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First Circuit Illuminates the Importance of the Fiduciary Responsibilities of Health and Welfare Plan Sponsors and Service Providers Under ERISA

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As ERISA plan advisors, we have long stressed the importance of fiduciary duties and the liability associated with those duties in the retirement plan arena. Equally important, and often overlooked, are fiduciary duties and liabilities applicable to the sponsors of health and welfare plans and those plans' service providers, including insurers. For too long perhaps, insurers and plan sponsors have allowed a system of benefits that enriches the insurers, without the financial risk that should be involved and without enforcing their fiduciary responsibility to timely determine whether a participant qualifies for that coverage. This system allows insurers to collect premiums for coverage without contemporaneously determining eligibility, and then, in the few circumstances where a claim is made, to simply return the premiums paid if the participant is determined to be ineligible for coverage.

Earlier this year, the Eighth Circuit Court of Appeals held that a life insurance company can be a functional ERISA fiduciary owing participants and beneficiaries a fiduciary duty to make eligibility determinations within reasonable time proximity to collecting premiums for that coverage. In its decision, the Eighth Circuit described the system by which plan sponsors and insurers divide the responsibilities of administering life insurance coverage as a "haphazard system of ships passing in the night."[1]

More recently, the First Circuit Court of Appeals came to a similar conclusion based on similar facts, casting an even brighter beacon of light on this system, its potential failures, and the liabilities associated with those failures. This article exams the portion of the First Circuit's decision in *Shields v. United of Omaha Life Insurance Co.*[2] that deals with the insurer's fiduciary responsibilities and the implications of plan sponsors and insurers reevaluating the current system of life insurance plan administration, the im-

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[1] *Skelton v. Radisson Hotel Bloomington*, 33 F.4th 968 at 976 (8th Cir. 2022).

[2] 55 F.4th 236 (1st Cir. 2022).

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plications of the Department of Labor siding with the plan participants and beneficiaries, and the secondary implications as the light shines brighter and wider illuminating the fiduciary duties of all types of health and welfare plan sponsors and service providers.

BACKGROUND OF 'SHIELDS'

Myron Shields was an employee of Duramax Maine LLC (''Duramax''). When he was hired in 2008, Duramax offered him two ERISA-covered life insurance plans, both issued by United of Omaha Life Insurance Company (''United''). The United Basic Life Policy provided coverage up to twice the employee's salary, but not to exceed $300,000. This benefit could be supplemented with the United Voluntary Life Plan, which provided additional coverage up to three times the employee's salary, but not to exceed $200,000. Thus, the total coverage under both policies was capped at $500,000. Duramax was the plan administrator, but United had the authority under these policies to decide all questions of eligibility and benefits.

Under the 2007 version of the Voluntary Policy, to receive coverage in excess of $100,000, referred to as the Guarantee Issue Limit, United required an applicant to provide evidence of good health.[3] Coverage above the $100,000 Guarantee Issue Limit began only when United approved the statement of physical condition or other evidence of good health, which it later referred to as evidence of insurability (''EOI'').

Mr. Shields made an election under the Voluntary Policy for an amount equal to three times his salary, which exceeded the Guarantee Issue Limit, and therefore required EOI. However, all that the election form indicated with respect to EOI was that ''coverage may be conditional upon my furnishing satisfactory evidence of insurability information.''

The system that United had established to deal with evidence of insurability, based on records in the case, left a lot to be desired, with such assessment being not simply a hindsight judgment. United provided Duramax with EOI forms under the expectation that Duramax would have the form completed by the employee who elected coverage above the Guarantee Issue Limit. United's further expectation appears to have been that Duramax would then forward the completed EOI forms to United. The difficulty in this case was that Duramax did not provide an EOI form to Mr. Shields or inform him that he was required to provide EOI to receive benefits under the Voluntary Policy in excess of the Guarantee Issue Limit. United also did not request EOI from either Duramax or Mr. Shields. In this regard, United's position was that it makes a determination of insurability only when it is advised by an employer that an employee is enrolling for coverage that requires EOI. There was no disagreement in this matter that United had been advised of Mr. Shields's need to provide EOI at the time he made his initial election.

