

ERISA Health Plans: Changes and Challenges in the Fiduciary Arena

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The Employee Retirement Income Security Act (ERISA)¹ was first enacted more than twenty-five years ago, yet this broad federal benefits statute continues to challenge nearly everyone involved in employee benefit plans, including the courts. One topic that has been a source of concern and confusion—and, accordingly, the subject of many agency opinions, regulations, and court decisions over the years—is the concept of the ERISA plan fiduciary and the scope of fiduciary duties. The evolving rules and tightening scrutiny of federal regulators and the courts create heightened risks that health plans and their sponsors or insurers may face more claims alleging breach of fiduciary duties.

The U.S. Department of Labor (DOL) recently proposed regulations that would alter the existing definition of an ERISA fiduciary by broadening its scope, and issued new fiduciary- and participant-level fee disclosure regulations. At the same time, the U.S. Supreme Court issued its decision in *CIGNA Corp. v. Amara*,² which involved a pension plan but has implications for health benefit plans as well. DOL interprets the *Amara* case as expanding the potential available remedies for breaches of fiduciary duty, and has taken the position that monetary damages should be available in cases involving disputes over health benefits.

This article focuses on these developments and how they impact health plans and plan administration. After briefly reviewing some basic ERISA concepts and how ERISA applies to health plans, the article summarizes existing law regarding ERISA plan fiduciaries and fiduciary duties. It then summarizes the proposed fiduciary regulations and discusses the *Amara* case, including the DOL's position on damages.

ERISA: Overview and Application to Health Plans

ERISA applies to virtually all types of employee benefit plans, including health and disability plans.³ With few exceptions,⁴ ERISA applies to such employee group health plans regardless of whether benefits are provided through insurance (insured) or funded directly by the employer or union (self-funded).

ERISA does not require employers to provide benefits to their employees, nor does it mandate the types of benefits to be provided.⁵ Instead, it requires plans to be established pursuant to a written document,⁶ sets forth reporting and disclosure requirements for plans, details the claim procedures for health plans,⁷

and imposes specific obligations on the entities and persons that administer the plan. ERISA also sets forth the types of legal claims and relief that plan participants can seek if they believe they have been wrongfully denied a benefit under the plan or have other complaints regarding plan administration.

Who Is a Plan Fiduciary?

Much of ERISA is based on principles of trust law. Given this background, certain parties involved in employee benefit plan administration are considered to be fiduciaries of the plan. ERISA defines a “fiduciary” as follows:

A person [or an entity] is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control over the management of such plan or exercises any authority or control respecting management or disposition of its assets; (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan.⁸

As the U.S. Supreme Court has noted, ERISA “defines ‘fiduciary’ not in terms of formal trusteeship, but in *functional* terms of control and authority over the plan.”⁹ A person (including an entity) can be a fiduciary by virtue of the level of discretion and control over the administration of the plan or its assets, even if that person does not hold a typical fiduciary position such as a trustee or plan administrator and regardless of whether that person is specifically named as a fiduciary in the plan documents. Someone who has the discretion to interpret plan terms and make final decisions regarding benefits is commonly determined to be a fiduciary of the plan for that purpose. Similarly, a person who has control over plan assets (such as a self-funded plan's bank or trust account) may be found to be a fiduciary.¹⁰

DOL and the courts that have reviewed the issue of fiduciary status make a distinction between “ministerial” versus “discretionary” conduct.¹¹ For example, a third-party administrator (TPA) that performs only ministerial functions, such as processing claims pursuant to a plan's rules, policies, and procedures without discretion to interpret plan terms or make final decisions in questionable or disputed cases, is usually not a fiduciary. In such cases, another person or entity (typically the plan administrator or claims committee) retains final authority to decide benefit claims, and is therefore the fiduciary.

