The Impact of External Reviews on Discretion in ERISA Health Litigation

The uptick in external medical reviews for ERISA health claims has potential consequences when plan administrators seek to assert a discretionary standard of review in federal court. The Affordable Care Act has increased the usage of the federal external review process, in addition to state external review programs. As the final, and optional, appeal opportunity, external reviews make medical necessity decisions which are binding on ERISA administrators. In doing so, the external reviews may result in ERISA administrators relinquishing discretionary authority over health claims.

De Novo is the Default Standard of Review in ERISA Cases

The default standard of review in an ERISA matter is de novo because an administrator is presumed to have no discretion to interpret the terms of an ERISA plan. The administrator bears the burden of showing that the written ERISA plan...
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Uncertainty Looms in Face of Missing Guidance for Missing Participants

Originally launched in 2016 as a pilot program for the Philadelphia Regional Office of the Employee Benefits Security Administration (“EBSA”), an agency within the U.S. Department of Labor (“DOL”), EBSA's missing participant initiative is now a nationwide enforcement effort that has impacted dozens upon dozens, if not hundreds, of plan sponsors. EBSA's focus generally centers on examining a plan’s procedures for locating missing terminated vested participants who may be owed benefits under a plan (or for whom benefits may be owed to a beneficiary).

During the course of an audit, EBSA investigators review the procedures established by a plan to locate and contact missing participants or participants who may be suspected missing, for instance, due to the receipt of returned mail. In this regard, EBSA investigators typically inquire into how participant information is maintained and the frequency with which it is updated, as well as the exact efforts—such as online searches, cross-comparison of HR files, outreach to family members—that are taken to establish contact with a missing participant.

Notably, EBSA's most recent activity Fact Sheet states that in 2017, “EBSA helped terminated vested participants in defined benefit plans collect benefits of $326.7 million due and owing to them.” But while such results are commendable, due to the absence of any specific regulatory guidance in this area, EBSA's methods for attaining them has created significant confusion and anxiety for plan sponsors.

Three Federal Agencies

Importantly, the missing participant issue falls within the jurisdiction of three federal agencies, namely, the DOL, the Pension Benefit Guaranty Corporation (“PBGC”), and the Internal Revenue Service (“IRS”). Compounding the need for clear guidance is the fact that all three agencies have issued some form of guidance applicable to certain circumstances relating to missing participants.

The DOL articulated what it considers to be “reasonable efforts” to locate missing participants in Field Assistance Bulletin (“FAB”) 2014-01, guidance that is technically only applicable to the specific context of a terminated defined contribution plan. In FAB 2014-01, EBSA advised that “at a minimum,” fiduciaries should use certified mail, check related plan and employer records, check with designated beneficiaries, and use free electronic search tools to locate missing participants. Importantly, EBSA also cautioned that “the duties of prudence and loyalty require the fiduciary to consider

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Are ERISA Cases the Next Frontier in the Ever-Expanding Realm of Arbitration?: The Implications of Munro v. University of Southern California in the Ninth Circuit

In a legal landscape that has resoundingly embraced arbitration, a recent Ninth Circuit case stands out for applying the breaks to binding arbitration in an ERISA matter. In Munro v. University of Southern California, 2018 WL 3542996 (9th Cir. July 24, 2018), the court found that employees pursuing a putative class action lawsuit for breaches of fiduciary duty related to their retirement plans under ERISA Section 502(a)(2) could not be compelled to arbitrate the dispute, even though their employment agreements included arbitration agreements.

I. The Case of Munro v. University of Southern California
   A. Case Background

The employees in Munro were participants in two employer-sponsored retirement and annuity plans governed by ERISA (“the Plans”) and "sought financial and equitable remedies to benefit the Plans and all affected participants and beneficiaries, including but not limited to: a determination as to the method of calculating losses; removal of breaching fiduciaries; a full accounting of Plan losses; reformation of the Plans; and an order regarding appropriate future investments.” 2018 WL 3542996 at *1. The employer sought to compel arbitration on the basis of arbitration agreements executed by the employees, which applied to claims “an Employee may have against the [Employer] or any of its related entities.” Id. The district court held that the Plans themselves were not subject to the arbitration agreements and that the employees could not so bind the Plans, therefore arbitration could not be compelled. Id.

