No. 09-16818

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

DAVID BARBOZA,
Plaintiff-Appellant

v.

CALIFORNIA ASSOCIATION OF FIREFIGHTERS; et al.,
Defendants-Appellees

Appeal from the United States District Court
for the Eastern District of California
Case No. 2:08-CV-00519-FCD-GGH

Brief of the Secretary of Labor as amicus curiae in support of the Plaintiff-Appellant

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STATEMENT OF THE ISSUES

1. Whether the district court erred in dismissing the plaintiff's claim for benefits, brought under section 502(a)(1)(B) of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1132(a)(1)(B), for failure to exhaust administrative remedies when the plan administrator did not issue a timely decision under any permissible reading of the Secretary of Labor's claims regulation, and the plan and its administrator therefore failed to provide and follow a full and fair claims procedure.

2. Whether the district court erred in dismissing on exhaustion grounds the plaintiff's fiduciary breach claim brought under ERISA section 502(a)(3), 29 U.S.C. § 1132(a)(3).

STATEMENT OF IDENTITY, INTEREST AND AUTHORITY TO FILE

The Secretary of Labor has primary regulatory and enforcement authority for Title I of ERISA. Pursuant to that authority and to ERISA section 503, 29 U.S.C. § 1133, the Secretary issued regulations, first in 1977 and most recently in 2000, that govern claims procedures applicable to benefit claims under the Act. The key issue in this case may be answered primarily by reference to the Secretary's claims regulation, namely: whether a benefit claim must be deemed exhausted under the Secretary's claims regulation when the plan administrator fails to issue a timely decision under

any permissible reading of the regulation and the plan and its administrator therefore failed to provide and follow a full and fair claims procedure.

The Secretary's interests include promoting uniformity of law, protecting beneficiaries, enforcing fiduciary standards, and ensuring the financial stability of employee benefit plan assets. Secretary of Labor v. Fitzsimmons, 805 F.2d 682, 692-93 (7th Cir. 1986) (en banc). Strict enforcement of the time frames and other requirements set forth in the claims regulation is necessary to protect claimants who need the replacement income that disability benefits provide. The Secretary therefore has a substantial interest in ensuring proper application of the regulation and in ensuring that plans are operated in compliance with the regulatory requirements.

The Secretary files this brief as amicus curiae under Federal Rule of Appellate Procedure 29(a).

STATEMENT OF THE CASE

I. Factual Background

The plaintiff, David Barboza, is a disabled firefighter who worked for the city of Tracy, California and is a participant in the California Association of Professional Firefighters Plan (the "Plan"), an ERISA-covered welfare plan. 2 Excerpts of Record, "ER," 113; 2 ER 60, Par.3; 2 ER 50, Par.3. As

relevant here, the Plan provides benefits to covered firefighters who become disabled from performing their work. 2 ER 137. The Plan further provides that if an initial claim for benefits is denied, the claimant can appeal to the Claims Committee of the Board of Directors of California Administration Insurance Services ("CAIS"), the Plan's third-party administrator. 2 ER 188, Section 15.5. If the Claims Committee denies the appeal, then the claimant can apply for reconsideration with the Executive Board. 2 ER 188, Section 15.6. If a dispute still exists, the claimant, according to the Plan, must negotiate in good faith for 30 days prior to filing suit. 2 ER 189, Section 16.2.

Defendants do not contend that the Plan is a multiemployer plan established pursuant to a collective bargaining agreement.[1] See 29 U.S.C. § 1002(37)(A). Instead, they admit in their answer that the Plan is subject to ERISA and sponsored by a California non-profit corporation organized as a benefit and relief association, the California Association of Professional Firefighters. 2 ER 60, Par. 4; 2 ER 50, Par.4.

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[1] As discussed below, the Secretary's claims regulation, as revised and promulgated in 2000, shortens the time limits for the review of claim denials with regard to both healthcare and disability claims from 60 to 45 days and expressly restricts the quarterly meeting rule (permitting reviews to take place at scheduled quarterly meetings) to multiemployer plans. 29 C.F.R. § 2560.503-1(i)(2), (3).