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The fact that a person or entity says or believes that it is not a plan fiduciary has little bearing on whether that person or entity is in fact a fiduciary. Further, a disclaimer of fiduciary status in an administrative services agreement or in a plan document such as a summary plan description (SPD) is not dispositive of fiduciary status. A functional approach to determining fiduciary status applies, and numerous courts have found persons or entities to be fiduciaries even in the face of express contractual language disclaiming the role.¹²

General Fiduciary Duties Under ERISA

The basic duties of an ERISA fiduciary with respect to an ERISA-covered plan are:

- **Undivided Loyalty**—Act solely in the interests of participants and beneficiaries;
- **Exclusivity**—Act for the exclusive purpose of providing plan benefits or for defraying reasonable expenses of plan administration;
- **Prudence**—Exercise the care, skill, prudence, and diligence that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims;
- **Diversification**—Diversify the plan's investments to minimize the risk of large losses;
- **Adherence to Plan Documents**—Act in accordance with the documents and the instruments governing the plan insofar as those documents and instruments are consistent with ERISA.

Consistent with these duties, a health plan claims fiduciary is expected to administer benefits in a manner that is fair to all of the plan participants and takes their interests into account. This does not mean that the plan must approve every benefit claim; indeed, a claims fiduciary is bound to follow the plan documents as written (unless they conflict with ERISA) and should deny claims that are unsupported or excluded by plan terms. If, however, a claims fiduciary has a potential conflict of interest (for example, an insurer who both decides and pays claims), it should take steps to reduce any potential bias and promote accuracy, such as by separating the claims determination process from the financial side of the business. Further, if a benefits decision is subsequently challenged in court, the existence of a conflict of interest is a factor that may be taken into account in determining whether a claims administrator has abused its discretion.¹³

Other health plan fiduciary responsibilities include the prudent selection and monitoring of service providers such as TPAs or COBRA administrators and healthcare providers, including determining reasonable compensation for such service providers. DOL has taken the view¹⁴ that a responsible plan fiduciary must engage in a prudent selection process and must take into account the qualifications of the provider, the quality of services offered, and the reasonableness of the fees charged.¹⁵

Fiduciary Status of Administrative Service Providers and the DOL's Proposed Regulations

As noted, a company or person providing administrative services to an ERISA-covered health plan may be a fiduciary, depending on the type of service provided and the level of discretion and control over the plan and its assets. Service providers that have been found to be ERISA fiduciaries include TPAs, insurance companies and agents, and consulting firms. Although the definition of a fiduciary has always included administrative service providers responsible for the selection of investments (so-called investment advisors), DOL has proposed regulations that would significantly expand the types of advice and recommendations given to a plan, plan fiduciary, participant, or beneficiary that may lead to ERISA fiduciary status.

The proposed regulations would amend regulations issued in 1975 that use a five-factor test to define when a person is considered an ERISA fiduciary by reason of giving investment advice. For an adviser to be deemed a fiduciary under this five-factor test, it must: (1) provide investment recommendations or advice on property values; (2) on a regular basis; (3) pursuant to a mutual agreement, arrangement, or understanding with the plan; (4) that the advice will serve as a primary basis for plan investment decisions; and (5) that the advice will be individualized based on the particular needs of the plan. Generally, all five elements of this test must be satisfied for a service provider rendering investment advice to be considered a fiduciary.

DOL's proposed regulation expands the definition of a fiduciary as it relates to rendering investment advice to a plan for a fee or other compensation.¹⁶ Issued on October 13, 2010, the new regulation would:

- Eliminate the requirement (for fiduciary status) that the investment advice be rendered on a regular basis;
- Cover any advice pursuant to an agreement, arrangement, or understanding that may be considered in connection with investment or management decisions;
- Eliminate the rule that the advice must be provided pursuant to a mutual agreement; and
- Specifically cover fairness opinions and appraisals as types of investment advice.

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The new standards apply to all employee benefit plans subject to ERISA—including health plans—although their primary application is to defined contribution retirement plans.

