No. 11-57

In The Supreme Court of the United States

HARPER EXCAVATING, INC.,

Petitioner,

v.

JEFFREY HANSEN,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Tenth Circuit

BRIEF IN OPPOSITION

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QUESTIONS PRESENTED

(1) If a former employee lacks an colorable claim to benefits under an employee benefit plan, does the employee nonetheless have standing to maintain an action under section 502(a) of the Employment Retirement Income Security Act because he would have been a participant in that plan "but for" action by the defendant that violated ERISA?

(2) Is the standing of a former employee to maintain an action under section 502(a) determined at the time when the individual commences such an action, or at the earlier point in time when the asserted violation occurred?

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STATUTES INVOLVED

Section 3(7) of the Employment Retirement Income Security Act, 29 U.S.C. § 1002(7), provides:

> The term "participant" means any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit.

Section 502(a) of ERISA, 29 U.S.C. § 1132(a), provides in pertinent part:

> A civil action may be brought –
>
> (1) by a participant ... –
>
> (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....

STATEMENT

This case arises out of a series of highly unusual events. The ERISA violation at issue occurred when the employer gave the plaintiff, in writing, inaccurate information about the deadline for applying for health insurance. The employer repeatedly deducted

(and pocketed) insurance premiums from the plaintiff's paycheck, even though it knew (as the plaintiff did not) that the plaintiff's insurance application had been rejected as untimely by the insurance carrier. The subsequent procedural history – which ultimately led to separate ERISA and state law actions – was entirely unique; the later-filed state law action was based largely on company documents that were only disclosed to the plaintiff seven months *after* the plaintiff had moved for summary judgment in the earlier federal action. The idiosyncratic circumstances of this appeal do not present an appropriate vehicle for deciding any legal issue of general importance.

Respondent Hansen was hired by Harper Excavating in late November, 2003. Harper Excavating provided employees with medical insurance from Regence Blue Cross Blue Shield ("Blue Cross"). Harper itself was the administrator of the plan for ERISA purposes. New workers were not initially eligible for health insurance or certain other benefits. Rather, new employees were only eligible for those benefits after their official "hire date," which occurred following a period of probationary employment. Under Harper's contract with Blue Cross, applications from newly hired workers would be accepted by Blue Cross for a 30-day period following the post-probation hire date. Workers filled out an application for health care benefits and gave it to Harper officials; Harper itself was responsible for submitting applications to Blue Cross.

When Hansen was hired, "he was told by Harper that employees are eligible to enroll in its health insurance plan after 90 days on the job." (App. 3). He was given and required to sign a document entitled "Harper Companies Insurance Benefit Disclosure & Acknowledgment." (App. 27-28, 31 n.2, 38). That official company notice specifically stated, "All full time regular employees are eligible for benefits beginning on the 1st day of the month following 90 days of employment." "Harper's Human Resources Director ... testified that employees ... were not eligible for benefits until after ninety days of employment and that he reads this provision to every new hire." (App. 28). Because Hansen had begun work in late November 2003, the first day of the month following 90 days of employment would have been March 1, 2004.[1] Under the plan "an employee is entitled to initially enroll for coverage ... within thirty ... days of first becoming eligible for benefits." (App. 28). Under those

[1] The notice also explained, "You must enroll within 30 days from your hire date or wait until the next open enrollment period." Under the plan "hire date" refers to the end of the probationary period, the point at which a worker becomes eligible for benefits. A worker could not "enroll" in a benefit plan until he became eligible.

The company contended that "hire date" in this sentence referred to the date on which an employee began work, and that the sentence thus meant that a worker was supposed to apply for benefits (not "enroll") within 30 days of beginning work, even though he was not yet eligible for benefits. "It is undisputed, however, that this was Harper's own internal policy, which was not enforced. The actual Plan document states that [workers] must enroll within 30 days of becoming eligible." (App. 28 n.1).

standards Hansen would have been eligible to apply for health benefits between March 1, 2004 and March 31, 2004.

Shortly after he was hired in late November 2003, Hansen filled out and gave to Harper officials an application for health insurance.[2] It was Harper's practice to begin deducting premiums the month before a worker became eligible for health benefits, so that it could use a worker's paid-in premiums to pay for the insurance, rather than having to advance its own funds.[3] In February 2004 Hansen noticed that Harper had not begun to deduct premiums for health insurance. Hansen raised that discrepancy with a Harper official, who "told Hansen that his original paperwork had been lost." (App. 3). Harper officials instructed Hansen to submit a new application form, but said nothing further about the deadline for doing so. Hansen submitted a new health insurance form on March 9, 2004, three weeks prior to the March 31,

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[2] In a response to a request for admission, Harper stated that there was no copy of any health insurance application from late 2003 in Hansen's file, and argued that this "strongly suggests" that Hansen had not submitted such an application at that time. Defendant Harper Excavating's Response to Plaintiff's First Set of Interrogatories, Requests for Production of Documents, and Requests For Admissions, p. 15. However, the human resources officials who dealt with Harper when he was first hired did not submit affidavits affirmatively denying that such an application had been submitted in this period.

[3] Grissetti Deposition, p. 89.

