EMPLOYEE BENEFITS LAW:
POLICY AND PRACTICE (4TH EDITION 2014)

STUDENT SUPPLEMENTAL MATERIALS
(SPRING 2018)

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CHAPTER TWO

B. TYPES OF PLANS SUBJECT TO ERISA

3. WHO IS A SPOUSE?

Add the following new paragraph after the first full paragraph on p. 54

Two years after *Windsor*, the Supreme Court held in *Obergefell v. Hodges*, 135 S. Ct. 2584 (2015), that Section 2 of DOMA violated the Due Process and Equal Protections Clauses under the Fourteenth Amendment. According to the Supreme Court, the Fourteenth Amendment requires that the civil marriage laws of each state must apply to same-sex couples "on the same terms and conditions as opposite-sex couples," and that a state cannot refuse to "recognize a lawful same-sex marriage performed in another State on the ground of its same-sex character." 135 S. Ct. at 2605, 2608. *Obergefell*'s most direct impact was on employee benefit plans that were not subject to regulation under Title I of ERISA (i.e., governmental plans and non-electing church plans). Prior to *Obergefell*, these non-ERISA plans that were operating in states that did not recognize same-sex marriages were permitted by Section 2 of DOMA to exclude same-sex spouses from the definition of a "spouse" under state civil marriage laws. After *Obergefell*, these non-ERISA plans are required to recognize same-sex spouses.

For employee benefit plans subject to Title I of ERISA, *Obergefell* had two indirect, but nevertheless important, effects for plan sponsors and plan participants located in states that previously had not recognized same-sex marriages under state civil marriage laws. First, the state income tax treatment of spousal plan benefits became the same as under federal law, with same-sex spouses being afforded equal treatment for state taxation purposes. Second, *Obergefell* eliminated the problems that emerged after *Windsor* when same-sex couples attempted to divide qualified retirement plan benefits in divorce proceedings using qualified domestic relations orders ("QDROs"). QDROs and the Internal Revenue Code rules for the distribution of retirement plan benefits upon divorce are discussed in Section G of Chapter Three.

D. PLAN REPORTING AND DISCLOSURE REQUIREMENTS

3. NOTE ON REPORTING AND DISCLOSURE REQUIREMENTS UNIQUE TO HEALTH CARE PLANS

Insert the following new paragraph after the introductory first paragraph in this section on p. 81

The Tax Cuts and Jobs Act, Pub. L. No. 115-97, signed into law on December 22, 2017, reduced to zero beginning in 2019 the tax imposed by the Affordable Care Act on individuals who fail to obtain *minimum essential coverage* of health care services. The Tax Cuts and Jobs Act did not, however, repeal the requirements imposed on employers who sponsor group health plans for their employees, including the reporting and disclosure requirements discussed below.

Delete the first two sentences of the last paragraph on p. 83.

Insert the following material at the end of the second full paragraph on p. 84

Reporting on group health plan coverage for purposes of enforcing the employer and individual mandates became effective in 2016 for the prior 2015 calendar year. Employers and health plan insurers provide must information on group health plan coverage using the Form 1094/1095 reporting series. Form 1095, which is analogous to the W-2 form that an employee receives from the employer stating wages paid and taxes withheld, is used to report health plan coverage information for each individual employee. Form 1094 is a collective transmittal form that is used to report to the IRS certain information about plan coverage, along with copies of the Form 1095s showing the individuals (including spouses and dependents) who obtained coverage under the plan.

CHAPTER THREE

4. MECHANISMS TO AVOID PLAN DISQUALIFICATION

Add the following new material at the end of the last paragraph at the bottom of p. 232

In Announcement 2015-09, the Internal Revenue Service announced that effective January 1, 2017, it will eliminate the staggered 5-year determination letter amendment cycle procedure for all individually designed (i.e., "custom written") qualified plans. Going forward, the Service will limit the scope of determination letters for individually designed qualified plans to initial plan qualification and qualification upon termination of the plan. Employers who use prototype and volume submitter retirement plan documents, however, still will be able to obtain determination letters for interim plan amendments. The demise of the determination letter process for individually designed qualified plans is likely to accelerate the trend toward the use of more standardized prototype and volume submitter plans by employers to reduce the administrative costs associated with plan sponsorship.

2. QUALIFIED DOMESTIC RELATIONS ORDERS

Delete Note 5 on p. 248 and insert the following new Note 5

5. *QDROs and Divorce for Same-Sex Spouses.* As a result of the Supreme Court's decisions in *United States v. Windsor*, 133 S. Ct. 2675 (2013), and *Obergefell v. Hodges*, 135 S. Ct. 2584 (2015), the QDRO rules apply to a former same-sex spouse of a plan participant who is named as an alternate payee in a domestic relations order. Prior to the Supreme Court's decision in *Obergefell*, a divorcing same-sex couple domiciled in a state that did not recognize the marriage under state law could not obtain a divorce (and therefore could not obtain a QDRO) from a state court in their jurisdiction of domicile. In these situations, a same-sex divorcing couple had to obtain a divorce decree and a QDRO from a state court in another state that recognized the marriage, permitted the divorce, and therefore would issue a QDRO. If a QDRO could be obtained from a state court in another jurisdiction, then the plan administrator was required to honor the terms of the QDRO. After *Obergefell*, all states must recognize same-sex marriage, permit divorce, and issue QDROs to divorcing same-sex couples. Thus, *Obergefell* eliminated a significant practical obstacle to the division and distribution of qualified retirement plan benefits for a divorcing same-sex couple.

CHAPTER FOUR

2. HISTORIC NATIONAL HEALTH CARE REFORM

Insert after the carryover paragraph at the top of p. 293

As part of the Consolidated Appropriations Act of 2016, Congress delayed the date for implementation of the Cadillac tax from 2018 until 2020. In addition, the 40% excise tax was made deductible, and collection of the 2.3% tax on sales of medical devices was suspended for two years (2016-2017).

Insert after the CBO Table on p. 298

The health care reform and the future of the Affordable Care Act once again was a central issue in the United States presidential election in 2016. The election of President Donald Trump, along with the election of Republican majorities in both the House of Representatives and the Senate, moved health care reform back again to the top of the domestic policy agenda. On May 4, 2017, the House of Representatives passed the American Health Care Act of 2017 (AHCA). The AHCA, which would have repealed both the individual mandate and the employer mandate tax penalties created by the ACA, failed to garner sufficient votes to pass the Senate. Determined to show progress toward what had been a major campaign issue for the Republicans in the 2016 election cycle, Republicans in the House of Representatives and Senate passed the Tax Cuts and Jobs Act, Pub. L. No. 115-97, which was signed into law by President Trump on December 22, 2017. Although the Tax Cuts and Jobs Act reduced the individual mandate tax penalty to zero beginning in 2019, the law did not repeal the employer mandate tax penalty or the

other insurance market reforms enacted by the Affordable Care Act.

The repeal of the individual mandate effective in 2019 makes it difficult to predict whether individuals who have health insurance coverage, either through an employer-sponsored group health plan or an individual policy purchased on the Exchange, will continue to obtain health insurance coverage in 2019. For employers, the ACA tax penalties that remain in effect provide a strong incentive to continue to offer group health plan coverage to their workers.

4. AFFORDABLE CARE ACT

A Preliminary Note About Federalism and Counting Employees

Delete the second full paragraph on p. 364 and the carryover paragraph at the bottom of p. 364 and the top of p. 365, then add the following new material at the end of the Preliminary Note

For insured group health plans, the ACA relies on state insurance laws to determine whether an employer qualifies for a group policy on the large employer or the small employer market. State insurance laws differ from the ACA in that typically state laws define the size of the employer by using the actual number of employees and not equivalencies.

Although the ACA originally defined a small employer under the PHSA as one having 100 or fewer employees, many state insurance laws used 50 employees as the dividing line between a small employer group policy and a large employer group policy. In the Protecting Affordable Coverage for Employees ("PACE") Act, Congress amended the ACA so that state law determines the number of employees used to define the large employer group health plan market for policies that cover state residents. As explained later in Section D, group health insurance policies sold in the small employer market generally are more expensive than large employer group policies in part because such policies must provide coverage of the full range of ten essential health benefits mandated by the ACA. In addition, the ACA requires that group policies sold on the small employer market must be part of a single risk pool for setting premiums, can only consider age, geographic location, family composition and tobacco use in setting rates, and must conform to the actuarial value categories (e.g., platinum, gold, silver, and bronze) established by the ACA. These additional requirements tend to increase the premiums that participants must pay for coverage under a small employer insured plan.

e. Automatic Enrollment Requirements for Very Large Plans (p. 370)

The automatic enrollment requirement for very large employers having more than 200 full-time equivalent employees described in the text was permanently repealed by the Bipartisan Budget Act of 2015.

i. Challenges to the Affordable Care Act

Insert after Question 3 on p. 401

4. *Payment of Premium Assistance Tax Credits in Federal Exchange States*. Three years after *NFIB v. Sebelius* was decided, the Supreme Court rejected another systemic challenge to the Affordable Care Act. *King v. Burwell*, 135 S. Ct. 2480 (2015), involved a challenge to a regulation promulgated by the Internal Revenue Service interpreting Section 36B of the Internal Revenue Code. Code Section 36B, which was created by the ACA, authorizes the payment of premium assistance tax credits to qualifying taxpayers who enroll in an insurance plan through "an Exchange established by the State." At the time the Supreme Court heard *King v. Burwell*, only 16 states had established their own Exchanges, with 34 states opting to use the federal Exchange operated by the Department of Health and Human Services. The question presented in *King v. Burwell* was "whether the Act's interlocking reforms apply equally in each State no matter who establishes the State's Exchange. Specifically, the question presented [was] whether the Act's tax credits are available in States that have a Federal Exchange." Id. at 2485. The Supreme Court held that "the context and structure of the Act compel us to depart from what would otherwise be the most natural reading of the pertinent statutory phrase." Id. at 2495. Relying on evidence that withholding tax credits from qualifying individuals in federal Exchange states would result in a "death spiral" of rising health insurance rates, the Supreme Court concluded:

> Congress passed the Affordable Care Act to improve health insurance markets, not to destroy them. If at all possible, we must interpret the Act in a way that is consistent with the former, and avoids the latter. Section 36B can fairly be read consistent with what we see as Congress's plan, and that is the reading we adopt. Id. at 2496.

5. *Employer Financial Incentives to Decline Group Health Plan Coverage*. As employers began to evaluate the cost of compliance with the ACA, it became apparent that in some situations it would be more cost-effective for the employer to provide monetary incentives to employees to purchase an individual policy on an Exchange and decline group health plan coverage. These monetary incentive arrangements either have been rejected outright by federal regulatory authorities or construed in a way that discourages employers from adopting them. See IRS Notice 2013-54, Q&A-1, Q&A-3 (employer reimbursement arrangements using either pre-tax or after-tax payments to employees who purchase individual policy coverage violate the ACA, subjecting the employer to penalties under Code Section 4980D); IRS Notice 2015-87, Q&A-9 (an employer who offers a cash incentive for employees to "opt-out" of plan coverage must add the opt-out amount to the premium cost in determining whether the employer's plan satisfies the affordability criteria necessary to avoid the free rider penalty under Code Section 4980H(b)).

6. *Employee Claims for Employer Violations of the ACA.* The ACA provides for two different ways for employees to protect their rights under the ACA. First, an employee may bring a private civil action under ERISA against an employer who interferes with the attainment of group health plan benefits. See ERISA §§ 502(a)(3), 510. Second, the ACA added a new

provision, Section 18C, to the whistleblower protection provisions of the Fair Labor Standards Act ("FLSA"). See ACA § 1558 (adding FLSA §18C); Procedures for the Handling of Retaliation Complaints Under Section 1558 of the Affordable Care Act, 78 Fed. Reg. 13222 (Feb. 27, 2013) (final interim regulations). New Section 18C of the FLSA is designed to protect full-time employees who purchase an individual insurance policy on an Exchange using a premium assistance tax credit from retaliatory employment actions by an employer, who may become subject to a penalty under Code Section 4980H as a result of the employee's purchase of subsidized Exchange coverage. Employee claims for violations of ERISA Section 510 and FLSA 18C are discussed in more detail in Section E.3 of Chapter Six.

G. RETIREE HEALTH CARE PLANS AND ERISA LITIGATION

2. THE EVOLUTION OF RETIREE HEALTH CARE PLAN CLAIMS

Delete the material after the carryover paragraph at the top of page 461 through the second full paragraph on page 462 and insert the following new material:

Id. at 1482. The Sixth Circuit's statements in *Yard-Man* became the inspiration for subsequent claims asserting that retiree health care benefits granted under the terms of a collective bargaining agreement were presumptively "vested" and could not be later changed or eliminated by a subsequent collective bargaining agreement. The scenario presented in *M & G Polymers USA, LLC v. Tackett* is typical of such claims.

M & G POLYMERS USA, LLC v. TACKETT

Supreme Court of the United States, 2015.
135 S. Ct. 926.

Justice THOMAS delivered the opinion of the Court.

This case arises out of a disagreement between a group of retired employees and their former employer about the meaning of certain expired collective bargaining agreements. The retirees (and their former union) claim that these agreements created a right to lifetime contribution-free health care benefits for retirees, their surviving spouses, and their dependents. The employer, for its part, claims that those provisions terminated when the agreements expired. The United States Court of Appeals for the Sixth Circuit sided with the retirees, relying on its conclusion in *International Union, United Auto., Aerospace, & Agricultural Implement Workers of Am. v. Yard–Man, Inc.*, 716 F.2d 1476, 1479 (1983), that retiree health care benefits are unlikely to be left up to future negotiations. We granted certiorari and now conclude that such reasoning is incompatible with ordinary principles of contract law. We therefore vacate the judgment of the Court of Appeals and remand for it to apply ordinary principles of contract law in the first instance.

I

A

Respondents Hobert Freel Tackett, Woodrow K. Pyles, and Harlan B. Conley worked at (and retired from) the Point Pleasant Polyester Plant in Apple Grove, West Virginia (hereinafter referred to as the Plant). During their employment, respondent United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial and Service Workers International Union, AFL–CIO–CLC, or its predecessor unions (hereinafter referred to as the Union), represented them in collective bargaining. Tackett and Pyles retired in 1996, and Conley retired in 1998. They represent a class of retired employees from the Plant, along with their surviving spouses and other dependents. Petitioner M & G Polymers USA, LLC, is the current owner of the Plant.