In March and April 2011, DOL held hearings and collected comments to better understand the implications of these proposed changes. A final regulation is expected by the end of the year, though DOL has suggested that the new rule might not be released until 2012.¹⁷ While the proposed regulation would make sweeping changes to the world of retirement plans, the potential impacts on health and welfare plans are unknown because it is not clear whether DOL intended for “investment advice” to be interpreted so broadly as to impose fiduciary status on a service provider assisting a health and welfare plan, such as a group medical insurance plan, by making recommendations as to the advisability of purchasing a health insurance policy, for example. A ranking official within the Employee Benefits Security Administration (EBSA) indicated that the proposed definition would have a “fair- to medium-size impact on health and welfare plans” and reiterated that the regulation applies to all ERISA plans, “including funded health plans.”¹⁸

Recent or Pending DOL Regulations Have Significant Implications for Health Plan Fiduciaries

This past year was an active one for developments in the fiduciary responsibility and disclosure areas of ERISA. DOL has been pursuing a variety of regulatory initiatives that have focused on expenses and fee transparency, including regulatory service provider and participant fee disclosures. The regulatory service provider disclosure regulations require certain plan service providers to disclose information to assist plan fiduciaries in understanding the reasonableness of the fees being charged for plan services and to assess potential conflicts of interest.¹⁹ The rules cover plan service providers such as trustees, record keepers, TPAs, and investment advisors. The fiduciary disclosure regulations are scheduled to apply as of April 1, 2012, both to new and existing contracts or arrangements for services between covered plans and covered service providers. A separate section covering welfare plan disclosures has been reserved for a future release because DOL recognizes that “there are significant differences between service and compensation arrangements of welfare plans and those involving pension plans.”²⁰ DOL believes, however, that “fiduciaries and service providers to welfare benefit plans would benefit from regulatory guidance in this area . . .”²¹ Further, DOL has already heard testimony at a public hearing on whether companies that provide services to ERISA-covered health plans should be subject to these same fee disclosure rules and DOL is “moving forward with [its] related welfare plan fee transparency initiative.”²²

Under this same expenses and fee transparency initiative, DOL also issued final participant disclosure regulations that establish new fiduciary requirements for disclosures to participants and beneficiaries in ERISA-covered 401(k) and other individual account retirement plans.²³ Importantly, the new disclosure

requirements do not apply to health plans; rather, DOL has indicated it will address health plans separately in future guidance. Fiduciary obligations to disclose fee-related information to participants has gained increased attention from both the courts and DOL. A fiduciary’s refusal to provide information about financial arrangements between itself and medical providers is just one example of a particularly troublesome breach of fiduciary claim²⁴ that has resonated throughout the courts and will benefit from such future regulatory guidance from DOL.

In addition to responding to DOL’s expenses and fee transparency initiative, plan sponsors, insurers, fiduciaries, and administrators of all health plans should consider tightening and strengthening their claims and appeals decision-making, documentation, and notice processes and procedures. Under the new interim final regulations on claims procedures and external reviews, a failure to follow procedures set forth in the new claims regulations could lead to an allegation that the claims fiduciary was in breach of fiduciary obligations. Further, the claim regulations themselves leave open certain questions regarding fiduciary status. Notably, the regulations do not expressly state whether independent review organizations (IROs) are designated as plan fiduciaries, even though the IROs make decisions that are binding on plans. Various employee benefits groups have sought clarification on this issue.²⁵

CIGNA v. Amara: Increased Exposure for Health Plan Fiduciaries?

