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## Summary Plan Descriptions After Amara, 45 J. Marshall L. Rev. 811 (2012)

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# SUMMARY PLAN DESCRIPTIONS AFTER *AMARA*

DAVID PRATT\*

## I. INTRODUCTION

Employee benefit plans are subject to comprehensive federal regulation under the Employee Retirement Income Security Act of 1974 (“ERISA”), as amended.<sup>1</sup> In general, ERISA applies to “employee benefit plans,” a term which includes both retirement plans and health and welfare plans.<sup>2</sup> Certain plans, notably governmental plans and most church plans, are wholly or partly exempt from ERISA.<sup>3</sup>

ERISA requires the administrator<sup>4</sup> of any covered employee benefit plan to distribute a summary of the plan terms, i.e., a “summary plan description” (“SPD”), to plan participants<sup>5</sup> and beneficiaries.<sup>6</sup> The SPD must include the information required by the statute and the U.S. Department of Labor (“DOL”) regulations, be “written in a manner calculated to be understood by the average plan participant,” and be “sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan.”<sup>7</sup> It is exceptionally difficult, as discussed below,<sup>8</sup> to satisfy all of these requirements.<sup>9</sup> Accordingly, there is a large volume of litigation<sup>10</sup>

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1. Employee Retirement Income Security Act (ERISA) of 1974, Pub. L. 93-406, 88 Stat. 851 (codified as amended at 29 U.S.C. §§ 1001 et seq. (1974) and in scattered sections of 26 U.S.C.).

2. ERISA § 3(3), 29 U.S.C. § 1002(3) (1974).

3. ERISA § 4(b), 29 U.S.C. § 1003(b).

4. See § 3(16), 29 U.S.C. § 1002(16) (defining the term administrator).

5. ERISA § 102(a), 29 U.S.C. § 1022(a).

6. ERISA § 104(b), 29 U.S.C. § 1024(b).

7. ERISA § 102(a), 29 U.S.C. § 1022(a).

8. See *infra* Part VI.

9. See, e.g., U.S. DEP'T OF LABOR, EMP. BENEFITS SEC. ADMIN., *Report Of The Working Group On Health And Welfare Benefit Plans' Communications* (Nov. 2005), available at [http://www.dol.gov/ebsa/publications/AC\\_1105c\\_report.html](http://www.dol.gov/ebsa/publications/AC_1105c_report.html). (summarizing the testimony of Marty Webb, Assistant Vice President of Benefits Operations for SBC Communications, on September

concerning whether an SPD complies with the statutory and regulatory requirements and, if not, what remedies (if any) are available to plan participants and beneficiaries.<sup>11</sup>

In May 2011, the U.S. Supreme Court issued its decision in *CIGNA Corp. v. Amara*.<sup>12</sup> This Article will discuss the *Amara* decision, and its implications for plan sponsors, plan administrators, plan participants, and beneficiaries, with respect to the SPD provisions. Section II outlines the basic statutory and regulatory requirements of SPDs. Section III summarizes the remedies available to participants and beneficiaries who have received noncompliant SPDs. Section IV gives a detailed summary of the *Amara* decisions. Section V provides a synopsis of how the *Amara* decisions have been applied in other cases. Section VI evaluates the usefulness of SPDs. Section VII outlines recent developments in the SPD requirement. And lastly, Section VIII gives a brief conclusion of where the SPD requirement stands today.

## II. THE BASIC STATUTORY AND REGULATORY REQUIREMENTS

### A. General Requirements

Sections 102(a)<sup>13</sup> and 104(b)<sup>14</sup> of ERISA require an SPD to be provided to plan participants and beneficiaries. The SPD must include the information described in section 102(b).<sup>15</sup> The long list of items required under section 102(b)<sup>16</sup> makes SPDs lengthy (typically, at least fifteen pages for even a simple retirement plan and longer for a health plan) reducing the likelihood that the plan participants will read the SPD.<sup>17</sup> Second, the SPD must be

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21, 2005 as that “[t]he DOL regulations require that the SPD be written in a manner calculated to be understood by the average participant—a difficult order to fill. When an SPD, which must explain complex plan provisions, is written following ERISA and DOL guidelines and drafted to mitigate litigation risk, the resulting communication is often ineffective in explaining the plan to participants. Town hall sessions, online information, plain speak benefit updates, web-based tools, Webinars and annual open enrollment materials are forms of benefit communications that provide more understandable information for participants”).

10. See *infra* Part V.

11. See *infra* Part III.

12. *CIGNA Corp. v. Amara*, 131 S. Ct. 1866 (2011) (hereinafter *Amara* or *Amara v. CIGNA Corp.*).

13. 29 U.S.C. § 1022(a).

14. *Id.* § 1024(b).

15. *Id.* § 1022(b).

16. See *infra* Part II.D.

17. See *infra* Part VI; see also Corey Rosen, *ESOP Sponsors: Be Careful What You Say in Your Summary Plan Description*, NAT'L CENT. FOR EMP. OWNERSHIP (June 30, 2011), [www.nceo.org/main/column.php/id/399](http://www.nceo.org/main/column.php/id/399) (stating “Legal issues aside, let’s be honest. Almost no one ever reads an SPD.

“written in a manner calculated to be understood by the average plan participant.”<sup>18</sup> Third, the SPD must be “sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan.”<sup>19</sup>

It is very difficult—some would say impossible—to write an SPD that is both understandable and comprehensive. How much detail is required? As Justice Breyer pointed out in *Amara*,<sup>20</sup> the SPD is only a summary of the plan. The SPD cannot describe every provision of the plan that could conceivably affect an individual participant. Many plan administrators have been faulted by courts for being insufficiently accurate and/or specific:<sup>21</sup> failure to be sufficiently understandable (as opposed to providing an SPD that is misleading) is much less likely to lead to eventual liability.<sup>22</sup> Accordingly, the natural tendency in drafting an SPD is to emphasize comprehensiveness rather than understandability.<sup>23</sup>

The regulations provide:

In fulfilling [the SPD requirements], the plan administrator shall exercise considered judgment and discretion by taking into account such factors as the level of comprehension and education of typical participants in the plan and the complexity of the terms of the plan. Consideration of these factors will usually require the limitation or elimination of technical jargon and of long, complex sentences, the

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When you learned to play a new board game, did you read the rules first? Did you do the tutorial or read the supporting material when you learned to use new software before you started? You are a rare individual if you did. Most of us (including me) start playing the game or using the technology and then check in on supporting material when needed. So don't confuse giving out an SPD with explaining a plan”).

18. ERISA § 102(a), 29 U.S.C. § 1022(a).

19. *Id.*

20. *Amara*, 131 S. Ct. at 1877-1878.

21. *See infra* Part III.

22. As appears from the discussion in the following sections of this Article, there has been considerable litigation involving allegedly misleading SPDs, including the *Amara* case itself. The author is unaware of a single case in which the plan administrator has been faulted for providing an SPD that was not sufficiently understandable.

23. E. Thomas Veal, *Amara's World: The Past and Future of SPD Litigation*, 2011 New York University Review of Employee Benefits and Executive Compensation (2011). As Justice Breyer noted in *Amara*:

To summarize is to make judgments about the comparative importance of plan provisions. Events may prove those judgments wrong, and it is all too easy for judges to opine, with acute hindsight, that a seemingly remote contingency should have been foreseen or the importance of a particular detail realized. The natural preventive measure, if the consequences of being wrong are severe, is to lower the bar for inclusion, lengthening the document and rendering it less accessible to its intended users. If the Court had pushed SPD preparers in that direction, the day would have come when plaintiffs would be bringing actions charging that SPD disclosures were incomprehensible.

*Id.*

use of clarifying examples and illustrations, the use of clear cross references and a table of contents.<sup>24</sup>

The regulations also provide:

The format of the summary plan description *must not have the effect to [sic] misleading, misinforming or failing to inform participants and beneficiaries*. Any description of exception, limitations, reductions, and other restrictions of plan benefits shall not be *minimized, rendered obscure or otherwise made to appear unimportant*. Such exceptions, limitations, reductions, or restrictions of plan benefits shall be described or summarized in a manner *not less prominent* than the style, captions, printing type, and prominence used to describe or summarize plan benefits. The advantages and disadvantages of the plan shall be presented *without either exaggerating the benefits or minimizing the limitations*. The description or summary of restrictive plan provisions need not be disclosed in the summary plan description in close conjunction with the description or summary of benefits, provided that adjacent to the benefit description the page on which the restrictions are described is noted.<sup>25</sup>

### B. Distribution of the SPD

Section 104(b) of ERISA<sup>26</sup> requires the plan administrator of a covered employee benefit plan to provide a copy of the SPD, and all modifications and changes, to each participant in the plan and to each beneficiary receiving benefits under the plan. The SPD must be provided (A) within 90 days after he or she becomes a participant, or (in the case of a beneficiary) within 90 days after he or she first receives benefits, or (B) if later, within 120 days after the plan becomes subject to Part I of Title I of ERISA.<sup>27</sup> The plan administrator must provide an updated SPD every five years that integrates all plan amendments made within that five-year period. If no plan amendments have been made, the plan administrator must provide an SPD every ten years.<sup>28</sup>

In some cases, a plan may provide different benefits for various classes of participants and beneficiaries, and the plan has the option to provide different SPDs.<sup>29</sup> Furthermore, if a significant number of plan participants are only literate in a non-English language, the plan administrator must provide those participants with an English-language SPD which prominently

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24. 29 C.F.R. § 2520.102-2(a) (2012).

25. *Id.* § 2520.102-2(b) (emphasis added).

26. 29 U.S.C. § 1024(b).

27. ERISA § 104(b)(1), 29 U.S.C. § 1024(b)(1).

28. *Id.* The regulations provide an alternative method of compliance for providing SPDs and SMMs to retired participants, separated participants with vested benefits, and beneficiaries receiving benefits. 29 C.F.R. § 2520.104b-4 (2012).

29. 29 C.F.R. § 2520.102-4.

displays a notice in the non-English language common to them offering them assistance.<sup>30</sup> The regulations also require the plan administrator to use “measures reasonably calculated to ensure actual receipt of the [SPD] by plan participants.”<sup>31</sup>

### C. Summary of Material Modifications

A summary of any material modification, i.e., a “summary of material modifications” (“SMM”), in the terms of the plan and any change in the information required under section 102(b) must be “written in a manner calculated to be understood by the average plan participant.”<sup>32</sup> The SMM must also be furnished in accordance with section 104(b)(1).<sup>33</sup> If there is a modification or change (other than a “material reduction” in covered services or benefits provided by a group health plan),<sup>34</sup> an SMM must be furnished to each participant and to each beneficiary receiving benefits under the plan no later than 210 days after the end of the plan year in which the change is adopted.<sup>35</sup> If there is a material reduction in covered services or benefits<sup>36</sup> provided under a group health plan, the SMM must be provided no later than 60 days after the date of adoption of the modification or change.<sup>37</sup>

30. *Id.* § 2520.102-2(c)(1)-(2).

31. *Id.* § 2520.104b-1(b)(1).

32. 29 U.S.C. § 1022(b).

33. *Id.*

34. *See* ERISA § 733(a)(1), 29 U.S.C. § 1191b(a)(1) (defining “group health plan” as “an employee welfare benefit plan to the extent that the plan provides medical care (as defined in paragraph (2) and including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise”).

35. 29 U.S.C. § 1024(b)(1)(B)

36. For this purpose,

a material reduction in covered services or benefits means any modification to the plan or change in the information required to be included in the SPD that, independently or in conjunction with other contemporaneous modifications or changes, would be considered by the average plan participant to be an important reduction in covered services or benefits under the plan.

29 C.F.R. § 2520.104b-3(d)(3)(i).

A ‘reduction in covered services or benefits’ generally would include any plan modification or change that: eliminates benefits payable under the plan; reduces benefits payable under the plan, including a reduction that occurs as a result of a change in formulas, methodologies or schedules that serve as the basis for making benefit determinations; increases premiums, deductibles, coinsurance, copayments, or other amounts to be paid by a participant or beneficiary; reduces the service area covered by a health maintenance organization; establishes new conditions or requirements (*e.g.*, preauthorization requirements) to obtaining services or benefits under the plan.

*Id.* § 2520.104b-3(d)(3)(ii).

37. *Id.* § 2520.104b-3(d)(2).

Alternatively, the plan sponsor may provide such a description at regular intervals of not more than 90 days.<sup>38</sup>

The plan administrator must make copies of the latest updated SPD and other plan-related documents "available for examination by any plan participant or beneficiary in the principal office of the plan administrator and in such other places as may be necessary to make available all pertinent information to all participants (including such places as the Secretary may prescribe by regulations)."<sup>39</sup>

#### *D. Contents of the SPD*

The SPD must contain the following information:<sup>40</sup>

1. The name and type of administration of the plan;
2. In the case of a group health plan,<sup>41</sup> whether a health insurance issuer<sup>42</sup> is responsible for the financing or administration (including payment of claims) of the plan and (if so) the name and address of such issuer;
3. The name and address of the person designated as agent for the service of legal process if that person is not the plan administrator;
4. The name and address of the plan administrator;
5. The names, titles, and addresses of any trustee or trustees if they are persons different from the plan administrator;
6. A description of the relevant provisions of any applicable collective bargaining agreement;
7. A description of the plan's provisions relating to eligibility to participate in the plan and the benefits information identified in

38. *Id.* § 2520.104b-3(d)(2).

39. ERISA § 104(b)(2), 29 U.S.C. § 1024(b)(2).

40. ERISA § 102(b), 29 U.S.C. § 1022(b). The regulations require additional factual information to be provided, including the name and address of the employer whose employees are covered by the plan. *See* 29 C.F.R. § 2520.102-3 (listing additional information which must be provided in the SPD).

41. *See* ERISA § 733(a)(1), 29 U.S.C. § 1191b(a)(1) (defining "group health plan").