When M & G purchased the Plant in 2000, it entered a master collective-bargaining agreement and a Pension, Insurance, and Service Award Agreement (P & I agreement) with the Union, generally similar to agreements the Union had negotiated with M & G's predecessor. The P & I agreement provided for retiree health care benefits as follows:

> Employees who retire on or after January 1, 1996 and who are eligible for and receiving a monthly pension under the 1993 Pension Plan ... whose full years of attained age and full years of attained continuous service ... at the time of retirement equals 95 or more points will receive a full Company contribution towards the cost of [health care] benefits described in this Exhibit B–1.... Employees who have less than 95 points at the time of retirement will receive a reduced Company contribution. The Company contribution will be reduced by 2% for every point less than 95. Employees will be required to pay the balance of the health care contribution, as estimated by the Company annually in advance, for the [health care] benefits described in this Exhibit B–1. Failure to pay the required medical contribution will result in cancellation of coverage.

Exhibit B–1, which described the health care benefits at issue, opened with the following durational clause: "Effective January 1, 1998, and for the duration of this Agreement thereafter, the Employer will provide the following program of hospital benefits, hospital-medical benefits, surgical benefits and prescription drug benefits for eligible employees and their dependents...." The P & I agreement provided for renegotiation of its terms in three years.

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B

In December 2006, M & G announced that it would begin requiring retirees to contribute to the cost of their health care benefits. Respondent retirees, on behalf of themselves and others similarly situated, sued M & G and related entities, alleging that the decision to require these contributions breached both the collective bargaining agreement and the P & I agreement, in violation of § 301 of the Labor Management Relations Act, 1947 (LMRA) and § 502(a)(1)(B) of the Employee Retirement Income Security Act of 1974 (ERISA). Specifically, the retirees alleged that M & G had promised to provide lifetime contribution-free health care benefits for

them, their surviving spouses, and their dependents. They pointed to the language in the 2000 P & I agreement providing that employees with a certain level of seniority "will receive a full Company contribution towards the cost of [health care] benefits described in ... Exhibit B–1." The retirees alleged that, with this promise, M & G had created a vested right to such benefits that continued beyond the expiration of the 2000 P & I agreement.

The District Court dismissed the complaint for failure to state a claim. 523 F. Supp. 2d 684, 696 (S.D. Ohio 2007). It concluded that the cited language unambiguously did not create a vested right to retiree benefits.

The Court of Appeals reversed based on the reasoning of its earlier decision in *Yard–Man*. 561 F.3d 478 (6th Cir. 2009) (Tackett I). *Yard–Man* involved a similar claim that an employer had breached a collective bargaining agreement when it terminated retiree benefits. 716 F.2d at 1478. Although the court found the text of the provision in that case ambiguous, it relied on the "context" of labor negotiations to resolve that ambiguity in favor of the retirees' interpretation. Id. at 1482. Specifically, the court inferred that parties to collective bargaining would intend retiree benefits to vest for life because such benefits are "not mandatory" or required to be included in collective bargaining agreements, are "typically understood as a form of delayed compensation or reward for past services," and are keyed to the acquisition of retirement status. Id. The court concluded that these inferences "outweigh[ed] any contrary implications [about the termination of retiree benefits] derived from" general termination clauses. Id. at 1483.

Applying the *Yard–Man* inferences on review of the District Court's dismissal of the action, the Court of Appeals concluded that the retirees had stated a plausible claim. Tackett I, 561 F.3d at 490. "Keeping in mind the context of the labor-management negotiations identified in *Yard–Man*," the court found "it unlikely that [the Union] would agree to language that ensures its members a 'full Company contribution,' if the company could unilaterally change the level of contribution." Id. The court construed the language about "employees" contributing to their health care premiums as limited to employees who had not attained the requisite seniority points to be entitled to a full company contribution. Id. And it discerned an intent to vest lifetime contribution-free health care benefits from provisions tying eligibility for health care benefits to eligibility for pension benefits. Id. at 490–491.

On remand, the District Court conducted a bench trial and ruled in favor of the retirees. It declined to revisit the question whether the P & I agreement created a vested right to retiree benefits, concluding that the Court of Appeals had definitively resolved that issue. It then issued a permanent injunction ordering M & G to reinstate contribution-free health care benefits for the individual respondents and similarly situated retirees. 853 F. Supp. 2d 697 (S.D. Ohio 2012).

The Court of Appeals affirmed, concluding that, although the District Court had erred in treating *Tackett I* as a conclusive resolution of the meaning of the P & I agreement, it had not erred in "presum[ing]" that, "in the absence of extrinsic evidence to the contrary, the agreements indicated an intent to vest lifetime contribution-free benefits." 733 F.3d 589, 600 (6th Cir. 2013) (Tackett II). And because the District Court had concluded that the proffered extrinsic evidence

was inapplicable, it had not clearly erred in finding that the agreement created those vested rights.

We granted certiorari, and now vacate and remand.

II

This case is about the interpretation of collective bargaining agreements that define rights to welfare benefits plans. The LMRA grants federal courts jurisdiction to resolve disputes between employers and labor unions about collective bargaining agreements. 29 U.S.C. § 185. When collective bargaining agreements create pension or welfare benefits plans, those plans are subject to rules established in ERISA. ERISA defines pension plans as plans, funds, or programs that "provid[e] retirement income to employees" or that "resul[t] in a deferral of income." § 3(A). It defines welfare benefits plans as plans, funds, or programs established or maintained to provide participants with additional benefits, such as life insurance and disability coverage. § 3(1).

ERISA treats these two types of plans differently. Although ERISA imposes elaborate minimum funding and vesting standards for pension plans, explicitly exempts welfare benefits plans from those rules. Welfare benefits plans must be "established and maintained pursuant to a written instrument," § 402(a)(1), but "[e]mployers or other plan sponsors are generally free under ERISA, for any reason at any time, to adopt, modify, or terminate welfare plans," Curtiss–Wright Corp. v. Schoonejongen, 514 U.S. 73, 78 (1995). As we have previously recognized, "employers have large leeway to design disability and other welfare plans as they see fit." Black & Decker Disability Plan v. Nord, 538 U.S. 822, 833 (2003). And, we have observed, the rule that contractual "provisions ordinarily should be enforced as written is especially appropriate when enforcing an ERISA [welfare benefits] plan." Heimeshoff v. Hartford Life & Accident Ins. Co., 134 S. Ct. 604, 611–612 (2013). That is because the "focus on the written terms of the plan is the linchpin of a system that is not so complex that administrative costs, or litigation expenses, unduly discourage employers from offering [welfare benefits] plans in the first place." 134 S. Ct. at 612.

We interpret collective bargaining agreements, including those establishing ERISA plans, according to ordinary principles of contract law, at least when those principles are not inconsistent with federal labor policy. See Textile Workers v. Lincoln Mills of Ala., 353 U.S. 448, 456–457 (1957). "In this endeavor, as with any other contract, the parties' intentions control." Stolt–Nielsen S.A. v. Animal Feeds Int'l Corp., 559 U.S. 662, 682 (2010). "Where the words of a contract in writing are clear and unambiguous, its meaning is to be ascertained in accordance with its plainly expressed intent." 11 R. Lord, Williston on Contracts § 30:6, p. 108 (4th ed. 2012) (Williston). In this case, the Court of Appeals applied the *Yard–Man* inferences to conclude that, in the absence of extrinsic evidence to the contrary, the provisions of the contract indicated an intent to vest retirees with lifetime benefits. Tackett II, 733 F.3d at 599–600. As we now explain, those inferences conflict with ordinary principles of contract law.

III

A

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The Court of Appeals has long insisted that its *Yard–Man* inferences are drawn from ordinary contract law. In *Yard–Man* itself, the court purported to apply "traditional rules for contractual interpretation." 716 F.2d at 1479. The court first concluded that the provision governing retiree insurance benefits—which stated only that the employer "will provide" such benefits—was ambiguous as to the duration of those benefits. Id. at 1480. To resolve that ambiguity, it looked to other provisions of the agreement. The agreement included provisions for terminating active employees' insurance benefits in the case of layoffs and for terminating benefits for a retiree's spouse and dependents in case of the retiree's death before the expiration of the collective-bargaining agreement, but no provision specifically addressed the duration of retiree health care benefits. Id. at 1481–1482. From the existence of these termination provisions and the absence of a termination provision specifically addressing retiree benefits, the court inferred an intent to vest those retiree benefits for life.

The court then purported to apply the rule that contracts should be interpreted to avoid illusory promises. It noted that the retiree insurance provisions "contain[ed] a promise that the company will pay an early retiree's insurance upon such retiree reaching age 65 but that the retiree must bear the cost of company insurance until that time." Id. at 1481. Employees could retire at age 55, but the agreement containing this promise applied only for a 3–year term. Thus, retirees between the ages of 55 and 62 would not turn 65 and become eligible for the company contribution before the 3–year agreement expired. In light of this fact, the court reasoned that the promise would be "completely illusory for many early retirees under age 62" if the retiree benefits terminated when the contract expired. Id.

Finally, the court turned to "the context" of labor negotiations. Id. at 1482. It observed that "[b]enefits for retirees are ... not mandatory subjects of collective bargaining" and that "employees are presumably aware that the union owes no obligation to bargain for continued benefits for retirees." Id. Based on these observations, the court concluded that "it is unlikely that such benefits ... would be left to the contingencies of future negotiations." Id. It also asserted that "retiree benefits are in a sense 'status' benefits which, as such, carry with them an inference that they continue so long as the prerequisite status is maintained." Id.

Although the contract included a general durational clause—meaning that the contract itself would expire at a set time—the court concluded that these contextual clues "outweigh[ed] any contrary implications derived from a routine duration clause." Id. at 1483.

* * *

B

We disagree with the Court of Appeals' assessment that the inferences applied in *Yard–Man* and its progeny represent ordinary principles of contract law.

As an initial matter, *Yard–Man* violates ordinary contract principles by placing a thumb on the scale in favor of vested retiree benefits in all collective bargaining agreements. That rule has no basis in ordinary principles of contract law. And it distorts the attempt "to ascertain the intention of *the parties*." 11 Williston § 30:2 at 18 (emphasis added). *Yard–Man* 's assessment of likely behavior in collective bargaining is too speculative and too far removed from the context of any particular contract to be useful in discerning the parties' intention.

And the Court of Appeals derived its assessment of likely behavior not from record evidence, but instead from its own suppositions about the intentions of employees, unions, and employers negotiating retiree benefits. See Yard–Man, 716 F.2d at 1482. For example, it asserted, without any foundation, that, "when ... parties contract for benefits which accrue upon achievement of retiree status, there is an inference that the parties likely intended those benefits to continue as long as the beneficiary remains a retiree." Id. Although a court may look to known customs or usages in a particular industry to determine the meaning of a contract, the parties must prove those customs or usages using affirmative evidentiary support in a given case. 12 Williston § 34:3; accord, Robinson v. United States, 13 Wall. 363, 366, 20 L.Ed. 653 (1872); Oelricks v. Ford, 23 How. 49, 61–62, 16 L.Ed. 534 (1860). *Yard–Man* relied on no record evidence indicating that employers and unions in that industry customarily vest retiree benefits. Worse, the Court of Appeals has taken the inferences in *Yard–Man* and applied them indiscriminately across industries.

Because the Court of Appeals did not ground its *Yard–Man* inferences in any record evidence, it is unsurprising that the inferences rest on a shaky factual foundation. For example, *Yard–Man* relied in part on the premise that retiree health care benefits are not subjects of mandatory collective bargaining. Parties, however, can and do voluntarily agree to make retiree benefits a subject of mandatory collective bargaining. Indeed, the employer and union in this case entered such an agreement in 2001. *Yard–Man* also relied on the premise that retiree benefits are a form of deferred compensation, but that characterization is contrary to Congress' determination otherwise. In ERISA, Congress specifically defined plans that "resul[t] in a deferral of income by employees" as pension plans, § 3(2)(A)(ii), and plans that offer medical benefits as welfare plans, § 3(1)(A). Thus, retiree health care benefits are not a form of deferred compensation.

Further compounding this error, the Court of Appeals has refused to apply general durational clauses to provisions governing retiree benefits. Having inferred that parties would not leave retiree benefits to the contingencies of future negotiations, and that retiree benefits generally last as long as the recipient remains a retiree, the court in *Yard–Man* explicitly concluded that these inferences "outweigh[ed] any contrary implications derived from a routine duration clause terminating the agreement generally." 716 F.2d at 1482–1483. The court's subsequent decisions went even further, requiring a contract to include a specific durational clause for retiree health care benefits to prevent vesting. E.g., Noe v. PolyOne Corp., 520 F.3d 548, 555 (6th Cir. 2008). These decisions distort the text of the agreement and conflict with the

principle of contract law that the written agreement is presumed to encompass the whole agreement of the parties. See 1 W. Story, Law of Contracts § 780 (M. Bigelow ed., 5th ed. 1874); see also 11 Williston § 31:5.

Perhaps tugged by these inferences, the Court of Appeals misapplied other traditional principles of contract law, including the illusory promises doctrine. That doctrine instructs courts to avoid constructions of contracts that would render promises illusory because such promises cannot serve as consideration for a contract. See 3 Williston § 7:7 (4th ed. 2008). But the Court of Appeals construed provisions that admittedly benefited some class of retirees as "illusory" merely because they did not equally benefit *all* retirees. See Yard–Man, supra, at 1480–1481. That interpretation is a contradiction in terms—a promise that is "partly" illusory is by definition not illusory. If it benefits some class of retirees, then it may serve as consideration for the union's promises. And the court's interpretation is particularly inappropriate in the context of collective bargaining agreements, which are negotiated on behalf of a broad category of individuals and consequently will often include provisions inapplicable to some category of employees.

The Court of Appeals also failed even to consider the traditional principle that courts should not construe ambiguous writings to create lifetime promises. See 3 A. Corbin, Corbin on Contracts § 553, p. 216 (1960) (explaining that contracts that are silent as to their duration will ordinarily be treated not as "operative in perpetuity" but as "operative for a reasonable time"). The court recognized that "traditional rules of contractual interpretation require a clear manifestation of intent before conferring a benefit or obligation," but asserted that "the duration of the benefit once clearly conferred is [not] subject to this stricture." Yard–Man, supra, at 1481, n. 2. In stark contrast to this assertion, however, the court later applied that very stricture to non-collectively bargained contracts offering retiree benefits. See Sprague v. General Motors Corp., 133 F.3d 388, 400 (6th Cir. 1998) ("To vest benefits is to render them forever unalterable. Because vesting of welfare plan benefits is not required by law, an employer's commitment to vest such benefits is not to be inferred lightly; the intent to vest must be found in the plan documents and must be stated in clear and express language"). The different treatment of these two types of employment contracts only underscores *Yard–Man*'s deviation from ordinary principles of contract law.

