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ERISA Advisory

Unambiguous Plan Terms Defeat Equitable Estoppel, First Circuit Declares

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Unlike several of its sister appellate courts, the US Court of Appeals for the First Circuit has never held that promissory or equitable estoppel is a form of relief available under Section 502(a)(3) of ERISA. Each time the issue has confronted it, the court has ruled that the plaintiff failed to allege the elements necessary for an estoppel claim, rendering it unnecessary to decide whether such a claim might in fact be cognizable. *See*, *e.g.*, *Livick v. Gillette Co.*, 524 F.3d 24 (1st Cir. 2008).

In its latest encounter with the issue, the First Circuit continued on the same path, rejecting a pension plan participant's claim for benefits that allegedly had been promised to him but that were not provided under the terms of the plan. *Guerra-Delgado v. Popular, Inc.*, 774 F.3d 776 (1st Cir. 2014).

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Contrary to the maxim about hard cases and bad law, the judges reached their conclusion despite a sympathetic set of facts. ("BPPR's legal victory here does not excuse its own problematic performance," the court says in a footnote.) When Banco Popular de Puerto Rico recruited the plaintiff in 1996, he was told that he would be entitled to pension credit for the 17 years during which he had worked for other banks. His annual benefit statements reflected that credit. Perhaps more significantly, in 2005, when the bank froze future accruals for participants with fewer than ten years of credited service, he was placed in the over-ten-years category. In 2008, when he began to contemplate early retirement, he specifically asked for confirmation of the amount of his pension and received an estimate of $2,372 per month, based on 24 years of credited service. Allegedly in reliance on that figure, he retired in February 2009.

But the bank's benefits department developed second thoughts at the last minute. A month and a half after the plaintiff's retirement, he was informed that the plan did not grant credit for his prior work with other employers and that his true entitlement was only $571 a month. The upshot was, naturally, a lawsuit.

The plaintiff put forward three theories to support his claim: that the prior service credit was provided for under the terms of the plan, that the bank had breached its employment agreement, and that the plan was equitably estopped from denying him the benefit that he had been repeatedly promised. The district and appellate courts disposed of the first two theories summarily. The plan plainly did not grant credit for service with unrelated employers and could not be amended by representations made by the benefits department. The contract claim arose under state law and was preempted by ERISA.

That left equitable estoppel, a remedy with a tangled history in the courts. It got a boost from *CIGNA Corporation v. Amara*, 131 S. Ct. 2900 (2011), in which the Supreme Court, albeit only in *dictum*, included it among the forms of "appropriate equitable relief" available under Section 502(a)(3) of ERISA, but the circumstances in which real-world plaintiffs may be able to invoke it remain controversial.

As a general proposition, an equitable estoppel claim rests on two elements: (1) one party must make a misrepresentation and have reason to believe that the other party will rely on it, and (2) the latter must then, as a result of the misrepresentation, reasonably change his position to his detriment. The First Circuit's analysis centered on what, in an ERISA context, constitutes reasonable reliance.

ERISA requires that employee benefit plans "be established and maintained pursuant to a written instrument," ERISA, §402(a)(1), which must include "a procedure for amending such plan, and for identifying the persons who have authority to amend the plan." ERISA, §402(b)(3). Courts have long held that these requirements preclude both unwritten plan amendments and written amendments that are not adopted in accordance with the prescribed procedure. It follows, inferred the First Circuit, that it is "inherently unreasonable" for a participant to rely on statements, written or unwritten, that contradict a plan's unambiguous terms. If those terms are to be changed, it must be through a properly adopted plan amendment. Only where the terms are unclear might a participant be able to "reasonably rely on an informal statement interpreting an ambiguous plan provision." In this case, the court held, no ambiguity existed.

Other courts, it should be noted, have been less cautious. Some have held that estoppel can override even unambiguous plan terms if "extraordinary circumstances" are present, *e.g.*, *Bloemker v. Laborers' Local 265 Pension Fund*, 605 F.3d 436 (6th Cir. 2010), whose facts were not dissimilar from *Guerra-Delgado*'s. The difference was that the Sixth Circuit thought "that it would have been impossible for [the plaintiff] to determine his correct pension benefit given the complexity of the actuarial calculations and his lack of knowledge about the relevant actuarial assumptions" and that this fact was an "extraordinary circumstance" that justified compelling a multiemployer plan to continue paying a pension in the amount promised by erroneous benefit statements.