42. *See* ERISA § 733(b)(2), 29 U.S.C. § 1191b(b)(2) (defining "health insurance issuer" as "an insurance company, insurance service, or insurance organization (including a health maintenance organization, as defined in paragraph (3)) which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance (within the meaning of section [514(b)(2),] 29 U.S.C. § 1144(b)(2) of this title). Such term does not include a group health plan." *Id.*

The term "health maintenance organization" means "(A) a federally qualified health maintenance organization (as defined in section 1301(a) of the Public Health Service Act (42 U.S.C. § 300e(a))), (B) an organization recognized under State law as a health maintenance organization, or (C) a similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization." § 733(b)(3), 29 U.S.C. § 1191b(b)(3)(A)-(C).

the regulations.<sup>43</sup>

For pension plans, the SPD must also describe the plan's normal retirement age,<sup>44</sup> "and a statement describing any other conditions which must be met before a participant will be eligible to receive benefits."<sup>45</sup> Plan benefits must also be described or summarized.<sup>46</sup> Additionally, the SPD must include "a description of the procedures governing qualified domestic relations order ("QDRO") determinations or a statement indicating that participants and beneficiaries can obtain, without charge, a copy of such procedures from the plan administrator."<sup>47</sup> For welfare plans, the SPD must include "a statement of the conditions pertaining to eligibility to receive benefits, and a description or summary of the benefits."<sup>48</sup> For plans providing extensive schedules of benefits, e.g., a group health plan, "only a general description of such benefits is required if reference is made to detailed schedules of benefits which are available without cost to any participant or beneficiary who so requests."<sup>49</sup> The SPD must also include "a description of the procedures governing qualified medical child support order ("QMCSO") determinations or a statement indicating that participants and beneficiaries can obtain, without charge, a copy of such procedures from the plan administrator."<sup>50</sup> For group health plans,<sup>51</sup> the SPD must include a description of

any cost-sharing provisions including premiums, deductibles, coinsurance, and copayment amounts for which the participant or beneficiary will be responsible; any annual or lifetime caps or other limits on benefits under the plan; the extent to which preventive services are covered under the plan; whether, and under what circumstances, existing and new drugs are covered under the plan; whether, and under what circumstances, coverage is provided for medical tests, devices, and procedures; provisions governing the use of network providers, the composition of the provider network, and whether, and under what circumstances, coverage is provided for out-of-network services; any conditions or limits on the selection of primary care providers or providers of specialty medical care; any conditions or limits applicable to obtaining emergency medical care; and any provisions requiring pre-authorizations or utilization review as a condition to obtaining a benefit or service under the

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43. 29 C.F.R. § 2520.102-3(j).

44. See ERISA § 3(24), 29 U.S.C. § 1002(24) (defining "normal retirement age").

45. 29 C.F.R. § 2520.102-3(j)(1)

46. *Id.*

47. *Id.*

48. *Id.* § 2520.102-3(j)(2).

49. *Id.*

50. *Id.*

51. See ERISA § 733(a)(1), *supra* note 34 (defining "group health plan").



plan.<sup>52</sup>

For plans with provider networks, the listing of providers may be furnished as a separate document that accompanies the SPD, provided that, (1) “the [SPD] contains a general description of the provider network,” and (2) “the SPD contains a statement that provider lists are furnished automatically, without charge, as a separate document;”<sup>53</sup>

8. A description of the provisions providing for non-forfeitable pension benefits;<sup>54</sup>

9. Circumstances that may result in disqualification, ineligibility, or denial or loss of benefits.<sup>55</sup> The regulations amplify this requirement:

For both pension and welfare benefit plans, a statement clearly identifying circumstances which may result in disqualification, ineligibility, or denial, loss, forfeiture, suspension, offset, reduction, or recovery (e.g., by exercise of subrogation or reimbursement rights) of any benefits that a participant or beneficiary might otherwise reasonably expect the plan to provide on the basis of the description of benefits required by paragraphs (j) and (k) of this section. In addition to other required information, plans must include a summary of any plan provisions governing the authority of the plan sponsors or others to terminate the plan or amend or eliminate benefits under the plan and the circumstances, if any, under which the plan may be terminated or benefits may be amended or eliminated; a summary of any plan provisions governing the benefits, rights and obligations of participants and beneficiaries under the plan on termination of the plan or amendment or elimination of benefits under the plan, including, in the case of an employee pension benefit plan, a summary of any provisions relating to the accrual and the vesting of pension benefits under the plan upon termination; and a summary of any plan provisions governing the allocation and disposition of assets of the plan upon termination. Plans also shall include a summary of any provisions that may result in the imposition of a fee or charge on a participant or beneficiary, or on an individual account thereof, the payment of which is a condition to the receipt of benefits under the plan;<sup>56</sup>

10. “The source of financing of the plan and the identity of any organization through which benefits are provided.”<sup>57</sup> “The SPD must describe the sources of contributions to the plan – for example, employer, employee organization, employees, and the method by which the amount of contributions is calculated. Defined benefit pension plans may merely state that the

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52. 29 C.F.R. § 2520.102-3(j)(3).

53. *Id.*

54. ERISA § 102(b), 29 U.S.C. § 1022(b).

55. *Id.*

56. 29 C.F.R. § 2520.102-3(l).

57. ERISA § 102(b), 29 U.S.C. § 1022(b).

contribution is actuarially determined.”<sup>58</sup> The SPD must identify “any funding medium used for the accumulation of assets through which benefits are provided.”<sup>59</sup> The SPD must also identify “any insurance company, trust fund, or any other institution, organization, or entity which maintains a fund on behalf of the plan or through which the plan is funded or benefits are provided.”<sup>60</sup> If a health insurance issuer<sup>61</sup>

is responsible, in whole or in part, for the financing or administration of a group health plan, the [SPD] shall indicate the name and address of the issuer, whether and to what extent benefits under the plan are guaranteed under a contract or policy of insurance issued by the issuer, and the nature of any administrative services, (e.g., payment of claims) provided by the issuer;<sup>62</sup>

11. “The date of the end of the plan year and whether the records of the plan are kept on a calendar, policy, or fiscal year basis;”<sup>63</sup>

12. “The procedures to be followed in presenting claims for benefits under the plan, including the office at the DOL through which participants and beneficiaries may seek assistance or information regarding their rights under [ERISA] and the Health Insurance Portability and Accountability Act of 1996” (“HIPAA”) with respect to health benefits that are offered through a group health plan.<sup>64</sup> The description of the procedures governing claims for benefits includes “procedures for obtaining pre-authorizations, approvals, or utilization review decisions in the case of group health plan services or benefits, and procedures for filing claim forms, providing notifications of benefit determinations, and reviewing denied claims in the case of any plan.”<sup>65</sup> The description also includes “applicable time limits, and remedies available under the plan for the redress of claims which are denied in whole or in part (including procedures required under section 503 of ERISA). The plan’s claims procedures may be furnished as a separate document that accompanies the plan’s SPD, provided that,” (1) “the document satisfies the style and format requirements of 29 C.F.R. § 2520.102-2,” and (2) “the SPD contains a statement that the plan’s claims procedures are furnished automatically, without charge, and as a separate document;”<sup>66</sup>

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58. 29 C.F.R. § 2520.102-3(p).

59. *Id.* § 2520.102-3(q).

60. *Id.*

61. See ERISA § 733(b)(2), *supra* note 42 (defining “health insurance issuer”).

62. 29 C.F.R. § 2520.102-3(q).

63. ERISA § 102(b), 29 U.S.C. § 1022(b).

64. *Id.*

65. 29 C.F.R. § 2520.102-3(s).

66. *Id.*

13. For a pension plan, “a statement describing any joint and survivor annuity benefits provided under the plan, including any requirement that an election be made as a condition to select or reject the joint and survivor annuity;”<sup>67</sup>

14. For a pension plan, information relating to insurance of plan benefits by the Pension Benefit Guaranty Corporation;<sup>68</sup>

15. For a pension plan,

a description and explanation of the plan provisions for determining years of service for eligibility to participate, vesting, and breaks in service, and years of participation for benefit accrual. The description [must] state the service required to accrue full benefits and the manner in which accrual of benefits is prorated for employees failing to complete full service for a year;<sup>69</sup>

16. For group health plans<sup>70</sup> subject to the COBRA health care continuation coverage provisions,<sup>71</sup> “a description of the rights and obligations of participants and beneficiaries with respect to continuation coverage, including . . . information concerning qualifying events and qualified beneficiaries, premiums, notice and election requirements and procedures, and duration of coverage;”<sup>72</sup>

17. A statement of ERISA rights. The regulations include a model statement.<sup>73</sup>

The statement of ERISA rights, [e.g., the model statement or a statement prepared by the plan,] must appear as one consolidated statement.<sup>74</sup> If a plan finds it desirable to make additional mention of certain rights elsewhere in the [SPD,] it may do so. The [SPD] may [also] state that the statement of ERISA rights is required by Federal law and regulation;<sup>75</sup>

18. For a group health plan<sup>76</sup> that provides maternity or newborn infant coverage, “a statement describing any requirements under federal or state law applicable to the plan, and any health insurance coverage offered under the plan, relating to hospital length of stay in connection with childbirth for the mother or newborn child.”<sup>77</sup> The regulations include a model description of federal law requirements;<sup>78</sup> and

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67. 29 C.F.R. § 2520.102-3(k).

68. *Id.* § 2520.102-3(m).

69. *Id.* § 2520.102-3(n).

70. See ERISA § 733(a)(1), *supra* note 34 (defining “group health plan”).

71. These provisions are set out in Part 6 of Title I of ERISA. ERISA §§ 601 *et seq.*, 29 U.S.C. §§ 1161 *et seq.*

72. 29 C.F.R. § 2520.102-3(o).

73. *Id.* § 2520.102-3(t)(2).

74. *Id.* § 2520.102-3(t)(1).

75. ERISA § 104(c), 29 U.S.C. § 1024(c).

76. See ERISA § 733(a)(1), *supra* note 3 (defining “group health plan”).

77. 29 C.F.R. § 2520.102-2(u)(1).

78. *Id.* § 2520.102-2(u).

19. The remedies available under the plan for redressing claims which are denied in whole or in part (including claim appeal procedures required under section 503 of ERISA),<sup>79</sup> and if the employer so elects for purposes of complying with section 701(f)(3)(B)(i) (relating to group health plans),<sup>80</sup> the model notice applicable to the State in which the participants and beneficiaries reside.<sup>81</sup>

#### *E. Providing Copies of the SPD*

On written request of any participant or beneficiary, the plan administrator must furnish a copy of the latest SPD by mailing the material requested to the last known address of the requesting participant or beneficiary within 30 days after such request.<sup>82</sup> The plan administrator may make a reasonable charge to cover the cost of doing so.<sup>83</sup> A plan administrator who fails or refuses to comply with such a request may, in the court's discretion, be personally liable to the participant or beneficiary in the amount of up to \$100 a day (indexed- the current maximum is \$110) from the date of such failure or refusal, unless the failure or refusal results from matters reasonably beyond the control of the administrator.<sup>84</sup> The court may also, in its discretion, order such other relief as it deems proper.<sup>85</sup> For this purpose, each violation with respect to any single participant or beneficiary is treated as a separate violation.<sup>86</sup>

### III. REMEDIES AVAILABLE TO PARTICIPANTS AND BENEFICIARIES WHO HAVE RECEIVED NON-COMPLIANT SPDs: PRE-AMARA CASES<sup>87</sup>

#### *A. In General*

ERISA confers a remedy against a plan administrator who fails to comply with a request from a participant or beneficiary for a copy of the SPD.<sup>88</sup> However, ERISA does not provide an explicit remedy against a plan administrator who distributes an SPD that does not comply with the statutory and regulatory requirements summarized above. Any state law remedy, e.g., for

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79. ERISA § 503, 29 U.S.C. § 1133.

80. ERISA § 701(f)(3)(B)(i), 29 U.S.C. § 1181(f)(3)(B)(i).

81. *Id.*

82. ERISA § 502(c)(1), 29 U.S.C. § 1132(c)(1).

83. ERISA § 104(b)(4), 29 U.S.C. § 1024(b)(4).

84. ERISA § 502(c)(1), 29 U.S.C. § 1132(c)(1).

85. *Id.*

86. *Id.*

87. See generally Veal, *supra* note 23 (providing detailed review of the pre-Amara cases); see also John H. Langbein, David A. Pratt & Susan J. Stabile, *Pension and Employee Benefit Law* 605-18 (Foundation Press 5th ed. 2010). I acknowledge my debt to both of these sources.

88. ERISA § 502(c)(1), 29 U.S.C. § 1132(c)(1).

misrepresentation, will generally be preempted by ERISA.<sup>89</sup> Accordingly, a plaintiff complaining that he or she has been damaged by a non-compliant SPD must pursue one of the general remedies provided by ERISA.

One possibility is section 502(a)(1)(B), which authorizes a participant or beneficiary to bring an action “to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.”<sup>90</sup> Plan fiduciaries<sup>91</sup> are required to act “in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with” the provisions of Titles I and IV of ERISA.<sup>92</sup> This provision raises several questions: Is the SPD one of “the documents and instruments governing the plan”? Does this section of the statute authorize a court to order the plan administrator to disregard the terms of the plan document and follow a conflicting provision in the SPD?

Several circuit court decisions have held that when the terms of the SPD and the plan document conflict, the language more favorable to the participant or beneficiary prevails and can be enforced through an action for benefits under section 502(a)(1)(B).<sup>93</sup> In *Amara*, the Court held that SPDs, “important as they are, provide communication with beneficiaries *about* the plan, but . . . their statements do not themselves constitute the *terms* of the plan for purposes of [section] 502(a)(1)(B),” and that an action under section 502(a)(1)(B) cannot seek benefits described in the SPD that are not provided under the plan documents.<sup>94</sup>

The other plausible source of a remedy is section 502(a)(3), under which a participant or beneficiary may obtain “other appropriate equitable relief” to redress “any act or practice which violates any provision of” Title I of ERISA or to enforce any such provision.<sup>95</sup> Justice Breyer, writing for the majority in *Amara*, described three possible grounds for equitable relief: reformation, estoppel, and surcharge.<sup>96</sup> “While that portion of the opinion was

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89. ERISA § 514, 29 U.S.C. § 1144(a).

90. ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B).

91. The term “fiduciary” is broadly defined in ERISA § 3(21), 29 U.S.C. § 1002(21)(A).

92. ERISA § 404(a)(1)(D), 29 U.S.C. § 1104(a)(1)(D).

93. *E.g.*, *Bergt v. Ret. Plan for Pilots Employed by MarkAir, Inc.*, 293 F.3d 1139, 1145 (9th Cir. 2002); *Hansen v. Cont'l Ins. Co.*, 940 F.2d 971, 981-2 (5th Cir. 1991); *Glocker v. W.R. Grace & Co.*, 974 F.2d 540, 544 (4th Cir. 1992); *Lee v. Blue Cross/Blue Shield of Ala.*, 10 F.3d 1547, 1550-1 (11th Cir. 1994); *Massella v. Blue Cross & Blue Shield of Conn., Inc.*, 936 F.2d 98 (2d Cir. 1991).

94. *Amara*, 131 S. Ct. at 1878.

95. ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3).

96. *Amara*, 131 S. Ct. at 1879.

dictum, as Justice Scalia observed in his opinion concurring in the judgment, any dictum joined by six Justices commands attention.”<sup>97</sup>

In view of the statute’s silence as to the appropriate remedy, it is not surprising that the pre-*Amara* case law reveals widely differing holdings as to (1) the causes of action available to plaintiffs, and (2) the elements that the plaintiff must prove in order to recover.<sup>98</sup> According to one commentator:

Judges approached conflicts between SPD’s and plan documents in widely different ways. All except the Federal Circuit handed down pertinent decisions, from which one court divined ‘a five-way circuit split regarding whether an ERISA claimant needs to establish reliance and/or prejudice based on the conflicting terms of an SPD.’ That may have been an understatement of the conflict. It would, in fact, be hard to say with confidence that any two Circuits followed the same law on this issue.<sup>99</sup>

When the terms of the SPD are more favorable to participants than the terms of the plan document, all circuits that addressed the question prior to *Amara* held that the SPD prevails.<sup>100</sup>

[ERISA] contemplates that the summary will be an employee’s primary source of information regarding employee benefits, and employees are entitled to rely on the descriptions contained in the summary. To allow the Plan to contain different terms that supersede the terms of the [SPD] would defeat the purpose of providing the employees with summaries.<sup>101</sup>

However, if the terms of the SPD are less favorable to participants than the plan, courts generally follow the terms of the plan: the plan sponsor should not be able to change the plan’s terms unless it follows the plan’s procedures for making amendments.<sup>102</sup>

There can be doubt as to what document or collection of documents constitutes the SPD.<sup>103</sup> Not all communications to employees about benefits are SPDs upon which a participant is entitled to rely.<sup>104</sup> However, how is a participant supposed to

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97. Veal, *supra* note 23, at 7-7.