Similarly, the Court of Appeals failed to consider the traditional principle that "contractual obligations will cease, in the ordinary course, upon termination of the bargaining agreement." Litton Financial Printing Div. v. NLRB, 501 U.S. 190, 207 (1991). That principle does not preclude the conclusion that the parties intended to vest lifetime benefits for retirees. Indeed, we have already recognized that "a collective bargaining agreement [may] provid[e] in explicit terms that certain benefits continue after the agreement's expiration." Id. But when a contract is silent as to the duration of retiree benefits, a court may not infer that the parties intended those benefits to vest for life.

C

There is no doubt that *Yard–Man* and its progeny affected the outcome here. As in its previous decisions, the Court of Appeals here cited the "context of ... labor-management negotiations" and reasoned that the Union likely would not have agreed to language ensuring its members a "full Company contribution" if the company could change the level of that contribution. Tackett I, 561 F.3d at 490. It similarly concluded that the tying of eligibility for health care benefits to receipt of pension benefits suggested an intent to vest health care benefits. Id. And it framed its analysis from beginning to end in light of the principles it announced in *Yard–Man* and its progeny. See 561 F.3d at 489; see also Tackett II, 733 F.3d at 599–600.

We reject the *Yard–Man* inferences as inconsistent with ordinary principles of contract law. But because "[t]his Court is one of final review, not of first view," Ford Motor Co. v. United States, 134 S. Ct. 510, 510 (2013) (per curiam), the Court of Appeals should be the first to review the agreements at issue under the correct legal principles. We vacate the judgment of the Court of Appeals and remand the case for that court to apply ordinary principles of contract law in the first instance.

Justice GINSBURG, with whom Justice BREYER, Justice SOTOMAYOR, and Justice KAGAN join, concurring.

Today's decision rightly holds that courts must apply ordinary contract principles, shorn of presumptions, to determine whether retiree health care benefits survive the expiration of a collective bargaining agreement. Under the "cardinal principle" of contract interpretation, "the intention of the parties, to be gathered from the whole instrument, must prevail." 11 R. Lord, Williston on Contracts § 30:2, p. 27 (4th ed. 2012) (Williston). To determine what the contracting parties intended, a court must examine the entire agreement in light of relevant industry-specific "customs, practices, usages, and terminology." Id. § 30:4, at 55–58. When the intent of the parties is unambiguously expressed in the contract, that expression controls, and the court's inquiry should proceed no further. Id. § 30:6, at 98–104. But when the contract is ambiguous, a court may consider extrinsic evidence to determine the intentions of the parties. Id. § 30:7 at 116–124.

Contrary to M & G's assertion, no rule requires "clear and express" language in order to show that parties intended health care benefits to vest. "[C]onstraints upon the employer after the expiration date of a collective bargaining agreement," we have observed, may be derived from the agreement's "explicit terms," but they "may arise as well from ... implied terms of the expired agreement." Litton Financial Printing Div., Litton Business Systems, Inc. v. NLRB, 501 U.S. 190, 203, 207 (1991).

On remand, the Court of Appeals should examine the entire agreement to determine whether the parties intended retiree health care benefits to vest. 11 Williston § 30:4, at 55–57. Because the retirees have a vested, lifetime right to a monthly pension, a provision stating that retirees "will receive" health care benefits if they are "receiving a monthly pension" is relevant to this examination. Id. at 415. So is a "survivor benefits" clause instructing that if a retiree dies, her surviving spouse will "continue to receive [the retiree's health care] benefits ... until death or

remarriage." Id. at 417. If, after considering all relevant contractual language in light of industry practices, the Court of Appeals concludes that the contract is ambiguous, it may turn to extrinsic evidence—for example, the parties' bargaining history. The Court of Appeals, however, must conduct the foregoing inspection without *Yard–Man*'s "thumb on the scale in favor of vested retiree benefits."

Because I understand the Court's opinion to be consistent with these basic rules of contract interpretation, I join it.

Notes and Questions

1. *Discerning Intent Based on the "Whole" Document.* Based on the document language quoted by Justice Ginsburg in her concurring opinion, is it clear that the parties intended the retiree health care benefits created under the collective bargaining agreement to vest? How much weight should the federal courts give to a contrary general durational clause in determining the parties' intentions regarding the vesting of retiree health care benefits? Under a whole document approach, is it inevitable that the retiree-plaintiffs will be able to introduce extrinsic evidence of the parties' bargaining history to support their claim of vested benefits?

2. *The Yard-Man Presumption and Bargaining History. Yard-Man* was decided in 1983, but not overruled until *M & G Polymers* was decided in 2015. How should a court evaluate the intent of the parties in circuits that applied the *Yard-Man* presumption for collective bargaining agreements that were negotiated before *M & G Polymers* was decided? What kinds of extrinsic evidence might tend to show that the parties negotiated the terms of the collective bargaining agreement based on the common understanding that the *Yard-Man* presumption applied?

3. *Equitable Estoppel Claims.* Outside of the collective bargaining agreement setting, the federal courts were reluctant to apply *Yard-Man*'s vested rights theory of retiree health plan benefits, even in the Sixth Circuit. For example, *General Motors v. Sprague*, 133 F.3d 388 (6th Cir. 1998), which is cited by Justice Thomas in the majority opinion, held that a presumption of vesting did not apply to a program of retiree health care benefits for *non-union* employees. See id. at 400. *M & G Polymers* validates this judicial reluctance.

Retirees whose benefits are not established pursuant to a collective bargaining agreement often claim that the employer is equitably estopped from amending or terminating their retiree health care plan. After *M & G Polymers*, collective bargaining unit retirees are likely to adopt a similar litigation strategy and look to equitable estoppel as an alternative theory for their claims. Equitable estoppel claims tend to arise when the employer or the plan administrator has made representations to an employee concerning the future availability of retiree health care benefits. Such representations often are used as an inducement to encourage the employee to accept an early retirement offer as part of a program to downsize the employer's workforce. The basic elements of an estoppel claim are discussed in the Note on Estoppel Claims in Chapter Two. Estoppel as an equitable remedy in private civil actions brought under ERISA is discussed in Chapter Six.

CHAPTER FIVE

B. WHO IS AN ERISA FIDUCIARY?

Delete the introductory material on p. 475-477 prior to *Varity Corporation v. Howe* and insert the following new material

ERISA recognizes five types of fiduciaries:

(1) named plan fiduciaries under Section 402(a)(1);

(2) plan administrators under Section 3(16);

(3) plan trustees under Section 403;

(4) plan investment managers under Section 3(38); and

(5) functional fiduciaries under Section 3(21)(A).

Section 402(a)(1) of ERISA requires that every plan must have at least one named fiduciary, who is the person designated in the plan document as having the overall authority to control and manage the operation and administration of the plan. As explained in Chapter Two, the purpose of the named fiduciary requirement is to inform the plan's participants exactly who is responsible for the overall administration and management of the plan and its assets. A named fiduciary must either be identified expressly in the plan document itself or be identifiable pursuant to a procedure specified in the plan document.

In addition to a named fiduciary, every plan needs an administrator. In a well-designed plan, the Section 3(16) plan administrator is designated under the terms of the plan document. If the plan does not designate a person to serve as the plan's administrator, then the employer who sponsors the plan becomes the plan's Section 3(16) administrator by default. If the corporate entity who sponsors the plan does not want to be liable for the fiduciary administrative responsibilities associated with the operation of the plan, the employer may designate a committee of officers and employees to serve as the plan's administrator. Or, the employer may outsource fiduciary administrative functions to a third-party professional plan administrator. See generally Colleen E. Medill, *Regulating ERISA Fiduciary Outsourcing*, 102 IOWA L. REV. 505 (2017).

In addition to requiring a named fiduciary and a plan administrator, Section 403 of ERISA requires that the assets of the plan must be held in trust by one or more trustees. As explained in Chapter Two, the authority of the trustee with regard to the management of the plan's assets can be structured in different ways. The trustee for the plan may have full discretion to manage the plan's assets (a "discretionary" trustee), or may instead have only the authority to manage the plan's assets according to the directions of a named plan fiduciary (a "directed" trustee). All or a portion of the assets of the plan held by the trustee may be managed

and invested by yet another third-party professional fiduciary, a Section 3(38) investment manager.

The named fiduciary for the plan, the plan administrator, the trustee, and (perhaps) an investment manager are all "formal" fiduciaries with identified titles and fiduciary functions specifically delineated by the statute. The fifth type of ERISA fiduciary is distinctly different. ERISA Section 3(21)(A) defines a fiduciary based on the functions actually performed by the person, rather than on the person's official title. See DOL Reg. § 2509.75–8, Questions D–3–D–5. Under Section 3(21)(A), a person can be a fiduciary under ERISA without knowing or intending to be a fiduciary. See Freund v. Marshall & Ilsley Bank, 485 F.Supp. 629, 635 (W.D. Wis. 1979) ("It is apparent from the evidence that many of these persons were confused about the nature of their fiduciary duties and indeed unsure whether they were fiduciaries with respect to the Plan….Their state of mind, however, does not determine their fiduciary status under ERISA.").

Section 3(21)(A) expressly limits fiduciary status "to the extent" the person performs fiduciary functions. This limitation means that the same person can act as an ERISA fiduciary when performing some functions, and yet not be an ERISA fiduciary when performing other nonfiduciary tasks. There are three main categories of fiduciary functions under Section 3(21)(A):

> (1) Persons who have discretionary authority over administration and management of the plan;
>
> (2) Persons who have any authority (whether discretionary or not) over the assets of the plan; and
>
> (3) Persons who render investment advice concerning assets held by the plan for compensation, regardless of whether the compensation is paid directly out of plan assets or indirectly in the form of a payment from a commission or fee resulting from the investment of plan assets.

In addition, regulations interpreting Section 3(21)(A) define a fiduciary as including any person who renders "retirement investment advice." See generally Definition of the Term "Fiduciary"; Conflict of Interest Rule—Retirement Investment Advice, 81 Fed. Reg. 20,946 (April 8, 2016) ("Retirement Investment Advice Regulations"). The Retirement Investment Advice Regulations, which became effective on June 9, 2017, address the public policy concern that newly-retired participants engaging in IRA rollover transactions from their plan accounts may steered by their personal investment advisors into higher-fee financial products that generate larger commission for the investment advisor. By including these retirement investment advisors in the definition of an ERISA fiduciary, these advisors become subject to ERISA's statutory and regulatory standards for fiduciary conduct.

The Department of Labor by regulation has created numerous exceptions to fiduciary status under Section 3(21)(A):

(1) Persons who assist in plan administration or management, but who perform only ministerial functions, are not plan fiduciaries. DOL Reg. § 2509.75–8, Questions D–2, D–3.
(2) Professionals such as attorneys, accountants, actuaries, and other consultants who assist in the administration and management of the plan by rendering professional services ordinarily are not considered to be fiduciaries of the plan. DOL Reg. § 2509.75–5, Question D–1.
(3) Persons who provide investment education (as opposed to investment advice for compensation) are not fiduciaries. DOL Reg. § 2509.96–1.
(4) Plan recordkeepers and third-party administrators who merely offer a platform of investments to participant-directed individual account plans are not fiduciaries. Retirement Investment Advice Regulations, 81 Fed. Reg. 20,946 (April 8, 2016) (to be codified at 29 C.F.R. §_____).
(5) Investment advisors who provide investment recommendations to an independent plan fiduciary who manages at least $50 million in plan assets are not fiduciaries. Retirement Investment Advice Regulations, 81 Fed. Reg. 20,946 (April 8, 2016) (to be codified at 29 C.F.R. §_____).

Finally, an employer does not act as a plan fiduciary when it performs certain actions known as *settlor functions*. Settlor functions of the employer include establishing, designing, terminating, or amending an employee benefit plan. The settlor function doctrine, a judicially-created exception to fiduciary status, is discussed in *Curtiss-Wright Corp. v. Schoonejongen*, reproduced in Chapter Two, and again in *Lockheed Corporation v. Spink*, reproduced in Section D of Chapter Five.

Fiduciary status is a crucial (and hotly contested) threshold issue in much of ERISA litigation. Whether or not a defendant is an ERISA fiduciary often is determinative of the defendant's liability. The Supreme Court's opinions in *Varity Corporation v. Howe*, reproduced below, and *Pegram v. Herdrich*, reproduced after *Varity*, illustrate this situation. As you read these two decisions, compare how the Supreme Court applied the statutory definition of a fiduciary to the particular facts of each case.

4. TRENDS IN 401(K) PLAN LITIGATION

Insert the following new material after the first full paragraph on p. 584

The following two Supreme Court cases, *Tibble v. Edison International* and *Fifth Third Bancorp v. Dudenhoeffer*, illustrate these litigation trends. In *Tibble*, the plan participants claimed that the fees associated with the menu of investment options for their company's 401(k) plan were unnecessarily high "retail" fees. The plan fiduciaries' defense was that the statute of limitations for asserting a breach of fiduciary duty claim regarding the selection of the challenged funds had expired. In *Fifth Third Bancorp*, the plan participants claimed that the plan

fiduciaries knew or should have known that the company stock held by the plan was overvalued and excessively risky. The plan fiduciaries' defense was that decisions regarding company stock were entitled to a presumption of prudence. As you read *Tibble* and *Fifth Third Bancorp*, consider the implications for both employers who sponsor retirement plans and the participants in those plans. Has the burden placed on plan fiduciaries actually been increased or decreased as a result of the decision? Are the benefits provided to the plan's participants more secure as a result of the decision?

TIBBLE v. EDISON INTERNATIONAL

Supreme Court of the United States, 2015.
135 S.Ct. 1823.

Justice BREYER delivered the opinion of the Court.

Under the Employee Retirement Income Security Act of 1974 (ERISA), a breach of fiduciary duty complaint is timely if filed no more than six years after "the date of the last action which constituted a part of the breach or violation" or "in the case of an omission the latest date on which the fiduciary could have cured the breach or violation." ERISA § 413. The question before us concerns application of this provision to the timeliness of a fiduciary duty complaint. It requires us to consider whether a fiduciary's allegedly imprudent retention of an investment is an "action" or "omission" that triggers the running of the 6–year limitations period.

In 2007, several individual beneficiaries of the Edison 401(k) Savings Plan (Plan) filed a lawsuit on behalf of the Plan and all similarly situated beneficiaries (collectively, petitioners) against Edison International and others (collectively, respondents). Petitioners sought to recover damages for alleged losses suffered by the Plan, in addition to injunctive and other equitable relief based on alleged breaches of respondents' fiduciary duties.

The Plan is a defined contribution plan, meaning that participants' retirement benefits are limited to the value of their own individual investment accounts, which is determined by the market performance of employee and employer contributions, less expenses. Expenses, such as management or administrative fees, can sometimes significantly reduce the value of an account in a defined contribution plan.