Sixth Circuit Nixes Post-Termination Plan Amendment

Pension Benefit Guaranty Corporation (PBGC) regulations state that the benefits provided following a standard termination of a defined benefit plan "are determined under the plan's provisions in effect on the plan's termination date," except for amendments that do not decrease the value of benefits or are required to comply with the qualification requirements of I.R.C., §401(a). That seemingly innocuous rule can be a trap for the unwary, as a new Circuit Court decision illustrates, *Pension Benefit Guaranty Corporation v. Kentucky Bancshares, Inc.*, 2015 FED App. 0052N (6th Cir. Jan. 15, 2015) (not for publication).

Kentucky Bancshares terminated its pension plan as of December 31, 2008, during the period for implementing changes under the Pension Protection Act of 2006 (PPA). One PPA provision permitted, but did not compel, plans to increase the interest rates used to convert participants' accrued benefits into lump sum distributions, thus producing smaller distributions for anyone who elected that optional form of benefit. The Bancshares plan made this change administratively at the beginning of 2008. The law, however, offered a grace period for the adoption of plan amendments, and the bank did not formally amend the applicable interest rate until February 2009.

Hence, as of the plan termination date, the plan document still said that lump sums were to be calculated using the prior, more expensive interest rate. The plan nonetheless followed the amendment when it made close-out distributions to participants. When the PBGC conducted its routine post-termination audit, it took note of the discrepancy between the plan provisions and the amounts distributed. In 2011, it ruled that the plan had failed to satisfy all benefit liabilities on termination and demanded that the plan sponsor make up the difference to the shortchanged distributees. The alternative would be a determination that the plan had never terminated, in which case rectifying the many resulting violations of ERISA and the qualification rules would be akin to putting an omelet back into the eggs.

The bank challenged the PBGC's decision in court. In the district court, it advanced two arguments. One – that the plan's administrative practice before the termination constituted a *de facto* plan amendment – had no chance in light of ERISA's prohibition against unwritten amendments and was abandoned on

appeal. The second argument was that the PBGC acted arbitrarily and capriciously when it refused to recognize a post-termination amendment that was allowed by the PPA and had already been applied to participants who received distributions during 2008.

> Kentucky Bancshares protests that PBGC's decision exalts form over substance. Kentucky Bancshares emphasizes that PBGC has acknowledged that the Plan amendment resulting in decreased benefits would have been permissible if only it had been adopted a mere two months earlier, prior to Plan termination. The PBGC's finding of a deficiency is thus said to be based on a technical timing violation of §4041.8 that results in an unwarranted windfall to Plan participants.

Conceding that "[t]he argument is not without facial appeal," the court remained unmoved.

> Yet we are not free to simply substitute our judgment for that of the agency. The problem for Kentucky Bancshares is that PBGC's enforcement of its own regulation – 29 C.F.R. §4041.8(a) ("plan benefits are determined under the plan's provisions in effect on the plan's termination date") and §4041.8(c)(1) (post-termination decreases are permissible if necessary to meet qualification requirements) – in a manner consistent with the regulation's plain language and consistent with the governing statute – [ERISA, §4041(b)(1)(D)] ("benefit liabilities" under the plan are "determined as of the termination date") – can hardly be deemed arbitrary or capricious, an abuse of discretion, or not in accordance with law.

The court might also have noted, though it did not, that the PBGC's position is buttressed by case law barring otherwise valid post-termination amendments specifically fashioned to prevent windfalls to participants. *Horn v. Berdon, Inc. Defined Benefit Pension Plan*, 938 F.2d 125 (9th Cir. 1991) (*per curiam*); *Audio Fidelity Corp. v. Pension Benefit Guaranty Corporation*, 624 F.2d 513 (4th Cir. 1980).

The PBGC's determination affects only the benefits distributed on plan termination. The amended interest rates were properly applied to pre-termination distributions. In effect, terminating the plan before amending it had the inadvertent effect of boosting the value of lump sum distributions and turning a few weeks' tardiness into a costly delay.

Addendum: Even more recently, a district court reached the same conclusion on the same issue in *Royal Oak Enterprises, LLC v. Pension Benefit Guaranty Corporation*, 2015 U.S. Dist. LEXIS 11172 (D. D.C. Jan. 28, 2015).

