Johnson v. Balt. Cty., Civil Action No. 11-cv-3616, 2012 U.S. Dist. LEXIS 92154 (D. Md. July 3, 2012).

A remaining question to be resolved by the courts is likely the pattern and practice exception to the "de minimis" exception, which does not appear to have been discussed (or raised) in any of the recent cases.

Conclusion and Take Away

The DOL has created new procedures in order to maintain ongoing, open communication between the insurer and insured, while helping relieve the insured's financial hardship. The express departure from a substantial compliance standard to the now codified "de minimis" violation standard is expected to bring about increased litigation. Review of recent case law since the Second Circuit's decision in Halo does, however, not necessarily suggest that the outcome of cases challenging the timeliness of benefit determinations will be vastly different from during the substantial compliance era. Indeed, while several district courts continue to apply the substantial compliance doctrine in deciding cases under the "old" regulations, they have been addressing the Halo factors alongside with the substantial compliance assessment with the same result.

While there are certainly many questions that remain, *e.g.* regarding the effects of the pattern and practice exception to the "de minimis" standard, it stands to hope that the departure from the substantial compliance standard may not bring about as sweeping changes in the case law as initially presumed. Based on the review of current case law post Halo and certainly the wording of the new regulations, it appears advisable from a claims handling perspective to remember to always maintain a meaningful dialogue with the claimant during the initial as well as during the appeal phase, providing updates relative to the status of the review, information obtained and still needed as well as steps completed and intended.

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When Payment of Plan Benefits Make Beneficiaries Whole They Get What They Get and They Can't Get Upset

Life Insurance Benefit Plan Settlement Option Litigation and ERISA's Remedial Scheme

By Ian S. Linker

Several insurers offer beneficiaries of group life insurance plans governed by the Employee Retirement Income Security Act of 1974 ("ERISA") the option of receiving payment of their benefits into a specialized account, akin to a checking account. Under this settlement option, beneficiaries receive a book of drafts, not dissimilar from a check book. They can immediately withdraw the full amount of the benefits by writing a single draft for the entire balance or use the drafts as they see fit over time. The beneficiaries receive interest on the benefits while the funds are in the account ("settlement-option account"), as if it was a bank account. And the insurance companies typically retain the funds in their general accounts to generate investment income as long as there are funds in the account, just like a bank. Everybody wins. Right? Not so fast.

Settlement-Option-Account Litigation

Many of these beneficiaries have filed lawsuits, including multiple putative class actions, against the insurers, which act as ERISA-plan claim fiduciaries, alleging the fiduciaries did not pay benefits in accordance with plan terms and therefore, breached their fiduciary duties under ERISA by:

- paying plan benefits into these accounts, instead of issuing a single check, and
- retaining and generating investment income on the funds.

Because the fiduciaries earned a profit on the funds, the plaintiffs sought disgorgement of these profits in amounts far exceeding the amount of the plan benefits. The results have been a mixed bag, with multiple courts agreeing with the plaintiffs that the fiduciaries breached their fiduciary duties, because they did not comply with the respective plan, some of which require payment into settlement-option accounts and others do not, but make the accounts available to beneficiaries. But the courts could be looking at these cases from a different perspective.

ERISA's Remedial Scheme

ERISA is a "comprehensive and reticulated statute," with a "carefully crafted and detailed enforcement scheme," providing "strong evidence that Congress did not intend to authorize other remedies that it simply forgot to incorporate expressly." G*reat-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002). Courts should therefore be "especially reluctant to tamper with the enforcement scheme embodied in the statute by extending remedies not specifically authorized by its text." Id.

ERISA's remedial scheme is found in 29 U.S.C. §1132. Congress set forth therein who may file suit and for what type of relief. Under 29 U.S.C. §1132(a):

> A civil action may be brought—
>
> (1) by a participant or beneficiary—
>
> (A) for the relief provided for in subsection (c) of this section, 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.

Plan participants and beneficiaries assert claims for benefits under 29 U.S.C. §1132(a)(1)(B). They may assert claims for breach of fiduciary duty under 29 U.S.C. §1132(a)(2) on behalf of a plan that suffers a loss. And participants and beneficiaries may assert individual claims for breach of fiduciary duties under 29 U.S.C. §1132(a)(3) "to obtain other appropriate equitable relief."

Varity and Its Progeny

Only "appropriate equitable relief" is available under 29 U.S.C. §1132(a)(3). The Supreme Court in *Varity Corp. v. Howe*, 516 U.S. 489 (1996), held "where Congress elsewhere provided adequate relief for a beneficiary's injury," relief, even if equitable, is not appropriate under §1132(a)(3); thus, is unavailable under that section.