As relevant here, petitioners argued that respondents violated their fiduciary duties with respect to three mutual funds added to the Plan in 1999 and three mutual funds added to the Plan in 2002. Petitioners argued that respondents acted imprudently by offering six higher priced retail-class mutual funds as Plan investments when materially identical lower priced institutional class mutual funds were available (the lower price reflects lower administrative costs). Specifically, petitioners claimed that a large institutional investor with billions of dollars, like the Plan, can obtain materially identical lower priced institutional class mutual funds that are not available to a retail investor. Petitioners asked, how could respondents have acted prudently in offering the six higher priced retail class mutual funds when respondents could have offered them effectively the same six mutual funds at the lower price offered to institutional investors like the Plan?

As to the three funds added to the Plan in 2002, the District Court agreed. It wrote that respondents had "not offered any credible explanation" for offering retail class, i.e., higher priced mutual funds that "cost the Plan participants wholly unnecessary [administrative] fees," and it concluded that, with respect to those mutual funds, respondents had failed to exercise "the care, skill, prudence and diligence under the circumstances" that ERISA demands of fiduciaries.

As to the three funds added to the Plan in 1999, however, the District Court held that petitioners' claims were untimely because, unlike the other contested mutual funds, these mutual funds were included in the Plan more than six years before the complaint was filed in 2007. As a result, the 6–year statutory period had run.

The District Court allowed petitioners to argue that, despite the 1999 selection of the three mutual funds, their complaint was nevertheless timely because these funds underwent significant changes within the 6–year statutory period that should have prompted respondents to undertake a full due diligence review and convert the higher priced retail class mutual funds to lower priced institutional class mutual funds.

The District Court concluded, however, that petitioners had not met their burden of showing that a prudent fiduciary would have undertaken a full due diligence review of these funds as a result of the alleged changed circumstances. According to the District Court, the circumstances had not changed enough to place respondents under an obligation to review the mutual funds and to convert them to lower priced institutional class mutual funds.

The Ninth Circuit affirmed the District Court as to the six mutual funds. 729 F.3d 1110 (2013). With respect to the three mutual funds added in 1999, the Ninth Circuit held that petitioners' claims were untimely because petitioners had not established a change in circumstances that might trigger an obligation to review and to change investments within the 6–year statutory period. Petitioners filed a petition for certiorari asking us to review this latter holding. We agreed to do so.

Section 413 reads, in relevant part, that "[n]o action may be commenced with respect to a fiduciary's breach of any responsibility, duty, or obligation" after the earlier of "six years after (A) the date of the last action which constituted a part of the breach or violation, or (B) in the case of an omission the latest date on which the fiduciary could have cured the breach or violation." Both clauses of that provision require only a "breach or violation" to start the 6–year period. Petitioners contend that respondents breached the duty of prudence by offering higher priced retail class mutual funds when the same investments were available as lower priced institutional class mutual funds.

The Ninth Circuit, without considering the role of the fiduciary's duty of prudence under trust law, rejected petitioners' claims as untimely under § 413 on the basis that respondents had selected the three mutual funds more than six years before petitioners brought this action. The Ninth Circuit correctly asked whether the "last action which constituted a part of the breach or violation" of respondents' duty of prudence occurred within the relevant 6–year period. It focused, however, upon the act of "designating an investment for inclusion" to start the 6–year period. 729 F.3d at 1119. The Ninth Circuit stated that "[c]haracterizing the mere continued offering of a plan option, without more, as a subsequent breach would render" the statute

meaningless and could even expose present fiduciaries to liability for decisions made decades ago. Id. at 1120. But the Ninth Circuit jumped from this observation to the conclusion that only a significant change in circumstances could engender a new breach of a fiduciary duty, stating that the District Court was "entirely correct" to have entertained the "possibility" that "significant changes" occurring "within the limitations period" might require "'a full due diligence review of the funds,'" equivalent to the diligence review that respondents conduct when adding new funds to the Plan. Id.

We believe the Ninth Circuit erred by applying a statutory bar to a claim of a "breach or violation" of a fiduciary duty without considering the nature of the fiduciary duty. The Ninth Circuit did not recognize that under trust law a fiduciary is required to conduct a regular review of its investment with the nature and timing of the review contingent on the circumstances. Of course, after the Ninth Circuit considers trust law principles, it is possible that it will conclude that respondents did indeed conduct the sort of review that a prudent fiduciary would have conducted absent a significant change in circumstances.

An ERISA fiduciary must discharge his responsibility "with the care, skill, prudence, and diligence" that a prudent person "acting in a like capacity and familiar with such matters" would use. § 404(a)(1); see also Fifth Third Bancorp v. Dudenhoeffer, 134 S.Ct. 2459 (2014). We have often noted that an ERISA fiduciary's duty is "derived from the common law of trusts." Central States, Southeast & Southwest Areas Pension Fund v. Central Transport, Inc., 472 U.S. 559, 570 (1985). In determining the contours of an ERISA fiduciary's duty, courts often must look to the law of trusts. We are aware of no reason why the Ninth Circuit should not do so here.

Under trust law, a trustee has a continuing duty to monitor trust investments and remove imprudent ones. This continuing duty exists separate and apart from the trustee's duty to exercise prudence in selecting investments at the outset. The Bogert treatise states that "[t]he trustee cannot assume that if investments are legal and proper for retention at the beginning of the trust, or when purchased, they will remain so indefinitely." A. Hess, G. Bogert, & G. Bogert, Law of Trusts and Trustees § 684, pp. 145–146 (3d ed. 2009) (Bogert 3d). Rather, the trustee must "systematically consider all the investments of the trust at regular intervals" to ensure that they are appropriate. Bogert 3d § 684, at 147–148; see also In re Stark's Estate, 15 N.Y.S. 729, 731 (Surr. Ct. 1891) (stating that a trustee must "exercis[e] a reasonable degree of diligence in looking after the security after the investment had been made"); Johns v. Herbert, 2 App. D.C. 485, 499 (1894) (holding trustee liable for failure to discharge his "duty to watch the investment with reasonable care and diligence"). The Restatement (Third) of Trusts states the following:

> [A] trustee's duties apply not only in making investments but also in monitoring and reviewing investments, which is to be done in a manner that is reasonable and appropriate to the particular investments, courses of action, and strategies involved. § 90, Comment b, p. 295 (2007).

The Uniform Prudent Investor Act confirms that "[m]anaging embraces monitoring" and that a trustee has "continuing responsibility for oversight of the suitability of the investments already made." § 2, Comment, 7B U.L.A. 21 (1995). Scott on Trusts implies as much by stating that, "[w]hen the trust estate includes assets that are inappropriate as trust investments, the trustee is ordinarily under a duty to dispose of them within a reasonable time." 4 A. Scott, W.

Fratcher, & M. Ascher, Scott and Ascher on Trusts § 19.3.1, p. 1439 (5th ed. 2007). Bogert says the same. Bogert 3d § 685, at 156–157 (explaining that if an investment is determined to be imprudent, the trustee "must dispose of it within a reasonable time"); see, e.g., State Street Trust Co. v. De Kalb, 259 Mass. 578, 583, 157 N.E. 334, 336 (1927) (trustee was required to take action to "protect the rights of the beneficiaries" when the value of trust assets declined).

In short, under trust law, a fiduciary normally has a continuing duty of some kind to monitor investments and remove imprudent ones. A plaintiff may allege that a fiduciary breached the duty of prudence by failing to properly monitor investments and remove imprudent ones. In such a case, so long as the alleged breach of the continuing duty occurred within six years of suit, the claim is timely. The Ninth Circuit erred by applying a 6–year statutory bar based solely on the initial selection of the three funds without considering the contours of the alleged breach of fiduciary duty.

The parties now agree that the duty of prudence involves a continuing duty to monitor investments and remove imprudent ones under trust law. The parties disagree, however, with respect to the scope of that responsibility. Did it require a review of the contested mutual funds here, and if so, just what kind of review did it require? A fiduciary must discharge his responsibilities "with the care, skill, prudence, and diligence" that a prudent person "acting in a like capacity and familiar with such matters" would use. § 404(a)(1). We express no view on the scope of respondents' fiduciary duty in this case. We remand for the Ninth Circuit to consider petitioners' claims that respondents breached their duties within the relevant 6–year period under § 413, recognizing the importance of analogous trust law.

A final point: Respondents argue that petitioners did not raise the claim below that respondents committed new breaches of the duty of prudence by failing to monitor their investments and remove imprudent ones absent a significant change in circumstances. We leave any questions of forfeiture for the Ninth Circuit on remand. The Ninth Circuit's judgment is vacated, and the case is remanded for further proceedings consistent with this opinion.

Notes and Questions

1. *Documenting A Prudent Monitoring Process.* After *Tibble*, what is a "prudent" monitoring process for plan investments? How should that process be documented by the plan's fiduciaries in case their plan investment decisions are challenged many years later? Although the Supreme Court in *Tibble* failed to address these practical questions, the Employee Benefit Security Administration ("EBSA") has published a series of practical compliance guidelines for plan fiduciaries on topics such as monitoring plan fees and expenses, selecting plan service providers, and selecting target retirement date mutual funds as plan investment options. See generally www.dol.gov/ebsa/compliance_assistance.html (scroll down to Retirement Plans).

Significantly, the EBSA compliance guidance for fiduciaries, which is reproduced in part below, does not dictate that the lowest fee investment options must be selected. Rather, the EBSA encourages plan fiduciaries to consider the totality of the services provided when selecting plan investments and plan service providers. Note too that the employer can pay all or a portion of the fees, or fees can be paid by "the plan" (meaning fees will be deducted from the

participants' accounts in a defined contribution plan).

> Fees are just one of several factors fiduciaries need to consider in deciding on service providers and plan investments. When the fees for services are paid out of plan assets, fiduciaries will want to understand the fees and expenses charged and the services provided. While the law does not specify a permissible level of fees, it does require that fees charged to a plan be "reasonable." After careful evaluation during the initial selection, the plan's fees and expenses should be monitored to determine whether they continue to be reasonable.
>
> In comparing estimates from prospective service providers, ask which services are covered for the estimated fees and which are not. Some providers offer a number of services for one fee, sometimes referred to as a "bundled" services arrangement. Others charge separately for individual services. Compare all services to be provided with the total cost for each provider. Consider whether the estimate includes services you did not specify or want. Remember, all services have costs.
>
> Some service providers may receive additional fees from investment vehicles, such as mutual funds, that may be offered under an employer's plan. For example, mutual funds often charge fees to pay brokers and other salespersons for promoting the fund and providing other services. There also may be sales and other related charges for investments offered by a service provider. The information provided by service providers noted above should include a description of all compensation related to the services to be provided that the service providers expect to receive directly from the plan as well as the compensation they expect to receive from other sources.
>
> Who pays the fees? Plan expenses may be paid by the employer, the plan, or both. In addition, for expenses paid by the plan, they may be allocated to participants' accounts in a variety of ways.

Employee Benefit Security Administration, Meeting Your Fiduciary Responsibilities, on-line at www.dol.gov/ebsa/publications/fiduciaryresponsibility.html.

The EBSA's recommended procedures for an employer who wants to document that it has engaged in a prudent selection and monitoring process for service providers and plan investment are set forth below.

> Fees and expenses are one of several factors to consider when you select and monitor plan service providers and investments. The level and quality of service and investment risk and return will also affect your decisions.
>
> - Begin by establishing an objective process to aid in your decision making. This process should include an understanding of the fees and expenses

you will pay and a review of those charges as they relate to the services to be provided and the investments you are considering.

- Before negotiating with prospective providers, think about the specific services you would like from a service provider (e.g., legal, accounting, trustee/custodian, recordkeeping, investment management, investment education or advice). Include the types and frequency of reports you wish to receive, communications to participants, meetings for participants, and the frequency of participant investment transfers.

- You will also need to consider the level of responsibility you want the prospective service provider to assume, the services that must be included in any retirement plan, the possible extras or customized services you wish to provide, and optional features, such as loans, Internet trading, and telephone transfers.

- Once you have a clear idea of your requirements, you are ready to begin receiving estimates from prospective providers. Give all of them complete and identical information about your plan and the features you want so that you can make a meaningful comparison. This information should include the number of plan participants and the amount of plan assets as of a specified date.

- For a service contract or arrangement to be reasonable, service providers must provide certain information to you about the services they will provide to your plan and the compensation they will receive. This information will assist you in understanding the services, assessing the reasonableness of the compensation (direct and indirect), and determining any conflicts of interest that may impact the service provider's performance.

- Once you have selected a service provider or investments, be prepared to monitor the level and quality of the services and performance of investments to make sure they continue to be reasonable and they suit the needs of your employees. Make sure that you receive information on a regular basis so that you can monitor investment returns and service provider performance and, if necessary, make changes. Review any notices received from the service provider about possible changes to their compensation and the other information they provided when hired (or when the contract or arrangement was renewed).

Employee Benefit Security Administration, Understanding Retirement Plan Fees And Expenses, on-line at www.dol.gov/ebsa/publications/undrstndgrtrmnt.html.

2. *Proof of Loss Caused by an Imprudent Investment Monitoring Process. Tatum v. RJR Pension Investment Committee*, 761 F.3d 346 (4th Cir. 2014), illustrates the consequences when plan fiduciaries conduct an imprudent monitoring and decision-making process regarding the retention of a plan investment. In *Tatum*, the plaintiff claimed that the plan's Investment Committee had acted imprudently when it decided to liquidate two funds holding company stock

on an arbitrary timeline without conducting a thorough investigation, thereby causing a substantial loss to the plan. After a bench trial, the district court found that the Investment Committee had breached its fiduciary duty of procedural prudence. Nevertheless, the district court granted summary judgement in favor of the Investment Committee because the Committee had meet its burden of proving that the fiduciary breach did not cause the loss to the plan. In making this finding, the district court determined that "a reasonable and prudent fiduciary *could* have [made the same decision] after performing [a proper] investigation." Id. at 355 (emphasis in original). The Fourth Circuit reversed the grant of summary judgement on the ground that the district court had applied the wrong standard in determining that the Investment Committee's imprudent procedure had not caused the loss to the plan. Rather than absolving the breaching fiduciary of liability for the loss to the plan upon a showing that a hypothetical prudent fiduciary "could" have made the same decision by following a prudent procedure, the Fourth Circuit held that a breaching fiduciary should be held to higher standard. Namely, the breaching fiduciary must show that a hypothetical prudent fiduciary "would" have made the same decision. Id. at 365. In other words, the breaching fiduciary must show not that it is *possible* (e.g., a 1% chance) for a hypothetical prudent fiduciary to make the same decision, but rather that is it *probable* (a 51% chance) that the same decision would be made.