From 2008 until his death in 2018, Mr. Shields paid premiums for the full level of coverage (in excess of $100,000) that he had selected under the Voluntary Policy. In 2012, 2014, and 2016, Duramax was working with a broker to seek continuity of its group life insurance policies. As part of that process, to enable United to provide quotes to Duramax, United was provided with census data. The census data listed the names and base salaries of each employee and how much supplemental coverage the employee had elected. Therefore, at each of those time periods, United had information showing that Mr. Shields had enrolled in coverage at a level that required EOI, information that would have allowed it to determine whether Mr. Shields, as well as the other employees on the census list, had provided United the EOI required for the coverage being paid for each employee. However, it did not verify at any of these times that it had the EOI required for coverage.[4]

In September 2017, Mr. Shields was diagnosed with cancer. At that time, he contacted the Human Resources manager at Duramax, inquiring as to whether there were any scenarios that could deny him life insurance benefits. The HR manager informed Mr. Shields that it did not know of any scenario in which a death benefit claim would not be honored. The manager also clarified for Mr. Shields the benefit to which his wife, Lorna Shields, the designated beneficiary, would be entitled. There was no mention of EOI at this exchange, and apparently neither Mr. Shields nor Duramax consulted with United at this time.

Mr. Shields died while an employee of Duramax in June 2018, and his beneficiary (his wife) submitted a claim for benefits. The benefit distributed to Ms.

[3] In 2017, United updated the Voluntary Policy to refer to the EOI. However, the term appears to be functionally the same as ''evidence of good health.'' EOI is defined in the 2017 version of the Voluntary Policy as ''proof of good health acceptable to [United]. This proof may be obtained through questionnaires, physical exams or written documentation.'' In 2021, when Mr. Shields's wife sued for death benefits based on his elected coverage, the district court reviewed the denial of her claim based on language from the 2007 policy, because United relied on evidence from that policy in its denial. *Shields v. United of Omaha Life Ins. Co.*, 527 F. Supp. 3d 22 (D. Me. 2021) at 32, n.12. However, the court indicated that it would have reached the same conclusion based on language in the 2017 Policy.

[4] United's position on this issue was that at most the census data only provided it with constructive knowledge of the missing EOI data (based on the bi-annual census), and that information is insufficient to establish a breach of fiduciary duty.

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Shields under the Voluntary Policy was limited to $100,000, because Mr. Shields had never submitted evidence of insurability. Ms. Shields appealed that partial denial of insurance benefits, but United denied her appeal. United subsequently refunded to Duramax $8,337.77, which was the total amount of all premiums Mr. Shields had paid for coverage in excess of the Guarantee Issue Limit.

Ms. Shields then brought an action in the District Court of Maine,[5] asserting a claim for benefits under ERISA Section 502(a)(1)(B) and an action for breach of fiduciary duty under ERISA Section 502(a)(3). Following cross-motions for judgment on the Administrative Record by both parties, the court found for United on both claims.[6] The court ruled in favor of United because it was ''not convinced that [United's] fiduciary duties as claims administrator extended to checking the work of Duramax to ensure that it fulfilled its fiduciary duty as plan administrator to inform [Mr. Shields] of the EOI requirement.''[7] According to the court, both the plan and ERISA placed that responsibility on the plan administrator, Duramax, and case law had established that ''there can be no insurer liability under ERISA for improper or incomplete enrollment in life insurance plans.''[8]

THE FIRST CIRCUIT'S DECISION

On appeal to the First Circuit, Ms. Shields made two separate allegations of breach of fiduciary duty. The first allegation was that United, by virtue of its discretion to make eligibility determinations, had a fiduciary duty to notify the plan participant of the outcome of any determination that it had made as to his eligibility for excess coverage and that it breached this duty by making such a determination without notifying him of the determination. The second allegation was that United, in consequence of its discretion to make eligibility determinations, owed the plan participant a fiduciary duty to determine in a timely manner his eligibility for excess coverage when it began accepting his premiums for excess coverage and that it breached that fiduciary duty as well by not making such a determination for nearly a decade thereafter. The district court had granted summary judgment to United, and denied summary judgment to Ms. Shields, on each of these claims.