Despite *Amara*, Summary Plan Descriptions Sometimes Set the Terms of a Plan

While it has become famous for its *dicta* concerning equitable remedies, the actual holding of *CIGNA Corporation v. Amara*, 131 S. Ct. 2900 (2011) was that statements in a summary plan description do not override the terms of the plan. The Supreme Court rejected the position, previously taken by many district and appellate courts, that inconsistences between a summary plan description (SPD) and a plan document are generally to be resolved in favor of the former.

While that decision was widely viewed as a victory for plan sponsors and administrators, it had a potential downside. Sometimes, particularly in welfare plans, documentation is rather informal, and important provisions, such as administrative discretion, subrogation, and procedures for submitting benefit claims and appealing denied claims, may appear only in the SPD. Does *Amara* render them unenforceable? *Board of Trustees of the National Elevator Industry Health Benefit Plan v. Montanile*, 2014 U.S. App.

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LEXIS 22438 (11th Cir. Nov. 25, 2014) (unpublished opinion) grappled with that question and concluded that an SPD may, in some circumstances, serve as both a summary of the plan and the plan itself.

The defendant in this case was a health and welfare plan participant who was injured in an automobile accident. The plan paid about $120,000 of his medical expenses. Thereafter, he sued the other driver and recovered $500,000 (about $250,000 after attorneys' fees and expenses). The plan then sued him, seeking recovery of what it had paid on his behalf.

The plan's right to reimbursement was set forth plainly in the SPD, but nowhere else. The only other pertinent documents were a trust agreement that gave the trustees "full discretionary authority to adopt a Plan of Welfare Benefits, which sets forth eligibility requirements, type, amount, and duration of benefits that are to be provided to eligible employees," but itself said nothing about those topics, and a collective bargaining agreement that merely incorporated the plan by reference.

The trustees never adopted a distinct "Plan of Welfare Benefits." Instead, the summary plan description set forth "detailed information regarding eligibility for health benefits, the extent of specific types of benefits, and claim-filing procedures," as well as the plan's right of reimbursement from "[a]mounts that have been recovered by a covered person from another party."

When the plan sought reimbursement from Mr. Montanile's tort recovery, he refused, and the plan sued him, seeking to enforce its claim under Section 502(a)(3) of ERISA (applicable because the recovery was a form of equitable relief).

The defendant's principal argument was based on a maximalist reading of *Amara*. He contended that the Supreme Court had drawn a clear line between plans and summaries of plans, with only the former being enforceable. The court's response was that (i) a plan without a plan document is impossible under ERISA, (ii) the plan document must "specify the basis on which payments are made to and from the plan," ERISA, §403(b)(3), and (iii) the only document that specified the basis of payments in this instance was the summary plan description. Hence, the summary *was* the plan.

The court had little trouble distinguishing the case before it from *Amara*, where the plaintiffs had asserted that, where the SPD and a distinct plan document were inconsistent, the SPD should govern. Here no contradiction had to be resolved. Only one document existed, and the issue was its status under ERISA.

The result in *Montanile* is consistent with other cases that considered similar issues, such as *Liss v. Fidelity Employer Services Co.*, LLC, 2013 FED App 0205N (6th Cir. 2013) (unpublished opinion) and *Eugene S. v. Horizon Blue Cross Blue Shield of New Jersey*, 663 F3d 1124 (10th Cir. 2011). *Montanile* does, however, call attention to difficulties that can arise when plan documentation is handled without exactitude, as is often the case with health and welfare plans in particular. The following are some concerns:

- The plaintiff plan's most immediate problem was that none of its documents was identified as "the plan," a fact that lent credibility to the participant's argument that he wasn't bound by statements in the SPD. A clear statement of the SPD's status would have been helpful.

- However, simply adding the sentence, "This summary constitutes the Plan of Welfare Benefits," does not pave over all possible pitfalls. Some plans have quite a few associated documents, *e.g.*, a trust agreement, a summary plan description, various benefit schedules, insurance contracts, a "wrap plan" incorporating the diverse programs into a single plan for Form 5500 filing purposes, etc. The *Montanile* court noted that a plan may be embodied in

more than one document; determining which ones can be a challenge. Likewise, the knot cannot easily be severed by labeling one or more documents as "the plan." It is then essential to make sure that the other non-"plan documents" do not contain provisions that the plan sponsor will want to enforce. For instance, a grant of discretionary authority to interpret the plan may appear in an insurance contract. One needs to make sure that also shows up in whatever constitutes "the plan."