The Ninth Circuit took up the issue. The court noted at the outset that it was tightly bound by the Federal Arbitration Act and attendant Supreme Court jurisprudence strongly favoring arbitration. Munro, 2018 WL 3542996 at *2 (citing Moses h. Cone Mem. Hosp. v. Mercury Constr., 460 U.S. 1, 24-25 (1983) for the proposition that “any doubts concerning the scope of arbitrable issues should be resolved in favor of arbitration...”). The Munro court explained, “Where there is no conflict between the FAA and the substantive statutory provision, ‘the FAA limits courts’ involvement to determining (1) whether a valid agreement to arbitrate exists and, if it does, (2) whether the agreement encompasses the dispute at issue.”’ Id. (quoting Cox v. Ocean View Hotel Corp., 533 F.3d 1114, 1119 (9th Cir. 2008)).

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What Is An ESOP Fiduciary To Do?

On the whole, employee stock ownership plans ("ESOPs") unquestionably deliver significant benefits to the companies that sponsor them, and their employees. ESOP sponsors tend to see increased productivity and employee morale, and the employees of successful ESOP-owned companies secure additional retirement benefits. Nevertheless, private company ESOPs attract more than their fair share of litigation, and most of this litigation arises out of transactions in which ESOPs buy and sell stock from the sponsor company. The Department of Labor ("DOL") has historically been particularly critical of those transactions, focusing on their vulnerability for abuse by conflicted fiduciaries.

These cases turn on two primary legal issues: (1) whether the ESOP's fiduciaries breached their duties of prudence and loyalty in authorizing the transaction, and (2) whether the purchase or sale violated ERISA's prohibited transaction provisions. These issues largely go hand in hand. (Most courts require fiduciaries to prove that an exemption applies to ERISA's prohibited transaction provisions.)

ERISA § 408(e) provides that a plan's acquisition or sale of employer stock does not constitute a prohibited transaction, provided certain conditions are met. One of those conditions is that the purchase or sale is for "adequate consideration."

What constitutes "adequate consideration?" As to assets for which there is no generally recognized market (such as private company stock), ERISA defines the term to mean "... the fair market value of the asset as determined in good faith by the trustee or named fiduciary pursuant to the terms of the plan and in accordance with regulations promulgated by the [Secretary of Labor]." (ERISA § 3(18)(B).) In 1988, the DOL issued proposed regulations (29 CFR 2510.3-18(b)) aimed at further defining "adequate consideration." Generally, the regulations required that in order for there to be a finding of adequate consideration: (1) the value assigned to the stock must reflect its fair market value - meaning the price at which the stock would change hands between a willing buyer and a willing seller when neither is under any compulsion to act and both parties are well informed about the stock, and (2) the value assigned to the stock must be the product of a determination made by the fiduciary in "good faith."

Not surprisingly, the proposed regulations - which have never been finalized - did little to clarify the meaning of "adequate consideration," and even less to give fiduciaries certainty about what they needed to do to carry out their duties prudently and in "good faith."
Although the DOL has issued no official guidance on the subject since the 1988 proposed regulations, it has recently provided unofficial guidance to ESOP fiduciaries in connection with settlements reached in three litigation matters: *Perez v. GreatBanc Trust Company*, No. 5:12-CV-01648, C.D. CA in 2014, *Perez v. First Bankers Tr. Servs., Inc.*, No. 12 CV 8649 (VB), 2016 WL 2343889 (S.D.N.Y. May 3, 2016), and *Acosta v. BAT Masonry Company*, Docket, No. 6:15-CV_00028, VA W.D. in 2017. The documents agreed to as part of these settlements focus largely on selecting an independent, qualified valuation advisor, avoiding conflicts of interest, and documenting a prudent process.

