MEMORANDUM

TO: Attorney Name, Esquire[1]

FROM: National Legal Research Group, Inc.
James P. Witt, Senior Attorney

RE: VA-Federal/Pensions/ERISA/Life Insurance—Coverage

FILE: 41-xxxxx-012 November 1, 2010

YOUR
FILE: Helen F. Troy

INTRODUCTION

One of the basic definitional provisions of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §§ 1001 et seq., states as follows:

> For purposes of this subchapter:
>
> (1) The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, *through the purchase of insurance* or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, *death* or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) of this title [not presently relevant] (other than pensions on retirement or death, and insurance to provide such pensions).

29 U.S.C. § 1002(1) (emphasis added).

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[1]**Names, addresses, and other identifying information have been redacted to protect privacy.**

There is no question that the life insurance policies involved in the present case are part of an "employee welfare benefit plan" as defined above in that the policies are a result of the employer's purchase of life insurance for the purpose of providing benefits for those designated by the employees as their beneficiaries under the policies. Moreover, the "Group Booklet-Certificate" under the Mayhem Insurance policy states on page x:

> As a participant in this plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

The Death Warmed Over Insurance booklet contains a "Statement of ERISA Rights" on page x. No reference to ERISA was found in the Coma Insurance booklet, but there would not seem to be a basis for exempting that policy from ERISA.

Given ERISA's coverage of all of the policies in the present case, the key legal element that will govern any recovery available to Helen F. Troy ("Helen") is the remedies provision of ERISA. Title 29 U.S.C. § 1132, "Civil Enforcement," provides at subsection (a), "Persons empowered to bring a civil action," in relevant part:

> A civil action may be brought—
>
> (1) by a participant *or beneficiary*—
>
> (A) for the relief provided for in subsection (c) of this section [remedies for administrator's refusal to provide requested information], or
>
> (B) *to recover benefits due to him under the terms of his plan*, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;
>
> (2) by the Secretary, or by a participant, *beneficiary* or fiduciary for appropriate relief under section 1109 of this title;

> (3) by a participant, *beneficiary*, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) *to obtain other appropriate equitable relief* (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan[.]

29 U.S.C. § 1132(a)(1)–(3) (emphasis added).

There is no question that Helen, as the designated beneficiary under the three policies, qualifies as a beneficiary under ERISA and therefore has standing to bring an action under the Act, as per 29 U.S.C. § 1132(a). Section 1102 provides:

> The term "beneficiary" means a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder.

Id. § 1102(8).

Therefore, Helen has standing (1) under § 1132(a)(1)(B) to "recover benefits"; (2) under § 1132(a)(2) to obtain "appropriate equitable relief under section 1109," which provides that a breaching plan fiduciary is liable to the plan to the extent of the losses he has caused; and (3) under § 1132(a)(3) to "(A) enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief."

Although our preliminary thinking has been that the most likely target for an action by Helen would be the employer, Rosedale Crematorium ("Rosedale"), it will become clear below that the recovery from Rosedale of an amount equal to the insurance proceeds will not be possible, because an action against Rosedale would be based on breach of fiduciary duty for "appropriate equitable relief." Such relief has been ruled not to include compensatory

damages. Therefore, the focus of this discussion is on the possibility of Helen's recovery of the benefits directly from the insurance companies under the authority of her standing as a plan beneficiary to "recover benefits" under § 1132(a)(1)(B).

The theory of recovery against the insurance companies would be estoppel, based not only on the insurance companies' retention of the premium payments and their issuance of premium notices including Queena Troy ("Queena") as a covered plan member but also on the basis of the minutes of the meetings of Rosedale's board of directors indicating that retirement packages, including Queena's, included life insurance coverage as well as salary continuation during a former employee's retirement.

Before dealing with the application of estoppel under ERISA, it should be noted that in the Virginia case that you furnished, *Stone Printing & Manufacturing Co. v. Dogan*, 234 Va. 163, 360 S.E.2d 210 (1987), the Supreme Court of Virginia addressed the status of estoppel under Virginia law. The case was in the context of an employee's assertion of estoppel in attempting to negate his employer's termination of his life insurance coverage under a group policy held by the employer. The court held that it was not clear that the doctrine of estoppel was recognized under Virginia law but that even if it were, the employee had not satisfied the requirements of the doctrine, *see W.J. Schafer Assocs. v. Cordant*, 254 Va. 514, 521, 493 S.E.2d 512, 516 (1997) ("[P]romissory estoppel is not a cognizable cause of action in the Commonwealth, and we decline to create such a cause of action."); apparently, the possibility of applying equitable estoppel (based on a misrepresentation of an existing fact, as opposed to a promise as to a future action or occurrence) was not denied.