2004 deadline described in the Harper Companies Insurance Benefit Disclosure statement.[4]

When Hansen submitted this second application, a Harper official "provided Hansen with the policy and group numbers of Harper's insurance policy in the event Hansen needed to use the insurance before his own enrollment card arrived." (App. 3; see App. 29). Because it had not begun deducting those premiums back at the beginning of February 2004, Harper actually deducted twice the normal premium to make up for that delay. (App. 29). Because Hansen had submitted two applications for health insurance, had been given Blue Cross policy numbers to use if he incurred medical expenses, and knew his employer was deducting health insurance premiums, Hansen reasonably concluded that he actually had health insurance.

In late April 2004, for reasons unrelated to this litigation, Hansen ended his employment with Harper. (App. 3). In May 2004, Hansen went to the hospital with breathing problems. "When he presented the group and policy numbers given to him by [Harper's human resources official], he was informed that he had no coverage under Harper's plan." (App. 3). "Because he was unable to obtain medical

[4] In a response to a request for admission, Harper stated only that no company official remembered such a conversation with Hansen. Defendant Harper Excavating's Response to Plaintiff's First Set of Interrogatories, Requests for Production of Documents, and Requests for Admissions, p. 15.

care, Hansen's condition worsened; he currently suffers from spinal cord damage and is blind in one eye due to glaucoma." (App. 4).

The significance of the hospital's statement that Hansen had no health insurance was initially unclear. Under COBRA Harper had 44 days after the termination of a worker's employment to notify the former employee that he was entitled to purchase a continuation of his health insurance. *See* 29 U.S.C. §§ 1166(a), 1166(c). If a former employee opted to do so, the coverage would be retroactive to the date on which the employment ended. 29 U.S.C. § 1165(a)(1); *Smith v. Rogers Galvanizing Co*., 128 F.3d 1380, 1384 (10th Cir. 1997). But when in May 2004 Hansen was told by the hospital that he had no insurance, he still had not received a COBRA notice and thus had not arranged for a continuation of his Blue Cross coverage.

But when the COBRA notification period ended in June 2004, Harper still had not provided Hansen with the opportunity mandated by COBRA to purchase a continuation of health insurance. Instead, in June 2004 Harper sent Hansen a check for $279.91, the total of the health insurance premiums which Harper had deducted from Hansen's paycheck. Harper also notified Hansen that three months earlier Blue Cross had rejected his application for medical insurance as untimely. Harper gave Hansen no explanation of what had been done with Hansen's insurance premiums after they had been collected by Harper in March and April 2004. Blue Cross's action

remained unexplained for several years, until Blue Cross itself produced the critical documents in subsequent litigation.

The Blue Cross rejection of Hansen's insurance application, and Harper's failure to provide Hansen with an opportunity under COBRA to purchase medical insurance, had serious financial and medical consequences. In the period following Hansen's application, Hansen incurred tens of thousands of dollars in medical bills for which he had no insurance. Even more harmfully, Hansen simply could not afford the even more expensive medical treatment that he needed to prevent a series of medical conditions from causing permanent injuries. (App. 33).

In November 2005, Harper filed in federal court an action under ERISA seeking, inter alia, to recover the insurance benefits to which he would have been entitled had he been provided the insurance for which he had applied and which Harper had promised.[5] The initial complaint against Harper was amended to include a claim against Blue Cross. In July 2004, after Blue Cross had been added as a defendant, Harper's Director of Human Resources insisted in a sworn deposition that Hansen only became eligible for health insurance after a 90-day probation period,[6] the same

[5] That federal action also included certain other ERISA claims not relevant here.

[6] Grissetti; Deposition, pp. 76-78.

eligibility standard that was set out in the Insurance Benefit Disclosure that Hansen had signed.

In August of 2006 Hansen moved for summary judgment as to liability against Harper. Hansen relied on the 90-day probationary period in the Insurance Benefit Disclosure. Harper argued that his second (March 9, 2004) application, as well as his earlier November 2003 application, had been given to Harper well before the 30th day following the March 1, 2004 end of the 90-day period specified in the company's Insurance Benefit Disclosure. Hansen's summary judgment motion was argued in January, 2007.

In March 2007, while Hansen's motion was still pending, Blue Cross filed a motion for summary judgment regarding Hansen's claim against the insurance company.[7] The Blue Cross motion included several key documents that Harper had not disclosed to Hansen.[8] Those documents made clear that Harper's

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[7] Following the District Court decision granting summary judgment against Harper, Hansen consented to the dismissal of his claims against Blue Cross.

[8] In his motion for summary judgment Hansen asserted that

> [t]here are no documents that state that Harper employees were subject to a 60-day waiting period in 2003 and 2004, and Harper has not produced any documentary evidence to suggest that the 90-day probationary period expressed in the Benefit Disclosure & Acknowledgement form signed by Hansen was supplanted or replaced by a 60-day probationary period.

(Continued on following page)

actual misconduct, although a clear violation of ERISA, was different from the practice that had been alleged in Hansen's 2005 complaint and had been the basis of Hansen's 2006 summary judgment motion.

