co., 588 F.3d 41, 47 (1st Cir. 2009), the court held that a “plaintiff who wishes to raise an ERISA claim in federal court must first exhaust all administrative remedies that the fiduciary provides.” The Medina court reviewed defendant’s determination with respect to plaintiff’s claim for short-term disability benefits but dismissed the complaint as to plaintiff’s request for LTD benefits. The court found that plaintiff had not actually filed a claim for long-term benefits and therefore could not proceed in federal court without first exhausting administrative remedies. Id. at 47.

B. Exceptions to the Exhaustion Requirement


The inadequacy exception has been properly invoked where the relief sought is of an urgent nature, such as a threat to the claimant’s health or life. Watts v. Organogenesis, Inc., 30 F. Supp. 2d 101, 104 (D. Mass. 1998) (“A failure to exhaust ‘is
easily forgiven for good reason, and no reason is better than an imminent threat to life or health.”) (quoting Ezratty v. Puerto Rico, 648 F.2d 770, 774 (1st Cir. 1981)).

District courts have held that exhaustion of administrative remedies is unnecessary when the claims brought are based exclusively on statutory violations of ERISA itself. See, e.g., Agosto v. Academia Sagrada Corazon, 739 F. Supp. 2d 90, 93 (D.P.R. 2010) (“majority position . . . holds that where a plaintiff brings an action under ERISA for a statute-based claim, the plaintiff is not first obligated to pursue administrative remedies before seeking relief in the federal courts”); Alexander v. Fujitsu Bus. Commc’n Sys., Inc., 818 F. Supp. 462, 471 (D.N.H. 1993) (“exhaustion of administrative remedies is unnecessary when plaintiffs’ claim is based on a statutory violation of ERISA”).

C. Consequences of Failure to Exhaust

The failure to exhaust administrative remedies is not a jurisdictional bar. Sidou v. UnumProvident, 245 F. Supp. 2d 207, 216 (D. Me. 2003). Rather, because ERISA itself does not specifically mandate exhaustion, courts apply the requirement as a matter of judicial discretion. Tarr v. State Mut. Life Assurance Co. of Am., 913 F. Supp. 40, 44 (D. Mass. 1996). The exhaustion doctrine has been held to serve important policy considerations, including (1) the reduction of frivolous litigation; (2) the promotion of consistent treatment of claims; (3) the provision of a nonadversarial method of claims settlement; (4) the minimization of costs of claims settlement; (5) a proper reliance on administrative expertise; and (6) the development of a complete record for review by the courts. Terry, 145 F.3d at 40; Tarr, 913 F. Supp. at 44. In noting these considerations, the First Circuit found that “[i]t would be anomalous if the same reasons which led Congress to require plans to provide remedies for ERISA claimants did not lead courts to see that those remedies are regularly utilized.” Terry, 145 F.3d at 40 (internal citation omitted).

When a complaint is dismissed solely on exhaustion grounds, it should be dismissed without prejudice as premature. Rivera-Diaz v. Am. Airlines, Inc., 229 F.3d 1133 (1st Cir. 2000). Plaintiffs remain free to pursue their administrative remedies under the plan, and to return to court to assert any claims they may have once they have exhausted that process. Id.; see also Belanger v. Healthsource of Me., 66 F. Supp. 2d 70, 73 (D. Me. 1999). Where the failure to exhaust constituted the filing of an appeal after the plan’s internal appeal deadline had run; however, the court dismissed the case with prejudice. See Terry, 145 F.3d at 36.

D. Minimum Number of Levels of Administrative Review

No First Circuit case has expressly decided how many levels of administrative review a claimant may be required to exhaust. The First Circuit has held, however, that a participant must attend all of the internal appeals opportunities provided by the plan prior to bringing suit. Medina, 588 F.3d at 47; Terry, 145 F.3d at 36; Drinkwater, 846 F.2d at 826.

E. Can a Defendant Waive a Failure-to-Exhaust Defense?

A defendant waived a failure-to-exhaust defense because “when [plaintiff] had first filed this lawsuit, the Plan had not yet resolved his benefits claim despite a
significant passage of time.” *Bard v. Boston Shipping Ass’n*, 471 F.3d 229, 235 (1st Cir. 2006). “Faced with no decision from the Board, [plaintiff] brought suit on a ‘deemed exhausted’ basis” and the First Circuit found that defendant “[had] expressly waived any claim that [plaintiff] failed to exhaust his administrative remedies prior to filing suit.” *Id.* at 235 n.6.

**F. Issue Exhaustion**

The First Circuit has not specifically addressed whether an ERISA claimant must exhaust individual issues as well as claims. In *Liston v. Unum Corp. Officer Severance Plan*, 330 F.3d 19, 26 (1st Cir. 2003), however, the court stated in dicta that in order to pursue discovery requests during litigation, “the issue should be raised in the first instance during the claims process.”