The First Circuit[9] dismissed Ms. Shields's first allegation in summary fashion, agreeing with the district court that nothing in the record permitted a supportable inference that United had made an insurability determination regarding Mr. Shields's excess coverage that could have triggered the claimed duty to notify.[10]

In *Shields*, the First Circuit acknowledged that it had previously not had occasion to decide whether an insurer was a functional fiduciary in connection with determining when to accept premiums from an employee and when to determine an employee's eligibility for coverage. Citing *Varity Corp. v. Howe*,[11] it indicated that the determination whether a party is a functional fiduciary is made by looking to the terms of the relevant plan instrument and taking into account the actual practices under that plan.[12] It primarily applied these principles in evaluating Ms. Shields's second breach-of-fiduciary allegation.

With respect to that second claim, it disagreed with the Maine District Court. The First Circuit found, as a general matter, that ERISA recognizes that the terms of an employee welfare benefit plan may impose on an insurer the fiduciary duty that Ms. Shields describes. Specifically, it concluded,

> if a plan confers on an insurer the discretion to choose when to accept premiums from an employee and when to determine if an employee is eligible for coverage, then the insurer has the kind of discretion in setting the relative timing of those two determinations that would suffice to impose a functional fiduciary duty on the insurer in exercising the discretion with respect to the plan's employees. As a result, such an insurer has a fiduciary duty to those employees to make eligibility determinations for each employee from whom the in-

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[5] *Shields v. United of Omaha Life Ins. Co.*, 527 F. Supp. 3d 22 (D. Me. 2021).

[6] Since the focus of this article is breach-of-fiduciary allegations against insurers, only the fiduciary breach claims at the district court and First Circuit levels are discussed herein. The district court opinion does, however, contain an interesting discussion of the possible application of the federal common law of agency to the insurer/employer relationship, which may have a bearing on an insurer's fiduciary obligations, to the extent those obligations are dependent on plan terms. *See* Salkin, ''Federal Common Law of Agency and Respondeat Superior,'' *New York University Review of Employee Benefits and Executive Compensation-2021*, ch. 9, pp. 12–16.

[7] 527 F. Supp. 3d at 22.

[8] *Id.* On appeal, in footnote 12 of its decision, the First Circuit distinguished each of these cases on which United was relying.

[9] *Shields v. United of Omaha Life Ins. Co.*, 50 F.4th 236 (1st Cir. 2022).

[10] The First Circuit expressed no view as to whether United had a duty to notify.

[11] 516 U.S. 489, 502 (1996) (''The ordinary trust law understanding of fiduciary. . . is to perform the duties imposed, or exercise the powers conferred, by the trust documents.'').

[12] *Pegram v. Herdrich*, 530 U.S. 211, 226 (2000) (''In every case charging breach of ERISA fiduciary duty . . . the threshold question is . . . whether that person was acting as a fiduciary.'').

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surer accepts premiums reasonably proximate[13] to the acceptance of those premiums.[14]

United contended there were many contrary precedents, but the First Circuit disagreed, stating that ''we are aware of no court that, when presented with an analogous breach-of-fiduciary-duty claim under ERISA, has held that the claim failed because the asserted duty to make an insurability determination at a time reasonably proximate to the acceptance of premiums from those employees could not be a fiduciary duty under ERISA at all.''[15]

The First Circuit also agreed with the DOL, and disagreed with the American Council of Life Insurers, both of which had filed amicus briefs, that the court's decision is congruent with the purposes of ERISA. The court found it

> significant that, in the absence of an insurer having the duty to make reasonable efforts to determine an employee's eligibility for coverage at a time reasonably proximate to the insurer's acceptance of that employee's premium payment for coverage, ''[t]he biggest risk [the insurer] would face . . . would be the return of their ill-gotten gains [through premium refunds], and even this risk would only materialize in the (likely small) subset of circumstances where plan participants actually needed the benefits for which they had paid.'' *McCravy*, 690 F.3d at 183. Moreover, with no such fiduciary duty in place, the upside for the insurer would be ''essentially risk-free windfall profits from employees who paid premiums for nonexistent benefits but who never filed a claim for those benefits.'' *Id.*[16]