In any event, for some reason there was no mention in the *Stone Printing* opinion of the possible application of ERISA. The denial of the application of estoppel under Virginia law will have no effect on the present case because of ERISA's preemption under 29 U.S.C. § 1144(a) of "all State laws insofar as they may now or hereafter relate to any employee benefit plan."

DISCUSSION OF AUTHORITY

I. ERISA Cause Of Action Against The Insurance Companies For Recovery Of Benefits.

Although not reported in F. Supp. 2d, the federal district court case of *Mooney v. Continental Assurance Co.*, No. 3:02-CV-01113, 2005 WL 1715746 (N.D.N.Y. July 21, 2005), provides a good overview of the factors relevant to recovering life insurance proceeds from the insurer under an ERISA-covered group life insurance plan on the basis of estoppel where the insurer has retained the premiums paid for the particular plan participant's coverage.

The plaintiff, Dennis P. Mooney, commenced the action against Continental Assurance Company, the defendant, as a beneficiary of a group life insurance plan. He alleged the wrongful denial of benefits on the bases of promissory estoppel, equitable estoppel, and common-law breach of contract. The defendant filed a motion for summary judgment.

On July 27, 2000, United Health Services Hospitals, Inc. ("UHSH"), hired the plaintiff's wife, Louise Mooney, as a medical secretary. As a UHSH employee, Louise was

eligible for certain benefits offered by UHSH, including group life insurance coverage, which UHSH had purchased from the defendant. The policy named UHSH as a "Holder" and a "Plan Administrator" and gave the UHSH the sole authority to determine eligibility for benefits under the policy. The UHSH plan offered basic and supplemental group life insurance to eligible employees. The basic life insurance coverage was paid for in full by UHSH and was provided to all eligible employees without the need for enrollment. The supplemental life insurance ("contributory insurance") had to be purchased by UHSH's employees through the employer by way of payroll deductions, and this coverage required enrollment by the plan participants in accordance with the policy provisions. One requirement for enrollment was that unless the participant had submitted the request for supplemental insurance before his or her eligibility date, such request had to be submitted within 31 days of the eligibility date. A participant was also required to submit proof of good health/insurability. Louise submitted her enrollment form on September 25, 2000 and designated the plaintiff as her beneficiary. UHSH recorded July 27, 2000 as Louise's hire date and August 1, 2000 as her eligibility date, meaning that the 31-day limit for filing the request had not been met. UHSH nevertheless determined that Louise was eligible for supplemental life insurance coverage and began deducting premium payments from her paycheck, which were submitted to the defendant. Louise died on August 6, 2001, and the defendant received the claims for payment on both the basic and supplemental policies on August 13, 2001. The defendant approved the payment of the basic life insurance amount, $20,300 but denied the claim for the supplemental insurance benefits in the amount of

$40,500. The defendant contended that Louise had failed to complete the enrollment form for the supplemental coverage within the time limit and had failed to provide evidence of her insurability.

The court, in granting the defendant's motion for summary judgment, first noted that an ERISA claim for benefits under § 1132(a)(1)(B) is essentially a contract claim that depends on the participant's qualification for the benefits.

The court discussed the plaintiff's estoppel claims, framing the issue raised by the claims as follows:

> Even though Louise Mooney did not qualify for benefits under the plan for purposes of the 29 U.S.C. § 1132(a)(1)(B) claim, plaintiff may still recover against defendant if he can demonstrate that principles of equitable or promissory estoppel apply in his case.

Id. at *3.

The court reviewed the requirements for the application of promissory and equitable estoppel:

> To succeed on a promissory estoppel claim, plaintiff must demonstrate that: (1) defendant made a promise to plaintiff, (2) plaintiff relied on that promise, (3) as a result of the reliance plaintiff suffered an injury, and (4) an injustice will occur if the promise is not enforced. *See Schonholz v. Long Island Jewish Med. Ctr.*, 87 F.3d 72, 79 (2d Cir.1996); *see also Delvin v. Empire Blue Cross and Blue Shield*, 274 F.3d 76, 85 (2d Cir.2001). To succeed on an equitable estoppel claim, plaintiff must demonstrate that (1) defendant made a material misrepresentation to plaintiff, (2) plaintiff justifiably relied on the misrepresentation, and (3) as a result of reliance plaintiff suffered damages. *See Lee v. Burkhart*, 991 F.2d 1004, 1009 (2d Cir.1993). *Additionally, [in ERISA cases] both theories require that the plaintiff adduce not only facts sufficient to support the basic elements of estoppel claims, but also facts sufficient to satisfy the "extraordinary circumstances" requirement. Devin v. Empire Blue Cross & Blue Shield*, 274 F.3d 76, 85-86 (2d Cir.2001).