**IV. Standard of Review**

**A. Plan Language**


There are no “magic words” necessary to confer discretionary authority. *See Brigham v. Sun Life of Can.*, 317 F.3d 72, 81 (1st Cir. 2003). However, the First Circuit has been clear that the existence of discretion in the plan must be unambiguous and specific in its retention of discretionary authority. In *Stephanie C. v. Blue Cross Blue Shield of Mass. HMO Blue, Inc.*, 813 F.3d 420 (1st Cir. 2016), the plan stated, “BCBS decides which health care services and supplies that you receive (or you are planning to receive) are medically necessary and appropriate for coverage.” *Id.* at 428. The insurer argued that the language describing the “power to decide” was sufficient to support the discretionary standard of review. The court disagreed and found that the language merely restated the obvious as to who made decisions regarding whether benefits were payable. But, whether the plan actually granted discretion required a much clearer set of directives. The court held: “Clarity of language is crucial to accomplishing a grant of discretionary authority under an ERISA plan, and the Certificate lacks that degree of clarity. Under our case law, the ‘BCBS decides’ language falls well short of what is needed for a clear grant of discretionary authority.” *Id.*
By contrast, in *Terry v. Bayer Corp.*, 145 F.3d 28, 37 (1st Cir. 1998), the court held that language that “specifically allocates to the Company the right to find necessary facts, determine eligibility for benefits, and interpret the terms of the Plan” is sufficient to compel an arbitrary and capricious standard of review. In *Gannon v. Metro. Life Ins. Co.*, 360 F.3d 211, 213–14 n.1 (1st Cir. 2004), the plan specifically granted the plan administrator “discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits.” This language was sufficient for the court to apply the arbitrary and capricious standard of review. See id.

However, in *Gross v. Sun Life Assurance Co. of Can.*, 734 F.3d 1 (1st Cir. 2013), the First Circuit considered whether plan language stating that the claimant must provide “satisfactory proof of claim” and that “[p]roof must be satisfactory to Sun Life” was sufficient to trigger deferential arbitrary and capricious review. The court held that such plan language was insufficient to trigger deferential review. Id. at 15–16. The court further held that plan language stating that “[p]roof must be satisfactory to Sun Life” was also insufficient. Id. The court “reiterate[d] that no precise words are required. Yet, to secure discretionary review, a plan administrator must offer more than subtle inferences drawn from such unrevealing language.” Id. at 15–16.

Finally, although the First Circuit has not specifically addressed this issue, district courts within the circuit have held that a grant of discretion appearing in the certificate of insurance or SPD, but not in the policy, is sufficient to warrant deferential review particularly where the terms of the certificate/SPD are expressly incorporated into the plan. See *Tetreault v. Reliance Standard Life Ins. Co.*, No. 10-11420-JLT, 2011 WL 7099961, at *6 (D. Mass. Nov. 28, 2011); *Bonanno v. Blue Cross & Blue Shield of Mass.*, No. 10-11322-DJC, 2011 WL 4899902, at *7 n.4 (D. Mass. Oct. 14, 2011) (noting that insurer could rely on language in SPD to show it had discretionary authority); see also *Maher v. Mass. Gen. Hosp. LTD Plan*, 665 F.3d 289, 292 (1st Cir. 2011) (reviewing the “plan instruments” including the SPD to determine if the plan delegated fiduciary responsibility).

**B. Arbitrary and Capricious**

When the court concludes that the plan language is sufficient to grant the administrator discretion in the interpretation and application of plan provisions, the court must afford deference to the administrator’s exercise of that discretion. *Colby v. Union Sec. Ins. Co. & Mgmt. Co. for Merrimack Anesthesia Assocs. LTD Plan*, 705 F.3d 58, 61 (1st Cir. 2013). “Therefore judicial review is for abuse of discretion or to determine if the decision was arbitrary and capricious. Whatever label is applied, the standard asks whether the decision is plausible in light of the record as a whole, or, put another way, whether the decision is supported by substantive evidence in the record.” *Niebauer v. Crane & Co., Inc.*, 783 F.3d 914, 923 (1st Cir. 2015). See also *Leahy v. Raytheon Co.*, 315 F.3d 11, 17 (1st Cir. 2002). A reviewing court must decide only whether the administrator’s decision was irrational with any doubts tending to be resolved in favor of the administrator. *Cannon v. Aetna Life Ins. Co.*, No. 12-10512, 2013 WL 5276555, at *5 (D. Mass. Sept. 17, 2013). “The question is not which side we believe is right, but whether the administrator had substantial
evidentiary grounds for a reasonable decision in its favor.” Ortega-Candelaria, 755 F.3d at 20. Although this is a deferential standard, it is not without some bite. There is a sharp distinction between deferential review and no review at all. McDonough v. Aetna Life Ins. Co., 783 F.3d 374, 379 (1st Cir. 2015).

C. Effect of Conflict of Interest or Procedural Irregularity

Prior to the Supreme Court’s ruling in Metro. Life Ins. Co. v. Glenn, 554 U.S. 105 (2008), the First Circuit addressed the issue of “conflict of interest” on several occasions and held that a so-called “inherent conflict,” without more, cannot change or heighten that standard. See Wright v. R.R. Donnelley & Sons Co. Group Benefits Plan, 402 F.3d 67 (1st Cir. 2005); Leahy, 315 F.3d at 16; Pari-Fasano v. ITT Hartford Life & Accident Ins. Co., 230 F.3d 415 (1st Cir. 2000); see also Fenton, 400 F.3d at 90 (recognizing that a stricter standard of review applies only when the plan participant can show that the administrator was improperly motivated to make the adverse determination).