98. *Id.* at 7-15 to -36.

99. See Veal, *supra* note 23, at 7-16 to -17 (quoting *Washington v. Murphy Oil USA, Inc.*, 497 F.3d 453, 458 n.1 (5th Cir. 2007)).

100. Langbein, *supra* note 87, at 606.

101. *Heidgerd v. Olin Corp.*, 906 F.2d 903, 907-08 (2d Cir. 1990); see also *Washington v. Murphy Oil USA, Inc.*, 497 F.3d 453 (5th Cir. 2007).

102. See *Shaw v. Conn. Gen. Life Ins. Co.*, 353 F.3d 1276 (11th Cir. 2003) (finding in favor of the plan participant), *reh’g en banc denied* 99 Fed. Appx 884 (11th Cir. 2004); *Ludlow v. Advo-Systems, Inc. Disability Income Plan*, No. 03-4964, 2004 WL 1844843, at \*3-4 (N.D. Cal. Aug. 18, 2004).

103. *E.g.*, *Admin. Comm. of Wal-Mart Stores, Inc. v. Gamboa*, 479 F.3d 538, 543 (8th Cir. 2007); *Hughes v. 3M Retiree Med. Plan*, 281 F.3d 786, 789-92 (8th Cir. 2007).

104. See *Hicks v. Fleming Cos., Inc.*, 961 F.2d 537, 543 (5th Cir. 1992)

distinguish between employer communications which can be relied on and those which cannot?

The majority of Circuits required something more than SPD language that varied from plan language for a plaintiff to prevail, such as “detrimental reliance”, “possible prejudice,” or “likely harm.”<sup>105</sup> Most courts held that the plaintiff “must show some significant reliance upon, or possible prejudice flowing from, the faulty plan description.”<sup>106</sup>

For example, in *Govoni v. Bricklayers*,<sup>107</sup> the First Circuit, in an opinion by then-Judge Breyer, held:

The trustees failed to comply with [section 102 of ERISA], for the summary plan description available to Govoni does not reveal that those with pre-1976 breaks will be treated more harshly than those with post-1976 breaks. Case law suggests, however, that to secure relief, Govoni must show some significant reliance upon, or possible prejudice flowing from, the faulty plan description [citations omitted]. And we can find no such reliance or prejudice here.<sup>108</sup>

A holding that individual reliance on the SPD must be proved may prevent the case from proceeding as a class action.<sup>109</sup>

In 2003, the Second Circuit adopted a likelihood of harm standard.<sup>110</sup> If the plan participant shows that he or she was likely to have been harmed as a result of the flawed SPD, then the burden shifts to the employer to prove that “the deficient SPD was in effect a harmless error.”<sup>111</sup> In the same year, the Third Circuit declined to impose any reliance or causation requirement, by analogy to the rule that “a court’s enforcement of a contract

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(holding that a booklet was not an SPD, so the employee’s reliance on it was not justified).

105. Langbein, *supra* note 87, at 607-8.

106. *See id.* (quoting *Govoni v. Bricklayers, Masons & Plasterers Intern. Union of Am., Local No. 5 Pension Fund*, 732 F.2d 250, 252 (1st Cir. 1984)).

107. *Govoni v. Bricklayers, Masons & Plasterers Int’l Union of Am., Local No. 5 Pension Fund*, 732 F.2d 250 (1st Cir. 1984).

108. *Id.* at 252. *See also* *Branch v. G. Bernd Co.*, 955 F.2d 1574, 1579 (11th Cir. 1992) in which the court held that

when an employer provides an inaccurate plan summary, the beneficiaries who rely on that summary are not accurately apprised of their rights. But when a beneficiary fails to read or rely on the summary, whether it is accurate or not, the beneficiary also prevents full appraisal of the rights under the plan. Beneficiaries must do their part if Congress’ objective is to be met. We thus hold that, to prevent an employer from enforcing the terms of a plan that are inconsistent with those of the plan summary, a beneficiary must prove reliance on the summary.

109. *See* *Heffner v. Blue Cross and Blue Shield of Ala., Inc.*, 443 F.3d 1330, 1346 (11th Cir. 2006) (denying class action certification).

110. *Burke v. Kodak Ret. Income Plan*, 336 F.3d 103, 113 (2d Cir. 2003), *cert. denied*, 540 U.S. 1105 (2004).

111. *Id.* at 113.

generally does not require proof that the parties to the contract actually read, and therefore relied upon the particular terms of the contract.”<sup>112</sup> Then, in 2007, the Fifth Circuit also declined to require proof of reliance, basing its holding on the rule that any ambiguity in an insurance contract is resolved against the drafter, i.e., the insurer.<sup>113</sup>

### B. *The Fiduciary Duty to Disclose*

Courts have accepted that the fiduciary duty to disclose information to participants and beneficiaries is not limited to the specific disclosures, e.g., the SPD, mandated by ERISA.<sup>114</sup> “ERISA’s fiduciary duty of disclosure derives from the duties of loyalty and prudence, [section] 404(a)(1)(A)–(B), hence the fiduciary duty applies independently of the regulatory disclosure requirements of ERISA Title 1, Part 1.”<sup>115</sup> In addition, “[t]rust law has long imposed a duty to inform or disclose, as an aspect of the trustee’s fiduciary duties of loyalty and prudence.”<sup>116</sup> The trustee has a duty to inform the beneficiaries about “significant developments concerning the trust and its administration, particularly material information needed by beneficiaries for the protection of their interests.”<sup>117</sup>

In one case, the court expressed doubt about the adequacy of the SPD but declined to decide the case on that ground.<sup>118</sup> The court instead rested its decision on the ground that the plan administrator “breached its fiduciary duty to provide [the participant] with complete and accurate information.”<sup>119</sup>

*Varity Corp. v. Howe*<sup>120</sup> “established that communication about plan benefits is a fiduciary function.”<sup>121</sup> In his opinion, Justice Breyer noted that “administrators, as part of their administrative responsibilities, frequently offer beneficiaries more than the minimum information that the statute requires—for example, answering beneficiaries’ questions about the meaning of the terms of a plan so that those beneficiaries can more easily obtain the plan’s benefits.”<sup>122</sup> The Court avoided “reach[ing] the question whether ERISA fiduciaries have any fiduciary duty to

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112. *Burstein v. Ret. Account Plan for Emps. of Allegheny Health Educ. and Research Found.*, 334 F.3d 365, 381 (3d Cir. 2003).

113. *Washington v. Murphy Oil USA, Inc.*, 497 F.3d 453, 458-59 (5th Cir. 2007).

114. Langbein, *supra* note 87, at 609 *et seq.*

115. *Id.* at 609.

116. *Id.*

117. RESTATEMENT (THIRD) OF TRUSTS § 82(1)(c) (2007).

118. *Estate of Becker v. Eastman Kodak Co.*, 120 F.3d 5, 9-10 (2d Cir. 1997).

119. *Id.* at 10.

120. *Varity Corp. v. Howe*, 516 U.S. 489 (1996).

121. Langbein, *supra* note 87, at 620.

122. *Varity*, 516 U.S. at 502-03.



disclose truthful information on their own initiative, or in response to employee inquiries.”<sup>123</sup> As speaking about plan benefits is fiduciary conduct, the fiduciary duty of loyalty applies, and “[l]ying is inconsistent with the duty of loyalty owed by all fiduciaries and codified in section 404(a)(1) of ERISA.”<sup>124</sup>

Some cases have required a fiduciary to volunteer relevant information, even in the absence of a request from a participant or beneficiary.<sup>125</sup> The “duty to inform is a constant thread in the relationship between beneficiary and trustee; it entails not only a negative duty not to misinform, but also an affirmative duty to inform when the trustee knows that silence might be harmful.”<sup>126</sup> The trustee is “under a duty to communicate to the beneficiary material facts which he knows the beneficiary does not know and which the beneficiary needs to know for his protection in dealing with a third person.”<sup>127</sup>

### C. The Oral Amendment Cases

Section 402(a)(1) requires that “every employee benefit plan shall be maintained pursuant to a written instrument.”<sup>128</sup> Courts have consistently cited this requirement in refusing to allow plaintiffs to make claims based on oral statements that allegedly varied the written plan terms, even if the plaintiff clearly relied on the oral statements.<sup>129</sup>

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123. *Id.* at 506.

124. *Id.* (quoting *Peoria Union Stock Yards Co. v. Penn Mut. Life Ins. Co.*, 698 F.2d 320, 326 (7th Cir. 1983)).

125. *E.g.*, *Bixler v. Cent. Pa. Teamsters Health & Welfare Fund*, 12 F.3d 1292, 1300 (3d Cir. 1993); *Eddy v. Colonial Life Ins. Co. of Am.*, 919 F.2d 747, 750-51 (D.C. Cir. 1990).

126. *Bixler*, 12 F.3d at 1300.

127. *Eddy*, 919 F.2d at 751; *see also* *Krohn v. Huron Mem'l Hosp.*, 173 F.3d 542, 547-51 (6th Cir. 1999); *Joyce v. RJR Nabisco Holdings Corp.*, 126 F.3d 166, 172-73 (3d Cir. 1997); *Farr v. U.S. West Commc'ns, Inc.*, 151 F.3d 908, 914 (9th Cir. 1998) (subsequent appellate history omitted); *Jordan v. Fed. Exp. Corp.*, 116 F.3d 1005, 1014 (3d Cir. 1997).

128. 29 U.S.C. § 1102(a)(1).

129. *See, e.g.*, *Schmidt v. Sheet Metal Workers' Nat'l Pension Fund*, 128 F.3d 541, 546 (7th Cir. 1997), *cert. denied*, 523 U.S. 1073 (1998) (stating, “As we have noted on many occasions, oral representations that conflict with the terms of a written plan will not be given effect, as the written instrument must control [citation omitted].”). *See also* *Nachwalter v. Christie*, 805 F.2d 956, 960 (11th Cir. 1986), in which the court stated

A central policy goal of ERISA is to protect the interests of employees and their beneficiaries in employee benefit plans. This goal would be undermined if we permitted oral modifications of ERISA plans because employees would be unable to rely on these plans if their expected retirement benefits could be radically affected by funds dispersed to other employees pursuant to oral agreements. This problem would be exacerbated by the fact that these oral agreements often would be made many years before any attempt to enforce them [internal citations

As Judge Easterbrook noted in *Frahm v. Equitable Life Assurance*:

Havoc would ensue if plans meant different things for different participants, depending on what someone said to them years earlier. Memory is weak compared to the written word, and there is a substantial risk that participants will not correctly recall what was said, will exaggerate (in their favor) what they heard, or will simply prevaricate in order to improve their position. Employers could do little to protect themselves against such claims—which is why ERISA calls for writings.<sup>130</sup>

One prominent case that held to the contrary, on somewhat unusual facts, is *Black v. TIC Investment Corp.*:

In cases . . . where there is no danger that others associated with the Plan can be hurt, there is no good reason to breach the general rule that misrepresentations can give rise to an estoppel. There is no reason for the employee who reasonably relied to his detriment on his employer's false representations to suffer. There is no reason for the employer who misled its employee to be allowed to profit from the misrepresentation. We hold, therefore, that estoppel principles are applicable to claims for benefits under unfunded single-employer welfare benefit plans under ERISA. We express no opinion as to the application of estoppel principles in other situations.<sup>131</sup>

In the oral amendment cases, it is often clear that the plaintiffs relied on the oral representations to their detriment.<sup>132</sup> In many of the SPD cases, it is much less clear that there was reliance, let alone detrimental reliance. Accordingly, it is somewhat anomalous that the courts are more willing to grant a remedy for SPD defects.

#### IV. AMARA

To date, there have been four opinions in *Amara*. District Judge Mark Kravitz issued two decisions in 2008: the first relating to liability ("*Amara Liability Decision*")<sup>133</sup> and the second relating to remedies ("*Amara Remedy Decision*").<sup>134</sup> On October 6, 2009, the Second Circuit issued a Summary Order affirming the decisions "for substantially the reasons stated in Judge Kravitz's two well-reasoned and scholarly opinions."<sup>135</sup> The Supreme Court granted CIGNA's petition for certiorari<sup>136</sup> to consider whether a

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omitted].

130. *Frahm v. Equitable Life Assurance Soc'y of U.S.*, 137 F.3d 955, 960 (7th Cir. 1998), *cert. denied* 525 U.S. 817 (1998).

131. *Black v. TIC Inv. Corp.*, 900 F.2d 112, 115 (7th Cir. 1990).

132. *E.g.*, *Schmidt v Sheet Metal Workers' Nat'l Pension Fund*, 128 F. 3d 541, 544-45 (7th Cir. 1997).

133. *Amara v. CIGNA Corp.*, 534 F. Supp. 2d 288 (D. Conn. 2008).

134. *Amara v. CIGNA Corp.*, 559 F. Supp. 2d 192 (D. Conn. 2008).

135. *Amara v. CIGNA Corp.*, 348 Fed. Appx. 627 (2d Cir. 2009).

136. *CIGNA Corp. v. Amara*, 130 S. Ct. 3500 (2010).

showing of “likely harm” is sufficient to entitle plan participants to recover benefits based on faulty disclosures.<sup>137</sup> The Supreme Court issued its decision in May 2011.<sup>138</sup> As discussed below, the Court’s opinion is far more wide ranging than the limited scope of the grant would suggest.<sup>139</sup> The following summary of facts is taken from the Liability Decision.

#### A. *The Factual Background*<sup>140</sup>

In 1997, CIGNA decided to convert its traditional defined benefit pension plan to a cash balance plan.<sup>141</sup> In November 1997, CIGNA’s Chief Executive Officer signed a plan amendment

freezing benefit accruals for all Tier 2 employees and for all Tier 1 employees with a combined age and years of service less than 45. The plan was that Tier 1 employees who had age and service credits of 45 or more would be grandfathered under the old plan and thus continue to accrue benefits under Part A. All other employees would be moved to the new cash balance plan.<sup>142</sup>

“On December 21, 1998, CIGNA’s CEO signed the plan document for the cash balance plan, Part B, as well as an updated Part A plan document.”<sup>143</sup> “Non-grandfathered employees who were employed as of December 31, 1997 became participants in Part B. Additionally, any employees hired for the first time after January 1, 1998 automatically became participants in Part B upon being hired.”<sup>144</sup>

“OPENING BALANCES. Non-grandfathered employees who were employed by CIGNA as of December 31, 1997 received a hypothetical opening account balance that was calculated by reference to the actuarial present value of their Part A accrued benefits.”<sup>145</sup> A portion of the subsidized Part A early retirement benefits was included in these opening balances.<sup>146</sup> “However, the full value of those benefits was not protected, and . . . CIGNA acknowledged that early retirement benefits, as a rule, were not included either in the account balances or, [as a result,] in the lump sums available under Part B.”<sup>147</sup> Also, mortality tables were used to discount the value of the retirement benefit for pre-

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137. CIGNA Corp. v. Amara, 131 S. Ct. 1866, 1871 (2011).