While these settlement documents are only technically binding on the parties to the agreements themselves (the defendant fiduciaries), when read together, they provide a checklist of items that, in the DOL’s view, ESOP fiduciaries should consider when entering into agreements on behalf of an ESOP to buy or sell company stock.

A detailed recitation of the points addressed in the settlement documents in those cases is beyond the scope of this article. But these are some of the more important points raised in the settlement documents:

**Steps Relating To The Selection and Reliance Upon the Valuation Advisor:**

1. The fiduciary should prudently investigate the valuation advisor’s qualifications, and document who performed the investigation and the steps that were taken to determine that the valuation advisor received complete, current, and accurate information.

2. The fiduciary should prudently determine that it is reasonable to rely upon the valuation advisor’s advice before entering into the transaction, and document its conclusions;

3. The fiduciary should determine that the valuation advisor has not previously performed work, including any “preliminary valuation,” for the ESOP sponsor or any other party involved in the transaction;

4. The fiduciary should prepare a written analysis describing the reason for selecting the valuation advisor, which sets forth: (a) a list of all advisors the fiduciary considered, (b) the qualifications that were considered, (c) at least three references the fiduciary checked regarding the selected advisor, and (d) whether the advisor was the subject of any criminal, civil, or regulatory proceedings or investigations, and the outcome of those proceedings. The fiduciary need not engage in this analysis anew if it engaged in that same analysis within 15
months of its selection. Note: the settlement document in the BAT Masonry matter would exempt the trustee in that case from engaging in the analysis anew if the prior analysis was conducted no more than 24 months before, but the more conservative approach would be to engage in a fresh analysis if the prior analysis was done more than 15 months before.

Analyzing The Transaction and the Valuation

(1) Identify in writing the persons responsible for providing projections to the valuation advisor, and conduct and document a reasonable inquiry as to whether any of those persons have a conflict of interest (including - without limitation - an interest in the purchase or sale of the ESOP sponsor’s stock) or serve as agents or employees of persons with a conflict of interest;

(2) Document how the fiduciary and the valuation advisory considered any conflicts of interest in determining the value of the stock;

(3) Document opinions regarding the reasonableness of the projections that were considered, and at minimum, consider how the projections compare to the sponsor’s five-year history averages and/or medians, and those of a group of comparable public companies, if they exist;

(4) If guideline public companies are used for any part of the valuation, document the bases for concluding that the companies are actually comparable to the company being valued;

(5) If a discounted cash flow analysis is not used as part of the valuation, explain why in writing;

(6) Explain in writing any material differences between the present valuation and the most recent prior valuation within the past 24 months.

The settlement documents addressed additional, equally significant considerations for fiduciaries. These include: (a) factors to be considered regarding the financial statements relied upon by the valuation advisor (including whether it is reasonable to rely upon unaudited or qualified financial statements); and (b) as part of the stock purchase agreement, requiring the purchaser or seller to make the ESOP whole for any losses caused by financial statements that did not accurately reflect the ESOP sponsor’s financial condition, if the purchaser or seller is an officer, manager or member of the board of directors.
Prudent fiduciaries should obtain and carefully review each of the settlement documents in these cases. While adhering to this checklist may not prevent litigation involving an ESOP transaction, it will provide valuable evidence that a fiduciary who approves an ESOP transaction did so prudently, and in the interests of the ESOP’s participants.
unambiguously confers such discretion on the administrator. Where that burden is met, the administrator’s denial of benefits is reviewed for abuse of discretion. Where that burden is not met, the Court reviews the administrator’s decision de novo.

**ERISA Plans Bear the Burden of Proving Discretion Was Delegated and Exercised**

To alter the standard of review from de novo to abuse of discretion, ERISA plan administrators have the burden of establishing a delegation evident in an ERISA plan document. ERISA explicitly states that an outside party not named in the Plan may only be vested with discretion “pursuant to a procedure specified in the plan.”