In the First Circuit, a procedural irregularity in the review of a benefit claim renders the resulting decision invalid only if the claimant is prejudiced in a relevant sense by the procedural flaw. Morgan v. Reliance Standard Life Ins. Co., No. 12-12151-NMG, 2014 WL 832585, at *3 (D. Mass. Mar. 3, 2014). Sometimes an administrator’s failure to follow its own procedures will reinforce an assessment that its decision was not reasonable. Ganem v. Liberty Life Assurance Co. of Boston, No. 1:12-cv-128-GZS, 2013 WL 5967005, at *9 (D. Me. Nov. 14, 2013) (citing Glista v. Unum Life Ins. Co. of Am., 378 F.3d 113, 123 (1st Cir. 2004)) (“Failure to adhere to internal policies and guidelines is yet another factor for consideration in determining whether the decision was reasoned and supported by substantial evidence.”).

In Bard v. Boston Shipping Ass’n, 471 F.3d 229 (1st Cir. 2006), the court declined to rule as to whether “procedural irregularities” such as violation of the DOL deadlines or insufficient denial letters can serve to change the standard of review from deferential to de novo. However, in Troiano v. Aetna Life Ins. Co., 844 F.3d 35 (1st Cir. 2016), the court found that under either standard of review the claimant would lose on its challenge of the district court’s finding against her. In doing so, the court acknowledged that there were procedural violations (failure to respond to an appeal letter) and in deciding the case it would assume that as a result of the violations Aetna forfeited the deferential standard of review. Id. at 42. The court cited Bard for the proposition that procedural violations of ERISA could indeed cause forfeit of the discretionary standard of review. Id.

D. Cases Interpreting MetLife v. Glenn

The First Circuit’s approach to the issue of conflict of interest was affected by the Supreme Court’s decision in Glenn, 554 U.S. 105. In Glenn the Court held that a “structural” conflict exists when the same entity pays benefits and adjudicates claims. Id. at 124–26. While rejecting the notion, previously advanced by the First Circuit, that market forces eliminate entirely the existence of this structural conflict, the Court held that such market forces could diminish the significance of such conflicts in individual cases. See id.
The Court then emphasized that in deciding how best to weigh such conflicts, its decision did not overturn, modify, or alter its decision in Firestone. As the Court stated, “We do not believe that Firestone’s statement [that an ERISA administrator’s conflict of interest should be weighed in determining whether there is an abuse of discretion] implies a change in the standard of review, say, from deferential to de novo review.” Id. at 115. The Court went on to hold that “[n]or would we overturn Firestone by adopting a rule that in practice could bring about near universal review by judges de novo, i.e., without deference of the lion’s share of ERISA plan claims denials.” Id.

The Court also rejected burden-shifting rules in the context of deferential review, stating:

Neither do we believe it necessary or desirable for courts to create special burden-of-proof rules, or other special procedural or evidentiary rules, focused narrowly upon the evaluator/payor conflict. . . . Indeed such rules would create further complexity, adding time and expense to a process that may already be too costly for many of those who seek redress.

Id. at 116–17.

The Court in Glenn further held that judges should weigh a conflict “as they would weigh any other pertinent factor; that is, when the relevant considerations are in equipoise, any one factor . . . may act as a tiebreaker. . . . In this regard, the Court counseled judges to take account of both the ‘degree of closeness’ and ‘the tiebreaking factor’s inherent or case specific importance.’” Denmark v. Liberty Life Assurance Co. of Boston, 566 F.3d 1, 8 (1st Cir. 2009) (quoting Glenn, 554 U.S. at 117). As such, the Court held that a conflict “should prove more important (perhaps of great importance) where circumstances suggest a higher likelihood that it affect[s] the benefits decision. . . . It should prove less important (perhaps to the vanishing point) where the administrator has taken active steps to reduce potential bias and to promote accuracy. . . .” Glenn, 554 U.S. at 117. The existence of a conflict is one factor that may justify the conclusion that a plan administrator’s decision was arbitrary and capricious. Niebauer v. Crane & Co., Inc., 783 F.3d 914, 924 (1st Cir. 2015).

In Denmark, the court reviewed its pre-Glenn standard and the key passages from Glenn, emphasizing that review remains deferential and that a conflict of interest is one factor of many that the court must consider in its review. Denmark, 566 F.3d at 5–9. The court held that its pre-Glenn approach was largely consistent with Glenn except that prior to Glenn, district courts in the First Circuit were not allowed to weigh a purely structural conflict in conducting deferential review, and would consider the conflict only if the plaintiff demonstrated that the conflict actually affected the decision. Id. at 9.