The documents filed by Blue Cross in March 2007 revealed that in January 2004, during Hansen's probationary period of employment, Harper had written Blue Cross changing the "[h]ire ... [e]ffective [d]ate" to the first of the month "following *60 days* of hire." (App. 30-31 and n.2) (emphasis added).[9] Harper had never disclosed to Hansen the January 2004 letter establishing the new eligibility date. Although Harper knew it had told Hansen in writing that he had until March 30 to enroll with Blue Cross,

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Harper did not dispute the correctness of that statement. Response to Plaintiff's Motion for Summary Judgment, p. 3 (Fact 12). In his reply brief in support of that motion, Hansen pointed out that "Harper does not provide any response to Mr. Hansen's undisputed fact that there are *no* documents that state that Harper employees were subject to a 60-day waiting period in 2003 and 2004." Plaintiff's Reply Memorandum in Support of Motion for Summary Judgment, p. 4. (emphasis in original). Six months after Harper filed that Response to Hansen's summary judgment motion, Blue Cross submitted with its own summary judgment motion two such documents.

[9] Blue Cross also filed a document indicating that a somewhat different 60-day rule was in effect even *before* Hansen was given the Insurance Benefit Disclosure stating that the eligibility date was the first day of the month following 90 days of employment. (Exhibit A). If that document was correct, the information in the Insurance Benefit Disclosure was inaccurate even before the Disclosure was given to Hansen in November 2003.

Harper never notified Hansen that the new deadline was actually 30 days from February 1, 2004, i.e., March 2. When, in February 2004, Hansen specifically asked Harper officials about his health insurance, and was told his first application had been lost, Harper inexcusably had failed to disclose to Hansen that as a result of its January 2004 letter to Blue Cross any substitute application was required by March 2, not by March 30. "[T]here is no evidence," nor indeed any claim by Harper, "that Plaintiff was ever told anything other than that he was subject to a ninety-day probationary period." (App. 31 n.2; see App. 4 ("During discovery in the federal lawsuit, Hansen learned of the actions of [Harper Human Resources officials]")).

On May 8, 2007, the district court granted Hansen's motion for summary judgment as to liability, relying on the new documents that had been provided by Blue Cross in connection with its own motion. The district judge held that Harper had a fiduciary duty under ERISA to provide Hansen with accurate material information regarding the health insurance plan, and that Harper had violated that duty by failing to disclose to Hansen that the eligibility cutoff would be based on a 60-day period, rather than the 90-day period set out in the Insurance Benefit Disclosure. The court emphasized that the written Insurance Benefit Disclosure unequivocally advised Hansen that he was not eligible for benefits until after more than 90 days. (App. 27, 38). That company statement, the court pointed out, was

inconsistent with the deadline actually established by Harper's January 2004 letter. (App. 30, 31 and n.2).

> Harper's duties as a fiduciary include proving material information to its employees regarding their eligibility for Plan benefits, educating them as to their enrollment requirements....
>
> Harper has offered no evidence that Mr. Hansen was ever told anything relating to a 60-day waiting period. There can be no dispute that Harper's representation to Mr. Hansen that he was subject to a 90-day waiting period for benefits constitutes "material information" related to the Plan.... Harper provided Mr. Hansen with materially inaccurate information regarding his eligibility and enrollment requirements.

(App. 37-39; see App. 50 ("Harper breached ... its fiduciary duties to Mr. Hansen by ... failing to convey accurate information to him regarding the eligibility and enrollment requirements for its health insurance plan")). "Hansen ... was denied necessary health insurance coverage as a result of Harper's conduct." (App. 40).[10] Harper did not appeal this liability finding.

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[10] The petition simply ignores the basis of the district court decision regarding the federal claim, stating instead that "[u]nfortunately, Hansen applied some eight days beyond the permitted application period." (Petition, p. 4).

On June 6, 2007, less than a month after[11] the summary judgment decision,[12] Hansen filed the instant action in state court. The new state law claims in this second action relied largely on the documents that Harper had for years withheld from Hansen, and that had only come to light as a result of the March 2007 Blue Cross motion.[13] The state court complaint asserted claims for fraudulent nondisclosure and negligent misrepresentation, both based on the fact that Harper had "made false representations to Hansen regarding the waiting period for his eligibility for

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[11] The petition suggests that the state action was filed well before Hansen moved for summary judgment in the federal action. (Petition, p. 5) ("The [state] action ... commenced on May 29, 2007.... Eventually, Hansen filed a motion for partial summary judgment in [the federal action]." (Petition, p. 5).

[12] In the wake of that decision, the only matter related to the insurance denial that remained for resolution in the federal action was the amount of Hansen's medical bills, costs and counsel fees.

[13] Harper itself explained in the court below that during the course of

> his ERISA claim, Hansen learned of certain conduct by Harper that contributed to his being without insurance. For instance, he discovered that Harper miscommunicated the timeframe within which he had to complete his health plan enrollment application.... He also learned that one of Harper's employees was able to deduct premiums from his paychecks despite Hansen not actually being enrolled in the health plan.... *Based on these discoveries*, ... Hansen filed suit in state court.

Brief of Appellee Harper Excavating, Inc., p. 2 (emphasis added).

health insurance."[14] Hansen had made no such allegations in his federal complaint, because he was unaware when he filed that action that the Insurance Benefit Disclosure statement was inaccurate. The state court complaint was limited to these new state law claims, and did not assert any claims under ERISA.

Harper removed the state court action to federal court. Harper asserted that Hansen's state law claims were completely preempted by ERISA, and that complete preemption established federal jurisdiction over the state court action. Hansen urged the district court to remand the case to state court. (App. 5). The district court held without further elaboration that "ERISA completely preempts all of the state court claims alleged in Plaintiff's complaint." (App. 66).