138. *Id.*

139. *See infra* Part IV.I.

140. *See Amara Liability Decision*, 534 F. Supp. 2d at 296-311.

141. *Id.* at 300.

142. *Id.*

143. *Id.*

144. *Id.*

145. *Id.* at 301.

146. *Id.* at 301 n.4.

147. *Id.*

retirement mortality.<sup>148</sup> “The discount was applied for purposes of determining employee opening balances, and therefore, as an employee grew older and the risk of pre-retirement mortality diminished, the employee would not recoup the amount of the discount taken in calculating the employee’s opening balance.”<sup>149</sup>

“BENEFIT CREDITS. Part B participants also earned benefit credits that had both a pay [component] and an interest component.”<sup>150</sup>

“MINIMUM BENEFITS AND WEAR AWAY. Under the terms of Part B, employees were to receive the greater of a retirement benefit based on their hypothetical account balances or their minimum benefit, as defined in the Plan.”<sup>151</sup> “In effect, the minimum benefit was the participant’s age-65 annuity benefit under Part A, enhanced by” a spouse’s benefit (if applicable).<sup>152</sup> The Plan “also protected the employee’s right to subsidized early retirement benefits to which they were entitled under Part A,” but only if those benefits were taken as an annuity (rather than as a lump sum).<sup>153</sup>

“As a consequence of the manner in which opening balances were calculated under Part B, a participant’s opening account balance was not always equivalent to the value of the participant’s Part A accrued benefit.”<sup>154</sup> An employee’s opening account balance could be much less than the present value of the employee’s Part A accrued benefit.<sup>155</sup>

Interest rate fluctuations also affected the relationship between an employee’s minimum benefit and the account balance . . .<sup>156</sup> Since the opening account balances were calculated by converting each participant’s annuity benefit into a lump sum using a particular interest rate (6.05% or 5.05%), if interest rates dropped, the employee’s minimum benefit could exceed the employee’s account balance.<sup>157</sup>

That is what actually happened, and “that exacerbated the gap between the employees’ opening account balances and their minimum benefits.”<sup>158</sup>

As Judge Kravitz explained:

Thus, the design of Part B, plus the drop in interest rates, led to . . .

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148. *Id.*

149. *Id.*

150. *Id.*

151. *Id.* at 302.

152. *Id.* at 303.

153. *Id.*

154. *Id.*

155. *Id.*

156. *Id.*

157. *Id.*

158. *Id.*

'wear away' for many, though by no means all, employees. Wear away means that there are periods of time in which the employee's account balance is less than the employee's minimum benefit. What wear away means in practice is that even though an employee is continuing each year to receive pay and interest credits under Part B, and the employee's account balance may even be growing, it nonetheless remains less than the minimum benefit earned as of December 31, 1997; in effect, where there is wear away, even though the employee continues to work for CIGNA and continues to receive benefit credits, the employee's expected retirement benefits have not grown beyond what the employee was entitled to under Part A as of December 31, 1997.<sup>159</sup>

The court found that "wear away should have been anticipated by CIGNA, though the precise amount of wear away or duration for any given employee could not be predicted with accuracy."<sup>160</sup> CIGNA was "aware that its Plan could result in wear away, although there is no evidence in the record that CIGNA made any estimates of the precise amount of wear away for its employee population."<sup>161</sup>

"CIGNA COMMUNICATIONS TO EMPLOYEES." During the conversion process, CIGNA sent various communications to its employees.<sup>162</sup> Some of these items were required by ERISA, including a section 204(h) notice,<sup>163</sup> SPDs, and an SMM. CIGNA also sent newsletters and other communications that were not so required.<sup>164</sup>

CIGNA's SPD stated:

'Each dollar's worth of credit is a dollar of retirement benefits payable to you after you are vested' [and that] '[y]our account balance grows in two ways—annual benefit credits and quarterly interest credits . . . . For each year in which you earn a year of credited service, CIGNA will add benefit credits to your account equal to a percentage of your annual eligible earnings . . . . Your account also will grow through interest credits.' The SPD did not mention or explain wear away, although it did state that participants would never receive less than the minimum benefit.<sup>165</sup>

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159. *Id.* at 303-04

160. *Id.* at 305.

161. *Id.* at 305-06.

162. *Id.* at 306-11.

163. 29 U.S.C. § 1054(h). As in effect at the time in question, section 204(h) required the plan administrator to provide advance notice of any plan amendment that provided for a "significant reduction in the rate of future benefit accrual." *Id.*

164. *Amara Liability Decision*, 534 F. Supp. 2d at 306-11.

165. *Id.* at 310.

### B. *The Plaintiffs' Claims*

The publications challenged by the Plaintiffs were: a 1997 newsletter that CIGNA identified as a section 204(h) notice; a December 1997 Retirement Program Information Kit that CIGNA identified as an SMM; an October 1998 SPD for Part B; and a September 1999 SPD for Part B.<sup>166</sup>

[The] Plaintiffs claim[ed] that the section 204(h) notice was deficient because it failed to inform plan participants of a significant reduction in the rate of future benefit accrual under Part B, and that the SMM and SPDs were deficient because they failed to inform plan participants of the possibility of wear away and of the possibility that accrued benefits under Part A might not be fully protected.<sup>167</sup>

### C. *The Section 204(h) Notice*

The court found that nothing in the Newsletter indicated to plan participants that their rate of benefit accrual might decrease, which is what happened.<sup>168</sup> Instead

CIGNA offered statements that misled plan participants into believing that significant reductions in the rate of future benefit accrual were not a component or a possible result of Part B . . . . Even looking outside the purported [section] 204(h) notice to the other publications provided by CIGNA, information regarding possible reductions in the rate of future benefit accrual is equally non-existent.<sup>169</sup>

The court concluded that

CIGNA was aware of the significant reduction in the rate of future benefit accrual that would affect at least a substantial proportion of its employees as a result of the transition to Part B, that CIGNA wished to avoid the employee backlash likely to result from a thorough discussion of these aspects of Part B, and that CIGNA sought to negate the risk of backlash by producing affirmatively and materially misleading notices regarding Part B. As a result, its [section] 204(h) notice failed to meet ERISA's stringent standards.<sup>170</sup>

### D. *The SMM and the SPDs*

First, the court found that CIGNA's disclosures with respect to the possibility of wear away were deficient.<sup>171</sup> CIGNA admitted "that it nowhere informed its employees that they might not be

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166. *Id.* at 335.

167. *Id.*

168. *Id.* at 339.

169. *Id.* at 340.

170. *Id.* at 344.

171. *Id.* at 346.

accruing benefits under Part B.”<sup>172</sup> The court further held that

CIGNA had a duty to inform plan participants of the possibility of wear away in its notices and disclosures regarding Part B. The fact that wear away might not have been intentional or the result of a single plan provision is irrelevant; CIGNA created a pension plan that was structurally susceptible to the wear away effect, and should have known, given the current state of interest rates, that further declines were of sufficient likelihood that wear away needed to be disclosed. The possibility of wear away was certainly a material fact regarding Part B, as some CIGNA employees’ pension benefits did not grow for several years as a result of the phenomenon. Treasury regulations require that ‘[a]ny description of exception[s], limitations, reductions, and other restrictions of plan benefits shall not be minimized, rendered obscure or otherwise made to appear unimportant.’ By ignoring the risk of wear away, CIGNA did exactly that.<sup>173</sup>

The court further noted that even if CIGNA “did not have an affirmative duty to inform plan participants regarding wear away, it nevertheless could not provide, instead of no information, materially misleading statements. Yet that is just what CIGNA did.”<sup>174</sup>

The court then turned to “the disclosure of which benefits accrued under Part A would be preserved in the opening account balance or as part of the protected minimum benefit established under Part B.”<sup>175</sup> The Plaintiffs argued that “CIGNA’s disclosures were faulty because they led plan participants to believe that all of their Part A accrued benefits, including their early retirement benefits, would be protected.”<sup>176</sup> After examining the statements CIGNA made about accrued benefits under Part A, however, the court concluded that the Plaintiffs

reasonably could have believed that their early retirement benefits were fully protected as part of their minimum benefit and/or their opening account balance under Part B . . . . In light of these documents and their unqualified references to ‘old plan benefits,’ it was reasonable for CIGNA employees to conclude that all of their early retirement benefits were included in the protected minimum benefit, and that the employees would receive the full value of those benefits, regardless of whether they chose an annuity or a lump sum. Thus, the notices were not written in a manner calculated to be understood by the average plan participant.<sup>177</sup>

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172. *Id.*

173. *Id.* at 348 (citing 29 C.F.R. § 2520.102-2(b)).

174. *Id.* at 349.

175. *Id.* at 350.

176. *Id.*

177. *Id.* at 350-51.

### E. Likely Harm

CIGNA argued that, even assuming that the notices and disclosures were statutorily defective, the Plaintiffs were not entitled to relief because they “failed to demonstrate injury.”<sup>178</sup> The court noted that the Second Circuit has identified likely harm as the appropriate standard of injury,<sup>179</sup> holding that

a prejudice standard is more consistent with ERISA’s objective to protect the employee against inadequate SPDs. A rule requiring detrimental reliance imposes an insurmountable hardship on many plaintiffs . . . and such a rule hardly advances the Congressional purpose of protecting the beneficiaries of ERISA plans by insuring that employees are fully and accurately apprised of their rights under the plan.<sup>180</sup>

Thus, the court concluded<sup>181</sup>

[the Second Circuit] require[s], for a showing of prejudice, that a plan participant or beneficiary was *likely* to have been harmed as a result of a deficient SPD. Where a participant makes this initial showing, however, the employer may rebut it through evidence that the deficient SPD was in effect a harmless error.<sup>182</sup>

The Second Circuit applied a “likely harm” standard to avoid imposing

harsh common law principles to defeat employees’ claims based on a federal law designed for their protection.’ In sum, [t]he result is a presumption of prejudice in favor of the plan participant after an initial showing that he was likely to have been harmed.<sup>183</sup>

The court also cited the Second Circuit’s broad conception of “likely harm”:<sup>184</sup>

As the court explained in *Frommert*, “[a]s a result [of the inadequate notices], [the plaintiffs] were deprived of the opportunity to take timely action in response to the purported ‘amendment.’ Such action might have included seeking injunctive relief, altering their retirement investment strategies, or perhaps considering other employment.”<sup>185</sup>

Accordingly, the Court concluded,

Applying the *Burke* and *Frommert* standard to the facts of this case,

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178. *Id.* at 351.

179. *Id.* (citing *Burke*, 336 F.3d 103).

180. *Id.* (citing *Burke*, 336 F.3d at 112).

181. *Id.* at 351-52.

182. *Id.* (quoting *Burke*, 336 F.3d at 113).

183. *Id.* (quoting *Burke*, 336 F.3d at 113-14).

184. *Id.* at 352.

185. *Id.* (quoting *Frommert v. Konkright*, 433 F.3d 254, 266 (2d Cir. 2006)); see also *Laurent v. PricewaterhouseCoopers LLP*, 448 F. Supp. 2d 537, 547 (S.D.N.Y. 2006).



the Court holds that Plaintiffs have met their burden of showing likely harm and prejudice. As in *Frommert*, the notices provided by CIGNA 'likely, and quite reasonably, led plan participants to believe' that wear away was not a likely result of the transition to Part B, that the full value of the accrued benefits under Part A, including early retirement benefits, would be included in the opening account balances, and that the accrual rates for both short- and long-term employees under Part B were at least roughly equivalent to those under Part A. Also as in *Frommert*, CIGNA's successful efforts to conceal the full effects of the transition to Part B 'deprived [plaintiffs] of the opportunity to take timely action in response to the purported 'amendment,' whether that action was protesting at the time Part B was implemented, leaving CIGNA for another employer with a more favorable pension plan, or filing a lawsuit like this one. As Ms. Amara testified, had she been told during her rehire interview that she would not be earning additional retirement benefits during a wear away period, she could have 'negotiated for a higher salary,' 'looked and talked to other employers,' or stayed at her previous position.'<sup>186</sup>

#### *F. Choices upon Retirement*

The Plaintiffs also claimed that CIGNA was required to inform plan participants that the lump sum option (unlike the annuity option) did not include any early retirement benefits (other than a preserved spouse's benefit).<sup>187</sup> The court agreed stating:

Looking at the terms of the Treasury regulations, the Court agrees with Plaintiffs that CIGNA was required to notify its employees that the subsidized early retirement benefits were available only through the annuity option. Treasury Regulation 1.401(a)-20, Q&A-36, for example, obligates employers to explain 'the extent to which optional forms are subsidized relative to the normal form of benefit.' Thus, under the plain language of the regulation, merely including the early retirement benefits in the value of the annuity, without making clear that those early retirement benefits were available as part of the annuity and only as part of the annuity, was insufficient . . . . Thus, the Court finds that CIGNA violated ERISA and the relevant Treasury regulations by not including an explicit statement in its benefit election forms to the effect that early retirement benefits accrued under Part A were only available under the annuity, and not as part of the lump sum payment.<sup>188</sup>

#### *G. Greater Benefits*

The Plaintiffs also claimed "that CIGNA should have informed its employees if the benefits under Part A were greater

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186. *Id.* at 354 (internal citations omitted).

187. *Id.* at 357.

188. *Id.* at 359-60.

than those under Part B.”<sup>189</sup> The court again agreed stating:

Although there is no support in the regulations for an obligation on CIGNA affirmatively to point out the greater of the available options, the Court finds that CIGNA assumed that obligation as a result of statements it made in materials describing the transition to Part B . . . . CIGNA was required, as a result of its promises in the SPDs, affirmatively to notify its employees if the present value of their retirement benefits under Part A exceeded those available under Part B . . . . Especially in light of the difficulty employees (and even experts) had in evaluating the comparative value of the different retirement options, CIGNA could only comply with its obligation by pointing out explicitly that the Part A annuity had the greater present value.<sup>190</sup>

#### *H. The District Court’s Remedy Decision*

The first decision issued by the district court addressed only liability. In its second decision, issued four months later, the court addressed remedies.<sup>191</sup> The court stayed “its judgment so that the parties [could] proceed to the Second Circuit for further guidance before the court and the parties [sought] to implement the Court’s judgment.”<sup>192</sup>

##### *1. Did the SPDs Modify the Terms of the Plan?*

The court held that the terms of Part B had been modified by the October 1998 and September 1999 SPDs.<sup>193</sup> In light of CIGNA’s statements that all early retirement benefits would be protected, and CIGNA’s failure to warn of wear away, the court ordered and enjoined the plan “to reform its records to reflect that all class members must now receive ‘A+B’ benefits.”<sup>194</sup> As such, all class members were to receive (1) their accrued benefits under the traditional pension formula (Part A), “in the form in which those benefits were available under Part A,” and (2) “their accrued benefits under Part B, in whatever form those benefits were available under Part B.”<sup>195</sup> As one commentator has noted:

Although the court showed no awareness of the point, the ‘additive’ formula that it imposed is not inherently more favorable to participants than CIGNA’s ‘greater of’ formula. High interest rates between the time of the cash balance conversion and a participant’s annuity starting date could cause his opening cash balance to grow

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189. *Id.* at 362.