Since the First Circuit's position was that United's fiduciary obligations were dependent on the terms of the plan, it analyzed them closely. There was no question that, at a general level, United had broad fiduciary responsibilities under the plan. The plan provided that United had

> ''the discretion and the final authority to construe and interpret'' the Plan, including to ''decide all questions of eligibility and all questions regarding the amount and payment of any [Plan] benefits within the terms of the [Plan] as interpreted by [United].'' The plan further provided that benefits under the plan ''will be paid only if [United] decide[s], in [United's] discretion, that a person is entitled to them.''[17]

United's response was that, even assuming that it has a general fiduciary duty under the plan, fiduciary duty is triggered only when United is asked to make such a determination upon receipt of an evidence-of-insurability form from Duramax. United further argued that the plan does not explicitly assign to United the responsibility of ensuring that an employee does not pay premiums for coverage for which the employee is ineligible. The First Circuit disagreed. After reviewing the language of the plan as a whole, the court concluded that ''a review of the Plan's terms makes clear that the Plan confers on United not only the discretion to make eligibility determinations but also the discretion to determine whether an employee is entitled to the coverage for which premiums are paid within a time that is reasonably proximate to United's acceptance of those premiums.''[18] Finally, it concluded that its reading of the plan did not render a nullity the language therein providing that Duramax had responsibility for enrolling eligible persons in coverage. As the court read that language, a plan administrator's responsibility for enrollment could include ''communicating with employees, aiding them in filling out forms, and collecting the correct premiums from employees and remitting them to United. By contrast, United retains control under the Plan over when it makes that eligibility determination in relation to its acceptance of premiums remitted to it from Duramax on an employee's behalf.''[19] However, having made the determination that United had a fiduciary duty, it remanded the case to determine whether United had taken reasonable steps to confirm Mr. Shields's eligibility for excess coverage in a timely manner after accepting his premium payments.[20]

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[13] ''Reasonably proximate'' means that an insurer does not have a fiduciary duty to make such a determination prior to accepting any premiums.

[14] *Shields*, 50 F.4th 236 at 250. The First Circuit noted that its decisions were consistent with those of other courts, citing *McCravy v. Metro. Life Ins. Co.*, 690 F.3d 176 (4th Cir. 2012); *Silva v. Metro. Life Ins. Co.*, 762 F.3d 711, 713–16 (8th Cir. 2014); *Skelton v. Davidson Hotels, LLC*, No. 18-3344 (MJD/DTS), 2020 BL 455709 (D. Minn. Nov. 23, 2020), *aff'd sub. nom. Skelton v. Radisson Hotel Bloomington*, 33 F.4th 968 (8th Cir. 2022); *Frye v. Metro. Life Ins. Co.*, 2018 WL 1569485 (E.D. Ark. Mar. 30, 2018).

[15] *Shields*, 50 F.4th 236 at 250.

[16] *Id.* at 252.

[17] *Id.*

[18] *Id.*

[19] *Id.* at 254.

[20] The First Circuit's remand addressed the issue of prudence, but other courts have found breaches of the duty of loyalty in the type of circumstances described in Shields. *See, e.g.*, *Skelton v. Radisson Hotel Bloomington*, 33 F.4th 968 (8th Cir. 2022) (accepting premiums without providing a benefit to a beneficiary violates the duty of loyalty).

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TAKEAWAYS

While the Court of Appeals for the First Circuit might be able to successfully distinguish all the cases on which United relied in support of its motion to dismiss, such legal legerdemain does not take away from the fact that the earliest case that it cites in support of its position is a 2012 case.[21] If the issue of incorrectly enrolling and accepting insurance premiums from employees were an atypical occurrence, perhaps a 2012 case as the earliest precedent would not be significant in and of itself, but mistakes in enrolling participants in insured arrangements cannot be characterized as a rarely occurring phenomenon. Thus, even if one were of the view that cases such as *Shields* and those cited therein were not properly decided, as a factual matter, it is more likely today than it was a decade ago that an insurer may be found liable for a breach of fiduciary duty.