On appeal the Tenth Circuit recognized that Hansen's state law claim was removable only if ERISA completely preempted Hansen's state law claim. (App. 6). ERISA completely preempts only claims that could have been brought by a participant, beneficiary or fiduciary under section 502(a). *Franchise Tax Board v. Constr. Laborers Vacation Trust*, 463 U.S. 1, 27 (1983). It was undisputed that Hansen was not a "beneficiary"[15] or "fiduciary" within the meaning of ERISA. The controlling issue was whether Hansen's

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[14] Complaint, p. 1, par. 33, 39; see *id*. par. 35 ("Harper failed to communicate ... the proper waiting period").

[15] Under section 3(8) a beneficiary is an individual designated by a participant to receive benefits. 29 U.S.C. § 1002(8).

state claim was completely preempted because he was a "participant" within the scope of section 502(a).

The term "participant" is defined in section 3(7) of ERISA. 29 U.S.C. § 1002(7). A former employee is a "participant" within the meaning of sections 3(7) and 402(a)(1)(B) if he or she either meets the eligibility requirements for benefits under a plan or has a "colorable claim" to such benefits. (App. 11-18). Hansen did not meet those eligibility requirements, because he had not applied for health insurance within the time period established (but not disclosed) by Harper. The court of appeals held that Hansen, at the time he brought the state court action, did not have a "colorable claim" to benefits, reasoning that his benefits claim had by then been resolved in the federal action.

> Hansen has *already* prevailed in a suit for benefits in [the earlier federal action]; he thus no longer has a "colorable claim" that he will do so in the future.

(App. 18) (emphasis in original). In thus concluding that Hansen's claim was not completely preempted, the Tenth Circuit held that whether a plaintiff has standing to sue under section 502(a) is to be determined at the time he filed that action, not at the time when any ERISA violation may have occurred. (App. 11-14). Harper itself had urged the court of appeals to determine standing as of that point in time. (See pp. 31-32, infra).

Following the decision of the court of appeals, the district court remanded Hansen's action to state court. In the state court Hansen amended his complaint to include claims against the key Harper personnel official. Harper moved for summary judgment, arguing that plaintiff's state law claims were barred by issue preclusion because Hansen should have litigated those claims in the earlier federal action.[16] The state court denied that motion, noting that "[s]everal of plaintiff's current [state law] causes of action only arose during the federal litigation, which was resolved expeditiously on summary judgment."[17] Those state law issues had only arisen well into the federal litigation because Harper itself had not disclosed to Hansen the documents revealing the inaccuracy of the 90-day probation period specified in the Insurance Benefit Disclosure. The state court reasoned that Hansen was not obligated to attempt to amend his federal complaint to add those new state law claims; it was unlikely that the federal court would have been willing to hear any state law claims because the merits of the federal claims had by then been resolved on summary judgment.[18] Federal courts do not ordinarily exercise supplemental jurisdiction

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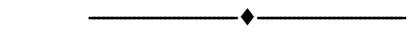
[16] Ruling & Order on Motion to Amend, Case 0709907873 (Utah D.Ct. 3d Judicial Dist.), Sept. 12, 2011, p. 5 ("Harper argues ... that plaintiff's amended claims are barred by the doctrine of res judicata on grounds of both claim and issue preclusion").

[17] *Id.* at 7.

[18] *Id.*

over state law claims when the federal claims have been resolved prior to a trial on the merits.



REASONS FOR DENYING THE WRIT

I. The Statutory Scheme

"Federal pre-emption is ordinarily a federal defense to the plaintiff's suit. As a defense, it does not appear on the face of a well-pleaded complaint, and, therefore, does not authorize removal to federal court." *Metropolitan Life Ins. Co v. Taylor*, 481 U.S. 58, 63 (1987); see App. 6. In unusual cases, however, a federal statute may displace entirely a state cause of action; thus "[a]ny such suit is purely a creature of federal law, notwithstanding the fact that state law would provide a cause of action in the absence of [the federal law]." *Id.* at 64 (quoting *Franchise Tax Board of Cal. v. Construction Laborers Vacation Trust*, 463 U.S. 1, 23 (1983); see App. 6-7). ERISA does not completely preempt every state law claim that might be related in some way to an employee benefit plan. *Franchise Tax Board*, 463 U.S. at 24-26.

ERISA does completely preempt claims cognizable under section 502(a) of ERISA, which authorizes suits "to recover benefits due ... under the terms of [the] plan, to enforce ... rights under the terms of the plan, or to clarify ... rights to future benefits." 29 U.S.C. § 1132(a). "[S]uits to enforce benefits rights under the plan or to recover benefits under the plan ... are to be regarded as arising under

the laws of the United States." *Metropolitan Life Ins. Co.*, 481 U.S. at 66 (quoting H.R.Conf.Rep.No. 93-1280, p. 327 (1974)). A state law claim is completely preempted by ERISA, and any state law claim is thus a federal claim subject to removal, if the "cause of action [is] within the scope of § 502(a)." *Id.*; see App. 9-10.

The central issue below was whether Hansen's state law claim was completely preempted because the state court action presented a claim "within the scope of § 502(a)." In the court of appeals both parties correctly assumed, as did the Tenth Circuit, that the state court action would be completely preempted only if Hansen would have been authorized by section 502(a) to bring an action. Section 502(a) does not authorize every person injured by conduct violative of ERISA to maintain a federal action related to an ERISA-regulated plan.