190. *Id.*

191. *Amara v. CIGNA Corp.*, 559 F. Supp. 2d 192 (D. Conn. 2008) [hereinafter *Amara Remedy Decision*].

192. *Id.* at 195.

193. *Id.* at 222.

194. *Id.*

195. *Id.*

to a greater value than his minimum benefit; the additive formula deprives him of that possibility, because it eliminates the need for an opening balance. The district court issued its order with the benefit of a decade of hindsight. If CIGNA had adopted an additive formula at the beginning and interest rates had thereafter headed upward, one can easily imagine a lawsuit decrying its failure to explain adequately that the value of frozen Part A benefits would not grow proportionately.<sup>196</sup>

## 2. Availability of Relief Under Section 502(a)(1)(B)

The court cited *Frommert*<sup>197</sup> for the proposition that benefits under the plan as a result of a misleading SPD fell “comfortably within the scope” of § 502(a)(1)(B).<sup>198</sup>

The court held

given the materially misleading statements in the SMM and the SPDs to the effect that wear away was not a likely result of the transition to Part B and that early retirement benefits would be included in the opening account balances and/or the Part B minimum benefit . . . these representations have become terms of the Plan under the reasoning of *Frommert*. [Citation] As such, the Court’s remedy here constitutes benefits under the terms of the plan under [section] 502(a)(1)(B).<sup>199</sup>

The court read “benefits under the terms of the plan” to “mean exactly that, regardless of whether those benefits derive from the literal terms of the plan or from the misleading statements in CIGNA’s required disclosures.”<sup>200</sup> The court believed that “any remedial benefits it orders as a result of the materially misleading statements in CIGNA’s notices and disclosures constitute benefits under the terms of the plan, and the CIGNA Plan is liable for those benefits under [section] 502(a)(1)(B).”<sup>201</sup>

The third misrepresentation, regarding so-called comparable benefits under Part A and Part B, appeared in the SMM and the section 204(h) notice; but not in the SPDs.<sup>202</sup> The Court expressed its reluctance “to treat a misleading SMM as a misleading SPD—that is, to reform the terms of the plan in conformity with the SMM.”<sup>203</sup> The court stated that there were

no concrete means of remedying [this misrepresentation] as A+B

196. Veal, *supra* note 23, at 7-14 (footnote omitted).

197. *Frommert*, 433 F.3d at 266.

198. *Amara Remedy Decision*, 559 F. Supp. 2d at 203. The court also cited *May Dept. Stores Co. v. Fed. Ins. Co.*, 305 F.3d 597, 601 (7th Cir. 2002) (stating, “The benefits sought were plan benefits; the question was how to compute them”).

199. *Amara Remedy Decision*, 559 F. Supp. 2d at 212.

200. *Id.* at 204.

201. *Id.* at 205.

202. *Id.* at 213.

203. *Id.*

serves to remedy the [other misrepresentations]. Instead, the Court views these statements as more relevant to the [section] 204(h) notices and CIGNA's attempts to lull its employees into thinking that Part B would not result in a significant reduction in the rate of future benefit accrual. In order to make these statements 'true' as Plaintiffs request, the Court would be required entirely to rewrite the Plan's provisions, with no clear guidance from the Plan itself or the relevant notices and disclosures. Plaintiffs concede that the Court does not have such authority.<sup>204</sup>

### 3. *Availability of Relief Under Section 502(a)(3)*

In light of its holding that relief was available under section 502(a)(1)(B), the court did not need to consider whether the relief ordered would also be available under section 502(a)(3).<sup>205</sup> It stated that "even if the latter course were theoretically possible, the Supreme Court has issued several opinions . . . that have severely curtailed the kinds of relief that are available under [section] 502(a)(3)."<sup>206</sup>

### 4. *Additional Relief*

The court also (1) ordered the Defendants to supply accurate section 204(h) notices to all members of the Plaintiff class, and (2) ordered the plan to provide new, accurate benefit election notices reflecting the court's determination as to the appropriate procedure for providing additional remedial benefits.<sup>207</sup>

#### I. *The Supreme Court*

In May 2011, the United States Supreme Court unanimously held that section 502(a)(1)(B) did not authorize relief.<sup>208</sup> In addition, Justice Breyer discussed at length the possible availability of equitable relief under section 502(a)(3), noting:

Section 502(a)(3) invokes the equitable powers of the District Court. We cannot know with certainty which remedy the District Court understood itself to be imposing, nor whether the District Court will find it appropriate to exercise its discretion under [section] 502(a)(3) to impose that remedy on remand. We need not decide which remedies are appropriate on the facts of this case in order to resolve the parties' dispute as to the appropriate legal standard in determining whether members of the relevant employee class were injured.<sup>209</sup>

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204. *Id.* at 214.

205. *Id.* at 205.

206. *Id.*

207. *Id.* at 222.

208. *CIGNA Corp. v. Amara*, 131 S. Ct. 1866, 1878 (2011) (Justice Sotomayor took no part in the decision).

209. *Id.* at 1880.

He added:

We have premised our discussion in Part III on the need for the District Court to revisit its determination of an appropriate remedy for the violations of ERISA it identified. Whether or not the general principles we have discussed above are properly applicable in this case is for it or the Court of Appeals to determine in the first instance. Because the District Court has not determined if an appropriate remedy may be imposed under [section] 502(a)(3), we must vacate the judgment below and remand this case for further proceedings consistent with this opinion.<sup>210</sup>

Justice Scalia wrote a concurring opinion, in which Justice Thomas joined, noting, "I agree with the Court that [section] 502(a)(1)(B) does not authorize relief for misrepresentations in a summary plan description (SPD). I do not join the Court's opinion because I see no need and no justification for saying anything more than that."<sup>211</sup>

He added:

The Court's discussion of the relief available under [section] 502(a)(3) and *Mertens* is purely dicta, binding upon neither us nor the District Court. The District Court need not read any of it—and, indeed, if it takes our suggestions to heart, we may very well reverse. Even if we adhere to our dicta that contract reformation, estoppel, and surcharge are "distinctively equitable" remedies, it is far from clear that they are available remedies in this case. The opinion for the Court does not say (much less hold) that they are and disclaims the implication.<sup>212</sup>

### 1. *Availability of Relief Under Section 502(a)(1)(B)*

The Court held unanimously that section 502(a)(1)(B) did not give the District Court authority to reform CIGNA's plan as that provision speaks of enforcing the plan's terms, not changing them.<sup>213</sup>

The Court rejected the Solicitor General's alternative argument, that the District Court enforced the summary plan descriptions and that they are plan terms.<sup>214</sup> Section 102(a) obliges plan administrators to furnish summary plan descriptions, but does not suggest that information about the plan provided by those disclosures is itself part of the plan.<sup>215</sup> The Court found that the Solicitor General's reading could not be squared with the statute's division of authority between the plan's sponsor and the plan's

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210. *Id.* at 1882.

211. *Id.* (Scalia, J., concurring in the judgment).

212. *Id.* at 1884 (Scalia, J., concurring in the judgment) (internal citations omitted).

213. *Id.* at 1876-77.

214. *Id.* at 1877.

215. *Id.*

administrator.<sup>216</sup> ERISA carefully distinguishes these roles, and there is “no reason to believe that the statute intends to mix the responsibilities by giving the administrator the power to set plan terms indirectly in the summary plan descriptions.”<sup>217</sup>

Finally, Justice Breyer said that it is difficult to reconcile an interpretation that would make an SPD’s language legally binding with the basic SPD objective of providing clear and simple communication:<sup>218</sup>

To make the language of a plan summary legally binding could well lead plan administrators to sacrifice simplicity and comprehensibility in order to describe plan terms in the language of lawyers. Consider the difference between a will and the summary of a will or between a property deed and its summary. Consider, too, the length of Part I of this opinion, and then consider how much longer Part I would have to be if we had to include all the qualifications and nuances that a plan drafter might have found important and feared to omit lest they lose all legal significance. The District Court’s opinions take up 109 pages of the Federal Supplement. None of this is to say that plan administrators can avoid providing complete and accurate summaries of plan terms in the manner required by ERISA and its implementing regulations. But we fear that the Solicitor General’s rule might bring about complexity that would defeat the fundamental purpose of the summaries.<sup>219</sup>

## 2. Availability of Relief Under Section 502(a)(3)<sup>220</sup>

Having held that section 502(a)(1)(B) does not authorize entry of the relief granted by the District Court, Justice Breyer turned to the availability of relief under section 502(a)(3):<sup>221</sup>

The District Court strongly implied, but did not directly hold, that it would base its relief upon this subsection were it not for (1) the fact that the preceding ‘plan benefits due’ provision, [section] 502(a)(1)(B), provided sufficient authority; and (2) certain cases from this Court that narrowed the application of the term ‘appropriate equitable relief.’ . . . . Our holding in Part II–A, *supra*, removes the District Court’s first obstacle. And given the likelihood that, on remand, the District Court will turn to and rely upon this

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216. *Id.* at 1868.

217. *Id.* at 1869.

218. *Id.* at 1877-78.

219. *Id.*

220. The availability of equitable relief under ERISA after *Amara* is the subject of Prof. Harthill’s article in this issue. Accordingly, the following is only a brief discussion of the points raised by Justice Breyer. See also Mary Ellen Signorille & Raven Merlau, *Current Developments in Employment Law: The Obama Years at Mid-Term: CIGNA Corporation v. Amara: A Whole New World?*, ALI-ABA COURSE OF STUDY (July 28-30, 2011) (discussing possible equitable remedies other than reformation, estoppel, and surcharge).

221. *Amara*, 131 S. Ct. at 1878.

alternative subsection, we consider the court's second concern. We find that concern misplaced.<sup>222</sup>

Justice Breyer noted that the District Court's injunctions "obviously fall within" the category of equitable relief.<sup>223</sup> The other relief it ordered resemble three forms of traditional equitable relief: reformation, estoppel, and surcharge.<sup>224</sup>

a. Reformation

What the District Court did "may be regarded as the reformation of the plan's terms, in order to remedy false or misleading information CIGNA provided. The power to reform contracts [as contrasted with the power to enforce contracts as written] is a traditional power of an equity court and is used to prevent fraud."<sup>225</sup>

Justice Breyer stated that detrimental reliance is not essential to the remedy of reformation, because an equity court would grant it "even if the 'complaining part[y]' was negligent in not realizing its mistake."<sup>226</sup>

Justice Scalia, in his concurring opinion, identifies two obstacles to reformation as a way to correct faulty SPDs.<sup>227</sup> First, the SPD is the responsibility of the plan administrator, who is not a party to the contract between the plan sponsor and the participant.<sup>228</sup> Reformation would "alter the terms of a contract in response to a third party's misrepresentations—not those of a party to the contract."<sup>229</sup> The sponsor and the administrator may be different parties, and may be unrelated.<sup>230</sup>

Secondly, Justice Scalia pointed out that "SPDs may be furnished months after an employee accepts a pension or benefit plan. § 1024(b)(1). Reformation is meant to effectuate mutual intent at the time of contracting, and that intent is not retroactively revised by subsequent misstatements."<sup>231</sup>

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222. *Id.* (citing *Mertens v. Hewitt Assocs.*, 508 U.S. 248 (1993); *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002)).

223. *Id.* at 1879.

224. *Id.*

225. *Id.*

226. *Id.* at 1881 (citing 3 S. SYMONS, *POMEROY'S EQUITY JURISPRUDENCE* §§ 856, 856b (5th ed. 1941)).

227. *Id.* at 1884 (Scalia, J., concurring in the judgment).

228. *Id.*

229. *Id.*

230. *Id.*

231. *Id.* at 1885 (Scalia, J., concurring in the judgment); *see also* RESTATEMENT (SECOND) OF CONTRACTS § 155 cmt. a (1981) (stating

"The province of reformation is to make a writing express the agreement that the parties intended it should. Under the rule stated in this Section, reformation is available when the parties, having reached an agreement and having then attempted to reduce it to writing, fail to

b. Estoppel

Justice Breyer stated that the part of the remedy holding CIGNA to its promise, that the new plan would not take from its employees benefits they had already accrued, resembles estoppel, another traditional equitable remedy.<sup>232</sup> “Although equitable estoppel and promissory estoppel differ in that the one is based on representations and the other on promises, they have in common the element of inducement, the detrimental reliance by the recipient of the representation or promise.”<sup>233</sup>

As Thomas Veal has noted, “[c]ourts that require reliance in SPD cases often strain to find a nexus between the words in the SPD, action by the participant and some form of detriment.”<sup>234</sup> A

express it correctly in the writing. Their mistake is one as to expression—one that relates to the contents or effect of the writing that is intended to express their agreement—and the appropriate remedy is reformation of that writing properly to reflect their agreement. For the rule stated in this Section to be invoked, therefore, there must have been some agreement between the parties prior to the writing. The prior agreement need not, however, be complete and certain enough to be a contract”);

DAN B. DOBBS, *LAW OF REMEDIES* § 11.6(1) (2d ed. 1993) (stating

“Mistake is not the only ground for reformation; contracts are sometimes reformed for fraud or to make the contract meet minimum legal standards. In trust law, a court may reform a trust instrument to accord with the settlor’s intent if there is evidence that a mistake of fact or law affected the terms of the instrument and if there is evidence of the settlor’s true intent.”);

RESTATEMENT (THIRD) OF TRUSTS §§ 12, 62; RESTATEMENT (THIRD) OF PROP. § 12.1 (2003); RESTATEMENT (SECOND) OF AGENCY § 8D cmt. a (1958).

232. *Amara*, 131 S. Ct. at 1880.

233. DOBBS, *supra* note 231, at § 2.3(5); *see also* RESTATEMENT (SECOND) OF CONTRACTS § 90(1) (stating

“A promise which the promisor should reasonably expect to induce action or forbearance on the part of the promisee or a third person and which does induce such action or forbearance is binding if injustice can be avoided only by enforcement of the promise. The remedy granted for breach may be limited as justice requires.”);

RESTATEMENT (SECOND) OF CONTRACTS § 90(1) cmt. b (stating

“The promisor is affected only by reliance which he does or should foresee, and enforcement must be necessary to avoid injustice. Satisfaction of the latter requirement may depend on the reasonableness of the promisee’s reliance, on its definite and substantial character in relation to the remedy sought, on the formality with which the promise is made, on the extent to which the evidentiary, cautionary, deterrent and channeling functions of form are met by the commercial setting or otherwise, and on the extent to which such other policies as the enforcement of bargains and the prevention of unjust enrichment are relevant.”);

RESTATEMENT (SECOND) OF CONTRACTS § 90(1) cmt. d (stating, “Unless there is unjust enrichment of the promisor, damages should not put the promisee in a better position than performance of the promise would have put him.”).