In addition to the delegation of discretion, there must be an actual exercise of that discretion. When an administrator is delegated with discretion, that fact alone is insufficient to confer a discretionary standard of review if an administrator fails to actually exercise discretion in the claims decision. If there is no exercise of discretion, it follows that the benefit decision cannot be reviewed for abuse of discretion. For example, numerous courts have held that where a plan fiduciary fails to act within time limits prescribed by ERISA regulations, a “deemed denied” decision is not entitled to deference under *Firestone* regardless of any grant of discretionary authority. In the same vein, Courts hold that decisions made by an entity that was not delegated discretionary authority are to be reviewed de novo.

**Decisions Addressing External Reviews and ERISA Health Claims**

External reviewers are usually called upon to decide questions of medical necessity pursuant to plan terms. The external reviewers are not named in the ERISA plan and are independently chosen. Therefore, the reviewers remain relatively unknown to claimants. Numerous courts have held “[d]ecisions made outside the boundaries of conferred discretion are not exercises of discretion, the substance of the decisions notwithstanding.” Because the decision of the external reviewer is not within the boundaries of the discretion conferred on the administrator, and the external reviewer had not itself been granted discretionary authority, courts must consider whether the decision on external review is entitled to deference. The question is further complicated by the fact that external reviews are binding on the administrator but not binding on the claimant who is still entitled to additional remedies, including legal action.

The few decisions addressing ERISA health claims and external reviews offer some guidance. In *Bailey v. Chevron Corp. Omnibus Health Care Plan,* the court held that the external review process was not mandatory and the Affordable Care
Act did not require an external review to exhaust administrative appeals pursuant to ERISA.\(^\text{18}\)

In *Adele E. v. Anthem Blue Cross,*\(^\text{19}\) the court held that the state law banning discretionary clauses applied to the policy and that the claimant did not forgo a de novo standard of review by availing herself of the state’s external review process.

In *B. v. Horizon Blue Cross Blue Shield of New Jersey,*\(^\text{20}\) the court held that documents reviewed during an external review were part of the ERISA administrative record. But the opposite conclusion was reached in *Yox v. Providence Health Plan.*\(^\text{21}\)

Courts are also split on whether an external review decision causes an ERISA administrator to relinquish its discretionary authority. In *K.F. ex rel. Fry v. Regence Blueshield,*\(^\text{22}\) the court held that the state’s external review procedure extinguished the administrator’s discretionary authority because the administrator was compelled by law to implement the external review’s final determination:

> As discussed in *Rush Prudential*, 536 U.S. at 2169 n. 16 and 2170, states are permitted to remove the administrator’s discretionary authority to determine an insured’s eligibility for benefits by incorporating binding external review procedures into the terms of the plan. Washington has done so through *RCW 48.43.535*, and the mandatory implementation provision set forth in subsection 7 became part of the benefit plan. In such circumstances, Regence’s adoption and implementation of the IRO’s decision was mechanical and did not involve the exercise of discretion. The de novo standard of review therefore applies.

Likewise, in *Alexandra H. v. Oxford Health Ins., Inc.*,\(^\text{23}\) the court held that the New York external appeal process “requires a plan to divest its discretion in favor of the external reviewer’s decision” and therefore a de novo standard of review is appropriate.\(^\text{24}\) Although most courts have declined to follow the *Fry* decision,\(^\text{25}\) the question remains the extent to which discretion and standard of review are affected by external reviews in ERISA health cases.\(^\text{26}\)

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**Endnotes**

2 29 C.F.R. § 2590.715–2719 (Internal claims and appeals and external review processes).
3 e.g. 215 ILCS 180/1 (IL Health Carrier External Review Act); N.Y. Ins. Law § 4914 (McKinney) (NY Right to External Appeal); Cal. Ins. Code § 10169 (West) (CA Department of Insurance Independent Medical Review System).
4 *Keaveney v. Standard Ins. Co.*, 175 F.3d 1084, 1089 (9th Cir. 1999) (en banc) cert. denied, 528 U.S. 964, 120 S.Ct. 398, 145 L.Ed. 2d 310 (1999) ("the default is that the administrator has no discretion, and the administrator has to show that the plan gives it discretionary authority in order to get any judicial deference to its decision.").
5 *Id.*
6.  Id.