> ERISA carefully enumerates the parties entitled to seek relief under § 502; it does not provide anyone other than participants, beneficiaries, or fiduciaries with an express cause of action.... A suit for ... relief by some other party does not 'arise under' that provision.

Franchise Tax Board, 463 U.S. at 27; see App. 9.

"Participant" is a term of art under ERISA, and includes several categories of individuals who would not be described as "participants" as that word is

used in ordinary English. Section 3(7) provides in pertinent part:

> The term "participant" means any employee or former employee of an employer ... who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization....

Thus under the terms of section 3(7) an individual is a participant if (1) he or she is actually enrolled in a benefit program (e.g., was accepted for and covered by a Blue Cross health insurance plan), (2) he or she actually satisfied the eligibility requirements, but was nonetheless denied enrollment (e.g., submitted a timely application that met all applicable requirements, but was rejected because the Plan administrator wanted to save money), or (3) he or she "may become eligible" for a benefit.

This Court explained the scope of the "may become eligible" clause in *Firestone Tire and Rubber Co. v. Burch*, 489 U.S. 101 (1989). That clause includes two distinct categories of individuals. First, the "may become eligible" clause encompasses workers or former workers who may in the future meet an eligibility requirement, e.g. by working for a longer period of time or being rehired. Second, the "may become eligible" clause includes individuals who have a "colorable claim" to benefits, such as individuals who failed to satisfy an eligibility requirement because of some violation of fiduciary duty by the Plan administrator (e.g., firing a worker in order to prevent his

or her benefits from vesting, or failing to provide a worker accurate material information about the steps to be taken to establish eligibility). 489 U.S. at 958.

II. There Is No Issue Regarding The Scope of Section 502(a) Standing Warranting Review by This Court

ERISA imposes on the administrator of an employee benefit fund, typically the employer, a fiduciary obligation to provide accurate material information that employees need to establish and maintain eligibility for employment benefits. All circuits agree that a former employee can maintain an action under section 502(a) if an employer violates that fiduciary obligation.

The lower courts have advanced varying explanations for why under section 502(a) a former employee has standing to sue in such a case. The Tenth Circuit relies on the principle that section 502(a) provides standing to a former employee with a "colorable claim" to benefits. Other circuits analyze these cases by holding that a former employee can sue where that individual would have been eligible for the benefit (e.g., would have been a member of the plan or covered by the insurance policy) "but for" the ERISA violation. Such differences in legal reasoning have little if any practical importance, and do not warrant review by this Court.

(1) The Tenth Circuit, applying this Court's decision in *Firestone*, holds that a former employee has

standing to sue under section 502(a), even if he or she failed to satisfy the eligibility requirements for a benefit, if the plaintiff has a colorable claim to the benefit.

> A plan participant includes a former employee with a colorable claim that she will prevail in a suit for benefits.... "[T]he requirements for a colorable claim are not stringent; [the plaintiff] need have only a non-frivolous claim for the benefit in question." *Kamler v. H/N Telecomm. Servs., Inc.*, 305 F.3d 672, 678 (7th Cir. 2002)....

Horn v. Cendant Operations, Inc., 69 Fed.Appx. 421, 425-36 (10th Cir. 2003). In *Horn* the Tenth Circuit held that the employer had breached its fiduciary duty to inform the plaintiff of the requirements for the particular benefit plan in question. 69 Fed.Appx. at 427-28. As the plan administrator, the employer "had an affirmative duty to provide complete and accurate eligibility information." 69 Fed.Appx. at 428.[19] Horn thus had a colorable claim against the employer and was a "participant," within the scope of sections 3(7) and 502(a), even though she had failed to satisfy the eligibility requirement that the employer had improperly not disclosed.

The complaint in Hansen's federal action satisfied this colorable claim standard. That Tenth Circuit

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[19] The Tenth Circuit reiterated the obligation of fiduciaries to provide accurate information in *Kerber v. Qwest Group Life Insurance Plan*, 647 F.3d 950, 971 (10th Cir. 2011).

standard was also applied in *Atwood v. Swire Coca-Cola, USA*, 482 F.Supp.2d 1305 (D.Utah 2007), in which the plaintiff had been denied disability benefits because his employer had failed to handle his application in a timely and diligent manner. In *Atwood* the defendant argued that, because the plaintiff had been denied coverage by the insurance carrier, the plaintiff was not a

> "participant" and thus lacked standing under section 502(a). To the extent Swire is contending that Mr. Atwood has no "participant" standing, the court disagrees.... Mr. Atwood is a participant with standing because he is a former employee with a colorable claim that he will prevail in a suit for benefits (the requirements for a colorable claim are not stringent). *See* 29 U.S.C. § 1002(7).

482 F.Supp.2d at 1315 n.8.

Petitioner suggests that, in the absence of a but-for participant rule, employers in the Tenth Circuit would not be subject to suit under section 502(a) for providing misinformation, or otherwise violating their fiduciary duties, in a manner that resulted in the exclusion of a former employee from a benefit program. (Petition, p. 3).

> [T]his Court should ... hold that those who have been deprived of their ERISA rights by the wrongful conduct of their former employer have standing to sue under ERISA.