- One obvious problem with assigning the dual role of plan and summary to a single document is that a summary plan description is supposed to be understandable by participants, while plan draftsmen often feel impelled to include material that, however legally essential, is obscure to a layman. At least one court has held that where an SPD serves as a plan document, its limitations on benefits are enforceable only if they meet an SPD standard of intelligibility. *Spinedex Physical Therapy USA Inc. v. United Healthcare of Arizona, Inc*., 770 F.3d 1282 (9th Cir., Nov. 5, 2014). Combining clarity with legal precision can be a daunting challenge.

The ultimate moral of *Montanile* and similar cases is that, in the post-*Amara* world, plan documentation demands greater care and attention to detail than it has often received in the past.

After *Windsor*, ERISA Leaves Plans Some Flexibility Regarding Same-Sex Marriage, Second Circuit Rules

Summarily affirming a district court opinion, the Second Circuit has ruled that, while the *Windsor* decision and subsequent Department of Labor and IRS rulings require employee benefit plans to treat legally married same-sex spouses as "spouses," ERISA does not mandate they treat all spouses identically in all respects. *Roe v. Empire Blue Cross Blue Shield*, 2014 U.S. App. LEXIS 24247 (2d Cir. Dec. 23, 2014) (unpublished opinion), *affirming* 58 Emp. Ben. Cas. (BNA) 1077 (S.D.N.Y. May 1, 2014).

The dispute arose after a hospital declined to let an employee enroll her same-sex partner in its self-insured health plan, because the plan excluded "[s]ame sex spouses and domestic partners." The employee sued, alleging that the refusal violated both Section 510 of ERISA, which makes it "unlawful for any person to discharge, fine, suspend, expel, discipline, or discriminate against a participant or beneficiary for exercising any right to which he is entitled under the provisions of an employee benefit plan . . . or for the purpose of interfering with the attainment of any right to which such participant may become entitled under the plan," and the fiduciary standards of Section 404.

The plaintiff's argument rested on the assumption that *Windsor* compels plans to treat opposite-sex and same-sex spouses identically. This is true where ERISA mandates spousal benefits. The DOL and IRS have ruled, for instance, that plans that are required to offer qualified joint-and-survivor annuities must offer them to all participants whose partnerships are recognized as "marriages" in the state where they were contracted. The reason is that *Windsor* requires the federal government to follow state definitions of "marriage," so a mandatory provision affecting "spouses" must apply to everyone whom the pertinent state recognizes as a "spouse."

The courts held, in this case, that this reasoning does not extend to benefits that are not mandated, such as the enrollment of spouses and dependents in medical plans. The District Court explained:

> Here, the Court is presented with a Plan provided by a private actor that does not define "spouse," but contains an Exclusion that specifically eliminates same-sex spouses from qualifying for benefits. The question before the Court, then, is whether ERISA prohibits a

> private employer from excluding from the definition of "spouse" an entire category of people such that the outcome is that same-sex married couples are not entitled to the same benefits under their employer-sponsored plan as other legally married couples. ERISA has long been held to be a regulator of plans, not a dictator of plan terms. . . . Further, the legislative history provides that although an outright anti-discrimination provision of ERISA was contemplated, it was ultimately not included in the Act because other federal laws already proscribed such discrimination. . . .
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> Moreover, section 510 has consistently been excluded from application to allegedly discriminatory plan terms, especially by courts in this Circuit. [footnote omitted] The "discrimination" proscribed by that section was not intended to conflict with the strong policy under ERISA that has long been held to allow plans to provide benefits under terms as it sees fit. [footnote omitted] An employer enjoys the "flexibility . . . to amend or eliminate its welfare plan[,]" *Inter-Modal Rail Emps. Ass'n v. Atchison, Topeka and SantaFe. Ry. Co.*, 520 U.S. 510, 515, 117 S. Ct. 1513, 137 L. Ed. 2d 763 (1997), meaning that a plan may, for example, choose not to provide benefits to spouses at all. Jane Roe suffered no adverse employment action in this case; she remains employed by St. Joseph's.

Since ERISA did not bar the plan from excluding same-sex partners, the courts also concluded that the plan's fiduciaries were entitled (and, in fact, required) to adhere to its terms.