234. Veal, *supra* note 23, at 7-62.



further question is whether a participant must actually read an SPD in order to rely on it.<sup>235</sup> The participant could become aware of information contained in the SPD without actually reading it.

c. Surcharge

The District Court's injunctions "require the plan administrator to pay to already retired beneficiaries money owed them under the plan as reformed. Equity courts possessed the power to provide relief in the form of monetary 'compensation' for a loss resulting from a trustee's breach of duty, or to prevent the trustee's unjust enrichment."<sup>236</sup> This remedy is known as surcharge.

3. *The Standard for Determining Harm*

As Justice Breyer noted:

The relevant substantive provisions of ERISA do not set forth any particular standard for determining harm. They simply require the plan administrator to write and to distribute written notices that are 'sufficiently accurate and comprehensive to reasonably apprise' plan participants and beneficiaries of 'their rights and obligations under the plan.' [citations omitted] Nor can we find a definite standard in the ERISA provision, [section] 502(a)(3) (which authorizes the court to enter 'appropriate equitable relief to redress ERISA 'violations'). Hence any requirement of harm must come from the law of equity.<sup>237</sup>

The Court held that the relevant standard of harm will depend on the equitable theory by which the District Court provides relief.<sup>238</sup> In equity, there is no general principle that "detrimental reliance" must be proved before a remedy is decreed.<sup>239</sup> "To the extent that any such requirement arises, it is because the specific remedy being contemplated imposes such a requirement . . . . [W]hen a court exercises authority under [section] 502(a)(3) to impose a remedy equivalent to estoppel, a showing of detrimental reliance must be made."<sup>240</sup> However, equity courts did not insist on a detrimental reliance showing where they ordered reformation of a contract or when they ordered surcharge.<sup>241</sup> A fiduciary can be

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235. See *Moriarity v. United Techs. Corp. Represented Emps. Ret. Plan*, 947 F. Supp. 43, 53 (D. Conn. 1996), *aff'd* 158 F.3d 157 (2d Cir. 1998) (noting, "Plaintiff's own affidavit proves fatal to his claim—Plaintiff stated that he is not certain if he ever read the alleged faulty SPD. Without having read the SPD, Plaintiff could not have relied on it or been prejudiced or misled by its contents").

236. *Amara*, 131 S. Ct. at 1880.

237. *Id.* at 1881.

238. *Id.*

239. *Id.*

240. *Id.*

241. *Id.*

surcharged under section 502(a)(3) only upon a showing of actual harm, and such harm may consist of detrimental reliance,

but it might also come from the loss of a right protected by ERISA or its trust-law antecedents. In the present case, it is not difficult to imagine how the failure to provide proper summary information, in violation of the statute, injured employees even if they did not themselves act in reliance on summary documents- which they might not themselves have seen- for they may have thought fellow employees, or informal workplace discussion, would have let them know if, say, plan changes would likely prove harmful. We doubt that Congress would have wanted to bar those employees from relief.<sup>242</sup>

Thus, to obtain relief by surcharge for violations of sections 102(a) and 104(b), a plan participant or beneficiary must show that the violation caused injury, but need show only actual harm and causation, not detrimental reliance.<sup>243</sup>

The purpose of the surcharge remedy is to put the beneficiaries of a trust in the position that they would have occupied if no breach had occurred.<sup>244</sup>

If the CIGNA plan's SPD had been of the quality demanded by the district court, the participants would not have avoided wear-away; they would simply have been able to read about it in the SPD rather than having to consult the plan document. The 'harm' they suffered derived from the plan sponsor's choice of

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242. *Id.*

243. *Id.*

244. See RESTATEMENT (SECOND) OF TRUSTS § 205 cmt. a (stating,

"If the trustee commits a breach of trust, the beneficiary may have the option of pursuing a remedy which will put him in the position in which he was before the trustee committed the breach of trust; or of pursuing a remedy which will give him any profit which the trustee has made by committing the breach of trust; or of pursuing a remedy which will put him in the position in which he would have been if the trustee had not committed the breach of trust");

see also *id.* at cmt. f (stating

"As is stated in Clause (a), a trustee is liable for a loss resulting from a breach of trust. A question may arise, therefore, as to the causal connection between the breach of trust and the loss. If the trustee commits a breach of trust and if a loss is incurred, the trustee may not be chargeable with the amount of the loss if it would have occurred in the absence of a breach of trust.");

§ 409(a), 29 U.S.C. § 1109(a) (stating,

"Any person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by this title shall be personally liable to make good to such plan any losses to the plan resulting from each such breach, and to restore to such plan any profits of such fiduciary which have been made through use of assets of the plan by the fiduciary, and shall be subject to such other equitable or remedial relief as the court may deem appropriate, including removal of such fiduciary").

wear-away, rather than some more generous technique, as the plan's method for complying with the legal prohibition against retroactive reductions in accrued benefits. As an 'information-related harm', that seems minuscule and unquantifiable.<sup>245</sup>

#### V. HOW HAS *AMARA* BEEN APPLIED IN LATER CASES?

The following are some of the cases that have applied and interpreted *Amara*:

In *Grant v. Eaton Disability Long-Term Disability Plan*,<sup>246</sup> the SPD for a long-term disability plan provided that claim forms must be completed and returned to the claims administrator within one year of a participant's last day of work.<sup>247</sup> The plan document did not include any time limitation for filing claims but did refer to "operative documents," including plan summaries, as being part of the plan.<sup>248</sup> In denying the participant's claim for benefits, the issue that the claim was untimely was raised for the first time at the administrative appeal stage.<sup>249</sup> The court initially held for the plan, based on the one-year limitation in the SPD.<sup>250</sup> The participant then filed a motion for reconsideration, arguing that (1) *Amara* prevented the terms of an SPD from becoming part of a plan, and (2) the plan had waived the time limitation when it was not raised in the initial claim denial.<sup>251</sup>

The court held that *Amara* did not stand for the blanket proposition that the terms of an SPD could never become part of a plan.<sup>252</sup> Instead, the court held *Amara* stands for the general proposition that an SPD does not alter the terms of a plan. Here, since the plan document incorporated the terms contained in plan summaries, the SPD terms were also terms of the plan.<sup>253</sup>

Thus, the time limitation was part of the plan document. Accordingly, the court stated:

[T]his court does not read *Amara* as holding that the terms of a summary plan description cannot be part of a benefit plan, at least where, as here, the terms of the plan summary at issue do not conflict with the language of the formal plan document and the plan document authorizes the creation of the terms in the summary plan

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245. Veal, *supra* note 23, at 7-64 to -65.

246. *Grant v. Eaton Disability Long-Term Disability Plan*, No. 3:10CV164TSL-FKB (S.D. Miss. Dec. 13, 2011) (memorandum opinion and order).

247. *Grant v. Eaton Disability Long-Term Disability Plan*, 797 F. Supp. 2d 732, 739 (S.D. Miss. 2011).

248. *Grant*, No. 3:10CV164TSL-FKB, at 6-7.

249. *Grant*, 797 F. Supp. 2d at 738-39.

250. *Id.* at 739-40.

251. *Grant*, No. 3:10CV164TSL-FKB, at 12.

252. *Id.*

253. *Id.* at 9-11.

description.<sup>254</sup>

In *Merigan v. Liberty Life Assurance Co. of Boston*,<sup>255</sup> the plan document did not contain any time limit for an appeal of a denied benefit.<sup>256</sup> The SPD required that an appeal must occur within 180 days.<sup>257</sup> The court held that the plan could not dismiss the appeal, even though the denial had occurred more than two years earlier.<sup>258</sup>

Citing *Amara*, the court held that the terms of the plan govern, and that the terms of the SPD are not terms of the plan.<sup>259</sup> Because the plan document did not contain any time limit, the plan acted improperly in refusing to consider the plaintiff's appeal on the ground that it was untimely:

In this case, the SPD and the LTD Policy are separate documents. Under *Amara*, the terms of the SPD are not the terms of the plan. It is undisputed that the Policy does not incorporate any time limit within which an appeal from a negative decision must be taken. In these circumstances, Liberty acted improperly in refusing to consider Merigan's appeal of the termination of his LTD benefits on the grounds that the appeal was untimely.<sup>260</sup>

In *Kaufmann v. Prudential Insurance Co. of America*,<sup>261</sup> the court held that a disability plan participant can challenge the termination of her benefits after the appeals deadline in the SPD expired because the plan document did not require any administrative appeals.<sup>262</sup> The court said that an SPD cannot add to the plan procedures that must be written into the plan itself.<sup>263</sup> The SPD deadline was ineffective, because the plan only required that a lawsuit be filed within three years from the time the proof of claim was given:

Prudential acknowledges that the SPD is the only plan document that contains appeal procedures. Prudential maintains, however, that the appeal provisions in the SPD constitute the terms of the Plan. This position is untenable for a number of reasons. First, the SPD expressly declares that its provisions are not part of the Plan . . . . Second, the Supreme Court in *Amara* expressly rejected the argument that 'the terms of the [SPD] are terms of the plan.'

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254. *Id.* at 9.

255. *Merigan v. Liberty Life Assurance Co. of Bos.*, 826 F. Supp. 2d. 388 (D. Mass. 2011).

256. *Id.* at 395.

257. *Id.* at 391.

258. *Id.* at 395-96.

259. *Id.* at 397.

260. *Id.* at 395.

261. *Kaufmann v. Prudential Ins. Co. of Am.*, No. 11-cv-119-PB, 2012 WL 19673 (D.N.H. Jan. 5, 2012).

262. *Id.* at \*4.

263. *Id.*

\* \* \*

By including the appeal procedures only in the SPD, the Plan administrator here effectively sought to amend the written instrument constituting the Plan without following the Plan's procedure for making amendments. It had no authority to do so. As Justice Breyer remarked in *Amara*, ERISA does not give plan administrators 'the power to set plan terms indirectly by including them in the summary plan descriptions.' Only the plan sponsor can set the terms of the plan and it must do so in the written instrument establishing the plan. The SPD, which the Plan administrator is responsible for distributing to participants, therefore, cannot graft onto the Plan procedures that must be in the written instrument constituting the Plan. Here, the SPD purports to add terms establishing administrative appeal procedures. Because the written instrument constituting the Plan does not require that administrative appeals be pursued before a lawsuit is filed, those SPD provisions are ineffective.<sup>264</sup>

In *Tomlinson v. El Paso Corp.*,<sup>265</sup> the plaintiffs argued that the SPD was defective because it did not include information regarding "wear-away periods and benefit reductions."<sup>266</sup> The district court<sup>267</sup> concluded that the plaintiffs were not prejudiced by the SPD, because they did not rely on it in any meaningful way as required by *Chiles v. Ceridian Corp.*,<sup>268</sup> and because they received the information from other sources.<sup>269</sup>

The employer also argued that Section 102 "does not require disclosure of the information forming the basis of the plaintiffs' SPD claim."<sup>270</sup> The Tenth Circuit held that:

The Supreme Court recently rejected *Chiles'* reliance requirement. In *Amara*, the Court emphasized that the need to show reliance depends on the remedy sought. A reliance requirement arises only 'because the specific remedy being contemplated imposes such a requirement.' In some instances, for example, when plaintiffs are seeking an estoppel remedy, it may be necessary to prove detrimental reliance. However, 'this showing is not always necessary for other equitable remedies.' Even when a showing of reliance is required, reliance need not turn on reading the SPD. For example, if the claim stems from 'the loss of a right protected by ERISA . . . it is not difficult to imagine how the failure to provide proper summary information . . . injured employees if they did not themselves act in reliance on summary documents—which they

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264. *Id.* at \*3.

265. *Tomlinson v. El Paso Corp.*, 653 F.3d 1281 (10th Cir. 2011), *cert. denied* 132 S. Ct. 1574 (2012).

266. *Id.* at 1294.

267. *Tomlinson v. El Paso Corp.*, No. 04-cv-02686-WDM-MEH, 2007 WL 891378 (D. Colo. Mar. 22, 2007).

268. *Chiles v. Ceridian Corp.*, 95 F.3d 1505, 1519 (10th Cir. 1996).

269. *Tomlinson*, 653 F.3d at 1294.

270. *Id.*

might not themselves have seen—for they may have thought fellow employees, or informal workplace discussion, would have let them know if, say, plan changes would likely prove harmful. We doubt that Congress would have wanted to bar those employees from relief.<sup>271</sup>

Thus, the court continued, “for the injunctive relief sought by the plaintiffs, it would be sufficient to show harm caused by El Paso’s breach of [section] 102. ‘Although it is not always necessary to meet the more rigorous standard implicit in the words ‘detrimental reliance,’ actual harm must be shown.’”<sup>272</sup>

The Tenth Circuit then stated that, although the district court’s rationale could not be affirmed in view of *Amara*, the plaintiffs’ SPD claim still failed: “under our precedent it is clear that wear-aways need not be explicitly disclosed in the SPD.”<sup>273</sup>

In its 2010 *Jensen* decision, the Tenth Circuit considered the failure of a company to include in its SPD any information regarding wear-away of early retirement benefits.<sup>274</sup> The *Tomlinson* court noted that it

rejected the suggestion that wear-away periods are tantamount to eligibility requirements that would have to be disclosed in the SPD. Instead, we concluded that a wear-away period is a ‘consequence of the change in plan terms’ that ‘need not be disclosed as a new eligibility requirement.’ Absent a finding of deceit on the part of the employer or a failure on the part of the employer to explain how benefits are calculated, we will not invalidate an SPD that neglects to inform employees of a wear-away period.<sup>275</sup>

The plaintiffs presented evidence that the SPD and other notices were confusing.<sup>276</sup> However, the court noted, “[The plaintiffs] do not provide any evidence supporting an inference that the SPD was deceitful or failed to explain the manner of conversion to cash balance accounts. Thus, we are bound by our prior conclusion that wear-away periods ‘need not be disclosed’ explicitly in the SPD.”<sup>277</sup>

In 2003, the Third Circuit in *Burstein* refused to impose any reliance or causation requirement for a claim under section 502(a)(1)(B), by analogy, to the principle that “a court’s enforcement of a contract generally does not require proof that the parties to the contract actually read, and therefore relied upon, the

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271. *Id.* at 1295 (citing *Amara*, 131 S. Ct. at 1881-82).

272. *Id.* (citing *Amara*, 131 S. Ct. at 1882).

273. *Id.* at 1295-96 (citing *Jensen v. Solvay Chems., Inc.*, 625 F.3d 641, 658 (10th Cir. 2010)).

274. *Jensen*, 625 F.3d at 658.

275. *Tomlinson*, 653 F.3d at 1296 (citing *Jensen*, 625 F.3d at 658).