(Petition, pp. 18-19). But as *Horn* makes clear, the Tenth Circuit does recognize that section 502(a) provides standing to former employees who have colorable claims that they lost benefits because of "wrongful conduct of their former employer." In Hansen's federal ERISA action he was able to recover benefits that had been lost as a result of just such a wrongful denial of needed information.

(2) Other circuits have also concluded that an employee or former employee has standing to sue under section 502(a) if – because of an employer's breach of its fiduciary obligations – the worker lost, or never attained, eligibility for an employment benefit subject to ERISA. Although those circuits have offered a number of explanations for that result, those various rationales lead to essentially the same result as the Tenth Circuit's colorable claim standard.

Some circuits reason that a former employee who is not a "participant" in a benefit plan because of misconduct by an employer may nonetheless bring an action under section 502(a) – which is limited to suits by "participants."[20] This seemingly internally inconsistent rule can best be understood as reflecting the difference between the ordinary English meaning of "participant" and the broader legal definition of

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[20] *Leuthner v. Blue Cross and Blue Shield*, 454 F.3d 120, 129 (3d Cir. 2006); *Adamson v. Armco, Inc.*, 44 F.3d 650, 654-55 (8th Cir. 1994); *Christopher v. Mobil Oil Corp.*, 950 F.2d 1209, 1220-21 (5th Cir. 1992).

"participant" in section 3(7).[21] A former employee who does not meet the eligibility requirements for a benefit plan would not be a plan "participant" in ordinary English; for example, a worker who was dismissed just before his or her pension vested, and thus was denied a pension, would not be described, in common parlance, as participating in the pension plan. But such a worker would be a "participant" within the meaning of section 3(7) and *Firestone* if his or her dismissal was the result of an unlawful intent to prevent the worker from receiving pension benefits, and the dismissed worker thus had a colorable claim to benefits. An individual who is not a plan

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[21] These opinions refer, for example, to whether a plaintiff is a "plan participant," evidently relying on the colloquial usage. In *Leuthner v. Blue Cross and Blue Shield*, 454 F.3d 120 (3d Cir. 2005), the court noted that the plaintiff was not "a Plan participant," but could sue because she had a "colorable claim" to benefits. 454 F.3d at 128-29; see *Swinney v. General Motors Corp.*, 46 F.3d 512, 519 (6th Cir. 1995) ("member of the plan").

The petition uses the same phrase.

> [A]n employee may claim that, but for the misrepresentation or misconduct of the employer, he or she would have been a participant in the employer's ERISA plan.... [A] common scenario ... is that of an employee who is told there will never be a better retirement plan, and, based on that representation, takes early retirement. The employee later learns the employer did, in fact, offer a better retirement plan. Of course, the employee never became a participant in the better plan because of the early retirement.

Petition, p. 11; see *id.* at 19 (urging Court to hold that section 502(a) authorizes suit "where an employer's alleged misconduct deprives an employee of plan participant status").

"participant" in the ordinary English sense could be a participant as defined in section 3(7), and would be if there were a colorable claim that eligibility for the plan was lost, or not attained, as a result of misconduct by the employer. These "but-for participant" decisions reason that a former employee who is not an (ordinary English) participant, but would have been but for an employer's misconduct, is a section 502(a) participant.

There is little practical difference between this but-for participant approach and the colorable claim analysis in *Firestone* and the Tenth Circuit. Under both approaches a plaintiff must establish that there was a breach of fiduciary duty by the employer, and that plaintiff would have been eligible for the benefit in question but for that breach. It is of little apparent importance whether that evidence is said to establish standing because it shows that the plaintiff has a colorable claim to benefits, or because it demonstrates that the plaintiff would have been an (ordinary English) participant but for the breach of fiduciary duty.

The overlap between these two approaches is underlined by decisions which blend elements of both. In *Swinney v. General Motors Corp.*, 46 F.3d 512 (6th Cir. 1995), the Sixth Circuit held that the term "participant" in section 3(7) includes an individual who would have been eligible for a benefit "but for" an employer's breach of its fiduciary obligations under ERISA.

> So long as a former employee would have been in a class eligible to become a member of the plan but for the fiduciary's alleged breach of duty, he "may become eligible" for benefits under the plan, and is therefore a "participant" under § 1002(7) for the purposes of standing.

46 F.3d at 519.[22] The "may become eligible" clause is the same provision of section 3(7) on which the "colorable claim" rule in *Firestone* is based.

Similarly, in *Horn v. Cendant Operations, Inc.*, the Tenth Circuit in holding that the plaintiff had a colorable claim, and thus standing under section 502(a), cited the Sixth Circuit decision in *Swinney*. 69 Fed.Appx. at 426. The Second Circuit decision in *Borowski v. International Business Machines Corp.*, 1998 WL 777457 (2d Cir. 1998), relied on both the colorable claim standard in *Firestone* and the but-for standard in *Mullins*. 1998 WL 777457 at *1. In *Pannaras v. Liquid Carbonic Industries Corp.*, 74 F.3d 786 (7th Cir. 1996), the Seventh Circuit relied on both the colorable claim standard in *Firestone* and the but-for standard in *Vartanian* and *Christopher*. 74 F.3d at 791.

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[22] See 46 F.3d at 618 ("if the employer's breach of fiduciary duty causes the employee to either give up his right to benefits or to fail to participate in a plan, then the employee has standing to challenge that fiduciary duty.")