Also, to the extent that an insurer's fiduciary language may be dependent on the specific language in a plan or policy, both plan sponsors and insurers will need to pay closer attention to language that may not have previously concerned them. The First Circuit's decision provides two illustrations of this point. First, what does it mean to state in a plan document or policy that ''payment of premiums does not guarantee eligibility for coverage''? If read literally, it could mean that paying premiums over an indefinite period of time did not mean that the payor would ever be eligible for coverage. However, a reasonable person would not generally read that expression in that fashion.[22] Going forward, parties may wish to expand on this language to make clear that a determination will be made, reasonably proximate to the receipt of premiums, as to whether an employee is eligible for coverage or whether additional actions need to be taken to determine whether or not a participant is eligible for coverage.

Second, what does it mean for a plan administrator to have responsibility ''for enrolling eligible persons for coverage''? The First Circuit defined it in terms of the steps needed to be taken to complete the paperwork, but that is not the only possible meaning of enroll. If one were to look to Black's Law Dictionary or a standard dictionary such as the Oxford Dictionary, its usual meaning is to officially register in some capacity. Here, too, for the avoidance of doubt, it would be appropriate to define in the policy what it means to enroll.

As a third comment, in other contexts, when courts speak of process, their focus is on the due diligence of the relevant fiduciary. In the insurer context, however, a failure of process means a systems failure. In *Frye v. Metropolitan Life Insurance Co.*,[23] an Arkansas district court found that an employer and an insurer had breached their fiduciary duties due to procedures with structural administrative defects that allowed participants to pay for coverage for dependents who were ineligible. In *Gaines v. Sargent Fletcher, Inc. Group Life Insurance Plan*,[24] the District Court for the Central District of California found that a ''failure to construct a system to ensure that coverage is properly in place before accepting premium payments violated the requirements'' of a procedural safeguard, resulting in a fiduciary breach. In *Skelton v. Davidson Hotels, LLC*, a district court held that a claims fiduciary ''ha[s] a duty to ensure its system of administration does not allow it to collect premiums until coverage was actually in force.''[25]

Tips for Health and Welfare Plan Fiduciaries

- Understand who is a fiduciary and that it may include a functional fiduciary.
- Ensure systems are in place to ensure timely determinations of eligibility and claims determinations under the terms of the plan.
- Ensure service provider roles are clearly defined.
- Ensure the plan sponsor is covering all nonservice provider roles, or that the service provider is performing all its assigned roles.
- Ensure plan documents are clearly written and accurately reflect plan operations.
- Ensure participants understand all requirements for eligibility and benefits.
- Ensure participants are notified of plan related determinations.
- Ensure the plan sponsor is monitoring the service providers.
- Ensure the selection of service providers considers the reasonableness of fees and the services that are being provided.
- Ensure the plan is engaging in all required reporting.

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[21] Even the DOL, in its amicus brief, cited to only one earlier case, *Gaines v. Sargent Fletcher, Inc. Grp. Life Ins. Plan*, 329 F. Supp. 2d 1198, 1221 (C.D. Cal. 2004).

[22] *See Silva v. Metro. Life Ins. Co.*, 762 F.3d 711, 723 (8th Cir. 2014) (''[i]t was arguably fraudulent for MetLife to collect premiums from an . . . employee who was never advised of an evidence of insurability requirement.'').

[23] 2018 WL 1569485 at *3–5 (E.D. Ark. Mar. 30, 2018).

[24] 329 F. Supp. 2d 1198, 1221 (C.D. Cal. 2004).

[25] No. 18-3344 (MJD/DTS), 2020 BL 455709 at *7 (D. Minn. Nov. 23, 2020), *aff'd sub. nom. Skelton v. Radisson Hotel Bloomington*, 33 F.4th 968 (8th Cir. 2022) (''Reliance [Standard Life Ins. Co.] . . . maintained a haphazard system of ships passing in the night.'' (at 976)).

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