276. *Id.*

277. *Id.* (citing *Jensen*, 625 F.3d at 658 (internal citations and footnote omitted)).

particular terms of the contract.”<sup>278</sup>

In *Engers v. AT&T, Inc.*,<sup>279</sup> the plaintiff argued “that he was not required to establish extraordinary circumstances under *Burstein*.”<sup>280</sup> The plaintiff argued that in that case, the court “permitted an employee to recover benefits misleadingly promised by an SPD without requiring a showing of extraordinary circumstances.”<sup>281</sup> The *Engers* court held:

[The plaintiff’s argument] confuses two different claims considered in *Burstein*. We did not require the plan participant in *Burstein* to show extraordinary circumstances to recover benefits promised in the SPD under [section] 502(a)(1)(B). But we did require the participant to show extraordinary circumstances to recover on a separate equitable estoppel claim under [section] 502(a)(3). Because *Engers* seeks equitable relief, and not a benefit promised him in his SPD, he must show extraordinary circumstances.<sup>282</sup>

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*Amara* “does not alter this conclusion. There the Court held that a showing of ‘detrimental reliance’ is not necessary for all forms of equitable relief under [section] 502(a)(3). . . . However, the Court expressly declined to address ‘other prerequisites’ for equitable relief, and thus we see no reason to depart from our longstanding rule that an equitable estoppel claim under [section] 502(a)(3) cannot be based merely on ‘simple ERISA reporting errors or disclosure violations, such as a variation between a plan summary and the plan itself, or an omission in the disclosure documents,’ without a showing of extraordinary circumstances.”<sup>283</sup>

In *Weitzenkamp v. Unum Life Insurance Co. of America*,<sup>284</sup> the employee was awarded long-term disability benefits.<sup>285</sup> The administrator discontinued benefits when it “determined that [the employee] had received all to which she was entitled under the plan’s self-reported symptoms limitation.”<sup>286</sup> The court determined that the administrator was estopped from relying on this limitation in denying benefits because the SPD failed to “reasonably apprise” her of the limitation, which was relevant to a wide range of plan participants.<sup>287</sup> The court held that

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278. *Burstein*, 334 F.3d at 381.

279. *Engers v. AT&T, Inc.*, No. 10-2752, 2011 WL 2507089 (3d Cir. June 22, 2011), *cert. denied* 132 S. Ct. 1101 (2012).

280. *Id.* at \*7 n.9.

281. *Id.*

282. *Id.*

283. *Id.* (quoting *Amara*, 131 S. Ct. at 1880-83; *Burstein*, 334 F.3d at 383).

284. *Weitzenkamp v. Unum Life Ins. Co. of Am.*, Nos. 10-3898, 11-1006, 2011 WL 2675427 (7th Cir. 2011), *withdrawn on grant of reh’g* 655 F.3d 608 (2011), *superseded on reh’g* 661 F.3d 323 (2011).

285. *Id.* at \*6.

286. *Id.* at \*1.

287. *Id.* at \*4.

reinstatement of benefits was appropriate.<sup>288</sup>

On rehearing,<sup>289</sup> the court held for the plaintiff on different grounds, and noted:

[Our] conclusion obviates our need to address the issue on which we rested our initial opinion, that Unum's failure to include the self-reported symptoms limitation in the SPD warranted granting Weitzenkamp equitable relief. We acknowledge, without deciding, that *CIGNA Corp. v. Amara* may undermine that result because Weitzenkamp has failed to identify any harm that flowed from the failure to include the limitation in the SPD.<sup>290</sup>

In *Eugene S. v. Horizon Blue Cross Blue Shield of New Jersey*,<sup>291</sup> the court determined that the SPD clearly stated that it, "along with an individual 'Certificate of Coverage . . . form[s] [the] Group Insurance Certificate,' that it 'is made part of the Group Policy,' and that '[a]ll benefits are subject in every way to the entire Group Policy, which includes' the SPD."<sup>292</sup>

The Court observed that "the SPD does unequivocally state that it is part of the Plan" and stated that:

We interpret *Amara* as presenting either of two fairly simple propositions, given the factual context of that case: (1) the terms of the SPD are not enforceable when they conflict with governing plan documents, or (2) the SPD cannot create terms that are not also authorized by, or reflected in, governing plan documents. We need not determine which is the case here, though, because the SPD does not conflict with the Plan or present terms unsupported by the Plan; rather, it *is* the Plan.<sup>293</sup>

In *US Airways, Inc. v. McCutchen*,<sup>294</sup> the plan paid the defendant's medical expenses after he was seriously injured.<sup>295</sup> Under the SPD, a beneficiary was required to reimburse the plan out of any monies recovered from a third party.<sup>296</sup> The plan administrator "demanded reimbursement of the entire \$66,866 it had paid without allowance for defendant's legal costs, which had reduced his net recovery to less than the amount demanded."<sup>297</sup> The defendant claimed that the administrator would be unjustly enriched if it were permitted to recover from him without any

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288. *Id.* at \*6.

289. *Weitzenkamp v. Unum Life Ins. Co. of Am.*, 661 F.3d 323 (7th Cir. 2011).

290. *Id.* at 331 n.5 (citing *Amara*, 131 S. Ct. at 1877).

291. *Eugene S. v. Horizon Blue Cross Blue Shield of N.J.*, 663 F. 3d 1124 (10th Cir. 2011).

292. *Id.* at 1132.

293. *Id.* at 1131.

294. *US Airways, Inc. v. McCutchen*, 663 F.3d 671 (3d Cir. 2011).

295. *Id.* at 672.

296. *Id.* at 673.

297. *Id.* at 672.



allowance for his attorneys' fees and expenses.<sup>298</sup> The court concluded that, "in the absence of any indication in the language or structure of [section] to the contrary, Congress intended to limit the equitable relief available under [section] 502(a)(3) through the application of equitable defenses and principles that were typically available in equity."<sup>299</sup> Thus, the defendant could assert equitable defenses such as unjust enrichment to the administrator's equitable reimbursement claim.<sup>300</sup> The court stated:

Moreover, as the Supreme Court recently demonstrated in *CIGNA*, the importance of the written benefit plan is not inviolable, but is subject—based upon equitable doctrines and principles—to modification and, indeed, even equitable reformation under [section] 502(a)(3). While the basis for the reformation in *CIGNA* was intentional misrepresentations by the employer and fiduciary, the broader and more relevant point is that when courts were sitting in equity in the days of the divided bench (or even when they apply equitable principles today) contractual language was not as sacrosanct as it is normally considered to be when applying breach of contract principles at common law. We do not suggest that US Airways' conduct was fraudulent or dishonest in the way that *CIGNA's* was, but equitable principles can apply even where no one has committed a wrong.<sup>301</sup>

In *Skinner v. Northrop Grumman Retirement Plan B*,<sup>302</sup> former employees received SPDs that did not adequately explain that their cash balance plan benefits would be reduced by an "annuity equivalent offset."<sup>303</sup> The plaintiffs conceded that they did not rely on any of the misleading information in the SPD when deciding whether to retire.<sup>304</sup> The Court noted that *Amara* had "overruled, in relevant parts, [its] two prior decisions that had treated SPD language as if it were an enforceable part of the retirement plan."<sup>305</sup> The committee did not ensure that participants received accurate SPDs that explained the circumstances that could result in the benefit offset, but the employees were not entitled to either reformation or surcharge.<sup>306</sup>

The court said that, under both trust law and contract law, reformation is available only in cases of fraud or mistake.<sup>307</sup> The employees did not present any evidence that Northrop's plan

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298. *Id.* at 674.

299. *Id.* at 676.

300. *Id.*

301. *Id.* at 678-79 (citing *Amara*, 131 S. Ct. at 1879).

302. *Skinner v. Northrop Grumman Ret. Plan B*, 673 F.3d 1162 (9th Cir. 2012).

303. *Id.* at 1164.

304. *Id.* at 1167.

305. *Id.* at 1165.

306. *Id.* at 1166-67.

307. *Id.* at 1166.

contained terms that failed to reflect the drafter's true intent.<sup>308</sup> The court was also not persuaded that the SPD reflected the true intent, as the employees did not provide any evidence of authorship of the 2003 SPD or that the intent was something other than the intent to create a comprehensive summary of the plan.<sup>309</sup> The employees did not present any evidence that the plan contained terms that were induced by fraud, explaining that the inconsistency between the SPD and plan documents was not evidence of fraudulent intent.<sup>310</sup> The Court distinguished the case from *Amara*, saying that in *Amara* the district court found that the employer had "intentionally misled its employees," which would make reformation an available remedy.<sup>311</sup>

The employees also argued that they were entitled to surcharge on the basis that "the administrative committee breached its fiduciary duty by failing to enforce the terms of the SPD instead of the terms of the plan."<sup>312</sup> The court said there was no such duty because, under *Amara*, "the terms of an SPD are not the terms of a plan."<sup>313</sup> The court added that "surcharge could hold the committee liable for benefits it gained through unjust enrichment" by breaching its duty to provide accurate SPDs.<sup>314</sup> However, the court found that the employees did not present any "evidence that the committee gained a benefit by failing to ensure that participants received an accurate SPD."<sup>315</sup> Finally, the court noted that

A trustee who breaches his or her duty could be liable for loss of value to the trust or for any profits that the trust would have accrued in the absence of the breach. The beneficiary can pursue the remedy that will put the beneficiary in the position he or she would have attained but for the trustee's breach.

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Appellants seek compensatory relief. But considering that Appellants did not rely on the inaccurate SPD, they establish no harm for which they should be compensated.

Appellants argue that the 'harm' of being deprived of their statutory right to an accurate SPD is a compensable harm, but we disagree. Appellants' interpretation would render the advisory committee strictly liable for every mistake in summary documents. In sum, Appellants have not shown that their current positions are any

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308. *Id.*

309. *Id.*

310. *Id.*

311. *Id.* at 1167 (citing *Amara*, 131 S. Ct. at 1874).

312. *Id.*

313. *Id.*

314. *Id.*

315. *Id.*

different than they would have been without the inaccurate SPD.<sup>316</sup>

## VI. HOW USEFUL ARE SPDs?

Ever since the enactment of ERISA, it has been clear that it is very difficult, if not impossible, to write an SPD that is accurate and understandable and cannot be misunderstood.<sup>317</sup> As Thomas Veal has noted, it would have been very difficult for CIGNA to explain wear away or the potential effect of interest rate declines.<sup>318</sup> The SPD cannot explain everything: as Justice Breyer noted in *Amara*, it is only a summary.<sup>319</sup>

To summarize is to make judgments about the comparative importance of plan provisions. Events may prove those judgments wrong, and it is all too easy for judges to opine, with acute hindsight, that a seemingly remote contingency should have been foreseen or the importance of a particular detail realized. The natural preventive measure, if the consequences of being wrong are severe, is to lower the bar for inclusion, lengthening the document and rendering it less accessible to its intended users. If the Court had pushed SPD preparers in that direction, the day would have come when plaintiffs would be bringing actions charging that SPD disclosures were incomprehensible.<sup>320</sup>

A 2006 study found that “[i]mportant information contained in many health plan SPDs is written at a reading level that may be too high for the average plan participant.”<sup>321</sup> It found that

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316. *Id.* (citing RESTATEMENT (THIRD) OF TRUSTS § 100(a); RESTATEMENT (SECOND) TRUSTS § 205 (1959)).

317. See U.S. DEPT. OF LABOR, *supra* note 9 stating that

As a result of the testimony heard, the Working Group concluded that the SPD is no longer accomplishing its original goals (*i.e.*, to be a *summary* of the plan and to be *easily understood* by the participant. There are a variety of reasons for this result: Case law has held that more favorable interpretation of benefits as described in the SPD prevails over the unambiguous plan document and that ambiguities between the SPD and the plan document be construed in favor of the participant. In response, the SPD language has become legalistic and omissions, limitations, and reservations are all listed to mitigate litigation. Complexity of the terms of the plan necessitates the use of a *variety* of communication tools, in lieu of a single document (*i.e.*, SPD), to explain benefit plans, not only at the time an employee becomes a participant, but also at the time of utilization; and Plan sponsors are placing greater reliance on electronic dissemination of employee communication due to the expense and limited ‘shelf life’ of hard copy communication vehicles.

318. Veal, *supra* note 23, at 7-43.

319. *Amara*, 131 S. Ct. at 1877-78.

320. Veal, *supra* note 23, at 7-44.

321. Colleen E. Medill, Richard L. Wiener, Brian H. Bornstein & E. Kiernan McGorty, *How Readable Are Summary Plan Descriptions for Health Care Plans?*, 27 EMPLOYEE BENEFIT RESEARCH INSTITUTE NOTES at 1 (Oct. 2006), available at [http://www.ebri.org/pdf/notespdf/EBRI\\_Notes\\_10-20061.pdf](http://www.ebri.org/pdf/notespdf/EBRI_Notes_10-20061.pdf).

the average readability level for important information concerning eligibility, benefits, and participant rights and responsibilities in [SPDs] is written at a first year college reading level. The average level of readability for SPDs is higher than the recommended reading level for technical material. Some of the SPDs in the study sample used language written at a 9th grade reading level. Other SPDs used language written at nearly a college graduate (16th grade) reading level.<sup>322</sup>

The study suggested that

fundamental improvements are needed in the readability of written SPDs, and that employers and plan administrators should explore the use of alternative methods of communication to plan participants beyond the written SPD. Also, the trend toward consumer-driven health care plans may make the challenge of communicating information to participants through written SPDs even more difficult, since these plans shift significant responsibility to the participants in the plan for decisions concerning the utilization of health care services. This shift in decision-making responsibility to participants makes it more important than ever that participants understand how their health plan works.<sup>323</sup>

It further pointed out that

[c]onsumer-driven health care plans shift significant responsibility to the participants in the plan for decisions concerning the utilization of health care services. This shift in decision-making responsibility to participants makes a consumer-driven health care plan more complex for the participant to navigate, in design and function, than an insured health care plan or a managed health care plan. This shift in responsibility also makes it more important for participants to understand how their health plan works.<sup>324</sup>

A similar point may be made with respect to 401(k) plans: when ERISA was enacted, it was very unusual for retirement plans to give plan participant the right to direct how their accounts were invested. Today, that is the norm, which means that participants need information to help them to make difficult investment choices.