The court noted that although Glenn mandates only a “modest” refinement on the First Circuit’s pre-Glenn standard, such modest refinement may be important with respect to the case at hand because the substantive issue as to whether the plaintiff is disabled is “hairs-breadth close” and therefore “even a slight adjustment in the mix of factors or in the weight of a single factor may make a decisive difference.” Id. The court also noted that after Glenn, “courts are duty-bound to inquire into what steps a plan administrator has taken to insulate the decisionmaking process against
the potentially pernicious effects of structural conflicts.” *Id.* Accordingly, the court remanded the case to the district court to apply the *Glenn* multifactor test in the first instance. *Id.* Post-*Denmark*, the First Circuit confirmed that a structural conflict of interest “does not change the standard of review.” *Cusson v. Liberty Life Assurance Co. of Boston*, 592 F.3d 215, 224 (1st Cir. 2010). The court in *Cusson* also stated that the structural conflict receives no “special weight” unless the plaintiff meets his or her burden in proving that the conflict actually influenced the benefits decision. *Id.* at 228.

Cusson argued that the decision was influenced by conflict because it allegedly overly relied on a peer review report that contained factual errors; because it relied on a hearsay conversation between a reviewing physician and a treating physician; because the reviewing physicians were allegedly “biased against patients with fibromyalgia”; because Liberty chose to obtain paper reviews rather than an independent medical examination (IME); because Liberty allegedly failed to provide the reviewing physicians with all the medical records; and because Liberty did not credit the Social Security Administration’s (SSA’s) award of disability benefits. The court rejected all of these arguments and stated, “We do not find that Liberty’s decision was improperly influenced by structural conflict. We therefore do not accord any special weight to the conflict in our analysis…” *Id.* at 228. See also *Earl T. Sydney & Sydney Sheet Metal, Inc. v. Sheet Metal Workers’ Pension Fund*, No. 15-10786-LTS, 2017 WL 507210, at *8 (D. Mass. Feb. 7, 2017) (holding that plaintiff had not satisfied their burden of showing that a structural conflict influenced the fund’s decision); *Wiggin v. Aetna Life Ins. Co.*, No. 1:13-cv-00081-JAW, 2013 WL 6198181, at *8 (D. Me. Nov. 27, 2013) (discussing active steps insurer took and the court not affording a structural conflict “special weight” in its analysis); *Cannon v. Aetna Life Ins. Co.*, No. 12-10512, 2013 WL 5276555, at *6 (D. Mass. Sept. 17, 2013) (a decision to award at least some benefits rather than deny benefits entirely demonstrates an unbiased interest that favors the claimant making the conflict factor less important); *Gernes v. Health & Welfare Plan of Metro. Cabinet*, 841 F. Supp. 2d 502, 509 (D. Mass. 2012) (“administrator can take ‘active steps to reduce potential bias and to promote accuracy’ and thereby reduce the effect of a structural conflict in the decision making process ‘to the vanishing point’” and holding that the use of an independent external review agency referred by the Massachusetts Department of Public Health’s Office of Patient Protection “effectively insulated” the insurer from any potential bias); *Estrella v. Hartford Life & Accident Ins. Co.*, No. CIV.A. 09-11824-RWZ, 2011 WL 4007679, at *4 (D. Mass. Sept. 6, 2011) (holding that an insurer’s paying of bonuses to appeals unit personnel when company experienced operating losses does not, in itself, prove that conflict influenced claim denial, especially when the insurer took active steps to eliminate conflict from impacting claims decisions).

**E. Other Factors Affecting Standard of Review**

Notwithstanding a proper grant of discretion under *Firestone*, the First Circuit has held that de novo review will apply in the event of an improper delegation of that discretion. In *Rodriguez-Abreu v. Chase Manhattan Bank*, 986 F.2d 580, 584 (1st Cir. 1993), the only decision makers referenced in the plan documents were “named fiduciaries.” The benefits decision was made, however, by a party (Chase) that was
not a “named fiduciary.” *Id.* And the plan documents contained no provision allowing “named fiduciaries” to delegate powers and duties, nor any provisions delegating any duties to Chase. *Id.* Accordingly, the court found a lack of appropriate delegation and reviewed the benefits decision de novo. *Id.* The court had occasion to once again address improper delegation of authority in *Rodriguez-Lopez v. Triple-S Vida, Inc.*, 850 F.3d 14 (1st Cir. 2017). In *Rodriguez-Lopez*, the plan was originally insured by Jefferson-Pilot under a group LTD policy. The plan named the employer as the plan sponsor and administrator and provided that “the Plan Sponsor is granted the discretionary authority to determine eligibility for benefits and to construe the terms of the Plan.” *Id.* Initially, the plan also provided that Jefferson-Pilot would handle all aspects of claim administration. Before the claim was filed, Jefferson-Pilot was replaced by a new claims administrator, Triple-S. However, neither the plan nor the SPD was amended to memorialize this change. The court held that there was not a clear designation of Triple-S as the party with discretionary decision-making authority and consequently applied the de novo standard of review. *Id.*

In *Terry v. Bayer Corp.*, 145 F.3d 28, 37–38 (1st Cir. 1998), by contrast, the plan document gave authority to the plan administrator to “appoint one or more individuals to act on its behalf.” An entirely different document established the existence of a “Committee” to “assist[] the Corporation in fulfilling its administrative duties.” *Id.* at 38. And it was the committee that made the final determination. The court held that this was an effective delegation. *Id.*