Based upon a medical examination that determined that he was physically unable to perform the duties of his position, Barboza filed a written claim for disability benefits with CAIS, on May 31, 2006. 2 ER 121-126; 2 ER 60, Par. 4-6; 2 ER 50, Par. 4-6. On May 18, 2007, CAIS denied the claim, stating that Barboza failed to provide sufficient evidence of his disability. 2 ER 102-103. Barboza then appealed the claims denial on November 15, 2007. 2 ER 80-85. The Claims Committee heard the appeal on February 20, 2008. 2 ER 71-73.

On March 6, 2008, before the Committee rendered its decision, Barboza filed suit in federal district court claiming benefits under ERISA section 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), and additionally asserting claims for statutory penalties under section 502(c), 29 U.S.C. § 1132(c), for failure to provide requested plan documents, as well as for fiduciary breach under 502(a)(3), 29 U.S.C. § 1132(a)(3), seeking damages, injunctive relief, including the removal of the plan fiduciaries, and "such other and further relief as the Court deems just and proper." 2 ER 59-70.

On April 21, 2008, while the district court case was pending, the Committee determined that Barboza was disabled and entitled to disability benefits under the Plan, but concluded that his benefits were subject to

certain offsets under the Plan based on disability benefits he obtained under State law, the applicability and amount of which are in dispute. 2 ER 55-58.

II. Procedural History and Rulings

On June 23, 2009, the United States District Court for the Eastern District of California granted summary judgment to the Defendants and dismissed Barboza's suit, without addressing the merits, for failure to exhaust administrative remedies. 1 ER 7-22. In apparent reliance on 29 C.F.R. § 2560.503-1(i)(1)(ii), the district court held that the regulation "permits plans with a committee to make determinations based on their schedule of quarterly meetings, rather than the redacted 45-day period outlined" elsewhere in the regulation. 1 ER 19-20. The district court found that the Committee's decision was timely under this provision, and consequently ruled that Barboza had failed to exhaust the Plan's administrative remedies by undergoing the second level of review and the 30-day negotiation period. 1 ER 20. The district court denied Barboza's motion to alter or amend. 1 ER 1-6.

SUMMARY OF ARGUMENT

The plan administrator did not meet the applicable 45-day deadline required by the claims regulation for deciding a disability benefits claim on review. The rule that the district court thought applicable is restricted to

committees acting on behalf of multiemployer plans in the context of disability claims and applies only when committees under such plans meet quarterly, neither of which is true of the committee that decided the benefit claim in this case. In addition, the Plan was not in compliance with the claims regulation in other significant ways and therefore was not written or administered in a manner that provided the participant with the full and fair review required by the statute. Thus, under the claims regulation, Barboza should be deemed to have exhausted his administrative remedies by the time he filed his claim in district court, almost four months after he appealed the initial denial of his disability benefits claim, but before the committee rendered its decision.

The district court also erred in dismissing Barboza's claim for fiduciary breach under section 502(a)(3) in which he sought an order removing the defendants and other equitable relief. The fiduciary breach claim was not subject to any exhaustion requirement applicable to benefit claims, and the district court therefore erred in dismissing that claim on the basis of exhaustion.

ARGUMENT

THE DISTRICT COURT ERRED IN DISMISSING THIS CASE ON EXHAUSTION GROUNDS

1. The Claims Procedure Regulation

ERISA section 503, 29 U.S.C. § 1133, provides that "[i]n accordance with regulations of the Secretary, every employee benefit plan shall . . . (2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for full and fair review by the appropriate named fiduciary of the decision denying the claim." Pursuant to this express delegation, the Secretary promulgated a claims regulation specifying the minimum requirements for the consideration and review of benefit claims, first in 1977 and then again in 2000.

Section 2560.503-1(h)(1)(i) and (ii) of the 1977 regulation generally provided a 60-day time limit for all benefit decisions on review to plan fiduciaries (with an extension of up to 120 days). In the case of a "plan with a committee or board of trustees designated as the appropriate named fiduciary, which holds regularly scheduled meetings at least quarterly," however, the committee could make its review decision at the next quarterly meeting (or in some cases, at the one after that). See 42 Fed. Reg. 27,429 (May 27, 1977).