CHAPTER SIX

2. CLAIMS TO ENFORCE A PLAN REIMBURSEMENT CLAUSE

Insert at the top of p. 734

Recall that in *Great-West Life & Annuity Insurance Co. v. Knudson*, the Supreme Court stated that "a plaintiff could seek restitution *in equity*, ordinarily in the form of a constructive trust or an equitable lien, where money or property identified as belonging in good conscience to the plaintiff could clearly be traced to particular funds or property in the defendant's possession." This statement from *Great-West* left unresolved the question of whether a plan participant who was subject to an equitable lien could avoid reimbursing the plan by simply spending the funds recovered in a tort action on nontraceable items, such as food, services, and other living expenses. As you read *Montanile*, consider how you would advise a plan administrator who wants to enforce a plan reimbursement clause. Does ERISA's civil enforcement scheme unduly constrain the ability of a self-insured group health plan to recoup medical expenses caused by a third-party tortfeasor?

MONTANILE v. BOARD OF TRUSTEES OF THE NATIONAL ELEVATOR INDUSTRY HEALTH BENEFIT PLAN.

Supreme Court of the United States, 2016.
136 S. Ct. 651.

Justice THOMAS delivered the opinion of the Court.

When a third party injures a participant in an employee benefit plan under the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001 et seq., the plan frequently pays covered medical expenses. The terms of these plans often include a subrogation clause requiring a participant to reimburse the plan if the participant later recovers money from the third party for his injuries. And under ERISA § 502(a)(3), plan fiduciaries can file civil suits "to obtain ... appropriate equitable relief ... to enforce ... the terms of the plan."

In this case, we consider what happens when a participant obtains a settlement fund from a third party, but spends the whole settlement on nontraceable items (for instance, on services or consumable items like food). We evaluate in particular whether a plan fiduciary can sue under § 502(a)(3) to recover from the participant's remaining assets the medical expenses it paid on the participant's behalf. We hold that, when a participant dissipates the whole settlement on nontraceable items, the fiduciary cannot bring a suit to attach the participant's general assets under § 502(a)(3) because the suit is not one for "appropriate equitable relief." In this case, it is unclear whether the participant dissipated all of his settlement in this manner, so we remand for further proceedings.

I

Petitioner Robert Montanile was a participant in a health benefits plan governed by ERISA and administered by respondent, the Board of Trustees of the National Elevator Industry Health Benefit Plan (Board of Trustees or Board). The plan must pay for certain medical expenses that beneficiaries or participants incur. The plan may demand reimbursement, however, when a participant recovers money from a third party for medical expenses. The plan states: "Amounts that have been recovered by a [participant] from another party are assets of the Plan ... and are not distributable to any person or entity without the Plan's written release of its subrogation interest." The plan also provides that "any amounts" that a participant "recover[s] from another party by award, judgment, settlement or otherwise ... will promptly be applied first to reimburse the Plan in full for benefits advanced by the Plan ... and without reduction for attorneys' fees, costs, expenses or damages claimed by the covered person." Participants must notify the plan and obtain its consent before settling claims.

In December 2008, a drunk driver ran through a stop sign and crashed into Montanile's vehicle. The accident severely injured Montanile, and the plan paid at least $121,044.02 for his initial medical care. Montanile signed a reimbursement agreement reaffirming his obligation to reimburse the plan from any recovery he obtained "as a result of any legal action or settlement or

otherwise."

Thereafter, Montanile filed a negligence claim against the drunk driver and made a claim for uninsured motorist benefits under Montanile's car insurance. He obtained a $500,000 settlement. Montanile then paid his attorneys $200,000 and repaid about $60,000 that they had advanced him. Thus, about $240,000 remained of the settlement. Montanile's attorneys held most of that sum in a client trust account. This included enough money to satisfy Montanile's obligations to the plan.

The Board of Trustees sought reimbursement from Montanile on behalf of the plan, and Montanile's attorney argued that the plan was not entitled to any recovery. The parties attempted but failed to reach an agreement about reimbursement. After discussions broke down, Montanile's attorney informed the Board that he would distribute the remaining settlement funds to Montanile unless the Board objected within 14 days. The Board did not respond within that time, so Montanile's attorney gave Montanile the remainder of the funds.

Six months after negotiations ended, the Board sued Montanile in District Court under ERISA § 502(a)(3), seeking repayment of the $121,044.02 the plan had expended on his medical care. The Board asked the court to enforce an equitable lien upon any settlement funds or any property which are " 'in [Montanile's] actual or constructive possession.' " 593 Fed. Appx. 903, 906 (11th Cir. 2014) (quoting complaint). Because Montanile had already taken possession of the settlement funds, the Board also sought an order enjoining Montanile from dissipating any such funds. Montanile then stipulated that he still possessed some of the settlement proceeds.

The District Court granted summary judgment to the Board of Trustees. The court rejected Montanile's argument that, because he had by that time spent almost all of the settlement funds, there was no specific, identifiable fund separate from his general assets against which the Board's equitable lien could be enforced. The court held that, even if Montanile had dissipated some or all of the settlement funds, the Board was entitled to reimbursement from Montanile's general assets. The court entered judgment for the Board in the amount of $121,044.02.

The Court of Appeals for the Eleventh Circuit affirmed. It reasoned that a plan can always enforce an equitable lien once the lien attaches, and that dissipation of the specific fund to which the lien attached cannot destroy the underlying reimbursement obligation. The court therefore held that the plan can recover out of a participant's general assets when the participant dissipates the specifically identified fund.

We granted certiorari to resolve a conflict among the Courts of Appeals over whether an ERISA fiduciary can enforce an equitable lien against a defendant's general assets under these circumstances. We hold that it cannot, and accordingly reverse the judgment of the Eleventh Circuit and remand for further proceedings.

II

A

As previously stated, § 502(a)(3) of ERISA authorizes plan fiduciaries like the Board of Trustees to bring civil suits "to obtain other appropriate equitable relief ... to enforce ... the terms of the plan." Our cases explain that the term "equitable relief" in § 502(a)(3) is limited to "those categories of relief that were *typically* available in equity" during the days of the divided bench (meaning, the period before 1938 when courts of law and equity were separate). Mertens v. Hewitt Associates, 508 U.S. 248, 256 (1993). Under this Court's precedents, whether the remedy a plaintiff seeks "is legal or equitable depends on (1) the basis for [the plaintiff's] claim and (2) the nature of the underlying remedies sought." Sereboff v. Mid Atlantic Medical Services, Inc., 547 U.S. 356, 363 (2006). Our precedents also prescribe a framework for resolving this inquiry. To determine how to characterize the basis of a plaintiff's claim and the nature of the remedies sought, we turn to standard treatises on equity, which establish the "basic contours" of what equitable relief was typically available in premerger equity courts. Great–West Life & Annuity Ins. Co. v. Knudson, 534 U.S. 204, 217 (2002).

We have employed this approach in three earlier cases where, as here, the plan fiduciary sought reimbursement for medical expenses after the plan beneficiary or participant recovered money from a third party. Under these precedents, the basis for the Board's claim is equitable. But our cases do not resolve whether the *remedy* the Board now seeks—enforcement of an equitable lien by agreement against the defendant's general assets—is equitable in nature.

First, in *Great–West*, we held that a plan with a claim for an equitable lien was—in the circumstances presented—seeking a legal rather than an equitable remedy. In that case, a plan sought to enforce an equitable lien by obtaining a money judgment from the defendants. The plan could not enforce the lien against the third-party settlement that the defendants had obtained because the defendants never actually possessed that fund; the fund went directly to the defendants' attorneys and to a restricted trust. We held that the plan sought a legal remedy, not an equitable one, even though the plan claimed that the money judgment was a form of restitution. We explained that restitution in equity typically involved enforcement of "a constructive trust or an equitable lien, where money or property identified as belonging in good conscience to the plaintiff could clearly be traced to particular funds or property in the defendant's possession." Id. at 213. But the restitution sought in *Great–West* was legal—not equitable—because the specific funds to which the fiduciaries "claimed an entitlement ... were not in the defendants' possession." Id. at 214. Since both the basis for the claim and the particular remedy sought were not equitable, the plan could not sue under § 502(a)(3).

Next, in *Sereboff*, we held that both the basis for the claim and the remedy sought were equitable. The plan there sought reimbursement from beneficiaries who had retained their settlement fund in a separate account. 547 U.S. at 359–360. We held that the basis for the plan's claim was equitable because the plan sought to enforce an equitable lien by agreement, a type of equitable lien created by an agreement to convey a particular fund to another party. See id. at

363–364. The lien existed in *Sereboff* because of the beneficiaries' agreement with the plan to convey the proceeds of any third-party settlement. We explained that a claim to enforce such a lien is equitable because the plan "could rely on a familiar rule of equity" to collect—specifically, the rule "that a contract to convey a specific object even before it is acquired will make the contractor a trustee as soon as he gets a title to the thing." Id. The underlying remedies that the plan sought also were equitable, because the plan "sought specifically identifiable funds that were within the possession and control" of the beneficiaries—not recovery from the beneficiaries' "assets generally." Id. at 362–363.

Finally, in *US Airways, Inc. v. McCutchen*, 133 S. Ct. 1537 (2013), we reaffirmed our analysis in *Sereboff* and again concluded that a plan sought to enforce an equitable claim by seeking equitable remedies. As in *Sereboff*, "the basis for [the plan's] claim was equitable" because the plan's terms created an equitable lien by agreement on a third-party settlement. See 133 S. Ct. 1537. And, as in *Sereboff*, "the nature of the recovery requested" by the plan "was equitable because it claimed specifically identifiable funds within the beneficiaries' control—that is, a portion of the settlement they had gotten." 133 S. Ct. at 1545.

Under these principles, the basis for the Board's claim here is equitable: The Board had an equitable lien by agreement that attached to Montanile's settlement fund when he obtained title to that fund. And the nature of the Board's underlying *remedy* would have been equitable had it immediately sued to enforce the lien against the settlement fund then in Montanile's possession. That does not resolve this case, however. Our prior cases do not address whether a plan is still seeking an equitable remedy when the defendant, who once possessed the settlement fund, has dissipated it all, and the plan then seeks to recover out of the defendant's general assets.

B

To resolve this issue, we turn to standard equity treatises. As we explain below, those treatises make clear that a plaintiff could ordinarily enforce an equitable lien only against specifically identified funds that remain in the defendant's possession or against traceable items that the defendant purchased with the funds (e.g., identifiable property like a car). A defendant's expenditure of the entire identifiable fund on nontraceable items (like food or travel) destroys an equitable lien. The plaintiff then may have a personal claim against the defendant's general assets—but recovering out of those assets is a *legal* remedy, not an equitable one.

Equitable remedies "are, as a general rule, directed against some specific thing; they give or enforce a right to or over some particular thing ... rather than a right to recover a sum of money generally out of the defendant's assets." 4 S. Symons, Pomeroy's Equity Jurisprudence § 1234, p. 694 (5th ed. 1941) (Pomeroy). Equitable liens thus are ordinarily enforceable only against a specifically identified fund because an equitable lien "is simply a right of a special nature *over* the thing ... so that the very thing itself may be proceeded against in an equitable action." Id., § 1233, at 692; see also Restatement of Restitution § 215, Comment *a*, p. 866 (1936) (Restatement) (enforcement of equitable lien requires showing that the defendant "still holds the property or property which is in whole or in part its product"); 1 D. Dobbs, Law of Remedies §

1.4, p. 19 (2d ed. 1993) (Dobbs) (similar). This general rule's application to equitable liens includes equitable liens by agreement, which depend on "the notion ... that the contract creates some right or interest in or over specific property," and are enforceable only if "the decree of the court can lay hold of" that specific property. 4 Pomeroy § 1234, at 694–695.

If, instead of preserving the specific fund subject to the lien, the defendant dissipated the entire fund on nontraceable items, that complete dissipation eliminated the lien. Even though the defendant's conduct was wrongful, the plaintiff could not attach the defendant's general assets instead. Absent specific exceptions not relevant here, "where a person wrongfully disposed of the property of another but the property cannot be traced into any product, the other ... cannot enforce a constructive trust or lien *upon any part of the wrongdoer's property*." Restatement § 215(1), at 866 (emphasis added); see also Great–West, 534 U.S. at 213–214 (citing Restatement § 160). The plaintiff had "merely a personal claim against the wrongdoer"—a quintessential action at law. Id., § 215(1), at 866.

In sum, at equity, a plaintiff ordinarily could not enforce any type of equitable lien if the defendant once possessed a separate, identifiable fund to which the lien attached, but then dissipated it all. The plaintiff could not attach the defendant's general assets instead because those assets were not part of the specific thing to which the lien attached. This rule applied to equitable liens by agreement as well as other types of equitable liens.

III

The Board of Trustees nonetheless maintains that it can enforce its equitable lien against Montanile's general assets. We consider the Board's arguments in turn.

A

First, the Board argues that, while equity courts ordinarily required plaintiffs to trace a specific, identifiable fund in the defendant's possession to which the lien attached, there is an exception for equitable liens by agreement. The Board asserts that equitable liens by agreement require no such tracing, and can be enforced against a defendant's general assets. According to the Board, we recognized this exception in *Sereboff* by distinguishing between equitable restitution (where a lien attaches because the defendant misappropriated property from the plaintiff) and equitable liens by agreement.

The Board misreads *Sereboff*, which left untouched the rule that *all* types of equitable liens must be enforced against a specifically identified fund in the defendant's possession. See 1 Dobbs § 4.3(3), at 601, 603. The question we faced in *Sereboff* was whether plaintiffs seeking an equitable lien by agreement must "identify an asset they originally possessed, which was improperly acquired and converted into property the defendant held." 547 U.S. at 365. We observed that such a requirement, although characteristic of restitutionary relief, does not "apply to equitable liens by agreement or assignment." Id. (discussing Barnes v. Alexander, 232 U.S. 117 (1914)). That is because the basic premise of an equitable lien by agreement is that, rather than physically taking the plaintiff's property, the defendant constructively possesses a fund to

which the plaintiff is entitled. But the plaintiff must still identify a specific fund in the defendant's possession to enforce the lien. See id. at 123 ("Having a lien upon the fund, as soon as it was identified they could follow it into the hands of the appellant").

B

Second, the Board contends that historical equity practice supports enforcement of its equitable lien against Montanile's general assets. The Board identifies three methods that equity courts purportedly employed to effectuate this principle: substitute money decrees, deficiency judgments, and the swollen assets doctrine. This argument also fails.