Turning to case law, in May the Supreme Court issued its only ERISA decision this past term, *CIGNA Corp. v. Amara*, with significant implications for plan fiduciaries. The central issue in *Amara* was whether CIGNA had violated ERISA’s notice and disclosure provisions in how it communicated to participants about its conversion of the company’s defined benefit plan to a cash balance plan and, if so, the level of harm that participants would need to establish in order to recover. Participants claimed that a transitional SPD had misled them about the value of their benefits and that they were entitled to relief because they were “likely harmed” by the allegedly deficient SPD. The district court, ruling in favor of the participants, ordered CIGNA to reform its cash balance pension plan to remedy the claimed violations and to then enforce the terms of the reformed plan (which would include payment of monetary benefits to certain retired participants).²⁶ The circuit court affirmed.²⁷

The Supreme Court reversed and remanded the case, finding that an SPD is not equivalent to the terms of a plan.²⁸ It further determined that ERISA’s provision enabling plan participants to recover benefits and enforce the terms of a plan (Section 502(a)(1)(B))²⁹—upon which the district court had based its decision—did not permit a court to enforce the terms of an SPD or to change the terms of a plan to comply with information provided in an SPD. Nevertheless, the Court found that a different provision of ERISA (Section 502(a)(3)), which permits “appropriate equitable remedies,”³⁰ could authorize the same types of relief that the district court had ordered. Significantly, the Court noted

that monetary compensation³¹ was a form of relief available in courts of equity and “extended to a breach of trust committed by a fiduciary encompassing any violation of a duty imposed upon that fiduciary.”³² In other words, contrary to what most lower courts had determined when interpreting Section 502(a)(3),³³ the Court signaled that monetary relief is available under ERISA as a remedy for a breach of fiduciary duty. The Court remanded the *Amara* case to the district court to determine which equitable theory and corresponding remedy, if any, it would apply and the relevant standard of proof that the participants must meet to secure such relief.

The aspect of the *Amara* decision regarding the status and enforceability of SPDs should be of interest to health plan TPAs. Previously, most courts—when faced with a conflict between the terms of an SPD provided to participants and the actual terms of the plan—had enforced the SPD provision if it was more beneficial or favorable to participants. This was true even if the SPD had stated that the plan terms would control in the event of a conflict. In *Amara*, however, the Court made it clear that an SPD was not on equal footing with the actual plan document in determining plan benefits, noting that while an SPD provides information about the plan, its statements do not themselves constitute the terms of the plan for purposes of ERISA section 502(a)(1)(B).³⁴

In *Amara*, the Court’s comments³⁵ regarding the availability of monetary damages under Section 502(a)(3) of ERISA have potentially far-reaching implications for plan fiduciaries. Plaintiffs’ attorneys will likely assert more claims for breach of fiduciary duty and name fiduciaries as defendants, particularly in situations where Section 502(a)(1)(B) does not provide a viable remedy. Courts may be more amenable to the pleading of fiduciary breach claims in the alternative, along with claims for wrongful benefit denials.³⁶ Further, parties asserting fiduciary breach claims will likely seek monetary damages, even though the Court indicated in *Amara* that participants would need to prove actual harm to receive such damages.

Indeed, DOL has already cited *Amara* when arguing (as an amicus party) that monetary damages should be awarded in *Kenseth v. Dean Health Plans*,³⁷ a fiduciary breach case pending before the Seventh Circuit. In *Kenseth*, the plaintiff (a health maintenance organization (HMO) plan participant) claimed that the HMO breached its fiduciary duties by denying payment for

a gastric bypass procedure that she had undergone, even though the HMO’s call center had told her before the surgery that it would be covered. The participant was left liable for more than \$77,000 in medical expenses (most of which was owed to HMO-affiliated providers). DOL argued that the participant should be compensated for the out-of-pocket expenses and liabilities she incurred as a result of the HMO’s breach, noting that the remedy could be in the form of an injunction requiring the HMO to assume responsibility for any such monetary liability and thereby leaving the HMO free to negotiate with the providers.

The authors submit that *Kenseth* case is the tip of the iceberg. We expect there will be more litigation regarding the scope and application of *Amara* and the remedies available for breaches of fiduciary duty. Federal district and appeals courts in 2012 and beyond will surely continue to wrestle with fiduciary obligations and confront plan fee issues, especially in light of the pending DOL health plan fiduciary regulations.