In 2000, the Secretary promulgated a new claims regulation designed "to ensure more timely benefit determinations, to improve access to information on which a benefit determination is made, and to assure that participants and beneficiaries will be afforded a full and fair review of denied claims." 65 Fed. Reg. 70,246 (Nov. 21, 2000). For claims that do not involve disability and healthcare benefits, this new regulation generally tracks the original 1977 time limits, including making the quarterly meeting rule applicable regardless of whether the benefits are provided under a multiemployer plan. See 29 C.F.R. § 2560.503-1(i)(1)(i). However, with regard to both healthcare and disability claims, the 2000 regulation shortens the time limits for the review of claim denials and expressly restricts the quarterly meeting rule to multiemployer plans. Id. at § 2560.503-1(i)(2), (3). As explained in the preamble, "speedy decision-making is a crucial protection for claimants who need either medical care or the replacement income that disability benefits provide." 65 Fed. Reg. 70,248. Thus, for review of a disability claim denial, the new regulation shortens the review period from 60 to 45 days, and restricts the "quarterly meeting" rule to multiemployer plans, providing that:

> (3) Disability Claims. (i) Except as provided in paragraph (i)(3)(ii) of this section, claims involving disability benefits (whether the plan provides for one or two appeals) shall be governed by paragraph (i)(1)

> of this section, except that a period of 45 days shall apply instead of 60 days for purposes of that paragraph.
>
> (ii) In the case of a multiemployer plan with a committee or board of trustees designated as the appropriate named fiduciary that holds regularly scheduled meetings at least quarterly, paragraph (i)(3)(i) of this section shall not apply, and the appropriate named fiduciary shall instead make a benefit determination no later than the date of the meeting of the committee or board that immediately follows the plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the plan's receipt of the request for review. If special circumstances ... require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the committee or board following the plan's receipt of the request for review.

29 C.F.R. § 2560.503-1(i)(3)(i), (ii).

The claims regulation was issued after notice-and-comment rulemaking pursuant to an express delegation of authority to the Secretary to determine procedures for full and fair review of benefit denials, 29 U.S.C. § 1133. Therefore, the regulation's terms govern and are entitled to full deference. Chevron U.S.A., Inc. v. Natural Res. Def. Council, Inc., 467 U.S. 837, 842-43 (1984). The Secretary's interpretation of her own regulation, whether stated in a contemporaneous preamble to the regulation or in later guidance, is likewise entitled to the highest degree of deference. See, e.g., Yellow Trans., Inc. v. Michigan, 537 U.S. 36, 45 (2002) (giving Chevron

deference to interpretation that was made in regulatory preamble); Auer v. Robbins, 519 U.S. 452, 462 (1997) (same for interpretation presented in brief).

2. The Plan Administrator Failed To Meet Applicable Deadlines

Under the plain terms of the regulatory provision applicable to disability claims, the claims administrator had 45 days in which to decide the claim. In order to extend this time, the plan administrator was required to provide written notice to the claimant prior to the end of the initial 45-day period. 29 C.F.R. § 2560.503-1(i)(1)(i); (i)(3)(i). The CAIS Committee failed to issue a decision within the 45-day period and did not provide written notice required for an extension.

Moreover, the regulatory provision applicable to disability benefit plans expressly limits the applicability of the "quarterly meeting" rule to multiemployer plans. Because the Plan at issue is not a multiemployer plan, the district court erred in holding that the regulation, as applicable to the facts of this case, "permits plans with a committee to make determinations based on their schedule of quarterly meetings, rather than the redacted 45-day period outlined" elsewhere in the regulation. 1 ER 19-20. This plain reading of the regulation is bolstered by the preamble, which, like the regulation itself, expressly states that an "extension of time for plans administered by boards of trustees or committees that meet at least quarterly is available, under the