8.  29 U.S.C. § 1102(a)(2); Rubio v. Chock Full O'Nuts Corp., 254 F. Supp. 2d 413, 423 (S.D.N.Y. 2003) (“for the de novo standard not to be applicable, discretionary authority must be explicitly allocated in the plan to a particular named fiduciary—not through subsequent delegations of authority.”).

9.  Nichols v. Prudential Ins. Co. of Am., 406 F.3d 98, 109 (2d Cir. 2005) (“even if Prudential was vested with discretion, it made no valid exercise of that discretion here. . . . we conclude that we may give deferential review only to actual exercises of discretion.”).

10.  See Firestone, 489 U.S. at 111 (“Where discretion is conferred upon the trustee with respect to the exercise of a power, its exercise is not subject to control by the court except to prevent an abuse by the trustee of his discretion”) (quoting Restatement (Second) of Trusts § 187).

11.  Gritzer v. CBS, Inc., 275 F.3d 291, 295 (3d Cir. 2002) (“[w]here a trustee fails to act or to exercise his or her discretion, de novo review is appropriate because the trustee has forfeited the privilege to apply his or her discretion; it is the trustee’s analysis, not his or her right to use discretion or a mere arbitrary denial, to which a court should defer.”); Gilbertson v. Allied Signal, Inc., 328 F.3d 625, 631 (10th Cir. 2003) (“[T]o be entitled to deferential review, not only must the administrator be given discretion by the plan, but the administrator’s decision in a given case must be a valid exercise of that discretion.”); Abatie v. Alta Health & Life Ins. Co., 458 F.3d 955, 972 (9th Cir. 2006) (“[W]hen a plan administrator’s actions fall so far outside the strictures of ERISA that it cannot be said that the administrator exercised the discretion that ERISA and the ERISA plan grant, no deference is warranted.”).

12.  See e.g., Gilbertson, 328 F.3d at 631; Jebian v. Hewlett Packard Co., 349 F.3d 1098, 1103 (9th Cir. 2003); Kinstler v. Standard Ins. Co., 181 F.3d 243, 252 (2d Cir. 1999); Gritzer, 275 F.3d at 296.

13.  Rodríguez-Lopez v. Triple-S Vida, Inc., 850 F.3d 14, 21 (1st Cir. 2017); Jebian v. Hewlett Packard Co., 349 F.3d 1098, 1103 (9th Cir. 2005) (“we may give deferential review only to actual exercises of discretion.”); Jebian, 349 F.3d at 1105 (“When an unauthorized body that does not have fiduciary discretion to determine benefits eligibility renders such a decision, de novo review is not warranted.”) (quoting Sanford v. Harvard Indus., 262 F.3d 590, 597 (8th Cir. 2001)).


15.  See Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 385 (2002) (noting that “[n]ot only is there no ERISA provision directly providing a lenient standard for judicial review of benefit denials, but there is no requirement necessarily entailing such an effect even indirectly”).

16.  I. e. N.Y. Ins. Law § 4914(b)(4)(A)(iv) (external review is “binding”).


18.  See also Goldman v. BCBSM Found., 841 F. Supp. 2d 1021, 1026 (E.D. Mich. 2012) (“the external review process is an option, not a mandatory requirement, of administrative review.”).


21.  No. 3:12-CV-01348-HZ, 2013 WL 6887530, at *5 (D. Or. Dec. 31, 2013), aff’d, 659 F. App’x 941 (9th Cir. 2016) (external review decision was not part of the administrative record).


Uncertainty... continued from page 3

if additional search steps are appropriate,” which may “include the use of Internet search tools, commercial locator services, credit reporting agencies, information brokers, investigation databases and analogous services that may involve charges.”