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- 1 ERISA is codified at 29 U.S.C. § 1101 *et seq.* It was enacted in 1974 as Pub. L. No. 109-280. Decades of often conflicting agency interpretations and court decisions have led some benefits professionals to opine that “ERISA” actually stands for “Every Rule Is Somewhat Ambiguous.”
- 2 131 S. Ct. 1866 (May 16, 2011).
- 3 ERISA broadly defines “employee benefit plan” or “plan” to include employee welfare benefit plans as well as pension benefit plans. 29 U.S.C. § 1002(3). A “welfare benefit plan” is in turn defined to include all types of health benefit plans established or maintained by an employer or union (or both), such as plans designed to provide medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, or disability. 29 U.S.C. § 1002(1).
- 4 Certain types of employee benefit plans are excluded from ERISA’s coverage. The more significant of these exclusions are: (1) governmental plans (i.e., plans established or maintained by states or municipalities for their employees, as well as certain Indian tribal plans established for employees performing essential government functions for the tribe); and (2) church plans (unless the church plan has specifically opted to be covered by ERISA). ERISA also does not apply to certain health-related benefits that are paid out of an employer’s general assets and where no formal plan or ongoing administration exists, such as paid sick days. Short-term disability benefits may also fall within this exception if they are paid directly by the employer from its general assets as, essentially, a wage or salary continuation rather than funded through insurance or a trust arrangement.
- 5 Of course, other federal laws (such as the Patient Protection and Affordable Care Act) or state insurance laws may impose such mandates.
- 6 Although ERISA states that plans shall be established and maintained pursuant to a written instrument, an ERISA plan can exist without a formal, written plan document. Even sparse, informal, or oral arrangements can be “plans” under ERISA; courts have held that the determination of the existence of a plan rests on “whether, from the surrounding circumstances, a reasonable person could ascertain the intended benefits, beneficiaries, source of financing, and procedures for receiving benefits.” *Donovan v. Dillingham*, 688 F.2d 1367 (11th Cir. 1982).

An Overview of Pharmacy Benefit Management

The PPMC PG mid-year luncheon at the Payors, Plans, and Managed Care Institute will provide an overview of issues faced by pharmacy benefit managers, including “any willing provider,” prompt pay, and other state pharmacy laws. It will be a great introduction for junior health attorneys and lawyers with work in this area. You can sign up when you register for the conference.