In *Rochow v. Life Ins. Co. of N. Am.*, 780 F.3d 364 (6th Cir. 2015)(en banc), the Sixth Circuit decided an issue, similar to the issue considered in *Varity*: whether a plan participant is entitled to recover both benefits under 29 U.S.C. §1132(a)(1)(B) and damages for breach of fiduciary duty under 29 U.S.C. §1132(a)(3), when what the participant really complains about under both causes of action is ultimately an improper denial or payment of plan benefits.

The defendant in *Rochow*, an ERISA-plan fiduciary, denied plaintiff's claim for long-term disability benefits under an ERISA plan. Plaintiff sued. And the court awarded plaintiff benefits under 29 U.S.C. §1132(a)(1)(B). Plaintiff also asserted a cause of action under 29 U.S.C. §1132(a)(3) for disgorgement of the investment income the defendant earned on the unpaid plan benefits. The district court and a Sixth Circuit panel ordered disgorgement of a massive sum, all because the fiduciary had commingled the unpaid benefits with its general assets. Sitting en banc and relying heavily on *Varity*, the court of appeals disagreed and reversed.

Rochow recognized that Congress designed ERISA's remedial scheme the way it did because it was "concerned with the adequacy of relief to redress the claimant's injury, not the nature of the defendant's wrongdoing." The Court held that the district court and the panel erred because, "[i]nstead of focusing on the relief available to make [plaintiff] whole, the award reflects concern that [the fiduciary] had wrongfully gained something, a consideration beyond the ken of ERISA make-whole remedies." The Court emphasized that a "claimant cannot pursue a breach-of-fiduciary-duty claim under §[1132](a)(3) based solely on an arbitrary and capricious denial of benefits where the §[1132](a)(1)(B) remedy is adequate to make the claimant whole." Because the plaintiff had not demonstrated that the benefits he recovered, "plus the attorney's fees awarded, plus the prejudgment interest that *may* be awarded on remand, [were] inadequate to make

[plaintiff] whole, … there is no trigger for 'further equitable relief' under *Varity*." (Emphasis in original).

The Court expressed its concern that if an improper benefit determination "implicated a breach of fiduciary duty entitling the claimant to disgorgement of the defendant's profits in addition to recovery of benefits, then equitable relief would be potentially available whenever a benefits denial is held to be arbitrary or capricious." This outcome, the court recognized, would be "inconsistent with ERISA's purpose to make claimants whole."

The plaintiff in *Rochow* claimed two injuries: "the arbitrary and capricious denial of benefits, and the breach of fiduciary duty consisting of the continued withholding of the wrongfully denied benefits." The Court determined that these injuries were "indistinguishable" from each other, because plaintiff's "loss remained exactly the same irrespective of the use made by [the fiduciary] of the withheld benefits." Plaintiff's "injury was remedied when he was awarded the wrongfully denied benefits and attorney's fees," and "potentially" prejudgment interest.

The Court further noted:

> Despite Rochow's attempts to obtain equitable relief by repackaging the wrongful denial of benefits claim as a breach-of-fiduciary-duty claim, there is but one remediable injury and it is properly and adequately remedied under §[1132](a)(1)(B). Rochow and our dissenting colleagues wholly fail to explain *how* his §[1132](a)(1)(B) remedies are inadequate to remedy his *injury*.

(Emphasis in original). If *Rochow* stands for nothing else, it holds that equitable relief under 29 U.S.C. §1132(a)(3) is not appropriate, as expressly required, if a plaintiff has a viable remedy elsewhere in ERISA's remedial scheme and the other remedy would make him or her whole.

Ogden v. Blue Bell Creameries U.S.A., Inc., 348 F.3d 1284 (11th Cir. 2003), stands for a similar principle. In that case, the Eleventh Circuit addressed whether a plaintiff could seek equitable relief under 29 U.S.C. §1132(a)(3) for plan benefits when *res judicata* bars the claim for benefits under 29 U.S.C. §1132(a)(1)(B). After an Alabama state court *sua sponte* dismissed the plaintiffs' suit for benefits on procedural grounds, plaintiffs filed a second suit in Alabama state court. The defendant removed the action because ERISA preempted plaintiffs' claims. The district court held *res judicata* barred plaintiffs' claim, but that plaintiffs were entitled to equitable relief under 29 U.S.C. §1132(a)(3), even though plaintiffs never sought it.