In *Hannington v. Sun Life & Health Ins. Co.*, 711 F.3d 226 (1st Cir. 2013), to determine whether plaintiff’s veteran’s benefits were an offset as “Other Income” to benefits available under the disability policy, Sun Life had to determine whether the Veterans Administration (VA) benefits were “disability or retirement benefits under: a) the United States Social Security Act . . . ; b) the Railroad Retirement Act; c) any other similar act or law provided in any jurisdiction.” The court reviewed Sun Life’s determination de novo, even though the policy granted it discretionary authority, stating that “when the plan fiduciary is required, in the course of determining the meaning of the plan language, to interpret material outside the plan, our review of the extraplan material is de novo.” *Id.* at 230. Thus, “because [Sun Life’s] decision to offset Mr. Hannington’s VA benefits was governed entirely by its interpretation of several statutes, the district court ought to have reviewed de novo Sun’s determination that Mr. Hannington’s VA benefits were ‘Other Income’ under the Plan.” *Id.* at 232.

**F. Bans on Discretionary Clauses**

Twenty-five states have now imposed some type of ban on the use of discretionary clause language in state-filed insurance policies. In the First Circuit, Maine (ME. REV. STAT. ANN. tit. 24-A, § 4303 (1995/2014)), New Hampshire (N.H. CODE ADMIN. INS. 401:03 (2008/2009)), and Rhode Island (R.I. GEN. LAWS § 27-4-28 and § 27-18-79 (2013)) have passed some form of law or regulation concerning the use of discretionary clauses. The First Circuit has not yet addressed the preemption issue. However, in *Troiano v. Aetna Life Ins. Co.*, No. 14-496-ML, 2015 WL 5775160 (D.R.I. Sept. 30, 2015), *aff’d on other grounds*, 844 F.3d 36 (1st Cir. 2016), the court found that ERISA did indeed preempt the statutory ban promulgated by the state of Rhode Island.
Caution should also be employed when litigating a claim under a policy issued in a state outside of the First Circuit that has passed a discretionary clause ban. This was the case in *Harding v. Aetna Life Ins. Co.*, No. 2:15-CV-411-DBH, 2016 WL 3983242 (D. Me. July 25, 2016). The court in *Harding* enforced the Texas ban on discretionary clauses and applied the de novo standard of review.

**G. Impact of DOL Regulations**

On December 19, 2016, the DOL released the final amendments to the regulations covering claims procedures for plans providing disability benefits, 29 C.F.R. § 2560.503-1. The vast majority of the changes are effective for claims filed on or after January 1, 2018. One of the changes that could impact the standard of review is found in the amendments to § 2560.503-1(l), *Failure to establish and follow reasonable claim procedures*. Specifically, § 2560.503-1(l)(2)(i), *Plans providing disability benefits*, states:

> In the case of a claim for disability benefits, if the plan fails to strictly adhere to all the requirements of this section with respect to a claim, the claimant is deemed to have exhausted the administrative remedies available under the plan, except as provided in paragraph (l)(2)(ii) of this section. Accordingly, the claimant is entitled to pursue any available remedies under section 502(a) of the Act on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. If a claimant chooses to pursue remedies under section 502(a) of the Act under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

Therefore, if a court finds that the plan has not strictly adhered to all of the ERISA claim regulations, the amendment dictates that the plan had unreasonable procedures and that any decision could not have been based on the merits. The concluding sentence establishes that when these procedural irregularities occur, a claim fiduciary will be held to have denied a claim without the exercise of discretion. Without discretion, there can be no deferential review.

As explained earlier, when there are procedural irregularities in the handling of a claim that result in prejudice to the claimant, the case law in the First Circuit, as set forth in *Morgan, Ganem*, and *Glista*, holds that the deferential standard of review should not apply. The amendment seemingly codifies this line of cases and goes one step further by assuming prejudice when there is a failure to strictly adhere to the ERISA claim regulations. It should be noted that the amendment does provide an exception for strict adherence when the procedural violations are de minimus, as long as they are not part of a pattern and practice.

**V. Rules of Plan Interpretation**

**A. Application of Federal Common Law**

Federal common law governs the interpretation of provisions in an ERISA benefit plan. *Vendura v. Boxer*, 85 F.3d 477, 484 (1st Cir. 2017); *Filiatrault v. Converse*
The provisions of an ERISA plan must be read in a natural, commonsense way. Colby v. Union Sec. Ins. Co. & Mgmt. Co. for Merrimack Anesthesia Assocs. LTD Plan, 705 F.3d 58, 66 (1st Cir. 2013).