- 7 ERISA's claims regulations have gone through numerous changes in the past few years. These recent changes are the subject of another article in this newsletter and are not covered here.
- 8 29 U.S.C. § 1002(21)(A).
- 9 *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 262, 113 S. Ct. 2063, 2071, 124 L. Ed. 2d 161 (1993).
- 10 Fiduciary status may be limited to a particular area, as the ERISA definition indicates a person or entity is a fiduciary only "to the extent" that they exercise discretion over the plan, its assets, or its administration. For example, an entity could be a fiduciary for purposes of benefit claims adjudication only and not take on fiduciary status for other aspects of plan administration.
- 11 See DOL Interpretive Bulletin 75-8, 29 C.F.R. § 2509.75-8, which describes the types of functions that may be viewed as ministerial.
- 12 See, e.g., *IT Corp. v. General American Life Ins. Co.*, 107 F.3d 1415, 1418-19 (9th Cir. 1997) (administrator who interpreted plan, controlled money in plan's bank account, and had authority to disallow benefits found to be a fiduciary despite disclaimer language in services agreement; the court also noted that a contract provision exonerating an ERISA fiduciary from fiduciary responsibility is void as a matter of law); *cert. denied*, 522 U.S. 1068 (1998); *Harold Ives Trucking Co. v. Spradley & Coker, Inc.*, 178 F.3d 523 (8th Cir. 1999) (TPA that assumed discretionary authority found to be a fiduciary notwithstanding contract language to the contrary); *Guyan Int'l v. Prof'l Benefits Adm'rs Inc.*, 2011 U.S. Dist. LEXIS 1620 (N.D. Ohio Jan. 7, 2011) (court found that the TPA had practical control over plan assets to qualify as an ERISA fiduciary and that the TPA had breached its fiduciary duty by paying its operational expenses out of plan assets); see also *Ellzey v. Carter*, 920 F. Supp. 26, 28 (D. Conn. 1995) (fiduciary status is determined by an objective standard; a person's subjective belief that he is not a fiduciary is irrelevant as long as ERISA's requirements are met).
- 13 *Metropolitan Life Ins. Co. v. Glenn*, 128 S. Ct. 2343 (2008).
- 14 Information Letter to Diana Orantes Ceresi (Feb. 19, 1998), available at www.dol.gov/ebsa/regs/ILs/il021998.html.
- 15 With respect to healthcare providers, although no method of selection is prescribed in assessing "quality of care," plan fiduciaries should consider the scope of healthcare services available, the qualifications of the providers and specialists, the ease of access to providers and to information about provider operations, the effectiveness of internal inquiry and complaint procedures, patient confidentiality, enrollee satisfaction, and the providers' ratings or accreditation.
- 16 Definition of the term "Fiduciary," 75 Fed. Reg. 65263 (proposed Oct. 22, 2010) (to be codified at 29 C.F.R. pt 2510). On September 19, 2011, DOL announced that it will withdraw its proposed regulation regarding amendments to the definition of "fiduciary" under ERISA. DOL anticipates revising provisions of the regulation to, among other things, clarify that fiduciary advice is limited to individualized advice directed to specific parties, respond to concerns about the application of the regulation to routine appraisals, and clarify the limits of the rule's application to arm's-length commercial transactions. The new proposed fiduciary rule is expected to be issued in early 2012. "US Labor Department's EBSA to re-propose rule on definition of a fiduciary," News Release, Sept. 19, 2011, available at www.dol.gov/opa/media/press/ebsa/EBSA20111382.htm.
- 17 Hazel Bradford, "Borzi: Final fiduciary rule might not be issued until 2012," *Pensions & Investments*, July 20, 2011, available at www.pionline.com/article/20110720/DAILYREG/110729987.
- 18 Andrea Ben-Yosef. "DOL Seeks Information on Applying Fee Disclosure Rules to Health Plans," *Human Resources Report*. Vol. 28, No. 42. Nov. 1, 2010: 1160.
- 19 Reasonable Contract or Arrangement Under Section 408(b)(2)—Fee Disclosure, 75 Fed. Reg. 41600 (proposed July 16, 2010).
- 20 *Id.* at 41603.
- 21 *Id.*
- 22 Phyllis Borzi, United States Department of Labor, DOL Regulations—Live Q&A Session with EBSA—Static Version (July 15, 2011), available at www.dol.gov/regulations/chat-ebsa-static-201107.htm.
- 23 Fiduciary Requirements for Disclosure in Participant-Directed Individual Account Plans, 75 Fed. Reg. 64910 (proposed Oct. 20, 2010).
- 24 See, e.g., *Pipefitters Local 636 v. Blue Cross & Blue Shield of Mich.*, 213 Fed. Appx. 473 (6th Cir. 2007) (alleging that Blue Cross & Blue Shield of Michigan, the health plan's former insurer and current TPA, breached its ERISA-imposed fiduciary duties by refusing to provide the health plan with information about the discount arrangements it had with medical providers).