In 2005, a DOL Working Group issued a report on health and welfare benefit plan communications (the “Working Group Report”).<sup>325</sup> The Working Group Report made three

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322. *Id.*

323. *Id.*

324. *Id.*

325. U.S. DEPARTMENT OF LABOR, *supra* note 9.

With respect to logistics, employers struggle with budget allocations for SPDs—development of the format and content, production and distribution. Ms. Melton discussed the complexity involved in drafting an SPD for H&W plans. She referenced the forty-seven page checklist that AON Consulting developed for its communication consultants to

recommendations with respect to SPDs:

1. DOL should “provide regulatory or advisory guidance to help plan administrators prepare understandable and user-friendly SPDs. Affirmation that the use of Executive Summaries or Life Event Summaries is considered a best practice would be extremely helpful;”

2. DOL should “enhance or create mechanisms to enforce the regulatory requirement that SPDs be understandable by the average plan participant;” and

3. DOL should “review court decisions granting legal superiority to SPDs and, if necessary, propose legislation to amend ERISA to restore the original purpose and status of SPDs that satisfy regulatory requirements.”<sup>326</sup>

“The consensus of the plan administrator advocates was that the DOL’s requirement that SPDs be written in a manner calculated to be understood by the average participant has become almost impossible to attain.”<sup>327</sup> Four reasons were cited:

1. The terms of employee plans, especially health and welfare plans, are becoming exceeding more complex<sup>328</sup> and new consumerism concepts are being introduced to reduce costs;

2. Due to case law that has resolved discrepancies between the SPD and the plan document in favor of the SPD, SPDs have

use when drafting an SPD. The checklist is used to identify information that should be included in an SPD prepared for an ERISA Plan. There is a sixteen-page checklist that addresses administrative issues, eligibility, participation, contributions, benefits, loss of benefits, disclaimers and rights under COBRA and HIPAA. This is information that is either required to be in the SPD by DOL regulations or recommended for clarification purposes. Then there are twenty pages of model language and notices and finally three pages of additional information. Not only is there complexity in the language required but the cost to develop, produce and distribute can be significant, especially for large employers. In addition, some employers are not in compliance because they are not fully aware of all of their compliance obligations. Therefore, they do not produce and distribute within the compulsory time frames. Even electronic distribution has problems because some employee populations have no PC access at work..

*Id.* (summarizing the testimony of Nicole Melton, Senior Vice President and Practice Leader of Organizational Communication in AON Consulting’s New York City office, on July 7, 2005).

326. *Id.*

327. *Id.*

328. *Id.* (stating,

“ERISA became law in a much simpler time. The materials that are distributed to plan participants under the requirements of ERISA do not, and in fact cannot, easily provide all the answers to all the possible benefits questions. And, it might be impossible to make all of the details of health plans simple enough to be readily understood by most plan participants”).

become more legalistic in an effort to mitigate the employer's risk;

3. Employers are utilizing a vast array of communication tools, using more manageable bytes of information, and delivered at teachable moments, in lieu of relying upon a single document to explain benefits; and

4. The administrative cost of developing, producing, and distributing hard copies has become burdensome.<sup>329</sup> Plan administrator advocates recommended that the DOL provide model language that sponsors could rely upon, and that the DOL permit other media forms beside hard copy for the dissemination of required materials.<sup>330</sup>

#### VII. A NEW COMPLICATION: THE SUMMARY OF BENEFITS AND COVERAGE

Under section 2715 of the Public Health Service Act ("PHSA"), added by section 1001 of the Affordable Care Act,<sup>331</sup> group health plans and health insurance issuers offering group health insurance coverage are required to provide a written summary of benefits and coverage ("SBC") that "accurately describes the benefits and coverage under the applicable plan or coverage" for each benefit package that is offered.<sup>332</sup> Section 2715 also calls for the "development of standards for the definitions of terms used in health insurance coverage."<sup>333</sup>

This new form is in addition to the existing SPD requirements and requires much of the same information.<sup>334</sup> Previously, there

329. *Id.*

330. U.S. DEP'T OF LABOR, *supra* note 9.

331. Patient Protection and Affordable Care Act, Pub. L. 111-148, 124 Stat. 1025 (2010); Health Care and Education Reconciliation Act, Pub. L. 111-152, 124 Stat. 1029 (2010) (collectively, "Affordable Care Act").

332. 42 U.S.C. § 300gg-15(a) (2010) (this requirement is also incorporated into ERISA § 715 and I.R.C. § 9815 by reference).

333. *Id.* § 300gg15(g)(1).

334. See Letter from consumer organizations, to Nancy Ann DeParle, Deputy White House Chief Of Staff and others (Nov. 9, 2011), *available at* [http://www.consumersunion.org/pdf/sbc\\_consumer\\_provider\\_letter\\_110911.pdf](http://www.consumersunion.org/pdf/sbc_consumer_provider_letter_110911.pdf),

which states

The SBC provision of the Affordable Care Act (ACA) requires group and individual health plans to use a uniform, four-page form that allows consumers to better understand health plan coverage and compare their options. Congress adopted this key provision—and applied it to every 'group health plan and a health insurance issuer offering group or individual health insurance coverage' in the United States, including grandfathered plans—because Congress concluded that Americans do not now have adequate information to choose and understand insurance coverage available to them. . . . [The SPD] 'is not an acceptable substitute for the SBC. The Summary Plan Description can be over a hundred pages long and is often incomprehensible to average American workers.'

was the risk of discrepancies between the plan documents and the SPD. Now there are two new risks: (1) discrepancies between the plan documents and the SBC, and (2) discrepancies between the SPD and the SBC.

On February 9, 2012, the Department of Health and Human Services, Department of Labor, and Department of the Treasury released final regulations detailing the form, content, and delivery requirements pertaining to the SBC.<sup>335</sup> Health insurance issuers and group health plans must provide the SBC to participants and beneficiaries: (1) as part of the plan's enrollment material; (2) by the first day of coverage if there are changes in the benefits or coverage after the enrollment SBC is provided; (3) upon renewal, if the employer requires participants to renew in order to maintain coverage; and (4) as soon as practicable, but no later than seven business days following receipt of a request. In the case of a special enrollment, an SBC must be provided within 90 days of enrollment.<sup>336</sup>

Both the insurer and the plan administrator have the obligation to provide the SBC.<sup>337</sup> The plan administrator is relieved of responsibility if the issuer provides a timely and complete SBC.<sup>338</sup> The plan administrator of a self-insured group health plan must provide the SBC.<sup>339</sup> A plan administrator may assign this responsibility to a third-party administrator and is relieved of responsibility if the third-party administrator provides a timely and complete SBC.<sup>340</sup>

For participants and beneficiaries who enroll or re-enroll through an open enrollment period, the rules apply as of the first day of the first open enrollment period that begins on or after September 23, 2012.<sup>341</sup> For participants and beneficiaries who enroll at other times, e.g., people who are newly eligible, the rules apply on the first day of the first plan year that begins on or after September 23, 2012.<sup>342</sup>

Furthermore, SBCs are not required for plans or benefit

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335. 29 C.F.R. § 2590; 45 C.F.R. § 147; 77 Fed. Reg. 8668 (Feb. 14, 2012) A Notice issued on the same date the above regulations were published provides more guidance. U.S. DEP'T OF THE TREASURY, INTERNAL REVENUE SERVICE, U.S. DEP'T OF LABOR, EMP. BENEFITS. SEC. ADMIN., U.S. Dep't of Health and Human Services, Centers for Medicare & Medicaid Services, *Summary of Benefits and Coverage and Uniform Glossary—Templates, Instructions, and Related Materials; and Guidance for Compliance*, 77 Fed. Reg. 87060 (Feb. 14, 2012).

336. 29 C.F.R. § 2590.715-2715(a)(1); 45 C.F.R. § 147.200(a)(1).

337. *Id.*

338. 29 C.F.R. § 2590.715-2715(a)(1)(iii)(A); 45 C.F.R. § 147.200(a)(1)(iii)(A).

339. 29 C.F.R. § 2590.715-2715(a)(1)(ii)(A)

340. 29 C.F.R. § 2590.715-2715(a)(1); 45 C.F.R. § 147.200(a)(1).

341. 29 C.F.R. § 2590.715-2715(f)(1)(i); 45 C.F.R. § 147.200(f)(1)(i).

342. 29 C.F.R. § 2590.715-2715(f)(1)(ii); 45 C.F.R. § 147.200(f)(1)(ii).

packages that qualify as “excepted benefits,” e.g., stand-alone dental or vision plans or exempt health flexible spending accounts (“FSA”).<sup>343</sup>

A group health plan or health insurance issuer that fails to comply can be liable for a fine of up to \$1,000 for each “willful” failure.<sup>344</sup> “A failure with respect to each participant or beneficiary constitutes a separate offense.”<sup>345</sup>

Where a material modification<sup>346</sup> is made to the terms of the plan that would impact the information in the most recently distributed SBC, and the change is effective during the plan year, i.e., prior to the first day of a subsequent plan year, a plan or insurer must provide notice of the material modification to “enrollees” at least 60 days prior to the effective date of the change.<sup>347</sup> If a change is effective as of the first day of the next plan year, a plan or insurer must provide the notice of material modification in accordance with the SBC rules for annual enrollment. The preamble indicates that an updated SBC or notice of modification provided in accordance with SBC rules will also satisfy ERISA’s SMM requirements.<sup>348</sup>

Furthermore, the preamble to the final regulations states that an SBC may be provided as either “a stand-alone document or in combination with other summary materials, ([e.g.], an SPD), if the SBC information is displayed prominently at the beginning of the materials (such as immediately after the table of contents in an SPD) and in accordance with the timing requirements for SBCs.”<sup>349</sup>

An SBC must consist of no more than four double-sided pages (a total of eight printed pages, front and back) and use no less than twelve-point font.<sup>350</sup>

In addition, the final regulations

343. 42 U.S.C. § 300gg-21(b).

344. 29 C.F.R. § 2590.715-2715(e); 45 C.F.R. § 147.200(e).

345. *Id.*

346. See Summary of Material Modifications, *supra* Part II.C.

347. 29 C.F.R. § 2590.715-2715(b); 45 C.F.R. § 147.200(b).

348. See 77 Fed. Reg. at 8677-78 which states

For ERISA-covered group health plans subject to PHS Act section 2715, this notice is required in advance of the timing requirements under the Department of Labor’s regulations at 29 C.F.R. § 2520.104b-3 for providing a summary of material modification (SMM) (generally not later than 210 days after the close of the plan year in which the modification or change was adopted, or, in the case of a material reduction in covered services or benefits, not later than 60 days after the date of adoption of the modification or change). In situations where a complete notice is provided in a timely manner under PHS Act section 2715(d)(4), an ERISA-covered plan will also satisfy the requirement to provide an SMM under Part 1 of ERISA.

349. *Id.* at 8675.

350. 29 C.F.R. § 2590.715-2715(a)(3); 45 C.F.R. § 147.200(a)(3).



set forth a list of requirements for the SBC that generally mirror those set forth in the statute. There are a total of 12 required content elements under the regulations, including uniform standard definitions of medical and health coverage terms, which will help consumers better understand their coverage; a description of the coverage including the cost sharing requirements such as deductibles, coinsurance, and co-payments; and information regarding any exceptions, reductions, or limitations under the coverage. The final regulations also require inclusion of coverage examples, which illustrate benefits provided under the plan or coverage for common benefits scenarios.<sup>351</sup>

Section 2715 of the PHS Act is incorporated into ERISA § 715, and Code § 9815, and is subject to the preemption provisions of ERISA § 731 and PHS Act § 2724.<sup>352</sup> The requirements of part 7 of ERISA and part A of title XXVII of the PHS Act, as amended by the Affordable Care Act, “are not to be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group or individual health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement” of part A of title XXVII of the PHS Act.<sup>353</sup> Accordingly, State laws that impose requirements on health insurance issuers that are stricter than those imposed by the Affordable Care Act will not be superseded by the Affordable Care Act.<sup>354</sup> The standards developed under PHS Act § 2715(a), “shall preempt any related State standards that require [an SBC] that provides less information to consumers than that required to be provided under this section, as determined by the [Departments].”<sup>355</sup>

#### VIII. CONCLUSION

It is likely to be some considerable time before the full effects of *Amara* become apparent.

*Amara* may, then, herald the advent of novel ways for plaintiffs to win ERISA litigation, but that future is not certain. All that the case actually holds is that one participant-friendly theory—that SPDs can be freely substituted for plan documents in determining benefit entitlements—has no basis in the law. They may be adequately replaced by the remedies that the Court suggests. On the other hand, adherence to the traditional prerequisites for equitable relief could reduce the SPD’s role to that of mere evidence in actions

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351. 77 Fed. Reg. at 8669; see also 29 C.F.R. § 2590.715-2715(a)(2); 45 C.F.R. § 147.200(a)(2).

352. 29 C.F.R. § 2590.731(a); 45 C.F.R. § 146.143(a).

353. *Id.*

354. 29 C.F.R. § 2590.715-2715(d); 45 C.F.R. § 147.200(d).

355. 42 U.S.C. § 300gg-15(e).

alleging that an employer, acting [as] a plan fiduciary has 'significantly and deliberately misled' participants.<sup>356</sup>

For example, the post-*Amara* cases discussed above have addressed the following issues:

1. Whether the SPD is part of the plan;<sup>357</sup>
2. The need to show harm;<sup>358</sup>
3. The relevance of deceit;<sup>359</sup>
4. The need for extraordinary circumstances in order to obtain relief under section 502(a)(3);<sup>360</sup>
5. The need for fraud or mistake in order to obtain reformation;<sup>361</sup>
6. What is "harm" for purposes of the surcharge remedy;<sup>362</sup>
7. The need to discuss wear away in the SPD;<sup>363</sup> and
8. The availability of equitable defenses to a claim for equitable relief.<sup>364</sup>

Some lessons appear to be clear. First, plan administrators should attempt to comply fully with ERISA's notice and disclosure requirements. Second, plan administrators should be even-handed in describing plan changes: do not overemphasize the positive aspects while downplaying any negative aspects. Third, be careful to avoid any communications or conduct that could be interpreted as intentionally misleading plan participants. Fourth, and perhaps most important, identify precisely which documents constitute (1) the plan documents, (2) the SPD, and (3) communications to employees that are not SPDs.

David Cowart has identified the following issues:

1. Does the employer know what the plan document is? If it does not, "it's time to find that out. Post-*Amara*, plan documents win for claims for benefit suits, SPDs don't."
2. If the SPD has a provision in it that is not in the plan, "your chances of enforcing that provision are very, very small."
3. Anybody communicating about a plan document is acting as a plan fiduciary, whether the person is an in-house benefits employee, a plan attorney, or others.

"A particular concern now is that if you start communicating about plan benefits, there's a definite predilection that that's a fiduciary communication." As a result, "you can be held to

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356. Veal, *supra* note 23, at 7-8 (citation omitted).

357. *Merigan*, 826 F. Supp. 2d at 392; *Kaufmann*, 2012 WL 19673, at \*2; *Eugene S*, 663 F. 3d at 1131-32.

358. *Tomlinson*, 653 F.3d at 1295.

359. *Id.* at 1295-96.

360. *Engers*, 2011 WL 2507089, at \*4-5.

361. *Skinner*, 673 F.3d at 1166-67.

362. *Id.* at 1167.

363. *Tomlinson*, 653 F.3d at 1287.

364. *McCutchen*, 663 F.3d at 674-80.

fiduciary standards, and you must be careful in doing that. Therefore, in-house benefits people need to be trained as a fiduciary, and be covered under fiduciary insurance". In addition, plan committees must consider how they will delegate the responsibility for plan communications, or whether they will involve themselves in plan communications.<sup>365</sup>

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365. Sean Forbes, *Employers Have Flexibility in Drafting SBCs, But Attorneys Worry About Ambiguous Rules*, BNA SNAPSHOT, ALI-ABA WEBINAR ON HEALTH PLANS, 39 PENS. & BENEFITS REP. 443 (2012).