Plan language is interpreted according to its plain meaning taken in context, and language is ambiguous only where an agreement’s “terms are inconsistent on their face” or where the language “can support reasonable differences of opinion as to the meaning” of the words employed and obligations undertaken. Guerra-Delgado v. Popular, Inc., 774 F.3d 776, 783 (1st Cir. 2014) (citing Smart v. Gillette Co. LTD Plan, 70 F.3d 173, 178 (1st Cir. 1995)). “[W]hether an ERISA plan term is ambiguous is generally a question of law for the judge.” Guerra-Delgado, 774 F.3d at 783; Balestracci v. NSTAR Elec. & Gas Corp., 449 F.3d 224, 230 (1st Cir. 2006). In Balestracci, the First Circuit held that ambiguous plan language can support a finding of an intention to vest lifetime ERISA benefits, rejecting the district court’s ruling that an intention to vest retirement benefits must be stated in clear and express terms. Id. at 231. In Guerra-Delgado, the court noted that a plan beneficiary might reasonably rely on oral statements to interpret an ambiguous plan provision, but an informal statement cannot modify a clear plan term. Such reliance would be inherently unreasonable. Guerra-Delgado, 774 F.3d at 782–83.

B. Application of Contra Proferentem

The First Circuit has applied the rule of contra proferentem to ERISA cases only where the standard of review was de novo and the interpretation of an ambiguous provision of a plan funded by an insurance policy was at issue. See Troiano v. Aetna Life Ins. Co., 844 F.3d 35, 44–45 (1st Cir. 2016). In Recupero v. New Eng. Tel. & Tel. Co., 118 F.3d 820, 825 (1st Cir. 1997), the court stated contra proferentem would be inapplicable in cases in which the administrator was given discretionary authority to interpret plan terms. The First Circuit confirmed that holding in Stamp v. Metro. Life Ins. Co., 531 F.3d 84, 92–93 (1st Cir. 2008). In Stamp, the court held that “[w]hen the administrators of a plan have discretionary authority to construe the plan, they have the discretion to determine the intended meaning of the plan’s terms. In making a deferential review of such determinations, courts have no occasion to employ the rule of contra proferentem” (quoting Morton v. Smith, 91 F.3d 867, 871 n.1 (7th Cir. 1996)).

The First Circuit has also specifically held that contra proferentem does not apply to ERISA plans that are not funded by insurance policies. Allen v. Adage, Inc., 967 F.2d 695, 701 n.6 (1st Cir. 1992). See also Jorstad v. Conn. Gen. Life Ins. Co., 844 F. Supp. 46, 52 n.10 (D. Mass. 1994).

C. Deference Afforded to an Administrator’s Interpretation of a Plan

When the court reviews an administrator’s determination under a de novo standard, the court must decide “whether, upon a full review of the administrative record, the decision of the administrator was correct.” Orndorf v. Paul Revere Life Ins. Co., 404 F.3d 510, 518 (1st Cir. 2005). The court should independently review the record and “grant[,] no deference to administrators’ opinions or conclusions.” Id. In terms of plan interpretation, as stated in Section B, the court applies the common law

When review of an administrator’s plan interpretation is deferential, by contrast, the court’s review focuses on whether the interpretation was reasonable. Dutkewych v. Standard Ins. Co., 781 F.3d 623, 636 (1st Cir. 2015); Terry v. Bayer Corp., 145 F.3d 28, 40 (1st Cir. 1998). Under the arbitrary and capricious standard, the court must decide “whether the administrator’s action on the record before him was unreasonable.” Liston v. Unum Corp. Officer Severance Plan, 330 F.3d 19, 24 (1st Cir. 2003). See also Stamp, 531 F.3d at 94 (“[W]e need not decide what is the best reading of the words in the insurance policy . . . nor how we would have applied those words de novo. Instead, we are called upon only to decide whether the plan administrator’s denial of benefits was ‘reasoned and supported by substantial evidence. . . .’”); Wright v. R.R. Donnelly & Sons Co. Group Benefits Plan, 402 F.3d 67, 74 (1st Cir. 2005). Substantial evidence exists if it is reasonably sufficient to support a conclusion. Niebauer v. Crane & Co., Inc., 783 F.3d 914, 922 (1st Cir. 2015).

After the Supreme Court’s decision in Metro. Life Ins. Co. v. Glenn, 554 U.S. 105 (2008), the First Circuit addressed how a structural conflict of interest affects the standard of review. In Ortega-Candelaria v. Johnson & Johnson, 755 F.3d 13 (1st Cir. 2014), the court stated the standard of review would remain deferential but that the conflict of interest “can, under certain circumstances, be accorded extra weight in the court’s analysis.” Id. at 27. As such, the conflict of interest does not alter the standard of review, but rather is one factor among many that a court may take into account. See also Dutkewych, 781 F.3d at 633 n.5.

VI. Discovery

Since the Supreme Court’s decision in Metro. Life Ins. Co. v. Glenn, 554 U.S. 105 (2008), and the First Circuit’s decision in Denmark v. Liberty Life Assurance Co. of Boston, 566 F.3d 1 (1st Cir. 2009), there has been a regular and frequent flow of decisions emanating from the district courts regarding the issue of discovery in ERISA cases.