We have long rejected the argument that "equitable relief" under § 502(a)(3) means "whatever relief a court of equity is empowered to provide in the particular case at issue," including ancillary legal remedies. Mertens, 508 U.S. at 256. In "many situations ... an equity court could establish purely legal rights and grant legal remedies which would otherwise be beyond the scope of its authority." Id. But these legal remedies were not relief "typically available in equity," and interpreting them as such would eliminate any limit on the meaning of "equitable relief" and would "render the modifier superfluous." Id. at 256; see also Great–West, supra, at 210. As we have explained—and as the Board conceded at oral argument—as a general rule, plaintiffs cannot enforce an equitable lien against a defendant's general assets. See Part II–B, supra. The Board contends that there is an exception if the defendant wrongfully dissipates the equitable lien to thwart its enforcement. But none of the Board's examples show that such relief was "typically available" in equity.[3]

The specific methods by which equity courts might have awarded relief from a defendant's general assets only confirm that the Board seeks legal, not equitable, remedies. While equity courts sometimes awarded money decrees as a substitute for the value of the equitable lien, they were still legal remedies, because they were "wholly pecuniary and personal." 4 Pomeroy § 1234, at 694. The same is true with respect to deficiency judgments. Equity courts could award both of these remedies as part of their ancillary jurisdiction to award complete relief. But the treatises make clear that when equity courts did so, "the rights of the parties are strictly legal, and the final remedy granted is of the kind which might be conferred by a court of law." 1 id., § 231, at 410; see also 1 Dobbs § 2.7, at 180–181, and § 4.3(3), at 602 (similar); New Federal Equity Rules 10 (rev. 5th ed. 1925) (authorizing equity courts to award such relief). But legal remedies—even legal remedies that a court of equity could sometimes award—are not "equitable relief" under § 502(a)(3). See Mertens 508 U.S. at 256–258.

3 The Board also interprets *CIGNA Corp. v. Amara*, 563 U.S. 421 (2011), as all but overruling *Mertens v. Hewitt Associates*, 508 U.S. 248 (1993), and *Great–West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002), in favor of the Board's broad interpretation of "equitable relief" under § 502(a)(3). But *CIGNA* reaffirmed that "traditionally speaking, relief that sought a lien or a constructive trust was legal relief, not equitable relief, unless the funds in question were 'particular funds or property in the defendant's possession.' " 563 U.S. at 439 (quoting Great–West, supra, at 213. In any event, the Court's discussion of § 502(a)(3) in *CIGNA* was not essential to resolving that case, and—as our later analysis in *US Airways, Inc. v. McCutchen*, 133 S. Ct. 1537 (2013), reinforces—our interpretation of "equitable relief" in *Mertens*, *Great–West*, and *Sereboff v. Mid Atlantic Medical Services, Inc.*, 547 U.S. 356 (2006), remains unchanged. See McCutchen, supra, 133 S. Ct. at 1544–1545.

The swollen assets doctrine also does not establish that the relief the Board seeks is equitable. Under the Board's view of this doctrine, even if a defendant spends all of a specifically identified fund, the mere fact that the defendant wrongfully had assets that belonged to another increased the defendant's available assets, and justifies recovery from his general assets. But most equity courts and treatises rejected that theory. See Taft, Note, A Defense of a Limited Use of the Swollen Assets Theory Where Money Has Wrongfully Been Mingled With Other Money, 39 Colum. L. Rev. 172, 175 (1939) (describing the swollen assets doctrine as "often ... rejected by the courts"); see also Oesterle, Deficiencies of the Restitutionary Right to Trace Misappropriated Property in Equity and in UCC § 9–306, 68 Cornell L. Rev. 172, 189, and n. 33 (1983) (similar). To the extent that courts endorsed any version of the swollen assets theory, they adopted a more limited rule: that commingling a specifically identified fund—to which a lien attached—with a different fund of the defendant's did not destroy the lien. Instead, that commingling allowed the plaintiff to recover the amount of the lien from the entire pot of money. See Restatement § 209, at 844; Scott, The Right To Follow Money Wrongfully Mingled With Other Money, 27 Harv. L. Rev. 125, 125–126 (1913). Thus, even under the version of the swollen assets doctrine adopted by some courts, recovery out of Montanile's general assets—in the absence of commingling—would not have been "typically available" relief.

C

Finally, the Board argues that ERISA's objectives—of enforcing plan documents according to their terms and of protecting plan assets—would be best served by allowing plans to enforce equitable liens against a participant's general assets. The Board also contends that, unless plans can enforce reimbursement provisions against a defendant's general assets, plans will lack effective or cost-efficient remedies, and participants will dissipate any settlement as quickly as possible, before fiduciaries can sue.

We have rejected these arguments before, and do so again. "Vague notions of a statute's 'basic purpose' are ... inadequate to overcome the words of its text regarding the *specific* issue under consideration." Mertens, 508 U.S. at 261. Had Congress sought to prioritize the Board's policy arguments, it could have drafted § 502(a)(3) to mirror ERISA provisions governing civil actions. One of those provisions, for instance, allows participants and beneficiaries to bring civil actions "to enforce their rights under the terms of the plan" and does not limit them to equitable relief. Great–West, 534 U.S. at 221 (quoting ERISA § 502(a)(1)(B).

In any event, our interpretation of § 502(a)(3) promotes ERISA's purposes by "allocating liability for plan-related misdeeds in reasonable proportion to respective actors' power to control and prevent the misdeeds." Mertens, 508 U.S. at 262. More than a decade has passed since we decided *Great–West*, and plans have developed safeguards against participants' and beneficiaries' efforts to evade reimbursement obligations. Plans that cover medical expenses know how much medical care that participants and beneficiaries require, and have the incentive to investigate and track expensive claims. Plan provisions—like the ones here—obligate participants and beneficiaries to notify the plan of legal process against third parties and to give the plan a right of subrogation.

The Board protests that tracking and participating in legal proceedings is hard and costly, and that settlements are often shrouded in secrecy. The facts of this case undercut that argument. The Board had sufficient notice of Montanile's settlement to have taken various steps to preserve those funds. Most notably, when negotiations broke down and Montanile's lawyer expressed his intent to disburse the remaining settlement funds to Montanile unless the plan objected within 14 days, the Board could have—but did not—object. Moreover, the Board could have filed suit immediately, rather than waiting half a year.

IV

Because the lower courts erroneously held that the plan could recover out of Montanile's general assets, they did not determine whether Montanile kept his settlement fund separate from his general assets or dissipated the entire fund on nontraceable assets. At oral argument, Montanile's counsel acknowledged "a genuine issue of ... material fact on how much dissipation there was" and a lack of record evidence as to whether Montanile mixed the settlement fund with his general assets. A remand is necessary so that the District Court can make that determination.

* * *

We reverse the judgment of the Eleventh Circuit and remand the case for further proceedings consistent with this opinion.

It is so ordered.

Justice GINSBURG, dissenting.

Montanile received a $500,000 settlement out of which he had pledged to reimburse his health benefit plan for expenditures on his behalf of at least $121,044.02. He can escape that reimbursement obligation, the Court decides, by spending the settlement funds rapidly on nontraceable items. What brings the Court to that bizarre conclusion? As developed in my dissenting opinion in *Great–West Life & Annuity Ins. Co. v. Knudson,* 534 U.S. 204 (2002), the Court erred profoundly in that case by reading the work product of a Congress sitting in 1974 as "unravelling forty years of fusion of law and equity, solely by employing the benign sounding word 'equitable' when authorizing 'appropriate equitable relief.' " John H. Langbein, What ERISA Means by "Equitable": The Supreme Court's Trail of Error in *Russell, Mertens,* and *Great–West,* 103 Colum. L. Rev. 1317, 1365 (2003). The Court has been persuasively counseled "to confess its error." Id. I would not perpetuate *Great–West* 's mistake, and would therefore affirm the judgment of the Court of Appeals for the Eleventh Circuit.

Questions

1. Is the Supreme Court encouraging plan participants (and their attorneys) to evade reimbursement by quickly spending the sums recovered in the tort action (and the attorneys' fees paid out of the recovery) on "nontraceable" items? Recall that in *Sereboff*, the plan participants

argued that the application of "strict tracing rules" was a condition for equitable restitution under the common law. Does the Supreme Court's statement in *Sereboff* that "no tracing requirement of the sort asserted by the Sereboffs applies to equitable liens by agreement or assignment" provide a measure of protection for self-insured group health plans against the potential dissipation of the funds recovered in the tort action?

2. *Injunctive Relief Against Dissipation of Funds.* Under Section 502(e)(1) of ERISA, the federal courts have exclusive jurisdiction over Section 502(a)(3) claims to enforce a reimbursement clause. Recall that subsection 502(a)(3)(A) authorizes claims to enjoin any act or practice that violates the terms of a plan. In light of *Montanile*, should plan administrators seek injunctive relief in federal court against a plan participant (and her attorney) *before* a state court approves the distribution of funds recovered in a tort action? Note that a federal court generally cannot directly enjoin the actions of the state court in distributing of the funds recovered in the state court tort action due to the Anti-Injunction Act, which provides that "[a] court of the United States may not grant an injunction to stay proceedings in a State court except as expressly authorized by Act of Congress, or where necessary in aid of its jurisdiction, or to protect or effectuate its judgments." 28 U.S.C. § 2283.

3. CLAIMS FOR INTERFERENCE WITH PROTECTED RIGHTS UNDER SECTION 510

Insert after Note 4 on p. 743

5. *Comparing Section 510 Claims with Whistleblower Claims.* An employer's actions or decisions involving the hiring of new employees, the firing of full-time employees, a reduction in hours to part-time status, or a refusal to promote to full-time status may trigger claims under the ACA. These claims may be brought under Section 510 of ERISA, or in some circumstances under Section 18C of the Fair Labor Standards Act ("FLSA"). Unlike Section 510 claims, which use the most analogous state law claim statute of limitations under the law of the state where the federal court sits, so-called "whistleblower claims" under Section 18C of the FLSA must be filed with the Occupational Safety and Health Administration ("OSHA") within 180 days of the adverse employment action.

ACA-related claims can arise because of the fact that the employer shared responsibility penalties under Code Section 4980H are tied to the number of full-time employees (i.e., those workers who on average work at least 30 hours per week or 130 hours per month). Specifically, to trigger a penalty under either the play or pay penalty or the free rider penalty contained in Section 4980H, a *full-time employee* must qualify for and receive health insurance coverage on an Exchange using a premium assistance tax credit.

As explained in Chapter Four, if it is possible for an employer to limit the number of full-time employees to 30 or fewer, there is a financial incentive for an employer who does not offer group health plan coverage to do so and thereby avoid the play or pay penalty of Code Section 4980H(a). Similarly, an employer who sponsors a group health plan that is not "ACA-compliant" under the standards of Code Section 4980H(b) (i.e., the plan's premiums are

unaffordable for some full-time employees or the plan does not provide at least 60% minimum value) has a financial incentive to limit the number of lower earning full-time employees. Lower earning full-time employees are the individuals who are most likely to trigger the free rider penalty under Code Section 4980H(b) by qualifying for and receiving Exchange coverage using a premium assistance tax credit. If the employer can limit this group to 30 or fewer full-time employees, the employer who offers group health plan coverage that is not ACA-compliant nevertheless will avoid the free rider penalty under Code Section 4980H(b).

How does an employer know that an employee is receiving Exchange coverage using a premium assistance tax credit? As part of the verification process to determine eligibility for premium assistance tax credits, the Exchange is required to send to the employer a "tax credit notice" that lists any individuals who have been determined to be eligible to receive a premium assistance tax credit to purchase health insurance in the Exchange and who have reported the name of their employer. See generally ACA §1411; 45 C.F.R. § 155.310. If an Exchange determines that an individual applicant is eligible to receive a premium assistance tax credit, that finding was based at least in part on a determination that the applicant's employer either: (1) did not provide minimum essential coverage; (2) provided coverage that was not affordable; or (3) the coverage provided did not provide minimum value. The tax credit notice sent to the employer must:

- identify the employee;
- indicate that the employee has been determined to be eligible for advance payments of the premium tax credit;
- notify the employer that if it has 50 or more full-time equivalent employees, it may be liable for a penalty under Code section 4980H; and
- notify the employer of the right to appeal the determination.

See 45 C.F.R. § 155.310(h).

As interpreted by the Supreme Court in *Inter-Modal*, Section 510 protects employees who are or may become eligible for "non-vested" group health plan benefits against adverse employment actions that interfere with their right to the attainment of plan benefits. Thus, employer actions such as refusing to hire as a full-time employee (in some jurisdictions), firing current full-time employees, reducing their hours to less than full-time status, or refusing to promote a part-time employee to full-time status may present prima facie evidence of a violation under Section 510. To successfully establish a violation of Section 510, however, the plaintiff must prove that the employer acted with the *specific intent* to interfere with an individual's current or future right to benefits under the group health plan. This evidentiary burden may present an insurmountable obstacle for the prospective plaintiff.

In contrast to Section 510, a claim under Section 18C of the FLSA places a very high burden of proof on the employer. Section 18C(a) provides in relevant part:

> (a) PROHIBITION. No employer shall discharge or in any manner discriminate against any employee with respect to his or her compensation, terms, conditions, or other privileges of employment because the employee (or an individual acting at the request of the employee) has:
>
> (1) received a credit under section 36B of the Internal Revenue Code of 1986 or a subsidy under section 1402 of [the ACA] * * *.

Thus, Section 18C(a) protects full-time employees who are receiving Exchange coverage using a premium assistance tax credit. Claims for a violation of Section 18C(a) are pursued under the whistleblower protection complaint procedure operated by OSHA, as described in Section 18C(b) of the FSLA:

> (b) COMPLAINT PROCEDURE.
>
> (1) IN GENERAL. An employee who believes that he or she has been discharged or otherwise discriminated against by any employer in violation of this section may seek relief in accordance with the procedures, notifications, burdens of proof, remedies, and statutes of limitation set forth in section 2087(b) of title 15, United States Code.
>
> (2) NO LIMITATION ON RIGHTS. Nothing in this section shall be deemed to diminish the rights, privileges, or remedies of any employee under any Federal or State law or under any collective bargaining agreement. The rights and remedies in this section may not be waived by any agreement, policy, form, or condition of employment.

The reference in the above statute to "section 2087(b) of title 15, United States Code" invokes the whistleblower protection administrative procedures established by OSHA. Under these procedures, once a complaint is filed with the agency then OSHA must investigate. If OSHA determines that a protected activity (here, receiving Exchange coverage using a premium assistance tax credit) was a contributing factor in the adverse employment action alleged in the complaint, the burden of proof shifts to the employer. Significantly, the complainant's initial burden of proof may be satisfied by showing that the adverse employment action took place shortly after the protected activity occurred, thereby giving rise to the inference that it was a contributing factor in the adverse employment action.