The PBGC has long had a voluntary Missing Participants Program that invites certain eligible plans—recently expanded in December 2017 to include terminated defined contribution plans—to transfer missing participant benefits or information on where such benefits are held to the PBGC so that the PBGC can search for such participants. As a prerequisite to using the program, a plan must conduct a “diligent search” for the missing participants. Importantly, the PBGC has advised on the program’s website that a “diligent search must include use of a commercial locator service.”

Lastly, the IRS issued a memorandum to employee plan examiners on October 17, 2017 directing examiners not to assess penalties for a plan sponsor’s failure to make required minimum distributions (“RMDs”) to missing participants provided that the plan sponsor has made certain search efforts. In this regard, the guidance states that penalties will not be assessed if the plan has (i) “searched plan and related plan, sponsor, and publicly-available records or directories for alternative contact information,” (ii) searched for the missing participant using a commercial locator service, a credit reporting agency, or a “proprietary internet search tool for locating individuals,” and (iii) used certified U.S. mail to contact the participant at his or her last known address and “through appropriate means for any address or contact information (including email addresses and telephone numbers).” If the foregoing steps are not taken, the IRS guidance states that “EP examiners may challenge a qualified plan for violation of the RMD standards for the failure to commence or make a distribution.”

EBSA Plan Audits

In the absence of any specific regulatory guidance describing fiduciary responsibility for locating missing participants, EBSA plan audits have become increasingly unpredictable. Rather than being conducted in any consistent manner, such audits instead appear to be driven almost entirely by the discretion of the specific office or investigator assigned to the case.

EBSA missing participant audits generally begin with an examination of a plan’s census data. EBSA investigators usually identify missing participants by examining whether the census data has any “bad” or missing addresses listed for certain participants, and reviewing any individuals who are listed as being past a certain age (i.e., normal retirement age or RMD commencement age) and checking to see if they are in fact receiving benefits under the plan. EBSA investigators will then inquire into a plan’s processes for tracking and responding to returned mail, and
the steps the plan takes to update “bad” or missing addresses with more current information (e.g., online searching, contacting beneficiaries).

While it is impossible to predict what an EBSA investigator may perceive as a deficiency in any particular audit, as a general trend, EBSA investigators appear to consider FAB 2014-01 as describing the minimum (but importantly, not necessarily the full extent of) fiduciary responsibility with respect to searching for missing participants. Despite the fact that FAB 2014-01 is technically only applicable to terminated defined contribution plans, EBSA investigators have signaled that the efforts described in the guidance are applicable regardless of the type of plan or even whether the plan is terminating.

Importantly, the existence of FAB 2014-01 does not minimize the need for more specific and more broadly applicable guidance on missing participants. For one thing, some EBSA investigators are of the view that this existing guidance does not describe the full extent of fiduciary responsibility for missing participants, thus leaving plan sponsors unclear on what they must do to avoid an adverse audit outcome. For example, some EBSA investigators have suggested that in addition to the steps described in FAB 2014-01, plans should also be conducting periodic address audits and death searches. It is also unclear how EBSA investigators view guidance issued by other agencies. In this regard, while EBSA investigators frequently inquire into how a plan deals with RMDs to missing participants, they have not articulated their view on whether a plan's compliance with the IRS's 2017 guidance is sufficient to avoid violating either ERISA or the Internal Revenue Code.

The Waiting Game

Both the retirement industry and government leaders recognize that missing participant guidance is critically needed. In 2017 and 2018, several industry groups, including the American Benefits Council, ERISA Industry Committee, Plan Sponsor Council of America, and U.S. Chamber of Commerce, as well as the Government Accountability Office formally requested the DOL to issue missing participant guidance. Moreover, in March 2018, Senators Elizabeth Warren (D, Massachusetts) and Steve Daines (R, Montana) introduced legislation titled the **Retirement Savings Lost and Found Act of 2018, 2017 CONG US S 2474**, which proposes creating a special office called the Office of Retirement Savings Lost and Found that would establish a nationwide database of retirement accounts to help connect participants to their benefits.