regulation, only for multiemployer plans," 65 Fed. Reg. 70,248 n.10 (emphasis added), because the Department believed that, as a result of the employee representation on multiemployer plan committees, such plans would delay appeals "only when it is necessary and not harmful to claimants." Id. Similarly, Department of Labor guidance states that, for disability claims, the "quarterly meeting" rule is exclusively available to multiemployer plans with a committee or board of trustees. FAQ D-7 of the Department's Questions and Answers on this issue indicates that timing provisions, such as the "quarterly meeting" rule, are "special timing rules" applicable only to multiemployer disability plans with a committee or board of trustees. See Frequently Asked Questions about the Claims Procedure Regulation, FAQ D-7, at http://www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html ("FAQ D-7"). As set forth above, the Secretary's regulation is entitled to Chevron deference, and so are her interpretations of this regulation as stated in the preamble, the FAQ guidance document, and this brief. See, e.g., Yellow Trans., Inc., 537 U.S. at 45; Auer, 519 U.S. at 462.

Even under the rule applicable to multiemployer plans, the administration of Barboza's appeal was still not decided in a timely manner. Barboza appealed the claims denial on November 15, 2007, and the Claims Committee did not decide the appeal until April 21, 2008, 157 days after

Barboza appealed the initial denial of his claim. The "quarterly meeting" rule allows a multiemployer plan to make a benefit appeals denial determination at its next quarterly meeting. If the next meeting is within 30 days of the appeal, the determination can be made at the meeting immediately following that. 29 C.F.R. § 2560.503-1(i)(3)(ii). Thus, the longest possible delay between an appeal and a decision under the "quarterly meeting" rule is 120 days. The Committee in this case, which does not even expressly claim to meet quarterly, took 157 days to decide Barboza's claim. Under any reading of the claims regulation, Barboza's claim was not decided in a timely manner.

3. The Plan Failed To Establish And Maintain A Reasonable Claims Procedure, And Barboza Consequently Is Deemed To Have Exhausted His Administrative Remedies

Taken together, the statute and regulation generally reflect a preference that claimants exhaust plan procedures before filing a civil action. Diaz v. United Agr. Employee Welfare Ben. Plan and Trust, 50 F.3d 1478, 1483 (9th Cir.1995); Linder v. BYK Chemie USA Inc., 313 F. Supp.2d 88, 91 (D. Conn. 2004) ("although ERISA itself does not include an exhaustion requirement, there is a 'firmly established federal policy favoring exhaustion of administrative remedies in ERISA cases'") (citations omitted). The exhaustion requirement, however, presupposes that a plan has provided a

full and fair claims process, as mandated by the claims regulations. Thus, as the consequence for a failure to establish and follow reasonable claims procedures, section (l) of the claims regulation deems the claimant to have exhausted the plan procedures and gives the claimant the right to file suit without a need to exhaust the faulty process:

> In the case of the failure of a plan to establish or follow claims procedures consistent with the requirements of this section, a claimant shall be deemed to have exhausted the administrative remedies available under the plan and shall be entitled to pursue any available remedies under section 502(a) of the Act on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

29 C.F.R. § 2560.503-1(l). As the preamble to the regulation explains, "[a] plan's failure to provide procedures consistent with [the regulations'] standards would effectively deny a claimant access to the administrative review process mandated by [ERISA]." "At a minimum, claimants denied access to the statutory administrative review process should be entitled to take that claim to court … for a full and fair hearing on the merits of the claim." 65 Fed. Reg. 70,246 and 70,256 (Nov. 21, 2000). As with the "quarterly meeting" rule, the "deemed exhausted" rule and the Secretary's interpretation of it are entitled to Chevron deference.

Applying this regulation, courts have correctly concluded that where an administrator fails to decide a claim denial appeal within the applicable

time limits, the claimant is "deemed to have exhausted the administrative remedies available under the plan," and may file suit without waiting for a denial of his claim. Nichols v. Prudential Ins. Co., 406 F.3d 98 (2d Cir. 2005). Thus, the court in Nichols held that where a plan administrator misses the applicable deadline and the disability claimant filed suit 197 days after her initial appeal date, the claimant's "administrative remedies are therefore exhausted, removing any procedural obstacle to the present suit." Id. at 104; see also Neathery v. Chevron Texaco Corp. Group Accident Policy, 303 Fed. Appx. 485, 2008 WL 5233207, at *1 (9th Cir. 2008) (plaintiff properly brought suit once her "administrative remedies were 'deemed exhausted'" through the "passing of ERISA deadlines") (unpublished); Burke v. PriceWaterhouseCoopers LLP Long Term Disability Plan, 572 F.3d 76, 106 (2d Cir. 2009) (same). Here, the Committee issued its decision a full 157 days after Barboza appealed the initial denial of his claim, well after the 45-day deadline established by the regulation. This failure to decide the appeal of the claims denial within the applicable time limits entitled Barboza to immediate access to the courts under the regulation's "deemed exhausted" directive, and the district court erred in dismissing Barboza's suit.