A. Limitations on Discovery

Discovery is permitted in limited circumstances in the First Circuit. However, despite the Supreme Court’s decision in Glenn, 554 U.S. 105, the party seeking discovery must still overcome the strong presumption that the record on review is limited to what was before the administrator. Troiano v. Aetna Life Ins. Co., 844 F.3d 35, 45 (1st Cir. 2016) (quoting Liston v. Unum Corp. Officer Severance Plan, 330 F.3d 19, 23 (1st Cir. 2003)). This rule applies to discovery regardless of whether the standard of review is de novo or deferential. Orndorf v. Paul Revere Life Ins. Co., 404 F.3d 510, 520 (1st Cir. 2005). See also Morales-Alejandro v. Med. Card Sys., Inc., 486 F.3d 693 (1st Cir. 2007) (plaintiff’s request for discovery properly denied where the plaintiff had no basis to allege a conflict of interest and showed no other reason to support the request for discovery).
In *Liston*, the First Circuit addressed the issue of judicial discretion to permit discovery in ERISA denial-of-benefits cases when the stated objective of discovery is to supplement the record with evidence pertaining to claims other than the one being reviewed. According to the court, “some very good reason is needed to overcome the strong presumption that the record on review is limited to the record before the administrator.” 330 F.3d at 23. In a denial-of-benefits claim, “the central issue must always be what the plan promised . . . and whether the plan delivered.” *Id.* However, the court recognized that the treatment afforded to similarly situated individuals can be an appropriate topic for discovery “in some cases.” *Id.*

Whether or not discovery may be permitted “turns on the nature of the challenge to the decision.” *Orndorf*, 404 F.3d at 519. Where the challenge is to the procedure used to reach the decision, personal bias by the plan administrator, or prejudicial procedural irregularity, discovery may be permitted. Also, discovery may be needed to explain a key item, such as the duties of a claimant’s occupation if omitted from the record. *Id.* at 519–20; *Liston*, 330 F.3d at 23–24; *Doe v. Travelers Ins. Co.*, 167 F.3d 53, 57–58 (1st Cir. 1999).

Courts in the First Circuit have allowed the plaintiff limited discovery of policy and procedures manuals and training manuals and limited depositions regarding whether the insurer failed to follow its own guidelines. *Glista v. Unum Life Ins. Co. of Am.*, 378 F.3d 113, 122–23 (1st Cir. 2004); see also *Kamerer v. Unum Life Ins. Co. of Am.*, No. 4:15-CV-40146-TSH, 2017 WL 1758095 (D. Mass. May 4, 2017) (denying discovery regarding efforts to mitigate structural conflicts, employee performance reviews, and documents regarding a regulatory settlement agreement; allows two-hour deposition of IME physician); *Adele E. v. Anthem Blue Cross & Blue Shield*, No. 2:15-CV-01-DBH, 2015 WL 4715753 (D. Me. Aug. 7, 2015) (ordering production of SPDs, certificates of coverage, or other documents that summarized the benefits to be paid by the plan; policies and procedures upon which defendant relied in administering claim; documents reviewed in the course of the claim; communications with other parties regarding the claim; and the curriculum vitae of its medical reviewers); *Al-Abbas v. Metlife Life Ins. Co. of Am.*, No. 12-11585-FDS, 2013 WL 5947996 (D. Mass. Nov. 4, 2013) (discovery allowed of procedural and substantive rules that were in existence while the plaintiff’s claim was adjudicated); *Ganem v. Liberty Life Assurance Co. of Boston*, No. 12-00128-GZS, 2012 WL 5464604, at *4 (D. Me. Nov. 9, 2012) (ordering the defendant to produce materials pertaining to the procedures or standards for handling fibromyalgia claims, claims management services referrals, or job versus occupation determinations); *Tebo v. Sedgwick Claims Mgmt. Servs., Inc.*, No. 09-40068, 2010 WL 2036961 (D. Mass. May 20, 2010) (requiring the defendant to produce internal guidelines, plans, and training materials that related to the standards under which the plaintiff’s application was analyzed, that existed at the time plaintiff’s claim was pending, and that related to the general topics addressed in the administrator’s decision); *Weed v. Prudential Ins. Co. of Am.*, No. 08cv10969-NG, 2009 WL 2835207 (D. Mass. Aug. 28, 2009) (ordering production of claim manual addressing the plan’s preexisting condition exclusion, subject to a confidentiality order).

Discovery in an ERISA case, however, is not open-ended. ERISA’s goal of speedy adjudication, in addition to the limitation of review on the merits to the
First Circuit

record, operates to circumscribe discovery. Discovery related to new evidence outside the administrative record, such as newly uncovered medical opinions that the plaintiff is disabled, is improper. Orndorf, 404 F.3d at 518; Doe, 167 F.3d at 58. “Plaintiff is not entitled to engage in discovery which could have or should have been presented to the administrator prior to action on the [ERISA] claim.” Ardolino v. Metro. Life Ins. Co., No. 00-12115-DPW, 2001 WL 34563168, at *3 (D. Mass. July 2, 2001); see also Sutera v. Aetna Life Ins. Co., No. 06-10802-NMG, 2007 WL 3020187 (D. Mass. Oct. 11, 2007) (request for production of documents allowed so long as it was narrowly tailored to the categories of documents defined as relevant by DOL claim regulations; remainder of requests denied).