Id. (emphasis added).

The court concluded that the plaintiff could not succeed with his estoppel claims, both promissory and equitable, because he had failed to show the existence of "extraordinary circumstances." In discussing the reasons for its conclusion, the court raised points that give at least some hope that an equitable estoppel claim could succeed against the insurance companies in the present case.

The court cited authority for the proposition that the extraordinary circumstances requirement could be satisfied where it was shown that the employer had intentionally induced the employee to accept employment through representations regarding benefits and then later reneged on its promise. The court cited *Patterson v. J.P. Morgan Chase & Co.*, No. 01 Civ. 7513(LMM), 2004 WL 1920215, at *9 (S.D.N.Y. Aug. 26, 2004), and *Pronti v. CNA Finance Corp.*, 353 F. Supp. 2d 320, 326-27 (N.D.N.Y. 2005).

The court dealt with the plaintiff's contention that extraordinary circumstances existed because

> (1) defendant retained premiums forwarded to it by the UHSH on behalf of Louise Mooney; (2) defendant failed to inform Louise Mooney that she was not covered by supplemental benefits; and (3) defendant refused to comply with the UHSH's directive to pay plaintiff requisite benefits.

Mooney, 2005 WL 1715746, at *4.

The plaintiff argued that if Louise had not relied on the defendant's alleged misrepresentation that she was covered by supplemental benefits and if the defendant had returned the premiums promptly, Louise could have obtained a supplemental insurance policy elsewhere. In the court's view, this allegation went toward satisfying only the basic estoppel

requirement of reliance on the defendant's actions but did not by itself "render the case 'extraordinary.'" *Id.*

The court mentioned that the Second Circuit had not yet expressly decided whether the retention of premium payments by the insurance company and subsequent denial of coverage based on improper enrollment satisfied the extraordinary circumstances requirement. The court observed that in *Devin v. Empire Blue Cross & Blue Shield*, 274 F.3d 76, 86 (2d Cir. 2001), the Second Circuit noted that it had not yet had the opportunity to decide whether the extraordinary circumstances requirement could be satisfied by evidence other than that of intentional inducement. However, the *Mooney* court stated, district courts had considered the question. For instance, in *Wallace v. Life Insurance Co. of North America*, No. 93 CIV. 6056(RJW), 1997 WL 375653 (S.D.N.Y. July 23, 1997), the defendant denied the plaintiff's claim for long-term disability benefits on the basis of the policy's preexisting condition exclusion. The plaintiff in *Wallace* argued that the defendant should have been estopped from denying her coverage, because it continued to treat her policy as valid by accepting her premiums and, thus, inducing her to relinquish the right to obtain other insurance. The *Wallace* court concluded that defendant's treatment of the policy was valid and that the defendant's continued acceptance of the premiums did not "'guarantee [plaintiff] benefits without regard to the terms of the policy.'" *Mooney*, 2005 WL 1715746, at *4 (quoting *Wallace*, 1997 WL 375653, at *4).

The *Mooney* court reviewed additional cases: *Stovall v. First Unum Life Insurance Co.*, 20 F. App'x 47 (2d Cir. 2001) (estoppel claim against insurance company found to lack

extraordinary circumstances where employer's error in processing plaintiff's application for long-term disability coverage resulted in failure of plaintiff's enrollment; defendant had retained premium payments made by employer); *Arocho v. Goodyear Tire & Rubber Co.*, 88 F. Supp. 2d 1175 (D. Kan. 2000) (extraordinary circumstances not found where defendant Aetna Life Insurance Company, which had retained premium payments, denied coverage on basis that insured had died two days prior to effective date of policy); and *Kaus v. Standard Life Insurance Co.*, 176 F. Supp. 2d 1193, 1198 (D. Kan. 2001) (insurer denied benefits under health-care plain on basis that coverage had terminated two years prior to plaintiff's submission of claim; estoppel claim based on insurer's acceptance of premium payments was rejected in that extraordinary circumstances required as minimum a showing of "lies, fraud, or intent to deceive").

In reaching its conclusion under the facts before it that the plaintiff's estoppel claim was not supported by the essential element of extraordinary circumstances, the *Mooney* court noted that it could find no factual support for the assertion that the defendant insurance company knew of the plaintiff's improper enrollment while it was receiving and retaining premium payments and long before its denial of the plaintiff's supplemental benefits.