Harper itself acknowledges the similarity of the colorable claim and but-for participant approaches by suggesting that

> *Firestone Tire & Rubber Co. v. Burch*, 489 U.S. 101 (1989), which extends federal court jurisdiction under ERISA to "a former employee with ... a colorable claim that he or she will prevail in a suit for benefits" (489 U.S. at 117-18), implicitly [e]ndorse[s] the "but for" basis for federal standing....

(Petition, p. ii).

Other decisions arrive at the same result as the colorable claim and but-for participant cases, without relying on the specific reasoning of either of those lines of cases. The First Circuit holds that an individual is a "participant" under sections 3(7) and 502(a) if a breach of fiduciary duty caused him to receive a smaller benefit, regardless of whether the breach did so by preventing him from becoming eligible for the greater benefit.

> We hold that where an employee alleges a decision to retire based on alleged misrepresentations by his employer amounting to a breach of fiduciary duty, and ... shows that in the absence of the employer's breach of fiduciary duty he would have been entitled to greater benefits than those which he received, then his receipt of payment cannot be used to deprive him of "participant" status and hence, standing to sue under ERISA.

Vartanian v. Monsanto Co., 14 F.3d 697, 703 (2d Cir. 1994).

Mullins v. Pfizer, Inc., 23 F.3d 663 (1st Cir. 1994), holds that "the basic standing issue is whether the plaintiff is '*within the zone of interests ERISA was intended to protect*.'" 23 F.3d at 668 (quoting *Vartanian*, 14 F.3d at 701) (emphasis in original). The First Circuit reasoned that a worker who takes early retirement because of material misrepresentations by his employer – a decision that rendered the employee ineligible for greater future benefits – is within that zone of interests. 23 F.3d at 668-69. Neither *Swinney*, *Vartanian* nor *Mullins* holds that an individual who loses or fails to attain eligibility for a benefit due to a breach of fiduciary duty is not a participant under section 3(7) or 502(a).

(3) Other circuits do not hold, as Harper suggests, that a former employee cannot base standing on a claim that his employer's misconduct resulted in exclusion from, or failure to establish eligibility for, a benefit plan.

The 1986 decision in *Stanton v. Gulf Oil Corporation*, 792 F.2d 432 (4th Cir. 1986), held that the "may become eligible" provision in section 3(7) refers only to "a current employee who was already covered by the present terms of a plan." 792 F.2d at 435. But this Court's subsequent decision in *Firestone* made clear that a former employee too can qualify as a participant under the "may become eligible" clause. The Fourth Circuit recognized that aspect of *Firestone* in

In re Mutual Funds Investment Litigation, 529 F.3d 207, 215 (4th Cir. 2008). In determining whether a former employee is a participant with standing to sue under section 502(a), the Fourth Circuit applies the *Firestone* colorable claim standard. *Davis v. Featherstone*, 97 F.3d 734, 737 (4th Cir. 1996). In *Sanson v. General Motors Corp.*, 966 F.2d 618 (11th Cir. 1992), the plaintiff had simply conceded that the terms of ERISA did not provide him with any claim. 966 F.2d at 621.

(4) Under ordinary circumstances a former employee who can satisfy the Tenth Circuit and *Firestone* colorable claim standard – because benefits were denied as a result of employer action, violative of ERISA, that prevented the plaintiff from establishing or retaining eligibility – would also be an employee who would have been eligible for the benefit (i.e., would have been an actual (ordinary English) participant in the plan) "but for" that violation. Conversely, a plaintiff who would have been eligible for (and thus an (ordinary English) participant in) a plan but for an employer's ERISA violation would, at least ordinarily have a colorable claim to benefits under ERISA.[23]

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[23] The lower courts appear to disagree about what the remedy would be in a case in which an employee, relying on misrepresentations by an employer, retires before a new benefit becomes available. The Tenth Circuit holds that in such a case the claim is for damages, not benefits, and thus is not actionable under section 502(a). E.g., *Felix v. Lucent Technologies, Inc.*, 387 F.3d

(Continued on following page)

Harper argues that the term "participant" in sections 3(7) and 502(a) includes all individuals who would have been participants (in some sense of the word) but for an employer's misconduct, even individuals who do *not* have a colorable claim to benefits. But *Firestone* provides an exclusive delineation of the claimants who are "participants."

> In our view, the term "participant" is naturally read to mean either "employees in, or reasonably expected to be in, currently covered employment," *Saladino v. I.L.G.W.U. National Retirement Fund*, 754 F.2d 473, 476 (CA2 1985), or former employees who "have ... a reasonable expectation of returning to covered employment" or who have "a colorable claim" to vested benefits, *Kuntz v. Reese*, 785 F.2d 1410, 1411 (CA9) (*per curiam*)....

489 U.S. at 117. If, as here, a plaintiff is neither an employee, a former employee with a reasonable expectation of returning to covered employment, nor a former employee with a colorable claim to benefits, that claimant falls outside the scope of a "participant."