Importantly, EBSA recently signaled that guidance may finally be on the horizon. While this is good news, it is unclear what form such guidance might come in, the expected timing, and whether it would be issued in collaboration with the PBGC and IRS.
In applying "the fundamental principle that arbitration is a matter of contract," the key question before the court was "whether the [arbitration] agreement encompass[ed] the dispute at issue." Munro, 2018 WL 3542996 at *2 (quoting AT&T Mobility LLC v. Concepcion, 563 U.S. 333, 339 (2011) and Cox, 533 F.3d at 1119).

B. The Reasoning of Munro

Central to the Munro court’s analysis was the nature of a claim under ERISA section 502(a)(2), which is brought on behalf of the benefit plan, and the remedies sought, which run to the plan and not the individual participants per se. Munro, 2018 WL 3542996 at *2, 4.

In light of the inherently representative nature of a 502(a)(2) claim, the Ninth Circuit analogized extensively to a recent qui tam case, noting that "[t]here is no shortage of similarities between qui tam suits under the FCA and suits for breach of fiduciary duty under ERISA." Munro, 2018 WL 3542996 at *3 (referencing United States ex rel. Welch v. My Left Foot Children’s Therapy, LLC, 871 F.3d 791 (9th Cir. 2017)). In both types of suits, "plaintiffs are not seeking relief for themselves. A party filing a qui tam suit under the FCA seeks recovery only for injury done to the government, … and a plaintiff bringing a suit for breach of fiduciary duty similarly seeks recovery only for injury done to the plan." Id. The Munro court went on to note that “neither the qui tam relator nor the ERISA § 502(a)(2) plaintiff may alone settle a claim because that claim does not exist for the individual relator or plaintiff’s primary benefit." Id. As to the qui tam action, the government has a right to be heard on the validity of the settlement but not “an absolute right to block the settlement.” Id. As to the ERISA claim, the plaintiff’s hands are even more tied: the action may only be settled if the plan approves the settlement. Id.

The Munro court restated its holding in the Welch case that the qui tam suit was outside the scope of the arbitration agreement because “the government, rather than the relator, stands to benefit most from the litigation…. even though the relator is entitled to more than a nominal share of the government’s recovery.” Munro, 2018 WL 3542996 at *3.

The Munro court highlighted the fact that the nature of the relief sought by the plaintiffs illustrated that they were “bringing their claims to benefit their respective Plans across the board, not just to benefit their own accounts….” Munro, 2018 WL 3542996 at *4. Although the court noted that the cause of action under ERISA section 502(a)(2) technically belongs to the individual plaintiff, it went on to say that in a qui tam action where the government elects not to intervene, the same is also true. That point did not tip the scales for the court. The court’s analysis leaned...
more heavily on the nature of the remedies sought and to whom they predominantly flowed rather than the technicality of ownership over the cause of action.

C. The Effect of the Munro Holding

Thus, it is now settled within the Ninth Circuit that ERISA Section 502(a)(2) actions are not subject to mandatory arbitration on the basis of arbitration agreements signed by the plan participants because the individual participants cannot bind the plan as a whole, and therefore there is no enforceable arbitration agreement as to the plan.

II. Questions After Munro

A. What if the Plan Itself Contains an Arbitration Provision?

This distinction raises an interesting question: is the result different where the plan document itself contains a binding arbitration agreement? The Northern District of California recently said no, that even where the arbitration agreement was contained in the plan document itself, the plan sponsor lacked the power to waive the plan’s rights and thus the claims were still not subject to mandatory arbitration. *Dorman v. Charles Schwab Co.*, 2018 WL 467357 (N.D. Cal. Jan. 1, 2018). That case is pending review at the Ninth Circuit.