Once the burden of proof shifts to the employer, to avoid liability *the employer must prove by clear and convincing evidence that it would have taken the same adverse employment action without regard to the fact that the full-time employee received coverage through an Exchange using a premium assistance tax credit.* See generally Procedures for the Handling of Retaliation Complaints Under Section 1558 of the Affordable Care Act, 78 Fed. Reg. 13,222 (Feb. 27, 2013) (codified at 29 C.F.R. §1984.100 et seq.). Under this evidentiary standard, it is far more likely that the individual's claim will be successful than if the claim is brought under Section 510 of ERISA.

CHAPTER SEVEN

Insert after Note 5 on p 852

GOBEILLE v. LIBERTY MUTUAL INSURANCE COMPANY

Supreme Court of the United States, 2016.
136 S. Ct. 936.

Justice KENNEDY delivered the opinion of the Court.

This case presents a challenge to the applicability of a state law requiring disclosure of payments relating to health care claims and other information relating to health care services. Vermont enacted the statute so it could maintain an all-inclusive health care database. Vt. Stat. Ann., Tit. 18, § 9410(a)(1) (2015 Cum. Supp.) (V.S.A.). The state law, by its terms, applies to health plans established by employers and regulated by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001 et seq. The question before the Court is whether ERISA pre-empts the Vermont statute as it applies to ERISA plans.

I

A

Vermont requires certain public and private entities that provide and pay for health care services to report information to a state agency. The reported information is compiled into a database reflecting "all health care utilization, costs, and resources in Vermont, and health care utilization and costs for services provided to Vermont residents in another state." 18 V.S.A. § 9410(b). A database of this kind is sometimes called an all-payer claims database, for it requires submission of data from all health insurers and other entities that pay for health care services. Almost 20 States have or are implementing similar databases. See Brief for State of New York et al. as Amici Curiae 1, and n. 1.

Vermont's law requires health insurers, health care providers, health care facilities, and governmental agencies to report any "information relating to health care costs, prices, quality, utilization, or resources required" by the state agency, including data relating to health insurance claims and enrollment. § 9410(c)(3). Health insurers must submit claims data on members, subscribers, and policyholders. § 9410(h). The Vermont law defines health insurer to include a "self-insured ... health care benefit plan," § 9402(8), as well as "any third party administrator" and any "similar entity with claims data, eligibility data, provider files, and other information relating to health care provided to a Vermont resident." § 9410(j)(1)(B). The database must be made "available as a resource for insurers, employers, providers, purchasers of health care, and State agencies to continuously review health care utilization, expenditures, and performance in Vermont." § 9410(h)(3)(B).

Vermont law leaves to a state agency the responsibility to "establish the types of information to be filed under this section, and the time and place and the manner in which such information shall be filed." § 9410(d). The law has been implemented by a regulation creating the Vermont Healthcare Claims Uniform Reporting and Evaluation System. The regulation requires the submission of "medical claims data, pharmacy claims data, member eligibility data, provider data, and other information," in accordance with specific formatting, coding, and other requirements. Under the regulation, health insurers must report data about the health care services provided to Vermonters regardless of whether they are treated in Vermont or out-of-state and about non-Vermonters who are treated in Vermont. The agency at present does not collect data on denied claims, but the statute would allow it to do so.

Covered entities (reporters) must register with the State and must submit data monthly, quarterly, or annually, depending on the number of individuals that an entity serves. The more people served, the more frequently the reports must be filed. Entities with fewer than 200 members need not report at all, and are termed "voluntary" reporters as distinct from "mandated" reporters. Reporters can be fined for not complying with the statute or the regulation.

B

Respondent Liberty Mutual Insurance Company maintains a health plan (Plan) that provides benefits in all 50 States to over 80,000 individuals, comprising respondent's employees, their families, and former employees. The Plan is self-insured and self-funded, which means that Plan benefits are paid by respondent. The Plan, which qualifies as an "employee welfare benefit plan" under ERISA, § 3(1), is subject to "ERISA's comprehensive regulation," New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 650 (1995). Respondent, as the Plan sponsor, is both a fiduciary and plan administrator.

The Plan uses Blue Cross Blue Shield of Massachusetts, Inc. (Blue Cross) as a third-party administrator. Blue Cross manages the "processing, review, and payment" of claims for respondent. Liberty Mut. Ins. Co. v. Donegan, 746 F.3d 497, 502 (2d 2014) (case below). In its contract with Blue Cross, respondent agreed to "hold [Blue Cross] harmless for any charges, including legal fees, judgments, administrative expenses and benefit payment requirements, ... arising from or in connection with the Plan or due to [respondent's] failure to comply with any laws or regulations." The Plan is a voluntary reporter under the Vermont regulation because it covers some 137 Vermonters, which is fewer than the 200–person cutoff for mandated reporting. Blue Cross, however, serves several thousand Vermonters, and so it is a mandated reporter. Blue Cross, therefore, must report the information it possesses about the Plan's members in Vermont.

In August 2011, Vermont issued a subpoena ordering Blue Cross to transmit to a state-appointed contractor all the files it possessed on member eligibility, medical claims, and pharmacy claims for Vermont members. (For clarity, the Court uses "Vermont" to refer not only to the State but also to state officials acting in their official capacity.) The penalty for noncompliance, Vermont threatened, would be a fine of up to $2,000 a day and a suspension of Blue Cross' authorization to operate in Vermont for as long as six months. Respondent, concerned in part that the disclosure of confidential information regarding its members might

violate its fiduciary duties under the Plan, instructed Blue Cross not to comply. Respondent then filed this action in the United States District Court for the District of Vermont. It sought a declaration that ERISA pre-empts application of Vermont's statute and regulation to the Plan and an injunction forbidding Vermont from trying to acquire data about the Plan or its members.

Vermont filed a motion to dismiss, which the District Court treated as one for summary judgment, and respondent filed a cross-motion for summary judgment. The District Court granted summary judgment to Vermont. It first held that respondent, despite being a mere voluntary reporter, had standing to sue because it was faced with either allegedly violating its "fiduciary and administrative responsibilities to the Plan" or assuming liability for Blue Cross' withholding of the data from Vermont. Liberty Mut. Ins. Co. v. Kimbell, 2012 WL 5471225 (D.Vt., Nov. 9, 2012), p. 12. The District Court then concluded that the State's reporting scheme was not pre-empted. Although that scheme "may have some indirect effect on health benefit plans," the court reasoned that the "effect is so peripheral that the regulation cannot be considered an attempt to interfere with the administration or structure of a welfare benefit plan." Id. at 31–32.

The Court of Appeals for the Second Circuit reversed. The panel was unanimous in concluding that respondent had standing, but it divided on the merits of the pre-emption challenge. The panel majority explained that "one of ERISA's core functions—reporting—[cannot] be laden with burdens, subject to incompatible, multiple and variable demands, and freighted with risk of fines, breach of duty, and legal expense." 746 F.3d at 510. The Vermont regime, the court held, does just that. Id. at 508–510.

This Court granted certiorari to address the important issue of ERISA pre-emption.

II

The text of ERISA's express pre-emption clause is the necessary starting point. It is terse but comprehensive. ERISA pre-empts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." ERISA § 514(a).

The Court has addressed the potential reach of this clause before. In *Travelers*, the Court observed that "if 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course." 514 U.S. at 655. That is a result "no sensible person could have intended." California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc., 519 U.S. 316, 336 (1997) (SCALIA, J., concurring). So the need for workable standards has led the Court to reject "uncritical literalism" in applying the clause. Travelers, 514 U.S. at 656.

Implementing these principles, the Court's case law to date has described two categories of state laws that ERISA pre-empts. First, ERISA pre-empts a state law if it has a "'reference to'" ERISA plans. Id. To be more precise, "where a State's law acts immediately and exclusively upon ERISA plans ... or where the existence of ERISA plans is essential to the law's operation ..., that 'reference' will result in pre-emption." Dillingham, supra, at 325. Second, ERISA pre-

empts a state law that has an impermissible "connection with" ERISA plans, meaning a state law that "governs ... a central matter of plan administration" or "interferes with nationally uniform plan administration." Egelhoff v. Egelhoff, 532 U.S. 141, 148 (2001). A state law also might have an impermissible connection with ERISA plans if "acute, albeit indirect, economic effects" of the state law "force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers." Travelers, supra, at 668. When considered together, these formulations ensure that ERISA's express pre-emption clause receives the broad scope Congress intended while avoiding the clause's susceptibility to limitless application.

III

Respondent contends that Vermont's law falls in the second category of state laws that are pre-empted by ERISA: laws that govern, or interfere with the uniformity of, plan administration and so have an impermissible "connection with" ERISA plans. Egelhoff, supra at 148; Travelers, 514 U.S. at 656. When presented with these contentions in earlier cases, the Court has considered "the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive," id., and "the nature of the effect of the state law on ERISA plans," Dillingham, supra, at 325. Here, those considerations lead the Court to conclude that Vermont's regime, as applied to ERISA plans, is pre-empted.

A

ERISA does not guarantee substantive benefits. The statute, instead, seeks to make the benefits promised by an employer more secure by mandating certain oversight systems and other standard procedures. Travelers, 514 U.S. at 651. Those systems and procedures are intended to be uniform. Id. at 656 (ERISA's pre-emption clause "indicates Congress's intent to establish the regulation of employee welfare benefit plans 'as exclusively a federal concern'" (quoting Alessi v. Raybestos–Manhattan, Inc., 451 U.S. 504, 523 (1981))). "Requiring ERISA administrators to master the relevant laws of 50 States and to contend with litigation would undermine the congressional goal of 'minimizing the administrative and financial burdens' on plan administrators—burdens ultimately borne by the beneficiaries." Egelhoff, supra, at 149–150 (quoting Ingersoll–Rand Co. v. McClendon, 498 U.S. 133, 142 (1990)); see also Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 9 (1987).

ERISA's reporting, disclosure, and recordkeeping requirements for welfare benefit plans are extensive. ERISA plans must present participants with a plan description explaining, among other things, the plan's eligibility requirements and claims-processing procedures. ERISA §§ 101(a)(1), 102, 104(b)(1). Plans must notify participants when a claim is denied and state the basis for the denial. ERISA § 503(1). Most important for the pre-emption question presented here, welfare benefit plans governed by ERISA must file an annual report with the Secretary of Labor. The report must include a financial statement listing assets and liabilities for the previous year and, further, receipts and disbursements of funds. ERISA §§ 101(b), 103(b)(1), 103(b)(3)(A)-(B), 104(a). The information on assets and liabilities as well as receipts and disbursements must be provided to plan participants on an annual basis as well. ERISA §§ 101(a)(2), 103(b)(3)(A)-(B), 104(b)(3). Because welfare benefit plans are in the business of

providing benefits to plan participants, a plan's reporting of data on disbursements by definition incorporates paid claims. See Dept. of Labor, Schedule H (Form 5500) Financial Information (2015) (requiring reporting of "benefit claims payable" and "benefit payment and payments to provide benefits"), online at http://www.dol.gov/ebsa/pdf/2015–5500–Schedule–H.pdf (as last visited Feb. 26, 2016).

* * *

It should come as no surprise, then, that plans must keep detailed records so compliance with ERISA's reporting and disclosure requirements may be "verified, explained, or clarified, and checked for accuracy and completeness." ERISA § 107. The records to be retained must "include vouchers, worksheets, receipts, and applicable resolutions." Id.

* * *

As all this makes plain, reporting, disclosure, and recordkeeping are central to, and an essential part of, the uniform system of plan administration contemplated by ERISA. The Court, in fact, has noted often that these requirements are integral aspects of ERISA. See, e.g., Dillingham, 519 U.S. at 327; Travelers, supra, at 651; Ingersoll–Rand, supra, at 137; Massachusetts v. Morash, 490 U.S. 107, 113, 115 (1989); Fort Halifax, supra, at 9; Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 732 (1985).

Vermont's reporting regime, which compels plans to report detailed information about claims and plan members, both intrudes upon "a central matter of plan administration" and "interferes with nationally uniform plan administration." Egelhoff, 532 U.S. at 148. The State's law and regulation govern plan reporting, disclosure, and—by necessary implication—recordkeeping. These matters are fundamental components of ERISA's regulation of plan administration. Differing, or even parallel, regulations from multiple jurisdictions could create wasteful administrative costs and threaten to subject plans to wide-ranging liability. Pre-emption is necessary to prevent the States from imposing novel, inconsistent, and burdensome reporting requirements on plans.

The Secretary of Labor, not the States, is authorized to administer the reporting requirements of plans governed by ERISA. He may exempt plans from ERISA reporting requirements altogether. See § 104(a)(3); 29 CFR § 2520.104–44 (2005) (exempting self-insured health plans from the annual financial reporting requirement). And, he may be authorized to require ERISA plans to report data similar to that which Vermont seeks, though that question is not presented here. Either way, the uniform rule design of ERISA makes it clear that these decisions are for federal authorities, not for the separate States.

B

Vermont disputes the pre-emption of its reporting regime on several fronts. The State argues that respondent has not demonstrated that the reporting regime in fact has caused it to suffer economic costs. But respondent's challenge is not based on the theory that the State's law must be pre-empted solely because of economic burdens caused by the state law. Respondent

argues, rather, that Vermont's scheme regulates a central aspect of plan administration and, if the scheme is not pre-empted, plans will face the possibility of a body of disuniform state reporting laws and, even if uniform, the necessity to accommodate multiple governmental agencies. A plan need not wait to bring a pre-emption claim until confronted with numerous inconsistent obligations and encumbered with any ensuing costs.

Vermont contends, furthermore, that ERISA does not pre-empt the state statute and regulation because the state reporting scheme has different objectives. This Court has recognized that "the principal object of ERISA is to protect plan participants and beneficiaries." Boggs v. Boggs, 520 U.S. 833, 845 (1997). And "in enacting ERISA, Congress' primary concern was with the mismanagement of funds accumulated to finance employee benefits and the failure to pay employees benefits from accumulated funds." Morash, supra, at 115. The State maintains that its program has nothing to do with the financial solvency of plans or the prudent behavior of fiduciaries. This does not suffice to avoid federal pre-emption.

"Pre-emption claims turn on Congress's intent." Travelers, 514 U.S. at 655. The purpose of a state law, then, is relevant only as it may relate to the "scope of the state law that Congress understood would survive," id. at 656, or "the nature of the effect of the state law on ERISA plans," Dillingham, supra, at 325. In *Travelers*, for example, the Court noted that "both the purpose and the effects of" the state law at issue "distinguished it from" laws that "function as a regulation of an ERISA plan itself." 514 U.S. at 658–659. The perceived difference here in the objectives of the Vermont law and ERISA does not shield Vermont's reporting regime from pre-emption. Vermont orders health insurers, including ERISA plans, to report detailed information about the administration of benefits in a systematic manner. This is a direct regulation of a fundamental ERISA function. Any difference in purpose does not transform this direct regulation of "a central matter of plan administration," Egelhoff, supra, at 148, into an innocuous and peripheral set of additional rules.