Harper insists that Hansen's claim would clearly be completely preempted if this Court were to hold that a but-for participant is a "participant" within the

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1146, 1159 (10th Cir. 2004). Other circuits treat such a claim as one for benefits, and thus actionable under section 502(a). The instant case does not involve a claim of misrepresentation-induced retirement, and thus does not present a vehicle for resolving that issue.

scope of section 3(7) and 502(a) regardless of whether the claimant does not also have a colorable section 502(a) claim. That is not correct. To the extent that a former employee lacks a colorable claim under ERISA, any state law claim that he or she does have would not be completely preempted by section 502(a). A claim is only within the scope of or completely preempted by section 502(a) if the substance of the claim – regardless of how pled in the complaint – would fairly be described as one arising under section 502(a). *Metropolitan Life Insurance Co v. Taylor*, 481 U.S. 58, 64 (1987). Only claims that can be said to arise under section 502(a) fall within the federal question jurisdiction of the district courts. 28 U.S.C. § 1331. A claim does not arise under section 502(a) merely because the plaintiff is in some sense a plan participant; for example, a worker actually enrolled in an employee benefit plan can still sue his or her employer for sexual harassment. To arise under section 502(a), it is not sufficient that the plaintiff be a participant (as defined in section 3(7)) and thus have standing, the substance of the claim must itself be "within the scope of § 502(a)." *Metropolitan Life*, 481 U.S. at 64. In the absence of a colorable section 502(a) claim, a state law action could not be said to be in substance one that arises under section 502(a) even if the plaintiff does have section 502(a) standing.

III. There Is No Circuit Conflict Regarding The Point In Time When Standing Under Section 502(a) Is Determined

There is no circuit conflict regarding the point in time at which a plaintiff must have standing under

section 502(a). Every circuit to address this issue has concluded that a plaintiff must have standing under section 502(a) at the time he or she commences an action.[24] Petitioner does not suggest that there is any disagreement among the lower courts about this issue.

In this Court Harper urges that standing under section 502(a) should be determined as of the time of the initial violation, and criticizes the Tenth Circuit for instead determining standing as of the time the action was filed. Determining section 502(a) standing at the time an action is filed, Harper now objects, "is problematic and contradicts the intent of ERISA." (Petition, p. 21). "[T]his Court should rule that ERISA standing is established at the time of the employer's alleged misconduct." (Petition, p. 22). But in the court of appeals Harper took the opposite position.

> Various circuits have analyzed the issue of at what point in time a plaintiff's status as ERISA participant should be appropriately evaluated. The overwhelming conclusion is that, for a plaintiff to have standing to bring

[24] *Morrison v. Marsh & McLennan Companies, Inc.*, 439 F.3d 295, 304 (6th Cir. 2006); *Nechis v. Oxford Health Plans, Inc.*, 421 F.3d 96, 101 (2d Cir. 2005); *Ericson v. Greenberg & Co., P.C.*, 118 Fed.Appx. 608, 610 (3d Cir. 2004); *McBride v. PLM Intern., Inc.*, 153 F.3d 972, 975-76 (9th Cir. 1998); *Harris v. Provident Life*, 26 F.3d 930, 933 (9th Cir. 1994); *Winchester v. Pension Comm. of Michael Reese Health Plan*, 942 F.2d 1190, 1194 (7th Cir. 1991); *Yancy v. American Petrofina, Inc.*, 768 F.2d 707, 708 (5th Cir. 1985).

> an ERISA claim, he must be an ERISA "participant" at the time the action is filed (as opposed to when the wrongful conduct giving rise to the action occurred). *See Raymond v. Mobil Oil Corp.*, 983 F.2d 1428, 1534-35 (10th Cir. 1993); *Morrison v. Marsh & McLennan Cos., Inc.*, 439 F.3d 295, 304 (6th Cir. 2006); *Harris v. Provident Life*, 26 F.3d 930, 933 (9th Cir. 1994)

(Supplemental Brief of Appellee Harper Excavating, Inc., p. 12). A petitioner may not ordinarily obtain review by this Court of a lower court decision adopted at the behest of the petitioner itself.

Harper suggests that if standing is determined as of the date on which an action is filed, employers, employees and former employees will all engage in manipulative behavior to create or prevent standing. (Petition, p. 21-22). But the standard applied by the Tenth Circuit has for two decades been the unquestioned law in the lower courts; Harper does not contend that the manipulation which it now predicts has actually occurred. An employer could not strip a worker of standing under ERISA by dismissing that employee; the former employee would still have a colorable ERISA claim for whatever violation preceded that dismissal, as well as an additional claim that the dismissal itself violated ERISA. An employee or former employee could not choose to first litigate his or her ERISA claim, and after the conclusion of that litigation file a second, state law claim based on the same conduct. Such a tactic would invariably be

barred by claim preclusion, and would often be barred by the statute of limitations as well. In the instant case those defenses were unavailable solely because of Harper's own conduct, in failing for years to disclose the documents underlying those state law claims.

CONCLUSION

There is no meaningful conflict regarding either the scope of standing under section 502(a) or the date on which section 502(a) standing should be determined.

This case actually turns on a dispute about how those settled principles should be applied in the quite unusual circumstances of this case, in which – because the defendant had long withheld the critical documents – the plaintiff did not know of the central problem and evidence giving rise to his state law claims until long after the federal ERISA action had been filed. Harper does not suggest that this procedural issue is the subject of any inter-circuit conflict, or even that the question has ever arisen before in any other case. Petitioner refers to this dispositive aspect of the decision below only once, dismissing it as "an interesting twist" (Pet. 9), and does not contend that this is a twist warranting consideration by this Court.

For the above reasons, the petition should be denied.

Respectfully submitted,

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