Furthermore, under the regulation, a claimant is deemed to have exhausted the administrative remedies not only if administrators failed to follow reasonable procedures but also if the plan does not establish reasonable claims procedures as defined in the regulation. 29 C.F.R. § 2560.503-1(1); Eastman Kodak Co. v. STWB, Inc., 452 F.3d 215, 221 (2d Cir. 2006) ("The 'deemed exhausted' provision was plainly designed to give claimants faced with inadequate claims procedures a fast track into court"); Linder, 313 F. Supp. 2d at 94 ("the regulation is unequivocal that any failure to adhere to a proper claims procedure is sufficient to deem administrative remedies exhausted"). Here, the Plan's procedures, as written, are inconsistent with the claims regulation in numerous ways. As described above, the Plan sets forth time limits that are inconsistent with those in the regulation by providing that claims will be decided either within 60 days or under the "quarterly meeting" rule rather than under the 45-day time limit applicable under the relevant regulatory provision. In addition, the Plan also sets out two levels of administrative appeal (from the Claims Committee to the Executive Board), whereas the regulation forbids combining the use of the quarterly meeting rule with a second level of administrative appeal. See FAQ D-7 ("a multi-employer group health plan or a disability benefit plan could not, in a manner consistent with the regulation, rely on both the special

rules governing the maintenance of two appeal levels and the special rules for regularly scheduled boards of trustees or committee meetings"). Indeed, by requiring that a claimant whose claim is denied on the second-level appeal negotiate in good faith for 30 days before filing suit, the Plan, in effect, requires a third level of administrative appeal, which the regulation prohibits in all circumstances. Thus, the fiduciaries have not established a reasonable claims procedure in the first instance, and the claimant could have proceeded directly to court rather than submit to an invalid procedure. However, the claimant did attempt to have his claims decided under the Plan's procedures, and, at a minimum, must be deemed to have exhausted his administrative remedies when his claim was not decided in a timely manner. His suit for benefits, therefore, was properly before the district court.

4. The District Court Also Erred In Dismissing Plaintiff's Fiduciary Breach Claim Because Such Claims Are Not Subject To Exhaustion Requirements

Focusing exclusively on Barboza's claim for benefits, the district court dismissed his suit in its entirety for failure to exhaust. Count 2, however, is a fiduciary breach claim that seeks injunctive and other equitable relief under ERISA section 502(a)(3) to remedy the failure of the Plan fiduciaries to operate the Plan in compliance with ERISA's full and fair review requirement, as elaborated in the Secretary's claims regulation. This section

502(a)(3) claim is not simply a disguised or restated claim for benefits under section 502(a)(1)(B). Rather, it seeks to remedy a fiduciary breach through injunctive and other equitable relief that may include removing the fiduciaries and/or ordering them to reform the Plan to comply with ERISA. Unlike Barboza's claim under section 502(a)(1)(B), it does not seek to obtain or clarify benefits.[2]