The *Mooney* case raises the possibility that the extraordinary circumstances requirement can be satisfied in the present circumstances so as to allow the assertion of an equitable estoppel claim against the insurance companies. First, as suggested at the end of the above discussion of *Mooney*, it may be sufficient to establish that the insurance companies had (or should have had) knowledge of Queena's loss of plan coverage due to her

retirement. More importantly, *Mooney* and the cases surveyed therein show that a finding of extraordinary circumstances in the context of applying the doctrine of estoppel to an insurance company denying benefits under an ERISA benefit plan can be supported by a showing that the *employer* (*and not just the insurance company*) made a misrepresentation to the plan participant/employee on which the employee reasonably relied to his or her detriment. Of course, communications from the insurance company, the party against which estoppel is to be applied, would also count. Given the tenor of the foregoing authorities, however, it is reasonable to conclude that if the extraordinary circumstances requirement is to be satisfied in the present case, it will have to be established that Rosedale, in combination with the insurance companies, made misrepresentations to Queena that can be categorized as intentional or fraudulent.

The evidence available to this point in the present case does not indicate that either Rosedale or any of the insurance companies was engaged in a deliberate attempt to deceive Queena. For instance, the representation made in the minutes of the meeting of Rosedale's Board of Directors on Date, 2003 seems to have been the result of negligence:

> [Queena Troy], Secretary-Treasurer plans to retire June 30, 2004. The Board approved a $15,000 a year retirement. A decision on paying her health insurance and Life Insurance is still under consideration.

The clear implication was that if the payment of Queena's life insurance were approved, such coverage would, like her $15,000 income continuation, be a retirement benefit that would carry through until her death. The fact that Rosedale in fact made all of the premium payments on the life insurance policies until Queena's death clearly supports

Queena's reasonable belief that she was covered by the policies through her retirement (the statement in the minutes of the Date, 1992 board meeting that Officer Ken B. Allgood's retirement package would include insurance on his life confirms that Rosedale represented that life insurance coverage was regarded as a retirement benefit, not as an employee benefit that would terminate with retirement). These representations, combined with the insurance companies' retention of the premium payments, the inclusion by Coma of Queena as an insured on a notice of a premium payment due on Date, 2010, and similar inclusions of Queena by Mayhem and Death Warmed Over on premium-due notices (Due Date, 2010 for Mayhem and Due Date, 2010 for Death Warmed Over), show that such notices were issued throughout Queena's retirement and strengthen the contention that Queena was deceived as to her life insurance coverage during retirement. At the same time, it would not seem possible to establish that such deception was intentional. Rosedale submitted a Group Policyholder's Statement to Coma following Queena's death, just as the company submitted a Life Insurance Claim Form—Employer's Statement to Death Warmed Over and a Life Claim Information form to Mayhem. Therefore, it would be difficult to cast doubt on the belief of Rosedale and the insurance companies that Queena legitimately had life insurance coverage at the time of her death and that neither Rosedale nor the insurance companies were engaged in some sort of program or conspiracy to deceive Queena.

The possible position for Helen to take would be that, despite the absence of any attempted deception, the extraordinary circumstances requirement is still satisfied because

the negligence on the part of Rosedale and the insurance companies was so egregious that it amounted to constructive fraud. As stated in *Corpus Juris Secundum*:

> Gross or culpable negligence
>
> Mere negligence is not sufficient to establish constructive fraud as a basis of estoppel, but it must be gross or culpable negligence.

31 C.J.S. *Estoppel and Waiver* § 139 (citing *Hertz Corp. v. Hardy*, 178 A.2d 833 (Pa. Super. Ct. 1962)).

To this point, no authority was found to discuss the possibility of basing the satisfaction of the requirement of extraordinary circumstances on constructive fraud, but it appears that this would be the only viable approach for recovering the insurance proceeds from the insurance companies on an estoppel theory. As explained below, this would most likely be the only possibility of recovery in the case, in that the restrictions imposed by ERISA on recovery for breach of fiduciary duty rule out a recovery of compensatory damages from an employer, with the result that any relief obtained from Rosedale could not include damages measured by the insurance proceeds.