- 25 For example, the ERISA Industry Committee (ERIC) has asked federal agencies responsible for implementing the regulations to: (1) acknowledge that external reviewers are plan fiduciaries to the extent that their decisions are binding on plan administrators; and (2) require external reviewers to follow the terms of a plan in deciding a claim on review. See July 25, 2011, comment letter from the ERIC to EBSA regarding the amendment to the interim final regulations on claims processes, submitted through the Federal eRulemaking Portal, and available on ERIC's website at www.eric.org/forms/documents/DocumentFormPublic/. The American Benefits Council (ABC) has raised similar concerns regarding the fiduciary status of IROs and suggested that the agencies should solicit additional public comment on the issue. See July 25, 2011, comment letter from ABC to EBSA, also submitted electronically, and available at www.americanbenefitscouncil.org/documents/hcr_claims-appeals_ebsa-cmts_072511.pdf.
- 26 The district court's decision is reported at 559 F. Supp. 2d 192 (D. Conn. 2008) and also 534 F. Supp. 2d 288 (D. Conn. 2008).
- 27 The opinion of the U.S. Appeals Court for the Second Circuit is reported at 348 Fed. Appx. 627 (2d Cir. 2009).
- 28 *Amara*, 131 S. Ct. at 1878. In the *Amara* case, the SPD was a separate document, distinct from the plan document. It is not uncommon, however, for plans—especially health plans—to have just one document, such as a member benefits guide that may serve as the plan document and perhaps also the SPD. Of course, the implementation of healthcare reform and recent proposed regulations regarding benefit summaries may change this.
- 29 29 U.S.C. § 1132(a)(1)(B), referred to in the U.S. Supreme Court's decision as "Section 502(a)(1)(B)," as that is the section number from the original act and one that is commonly used by ERISA practitioners.
- 30 29 U.S.C. § 1132(a)(3), referred to as "Section 502(a)(3)." The district court had referred to this section in its decision as a possible alternative means for relief but did not rely on it as the basis for its decision.
- 31 In equity, such monetary compensation was known as a "surcharge" and the Supreme Court uses this term in its decision.
- 32 *Amara*, 131 S. Ct. at 1880.
- 33 In prior decisions, the U.S. Supreme Court had interpreted the term "appropriate equitable relief" in Section 502(a)(3) as referring to the categories of relief that, traditionally speaking, were typically available in equity. *Sereboff v. Mid Atlantic Med. Servs. Inc.*, 547 U.S. 356, 361 (2006). The Court previously had found that Section 502(a)(3) precluded compensatory damages sought by a plan participant against a nonfiduciary and also precluded a fiduciary's claim against a beneficiary for monetary reimbursement through a lien on a tort recovery on the grounds that these claims were primarily legal, not equitable, in nature. *Mertens v. Hewitt Assocs.*, 508 U.S. 248 (1993) and *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002), respectively. The vast majority of lower courts had construed these prior Supreme Court cases as precluding monetary remedies under Section 502(a)(3) against fiduciaries in almost all situations. The *Amara* decision, however, represents a significant change, as it indicates that this common interpretation is *not* correct and that monetary damages (in the form of a "surcharge") can be a form of equitable relief for fiduciary breach claims.
- 34 *Amara*, 131 S. Ct. at 1878.
- 35 There is some question as to whether the Court's discussion concerning the availability of the surcharge (monetary) remedy—which was not the issue presented on appeal—constitutes part of the majority's holding or is merely *dicta*.
- 36 Prior to *Amara*, many courts would dismiss fiduciary breach claims pled in the alternative to claims to enforce the terms of a plan and/or recover benefits, on the ground that a fiduciary breach claim was, essentially, superfluous.
- 37 *Kenseth v. Dean Health Plans*, No. 11-1560 (7th Cir. 2011); DOL amicus brief filed June 13, 2011. A copy of DOL's brief is available at [www.dol.gov/so/media/briefs/kenseth\(A\)-6-13-2011.htm](http://www.dol.gov/so/media/briefs/kenseth(A)-6-13-2011.htm). As of this writing, the Seventh Circuit had not yet rendered a decision on the appeal.

We Look Forward to Seeing You!

The AHLA Payors, Plans and Managed Care Institute will be held in Chicago on Tuesday and Wednesday, December 6-7, 2011.