B. Is Amaro v. Continental Can Co. Open to Debate After Munro?

Perhaps the most provocative aspect of the *Munro* decision is a footnote in which the court left the door open to later revisit the previously settled question of whether claims for breach of fiduciary duty brought under ERISA section 409(a) are inarbitrable as a matter of law. A prior Ninth Circuit decision, *Amaro v. Continental Can Co.*, 724 F.2d 747 (9th Cir. 1984), had held that “ERISA’s mandated ‘minimum standards [for] assuring the equitable character of [ERISA] plans’ count not be satisfied in an arbitral proceeding.” *Munro, 2018 WL 3542996 at *4* n.1. The defendant in *Munro* had urged the court to overrule *Amaro* on the grounds that it was “clearly irreconcilable” with intervening Supreme Court case law.” *Id.* The *Munro* court did not have cause to reach this question since it found that the arbitration agreement in question did not apply to the instant claims. Interestingly, the court opined, in dicta, “Although the Supreme Court has never expressly held that ERISA claims are arbitrable, there is considerable force to [defendant’s] position.” *Id.*

This footnote in *Munro* is perhaps a foreshadowing that should the Ninth Circuit face a case where the arbitration agreement in question did encompass the dispute at issue, the court may be willing to roll back its prior holding that breach of fiduciary duty claims are inarbitrable as a matter of law. Five other circuits have previously...
concluded that many ERISA claims could be subjected to binding arbitration, for example the Second Circuit has held that breach of fiduciary duty claims under ERISA are arbitrable where the plan’s trustee formed an arbitration agreement with a fiduciary service provider that contained an agreement to submit any claims to arbitration. *Bird v. Shearson Lehman/American Express, Inc.*, 926 F.2d 116, 122 (2d Cir. 1991). The *Bird* court concluded that “Congress did not intend to preclude a waiver of a judicial forum for statutory ERISA claims,” and that “the FAA requires courts to enforce agreements to arbitrate such claims.” *Id.*

III. Conclusion

The Ninth Circuit remains much more restrictive than most other circuits regarding enforcement of binding arbitration provisions in ERISA cases, and *Munro* evidences the court’s willingness to carefully parse each scenario to determine whether arbitration must be compelled. However, the Ninth Circuit may be prepared to rescind its earlier pronouncements that ERISA claims may be inarbitrable as a matter of law. Or, indeed, the Supreme Court may settle that issue first, and the High Court has yet to reveal a willingness to staunch the flow of claims being funneled to binding arbitration and out of the halls of justice.
## Calendar

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<tr>
<td>January 16-18, 2019</td>
<td><strong>Fidelity &amp; Surety Law Midwinter Conference</strong></td>
<td>Hilton San Diego Bayfront&lt;br&gt;San Diego, CA</td>
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<td>January 17-19, 2019</td>
<td><strong>Midwinter Symposium on Insurance and Employee Benefits</strong></td>
<td>Hyatt Regency&lt;br&gt;Coral Gables, FL</td>
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<td>January 23-27, 2019</td>
<td><strong>ABA Midyear Meeting</strong></td>
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<td>February 21-23, 2019</td>
<td><strong>Insurance Coverage Litigation Midyear Conference</strong></td>
<td>Arizona Biltmore Resort &amp; Spa&lt;br&gt;Phoenix, AZ</td>
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<td>March 20-22, 2019</td>
<td><strong>Transportation MegaConference XIV</strong></td>
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<td>March 22-23, 2019</td>
<td><strong>Admiralty and Maritime Law National Program</strong></td>
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<td>April 4-5, 2019</td>
<td><strong>Motor Vehicle Products Liability Conference</strong></td>
<td>Hotel Del Coronado&lt;br&gt;Coronado, CA</td>
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<td>April 5-6, 2019</td>
<td><strong>Toxic Torts &amp; Environmental Law Conference</strong></td>
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<td>May 1-5, 2019</td>
<td><strong>TIPS Section Conference</strong></td>
<td>Westin NewYork Times Square&lt;br&gt;New York, NY</td>
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<td>May 8-10, 2019</td>
<td><strong>Fidelity &amp; Surety Law Spring Conference</strong></td>
<td>JW Marriott Hotel Austin, TX</td>
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