The *Mooney* court noted that in refusing to apply estoppel on the basis of the absence of extraordinary circumstances, it was not "deciding whether plaintiff satisfied basic elements of his promissory and equitable estoppel claims." 2005 WL 1715746, at *3. To repeat those requirements, the plaintiff, in order to establish equitable estoppel, must demonstrate that (1) the defendant made a material misrepresentation to plaintiff, (2) the plaintiff justifiably relied on the misrepresentation, and (3) as a result of reliance the plaintiff suffered damages. Under the present facts, there should be no question that the combination of the representations

made by Rosedale and the insurance companies qualified as material representations and that Helen suffered the damages of the loss of the insurance proceeds as a result of the misrepresentations. Whether the requirement of justifiable reliance is met is partially answered by the case you supplied, *Daniels v. Thomas & Betts Corp*., 263 F.3d 66 (3d Cir. 2001), an ERISA case involving a claim of breach of fiduciary duty by the plan administrator, based on his alleged misrepresentation to the participant that the level of his supplemental life insurance under the plan would be grandfathered in under new plan provisions so as to maintain the coverage at one and one-half times his earnings. The contention was that as a result of the participant's reliance on the misrepresentation, he had not filed the form needed to secure his supplemental coverage. The court of appeals reversed the district court's grant of the plaintiff's motion for summary judgment on this point, concluding that the district court on remand needed to determine if there was "uncontroverted evidence of detrimental reliance." *Id.* at 75. Therefore, in the present case, it would be a question of fact as to whether Queena justifiably relied upon the representations that her life insurance coverage remained in effect during her retirement, with the result that she did not seek to obtain alternative coverage. Additionally, as mentioned above, the *Mooney* court acknowledged that a plan participant's failure to acquire alternative insurance coverage on the basis of misrepresentations goes toward satisfying the reliance requirement of estoppel. *Mooney*, 2005 WL 1715746, at *4.

Title 29 U.S.C. § 1144(b)(2)(A) exempts from ERISA coverage "any law of any State which regulates insurance." If a Virginia statute or case regulating insurance could be found to apply in Helen's favor in this case, such law would apply, but no such law was found.

II. ERISA Cause Of Action Against The Employer, Rosedale Crematorium.

Title 29 U.S.C. § 1002 provides in relevant part that

> a person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets[.]

29 U.S.C. § 1002(21)(A).

There should be no question that Rosedale qualifies as the fiduciary of the plan in that the insurance companies' function was limited to providing the life insurance coverage under the plan. Because Rosedale was not directly responsible for the payment of the insurance proceeds, the only cause of action against the employer would be for breach of fiduciary duty. The problem, as mentioned above, is that ERISA restricts the form of recovery where the action is for breach of fiduciary duty. Again, as provided by § 1132(a):

> A civil action may be brought—
>
> . . . .
>
> (2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title [requiring a breaching fiduciary to make the plan whole];
>
> (3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other

> appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan[.]

In *Massachusetts Mutual Life Insurance Co. v. Russell*, 473 U.S. 134 (1985), the plaintiff sought compensatory and punitive damages against an administrator who had breached his fiduciary duty by wrongfully delaying the payment of her benefit claim. The plaintiff sought to recover under the "appropriate relief" language of § 1132(a)(2). The U.S. Supreme Court held that given the reference in that subsection to § 1109 and that provision's focus on recovery for an ERISA plan itself, individual relief was not available under the phrase "appropriate relief" as used in § 1132(a)(2).

In *Varity Corp. v. Howe*, 516 U.S. 489 (1996), the U.S. Supreme Court held that *Russell* did not control under the facts before it. The employer/plan administrator in *Varity* had misrepresented to employees that their benefits would remain secure if they voluntarily transferred to a separately incorporated subsidiary. The action was brought under the "appropriate equitable relief" language of 29 U.S.C. § 1132(a)(3). The Court noted that in *Russell*, the plaintiff had disavowed any intention of recovering under § 1132(a)(3), most likely, in the *Varity* Court's view, because the plaintiff was seeking compensatory and punitive damages and only "appropriate equitable relief" is available under § 1132(a)(3). In *Varity*, however, the plaintiffs were seeking the restoration of their status as plan participants and were not seeking damages. The *Varity* Court held:

> The words of subsection (3)—"appropriate equitable relief" to "redress" any "act or practice which violates any provision of this title"—are broad enough to cover individual relief for breach of a fiduciary obligation.

Id. at 510.

This is the status of the law on relief for an individual under ERISA for breach of fiduciary duty. Only equitable relief is available to the individual, and this would preclude Helen's recovery from Rosedale of compensatory damages measured by the proceeds of the insurance policies involved here.

RESEARCHER'S NOTE

If further research is thought to be worthwhile, I would recommend that it be focused on looking for any further developments as to the meaning of "extraordinary circumstances" as a requirement for applying estoppel in the context of ERISA.