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 by an employer, (3) for the purpose of providing medical, surgical, or hospital care, or sickness, accident, disability, death, or unemployment or vacation benefits, (4) 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 & Acc. 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. 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.” Wickman, 908 F.2d at 1083 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 Balestracci 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 Assur. Co. of Can., 734 F.3d 1 (1st Cir. 2013), the plaintiff argued that an employer’s long-term disability (LTD) policy, which was voluntary and employee funded, was not an ERISA plan. The 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 Pen. 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 left 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)). See also *Coon-Retelle v. Verizon New England, Inc.*, No. 16-11530-DJC, 2017 WL 1234115 (D. Mass. Mar. 10, 2017) (court found in deciding a motion to dismiss that complaint did allege sufficient facts to establish a colorable claim that participating was a common law employee sufficient to bring a claim under ERISA).

**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 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 the 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**


**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
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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). Lampron v. Group Life Ins. and Dis. Plan of United Technologies Corp., No. 12-197-GZS, 2013 WL 2237851 (D. Me. May 21, 2013) (court found that employer was not a proper defendant under ERISA because the facts failed to establish that it controlled or influenced the plan). 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. 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

In Stapleton v. Advocate Health Care Network, 137 S. Ct. 1652 (2017), the Supreme Court held that an ERISA plan maintained by a principal-purpose organization qualifies as a church plan and thus is exempt from ERISA, regardless of whether a church originally established the plan. The defendants in Stapleton were three church-affiliated hospitals. The plans in question were established by the hospitals and not by a church. The Court’s task was to interpret 29 U.S.C. § 1003(b)(2) to determine what fact scenarios support the finding of a “church plan.” The Court concluded that under the statute, certain plans for the employees of churches or church-affiliated nonprofits count as “church plans” even though not actually administered by a church. See id. § 1002(33)(C)(i).
CHAPTER 1

After Stapleton only one court in the First Circuit has applied its holding. In Cardoza-Estremera v. Berrios, No. 16-2318-ADC, 2017 WL 3098089 (D. P.R. July 20, 2017), the court refused to dismiss an ERISA claim based on the fact that a pension plan for Catholic Schools of the Roman Catholic Archdiocese of San Juan de Puerto Rico was a church plan. However, the Court observed that “the parties have failed to prove, based on the factual allegations in the complaint and other documents that may be consulted at the pleadings stage, whether the pension plan at issue is or is not an ERISA-exempt church plan.” Id. at *2. The Court then instructed the defendants to move for summary judgment on the church plan issue. Id.

II. Preemption

A. Scope of ERISA Preemption

ERISA sets forth employees’ rights under the various employee welfare benefit plans throughout the nation. In Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 53–55 (1987), 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 Hosp., 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 that 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 the 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 the plaintiff’s state law claims based on the defendant health maintenance organization’s (HMO’s) decision to deny the 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 the 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., 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 the plaintiffs’ attempts to use state law to remedy damages they claimed to have suffered as a result of the defendants’ denial of the plaintiffs’ health care claims. 542 U.S. at 209. The Court held that the claims were preempted because the plaintiffs could have brought claims for benefits under ERISA and the 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 the 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 (1) are 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 previously. 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 health benefit plans to include coverage for religious nonmedical care providers (Christian Science care facility); *Me. Educ. Ass’n Ben. 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 an employee’s claims against an employer for misrepresenting coverage under the plan were preempted because they touched on the 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 the 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 the defendant’s determination with respect to the plaintiff’s claim for short-term disability benefits but dismissed the complaint as to the plaintiff’s request for LTD benefits. The court found that the 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.*
B. Exceptions to the Exhaustion Requirement

An exception to the exhaustion requirement exists “when resort to the administrative route is futile or the remedy inadequate.” *Drinkwater v. Metro. Life Ins. Co.*, 846 F.2d 821, 826 (1st Cir. 1988). But a “blanket assertion, unsupported by any facts, is insufficient to call this exception into play.” *Id.*; *Madera v. Marsh, USA, Inc.*, 426 F.3d 56, 62 (1st Cir. 2005). “It is the defendant’s burden to show failure to exhaust and, if necessary, the plaintiff’s burden to show that the futility exception applies.” *Exeter Hosp. v. New Eng. Homes, Inc.*, No. 10-cv-377-JL, 2011 WL 3862146, at *3 (D.N.H. Sept. 1, 2011) (citing *Drinkwater*, 846 F.2d at 825). Courts are sometimes hesitant to grant motions to dismiss when a plaintiff asserts that exhaustion would have been futile. *See Barthelmes v. Kimberly-Clark Corp.*, No. 13-30164, 2015 WL 1431156, at *6 (D. Mass. Mar. 27, 2015) (denying the defendant’s motion to dismiss, noting that “the futility issue would be more appropriate to address at a later stage of the litigation”).

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 Sagrado 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”).

Finally, in *Fortier v. Hartford Life & Acc. Ins. Co.*, 916 F.3d 74 (1st Cir. 2019), the First Circuit affirmed dismissal for failure to exhaust due to the plaintiff’s failure to submit a timely appeal and rejected the plaintiff’s arguments that (1) insurer had to demonstrate that it was prejudiced by the untimely appeal and (2) the substantial compliance doctrine excused her untimely appeal. *Id.* at 83–86.

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 Assur. 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; *Fortier*, 916 F.3d at 81.

**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 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 the defendant “ha[d] 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 Sev. 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**

“some discretion” be given to out-of-court decision maker); *Diaz v. Seafarers Int’l Union*, 13 F.3d 454, 457 (1st Cir. 1994) (requiring “evidence” of discretionary authority). The “arbitrary and capricious” standard of review will still apply where the plan contains language conferring a grant of discretionary authority, but the SPD does not contain such language. See *Fenton v. John Hancock Mut. Life Ins. Co.*, 400 F.3d 83, 90 (1st Cir. 2005).

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.*

The First Circuit had an opportunity to revisit the issue of the appropriate language required to grant discretionary authority in *Rodriguez-Lopez v. Triple-S Vida, Inc.*, 850 F.3d 14 (1st Cir. 2017). In that case, the plan fiduciary argued that the grant of discretion could be found in the SPD for the plan, which stated:

In addition to creating rights for plan participants, ERISA imposes obligations upon the people who are responsible for the operation of the plan. The people who operate your plan[,] called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of all plan participants and beneficiaries.

*Id.* at 22. The court held that this language was wholly inadequate to confer discretion. In fact, the court observed that such language was required by all plans under 29 C.F.R. 2520.102–3(0)(1). *Id.* at 23. If these words truly granted discretion, then every regulatory compliant plan would be subject to the deferential standard of review. *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 Assur. 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. Long Term Dis. 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. Long Term Dis. 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 *Santana-Díaz v. Metro. Life Ins. Co.*, 919 F.3d 691 (1st Cir. 2019). 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-DJC, 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 v. Raytheon Co., 315 F.3d 11, 16 (1st Cir. 2002); Pari-Fasano v. ITT Hartford Life & Acc. 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. Bowden v. Group 1 Automotive, Long Term Dis. Plan, 359 F. Supp. 3d 156, 169 (D. Mass. 2019). Sometimes an administrator’s failure to follow its own procedures will reinforce an assessment that its decision was not reasonable. Ganem v. Liberty Life Assur. Co. of Boston, No. 12-128-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. However, as explained in both Bard and Troiano, the First Circuit has consistently refused to hold that procedural irregularities will automatically strip a plan of a deferential standard of review.

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 Assur. 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 decision making 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 Assur. 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.