The Vermont regime cannot be saved by invoking the State's traditional power to regulate in the area of public health. The Court in the past has "addressed claims of pre-emption with the starting presumption that Congress does not intend to supplant state law," in particular state laws regulating a subject of traditional state power. Travelers, supra, at 654–655. ERISA, however, "certainly contemplated the pre-emption of substantial areas of traditional state regulation." Dillingham, 519 U.S. at 330. ERISA pre-empts a state law that regulates a key facet of plan administration even if the state law exercises a traditional state power. See Egelhoff, 532 U.S. at 151–152. The fact that reporting is a principal and essential feature of ERISA demonstrates that Congress intended to pre-empt state reporting laws like Vermont's, including those that operate with the purpose of furthering public health. The analysis may be different when applied to a state law, such as a tax on hospitals, see De Buono v. NYSA–ILA Medical and Clinical Services Fund, 520 U.S. 806 (1997), the enforcement of which necessitates incidental reporting by ERISA plans; but that is not the law before the Court. Any presumption against pre-emption, whatever its force in other instances, cannot validate a state law that enters a fundamental area of ERISA regulation and thereby counters the federal purpose in the way this state law does.

IV

Respondent suggests that the Patient Protection and Affordable Care Act (ACA), which created new reporting obligations for employer-sponsored health plans and incorporated those requirements into the body of ERISA, further demonstrates that ERISA pre-empts Vermont's reporting regime. See ERISA § 715; 42 U.S.C. §§ 300gg–15a, 17; § 18031(e)(3). The ACA, however, specified that it shall not "be construed to preempt any State law that does not prevent the application of the provisions" of the ACA. 42 U.S.C. § 18041(d). This anti-pre-emption provision might prevent any new ACA-created reporting obligations from pre-empting state reporting regimes like Vermont's, notwithstanding the incorporation of these requirements in the heart of ERISA. But see ERISA § 731(a)(2) (providing that the new ACA provisions shall not be construed to affect or modify the ERISA pre-emption clause as applied to group health plans); 42 U.S.C. § 300gg–23(a)(2) (same).

The Court has no need to resolve this issue. ERISA's pre-existing reporting, disclosure, and recordkeeping provisions—upon which the Court's conclusion rests—maintain their pre-emptive force whether or not the new ACA reporting obligations also pre-empt state law.

ERISA's express pre-emption clause requires invalidation of the Vermont reporting statute as applied to ERISA plans. The state statute imposes duties that are inconsistent with the central design of ERISA, which is to provide a single uniform national scheme for the administration of ERISA plans without interference from laws of the several States even when those laws, to a large extent, impose parallel requirements. The judgment of the Court of Appeals for the Second Circuit is

Affirmed.

Justice Thomas, concurring.

* * *

We decided *Travelers* in 1995. I joined that opinion and have joined others applying the approach we adopted in *Travelers*. But our interpretation of ERISA's express pre-emption provision has become increasingly difficult to reconcile with our pre-emption jurisprudence. *Travelers* departed from the statutory text, deeming it "unhelpful." 514 U.S. at 656. But, in other cases involving express pre-emption provisions, the text has been the beginning and often the end of our analysis. E.g., Chamber of Commerce of United States of America v. Whiting, 563 U.S. 582, 594 (2011) ("'focusing on the plain wording'" to define the scope of the Immigration Reform and Control Act's express pre-emption clause); see also National Meat Assn. v. Harris, 132 S.Ct. 965, 969–970, 970–973 (2012) (parsing the text to determine the scope of the Federal Meat Inspection Act's express pre-emption clause). We have likewise refused to look to policy limits that are not "remotely discernible in the statutory text." Whiting, supra, at 599. We have

not given a sound basis for departing from these principles and treating § 514 differently from other express pre-emption provisions.

Travelers' approach to ERISA pre-emption also does not avoid constitutional concerns. We have continued to interpret § 514 as pre-empting "substantial areas of traditional state regulation" and "pre-empting a state law ... even if the state law exercises a traditional state power." Ante. Until we confront whether Congress had the constitutional authority to pre-empt such a wide array of state laws in the first place, the Court—and lower courts—will continue to struggle to apply § 514. It behooves us to address whether Article I gives Congress such power and whether § 514 may permissibly be read to avoid unconstitutional results.

Justice BREYER, concurring.

I write separately to emphasize that a failure to find pre-emption here would subject self-insured health plans under the Employee Retirement Income Security Act of 1974 (ERISA) to 50 or more potentially conflicting information reporting requirements. Doing so is likely to create serious administrative problems. The Court points out that the respondent's plan provides benefits to over 80,000 individuals living in 50 different States. In addition, amici curiae tell us that self-insured, ERISA-based health plans provide benefits to 93 million Americans. Brief for American Benefits Council et al. as Amici Curiae 8. If each State is free to go its own way, each independently determining what information each plan must provide about benefits, the result could well be unnecessary, duplicative, and conflicting reporting requirements, any of which can mean increased confusion and increased cost. Private standard setting can of course help alleviate these problems, but given the large number of different possible regulations, I do not believe that is sufficient. Cf. A. Costello & M. Taylor, APCD Council & NAHDO, Standardization of Data Collection in All–Payer Claims Databases 3–4 (Jan. 2011), online at https://www.apcdcouncil.org/publication/standardization-data-collection-all-payer-claims-databases (as last visited Feb. 26, 2016).

I would also emphasize that pre-emption does not necessarily prevent Vermont or other States from obtaining the self-insured, ERISA-based health-plan information that they need. States wishing to obtain information can ask the Federal Government for appropriate approval. As the majority points out, the "Secretary of Labor has authority to establish additional reporting and disclosure requirements for ERISA plans." Ante; see ERISA § 505. Moreover, the Secretary "is authorized to undertake research and surveys and in connection therewith to collect, compile, analyze and publish data, information, and statistics relating to employee benefit plans, including retirement, deferred compensation, and welfare plans." § 513(a)(1). At least one other important statute provides the Secretary of Health and Human Services with similar authority. See 42 U.S.C. § 300gg–17(a) (part of the Patient Protection and Affordable Care Act that is applicable to group health insurance plans including ERISA plans); Brief for United States as Amicus Curiae 4 (the Department of Labor, the Department of Health and Human Services, and the Department of Treasury are "currently considering a rulemaking to require health plans to report

more detailed information about various aspects of plan administration, such as enrollment, claims processing, and benefit offerings").

I see no reason why the Secretary of Labor could not develop reporting requirements that satisfy the States' needs, including some State-specific requirements, as appropriate. Nor do I see why the Department could not delegate to a particular State the authority to obtain data related to that State, while also providing the data to the Federal Secretary for use by other States or at the federal level.

Although the need for federal approval or authorization limits to some degree the States' power to obtain information, requiring that approval has considerable advantages. The federal agencies are more likely to be informed about, and to understand, ERISA-related consequences and health-care needs from a national perspective. Their involvement may consequently secure for the States necessary information without unnecessarily creating costly conflicts—particularly when compared with such alternatives as giving each State free rein to go its own way or asking nonexpert federal courts to try to iron out, regulation by regulation, such conflicts. Cf. Medtronic, Inc. v. Lohr, 518 U.S. 470, 506 (1996) (BREYER, J., concurring in part and concurring in judgment) (reading a complex, ambiguous regulatory statute to permit "informed agency involvement" is more likely to achieve Congress' general objectives).

For these reasons, and others that the majority sets forth, I agree that Vermont's statute is pre-empted because it "interferes with nationally uniform plan administration." Egelhoff v. Egelhoff, 532 U.S. 141, 148 (2001).

Justice GINSBURG, with whom Justice SOTOMAYOR joins, dissenting.

To better control health care outcomes and costs, Vermont requires all public and private entities that pay for health care services provided to Vermont residents to supply data to the State's all-payer claims database. Many States have similar databases in place or in development. The question presented in this case is whether Vermont's health care data-collection law is preempted by the Employer Retirement Income Security Act of 1974 (ERISA), the federal law regulating employee benefit plans. I would hold that Vermont's effort to track health care services provided to its residents and the cost of those services does not impermissibly intrude on ERISA's dominion over employee benefit plans.

* * *

The majority finds that the burden imposed by the Vermont reporting requirement warrants preemption of the data-collection statute. This conclusion falters for two primary reasons. First, the reporting requirement imposed by the Vermont statute differs in kind from the 'reporting' that is required by ERISA and therefore was not the kind of state law Congress intended to preempt. Second, Liberty Mutual has failed to show any actual burden, much less a

burden that triggers ERISA preemption. Rather, the Vermont statute ... does not interfere with an ERISA plan's administration of benefits." Id. at 511.

II

Essentially for the reasons [District Court] Judge Straub identified, I would hold that ERISA does not preempt Vermont's data-collection statute. That law and ERISA serve different purposes. ERISA's domain is the design and administration of employee benefit plans: notably, prescriptions on the vesting of benefits, claims processing, and the designation of beneficiaries. Its reporting requirements, geared to those functions, ensure that the plans in fact provide covered benefits. Vermont's data-collection statute, in contrast, aims to improve the quality and utilization, and reduce the cost, of health care in Vermont by providing consumers, government officials, and researchers with comprehensive data about the health care delivery system. Nor does Vermont's law impose burdens on ERISA plans of the kind this Court has found sufficient to warrant preemption.

* * *

As the United States explains, the supposition indulged by the Second Circuit that Vermont's law imposed a substantial burden "is not obvious, or even particularly plausible, without any factual support." Brief for United States as Amicus Curiae 28. The data-collection law "essentially requires Blue Cross, Liberty's third-party administrator, to take information generated in the ordinary course of its claims-payment operations and report that information in a prescribed format to the State." Id. The Court of Appeals majority accentuated the sheer number of data entries that must be reported to Vermont. Entirely overlooked in that enumeration is the technological capacity for efficient computer-based data storage, formatting, and submission. See Brief for National Association of Health Data Organizations et al. as Amici Curiae 7–9, 13 (describing three-step electronic path data take from health provider, to insurer or health care plan, and ultimately to the State's database).[7] Where regulatory compliance depends upon the use of evolving technologies, it should be incumbent on the objector to show concretely what the alleged regulatory burden in fact entails.[8]

* * *

Numerous States have informed the Court of their urgent need for information yielded by their health care data-collection laws. See Brief for National Governors Association et al. as

7 Amici supporting Liberty point to several allegedly burdensome features of compliance with Vermont's law, but they appear to be no more than everyday facets of modern regulatory compliance: installing and maintaining a software system to collect and remit data to the State, seeking variances from state regulators when health providers do not submit required information to the plan or its administrator, and reformatting data to comply with state-database formatting and encryption standards. See Brief for Blue Cross and Blue Shield Association as Amicus Curiae 30–32, and nn. 7–8; Brief for National Coordinating Committee for Multiemployer Plans as Amicus Curiae 11–13, 16–18.

8 Liberty contends that it need not quantify the precise cost of compliance with Vermont's law to prove that the law is burdensome. But Liberty should at least introduce concrete evidence of the alleged burdens. A finder of fact would reasonably ask, for example: Do Blue Cross's existing technologies for data storage already have capacity to store and report the data sought by Vermont? And is compliance with Vermont's reporting rules any more burdensome than compliance with other state reporting laws with which the plan already complies?

Amici Curiae; Brief for State of New York et al. as Amici Curiae; Brief for Connecticut Health Insurance Exchange as Amicus Curiae; Brief for State of New Hampshire as Amicus Curiae. Wait until the Federal Government acts is the Court's response. The Department of Labor's capacious grant of statutory authority, the Court observes, might allow it to collect the same data Vermont and other States seek about ERISA plan health-benefit payments. Once the information is collected, the Court conjectures, the Department could pass the data on to the States. It is unsettling, however, to leave the States dependent on a federal agency's grace, i.e., the Department of Labor's willingness to take on a chore divorced from ERISA's objectives.

* * *

Questions

1. Do you agree with the majority in *Gobeille* that the Vermont law intrudes upon matters of "central plan administration"? When a state law is challenged based on the administrative burden it creates for an ERISA plan, should the plan's administrator be required to submit evidence regarding the alleged burden imposed on the plan?

2. In his concurring opinion, Justice Breyer states:

> I see no reason why the Secretary of Labor could not develop reporting requirements that satisfy the States' needs, including some State-specific requirements, as appropriate. Nor do I see why the Department could not delegate to a particular State the authority to obtain data related to that State, while also providing the data to the Federal Secretary for use by other States or at the federal level.

What practical problems do you anticipate might arise if the Department of Labor were to follow Justice Breyer's suggested approach?

Insert at p. 935

APPENDIX E

LIMITS ON CONTRIBUTIONS AND BENEFITS (2018)

Maximum annual benefit payable from a defined benefit plan (Code § 415(b)(i)(A))	**$220,000**
Maximum annual contribution amount (including forfeitures) to a participant's defined contribution plan account (Code § 415(c)(i)(A))	**$55,000**
Maximum amount for traditional and safe harbor 401(k) plan elective salary deferral contributions (Code § 402(g)(1))	**$18,500**
Maximum amount for traditional and safe harbor 401(k) plan catch-up contributions for participants age 50 or older (Code § 414(v)(2)(B)(i))	**$6,000**
Maximum amount for SIMPLE 401(k) plan elective salary deferral contributions (Code § 408(p)(2))	**$12,500**
Maximum amount for SIMPLE 401(k) plan catch-up contributions for participants age 50 or older (Code § 414(v)(2)(B)(ii))	**$3,000**
Limit on compensation amount used to determine plan contributions or benefits (Code § 401(a)(17))	**$275,000**
Dollar amount used to determine:	
Highly compensated employee ("HCE") status (Code § 414(q))	**$120,000**
Key employee status for top heavy testing:	
1% owner (Code § 416(i)(1)(A)(iii))	**$150,000**
Officer (Code § 416(i)(1)(A)(i))	**$175,000**

Social Security taxable wage base	**$128,400**
Health savings accounts (Code § 223)	
Minimum HDHP deductible amount for individual/family coverage	**$1,350/$2,700**
Maximum annual contribution to a HSA for individual/family coverage	**$3,450/$6,900**
Maximum annual catch-up contribution (age 55 or older)	**$1,000**
Maximum annual out-of-pocket amount for individual/family coverage under a HDHP	**$6,650/$13,300**