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[2] Injunctions to prevent or correct violations of ERISA are not only expressly permitted under section 502(a)(3)(A) (permitting a civil action "to enjoin any act or practice which violates any provision of this title or the terms of the plan"), but are inherently equitable remedies. Great-West Life & Annuity Ins. Co. v. Knudson, 534 U.S. 211 n.1 (2002) (citing Reich v. Continental Casualty Co., 33 F.3d 754, 756 (7th Cir. 1994); 1 Dan B. Dobbs, Law of Remedies § 1.2, p. 11 (2d ed. 1993)). Thus, the Ninth Circuit has ruled that "equitable relief" includes injunctive relief necessary to put participants in the position they would have had but for the breach. Mathews v. Chevron Corp., 362 F.3d 1172, 1184 (9th Cir. 2004) (ordering Chevron to modify former employees' retirement-plan records to give them the benefits they would have received had Chevron not breached its fiduciary duties by "actively misinforming" them about their retirement options). See also Shaver v. Operating Eng'rs Local 428 Pension Trust Fund, 332 F.3d 1198 (9th Cir. 2003) (remanding to allow the plaintiff to pursue an order removing the fiduciaries or directing them to maintain records adequate to prepare the reports). While the Ninth Circuit has not addressed directly whether plan reformation is available as equitable relief under section 502(a)(3), a number of other circuits have recognized that reformation of plan terms may be available as an equitable remedy within the meaning of section 502(a)(3). See Nechis v. Oxford Health Plans, Inc., 421 F.3d 96, 103 (2d Cir. 2005) (reformation available where plan terms violate ERISA); Delgrosso v. Spang and Co., 769 F.2d 928, 936-39 (3rd Cir. 1985) (reformation where amendment illegal); Ross v. Rail Car Am. Group Disability Income Plan, 285 F.3d 735, 747 (8th Cir. 2002) (court dismissed case where the plaintiff challenged his employer's disability plan under section 502(a)(1)(B) because its terms allegedly violated ERISA's statutory

Because exhaustion is not required for claims of breach of fiduciary duty, the district court erred in dismissing this count on failure to exhaust grounds. The exhaustion requirement for ERISA benefit claims is rooted in an express statutory provision requiring plans to adopt procedures ensuring full and fair review in conformity with the Secretary of Labor's detailed regulations. See 29 U.S.C. § 1133; 29 C.F.R. § 2560.503-1(b) ("Every employee benefit plan shall establish and maintain reasonable procedures governing the filing of benefit claims, notification of benefit determinations, and appeal of adverse benefit determinations."). In accordance with ERISA's mandate for a full and fair claims process, courts, including this one, have uniformly required plaintiffs to avail themselves of these procedures before bringing suit in federal court to obtain benefits. Amato v. Bernard, 618 F.2d 559, 567 (9th Cir. 1980) ("It would certainly be anomalous if the same good reasons that presumably led Congress and the Secretary to require covered plans to provide administrative remedies for

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accrual provisions but observed that in light of Great-West, plaintiff had a claim for equitable reformation under section 502(a)(3)). And the Sixth Circuit has allowed claims to proceed for plan-wide injunctive relief under section 502(a)(3) based on systemic faulty claims administration or benefit calculations. Hill v. Blue Cross and Blue Shield of Michigan, 409 F.3d 710, 716-18 (6th Cir. 2005); Fallick v. Nationwide Mut. Ins. Corp., 162 F.3d 410, 420 (6th Cir. 1998).

aggrieved claimants did not lead the courts to see that those remedies are regularly used.").

In contrast, no provision of ERISA expressly or implicitly requires exhaustion of administrative remedies before a participant may bring a fiduciary breach claim in federal court under ERISA section 502(a)(3). This is not surprising because, in enacting ERISA, Congress expressly sought to protect "the continued well-being and security of millions of employees and their dependents" by imposing strict standards of conduct on plan fiduciaries, and providing "ready access to the Federal courts," to enforce those standards. 29 U.S.C. § 1001(a), (b). To this end, ERISA section 502(a)(3) provides that a civil action may be brought by a participant, beneficiary, or fiduciary to sue to "to enjoin any act or practice which violates" ERISA or "to obtain other appropriate equitable relief . . . to redress such violations" of ERISA's stringent fiduciary provisions (as well as the terms of the plan). Notably missing from sections 502(a)(3) is any requirement that the enumerated parties exhaust internal review procedures before bringing suit to remedy fiduciary breaches that harm the plan. Nor is there any other provision in ERISA indicating that Congress intended for an exhaustion requirement to apply in a suit for equitable or injunctive relief under this section.