In some circumstances, a defendant ordered to produce sensitive information such as the types of documents described previously may be granted a protective order prohibiting dissemination or use of the materials outside of the case. See Wilson v. Pharmerica Corp. LTD Plan, No. CV 14-CV-112345-LTS, 2015 WL 4572833, at *1 (D. Mass. July 29, 2015) (declining to enter protective order for internal guidelines regarding defendant’s 24-month limitations policy and documents regarding its efforts or procedures to prevent or mitigate a conflict of interest; and allowing protective order for documents regarding defendant’s financial arrangements with third-party vendors and medical consultants).

B. Discovery and Conflict of Interest

Following the Supreme Court’s decision in Glenn, the First Circuit addressed discovery in connection with a conflict of interest. In Denmark, 566 F.3d at 10, the court, while acknowledging that discovery was not a specific issue raised on appeal, stated that it had a “responsibility to offer guidance to the parties and the district court” regarding discovery. The court recognized that Glenn could fairly be read as contemplating some discovery on the issue of whether a structural conflict of interest had morphed into an actual conflict. The structural conflict in Denmark existed because Liberty both paid the benefits and made the benefits determination.

The First Circuit held that any discovery in the conflict issue “must be allowed sparingly and, if allowed at all, must be narrowly tailored so as to leave the substantive record essentially undisturbed.” Id. at 10. The court noted that in future cases it expected plan administrators would document in the administrative record the procedures used to prevent or mitigate the effect of structural conflicts. The court held that a conflict-oriented discovery would be needed only to the extent that gaps exist in the administrative record. The court used the example of a plan administrator’s failure to detail its procedures as one basis to allow discovery. Otherwise, the court held, discovery must normally be limited to clarifying ambiguities and ensuring that documented procedures were followed.

Since Denmark, the district courts in the First Circuit have addressed conflict-based discovery in a number of decisions. See Nicholas v. Cigna Life Ins. Co. of N.Y., No. 14-CV-14117-ADB, 2016 WL 755612 (D. Mass. Feb. 25, 2016) (denied discovery regarding the track record of the physician retained to review the claim and performance evaluations of Cigna employees; allowed discovery of the total compensation paid to the IME service, the basis of method for compensating the medical
reviewer, and documents regarding mitigation of the structural conflict of interest); Wilson v. Pharmerica Corp. LTD Plan, No. CIV.A. 14-12345-LTS, 2015 WL 1962812 (D. Mass. May 1, 2015) (requiring insurer-administrator to answer interrogatories disclosing the number of evaluations performed by each medical expert and the compensation paid to outside experts and ordering that it produce documents showing what procedures it took to prevent and mitigate the effect of a structural conflict of interest); Tracia v. Liberty Life Assurance Co. of Boston, No. CIV.A. 13-13248-JGD, 2014 WL 6485873 (D. Mass. Nov. 19, 2014) (discovery concerning the number and outcome of medical reviews undertaken by physicians used by Liberty denied); Lampron v. Group Life Ins. & Disability Plan of the United Tech. Corp., No. 2:13-cv-189-GZS, 2013 WL 5936683 (D. Me. Nov. 3, 2013) (request for two-hour depositions of Liberty’s claim representative and medical examiner, interrogatories, and request for production of documents denied); Petrone v. LTD Income Plan for Choices Eligible Employees of Johnson & Johnson & Affiliated Cos., No. 11-10720-DPW, 2013 WL 1282315 (D. Mass. Mar. 27, 2013) (request to conduct discovery to determine compensation of claim representative denied); Chapman v. Supplemental Benefit Ret. Plan of Lin Tel. Corp., 861 F. Supp. 2d 41, 46 (D.R.I. 2012) (denying request for discovery regarding how plan administrator treated other employees in similar situations); Ganem, 2012 WL 5464604, at *6–8 (ordering defendant to produce written materials that pertained to plaintiff’s claim, including the handling of fibromyalgia claims, but denying plaintiff’s request for depositions and further discovery on the topic; denying discovery regarding other fibromyalgia claims where plaintiff provided no “good reason” for discovery; and denying discovery relating to medical consultants hired by Liberty where plaintiff did not make any initial showing of an “enhanced” conflict of interest); Parent v. Principal Life Ins. Co., 763 F. Supp. 2d 257 (D. Mass. 2011) (denying request for discovery regarding other denied claims where the beneficiary was awarded Social Security Disability Insurance (SSDI) benefits, the compensation structure of employee reviewers and independent reviewers, and third-party vendor relationships, where plaintiff provided no “good reason” for the court to set aside the First Circuit’s clear preference against discovery).

C. The Fiduciary Exception

The First Circuit has not yet ruled on whether the fiduciary exception applies to the attorney-client privilege in the ERISA context. However, the issue has been addressed by the District of Massachusetts.

In Smith v. Jefferson Pilot Fin. Ins. Co., 245 F.R.D. 45 (D. Mass. 2007), suit was filed regarding the calculation of monthly disability benefits under a group policy. Prior to filing suit, Smith hired an attorney to represent him in connection with discussions with Jefferson Pilot’s claims personnel concerning the benefit amount. Jefferson Pilot’s claims personnel consulted in-house counsel in preparing responses to Smith’s counsel. In the litigation, Smith sought an order from the court compelling Jefferson Pilot to disclose the documents withheld from production based on the attorney-client privilege. Smith argued the documents must be produced pursuant to the fiduciary exception.