The Supreme Court has repeatedly commented on "ERISA's interlocking, interrelated, and interdependent remedial scheme, which is in turn part of a 'comprehensive and reticulated statute.'" Mass. Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 146 (1986) (quoting Nachman Corp. v. Pension Benefit Guar. Corp., 446 U.S. 359, 361 (1980)). As the Supreme Court noted, "carefully integrated civil enforcement provisions found in § 502(a) of the statute as finally enacted . . . provide strong evidence that Congress did not intend to authorize other remedies" or presumably other procedural requirements "that it simply forgot to incorporate expressly." Russell, 473 U.S. at 146. Thus, the absence of any provision in the statute indicating that Congress intended for plaintiffs bringing suit under sections 502(a)(3) to first exhaust internal review procedures is telling.[3]

For this reason, the Ninth Circuit and numerous courts have correctly and repeatedly held that although ERISA implicitly requires a plaintiff to exhaust statutorily-imposed review procedures before bringing suit for payment of benefits under a plan, there is no exhaustion requirement applicable to fiduciary breach claims. See, e.g., Horan v. Kaiser Steel Retirement Plan, 947 F.2d 1412, 1416 n.1 (9th Cir. 1991); Fujikawa v.

[3] The same analysis is applicable to fiduciary breach claims under ERISA section 502(a)(2), 29 U.S.C. § 1132(a)(2), which, like claims under section 502(a)(3), are not subject to any exhaustion requirements.

Gushiken, 823 F.2d 1341, 1345 (9th Cir. 1987). See also Zipf v. AT & T Co., 799 F.2d 889, 891-92 (3d Cir. 1986); Smith v. Sydnor, 184 F.3d 356, 364 (4th Cir. 1999); Milofsky v. American Airlines, Inc., 442 F.3d 311, 312 (5th Cir. 2006) (en banc); Richards v. General Motors, 991 F.2d 1227 (6th Cir. 1993); Burds v. Union Pacific Corp., 223 F.3d 814, 817 (8th Cir. 2000); Held v. Manufacturers Hanover Leasing Corp., 912 F.2d 1197 (10th Cir. 1990); but see Bickley v. Caremark RX, Inc., 461 F.3d 1325, 1328 (11th Cir. 2006). Because "there is no statutory requirement for an appeals procedure respecting claims not involving benefits, the logic of the exhaustion requirement no longer applies." Licensed Div. Dist. No. 1 v. Defries, 943 F.2d 474, 479 (4th Cir. 1991) (citations omitted). Thus, the primary reason for requiring exhaustion of benefit claims – the statutory text requiring a claims procedure – does not support requiring exhaustion of claims for breach of fiduciary duties.

Nor do the other reasons on which courts have relied in requiring exhaustion of benefit claims support requiring exhaustion of fiduciary breach claims. In the benefit context, the plan fiduciary is usually given discretionary authority to interpret the plan and to make benefit claim determinations, which are generally subject to a deferential standard of review. Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 111, 109 S.

Ct. 948, 954-55 (1989). In contrast, fiduciary breach claims (at least ones that do not require interpretation of disputed plan terms) do not "implicate[] the expertise of a plan fiduciary" but instead "involve[] an interpretation and application of a federal statute, which is within the expertise of the judiciary." Smith, 184 F.3d at 365. Accordingly, this "justification[] for an exhaustion requirement in other contexts, deference to administrative expertise, is simply absent." Zipf, 799 F.2d at 893. For these reasons, the district court had no basis for dismissing Count 2, Barboza's claim for fiduciary breach.

CONCLUSION

For the foregoing reasons, the Secretary respectfully requests that the Court reverse the decision of the district court dismissing this case.

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CERTIFICATE OF COMPLIANCE OF BRIEFS
AND VIRUS CHECK

Pursuant to Rules 32(a)(7)(B) and (C), Fed. R. App. P., I certify that this amicus brief uses a mono-spaced typeface of 14 characters per inch and contains four thousand four hundred and thirty-five (4,435) words.

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Dated: June 15, 2010

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CERTIFICATE OF SERVICE

I hereby certify that on the 15th day of June, 2010, true and correct copy of the foregoing - THE SECRETARY OF LABOR'S AMICUS CURIAE BRIEF IN SUPPORT OF PLAINTIFF-APPELLANT-was filed electronically with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the appellate CM/ECF system and served electronically via email to the following counsel at the addresses set forth below:

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