The district court reasoned that because the fiduciary had failed to review plaintiffs' claim in good faith, it breached its fiduciary duties. The fiduciary appealed. The Eleventh Circuit held that equitable relief under 29 U.S.C. §1132(a)(3) is inappropriate; thus, unavailable, where 29 U.S.C. §1132(a)(1)(B) affords an adequate remedy. This is true, the Court noted, even if a plaintiff does not prevail in his or her claim for benefits under §1132(a)(1)(B). The Court stated:

> our analysis is in no way altered by the fact that the Ogdens' Section [1132](a)(1)(B) claim is now barred by res judicata. At the time the Ogdens' cause of action arose, Section [1132](a)(1)(B) provided them with an adequate remedy. We refuse to grant plaintiffs in the Ogdens' position two bites at the apple by according them a second ERISA cause of action *solely because their first ERISA cause of action was unsuccessful*. The central focus of the *Varity* inquiry involves whether Congress has provided an adequate remedy for the injury alleged elsewhere in the ERISA statutory framework. … Thus, it is irrelevant for *Varity* purposes that the Ogdens no longer have a viable Section [1132](a)(1)(B) claim.

(Emphasis in original; citations and internal quotations omitted).

The outcome in *Korotynska v. Metropolitan Life Ins. Co.*, 474 F.3d 101 (4th Cir. 2006), was no different. There, the plaintiff asserted a claim on behalf of herself and a putative class for breach of fiduciary duties under 29 U.S.C. §1132(a)(3), but did not assert a claim for benefits under 29 U.S.C. §1132(a)(1)(B), reserving her right to assert it at a later time. Indeed, the plaintiff expressly maintained she was "not seeking individualized review of her" benefit claim. She argued that the defendant claim administrator engaged in improper claims procedures to deprive her of a full and fair review of its adverse long term disability benefits determination in violation of its fiduciary duties under ERISA.

The Court considered whether 29 U.S.C. §1132(a)(3) could adequately redress the plaintiff's alleged injury. The Court stated that "there is no question that what plaintiff is pressing is a claim for individual benefits" and "the only injury" the plaintiff complains about "is the termination of benefits and the resulting financial harm to her." Applying *Varity*, the Court recognized that there is "no question that [the plaintiff's] injury is redressable elsewhere in ERISA's scheme." The Court continued:

> Section 1132(a)(1)(B) allows plan participants to obtain individualized review of an allegedly wrongful denial of benefits. The plaintiff's injury here—denial of benefits by the plan administrator—plainly gives rise to a cause of action under §1132(a)(1)(B) and as such would usually be appealed under that provision. … The fact that the plaintiff has not brought

> an §1132(a)(1)(B) claim does not change the fact that benefits are what she ultimately seeks, and that redress is available to her under §1132(a)(1)(B).

The Court held that even though the plaintiff had not asserted a cause of action under 29 U.S.C. §1132(a)(1)(B), that section "affords the plaintiff adequate relief for her benefits claim, and a cause of action under §1132(a)(3) is thus not appropriate."

History of the Settlement-Option-Account Cases Under ERISA

Such should be the outcome in the settlement option account cases, in which the plaintiffs typically allege that:

- in setting up the accounts, the plan fiduciary—payor of benefits—failed to properly pay benefits in accordance with the terms of the plan; thus, breaching its fiduciary duties; and
- the fiduciary wrongfully retained and profited from the retained funds, a prohibited transaction under ERISA, and a further breach of fiduciary duty.

The defendant fiduciaries typically argue that they were not acting as a fiduciary when they established the accounts and invested the funds for profit, and even if they were, the complained-of conduct was not a breach of fiduciary duty. The litigants have drawn these battle lines from the beginning. There is a common thread among these cases, however, the significance of which the courts and parties have thus far overlooked. And a quick summary of the cases will help draw out the common thread.

In *Mogel v. Unum Life Ins. Co.*, 547 F.3d 23 (1st Cir. 2008), the First Circuit reversed the district court's dismissal of plaintiff beneficiaries' breach of fiduciary duty claims under ERISA for failure to state a claim. The plan in *Mogel* stated: "[u]nless otherwise elected, payment for loss of life will be made in one lump sum." The defendant plan fiduciary deposited the plan benefits into settlement-option accounts and sent the beneficiaries a draft book and a letter explaining that the funds were on deposit, that plaintiffs could write drafts on the benefits, and that they would receive interest on the account. The defendant moved to dismiss and argued that it was acting as a fiduciary when it approved payment, but that it was not acting as a fiduciary when it established the accounts and invested the proceeds.

The court of appeals found that "delivery of the checkbook did not constitute a 'lump sum payment' called for by the" plan and that the fiduciary "cannot be said to have completed its fiduciary functions under the plan when it set up the … [a]ccounts and mailed the checkbooks, retaining for its use the funds due until they were withdrawn." In other words, the fiduciary failed to pay benefits in accordance with the terms of the plan and continued to act as a fiduciary when it retained the funds.

In *Faber v. Metropolitan Life Ins. Co.*, 648 F.3d 98 (2d Cir. 2011), the plan language and the outcome were different, but the arguments were the same. Unlike the First Circuit in *Mogel*, the Second Circuit in *Faber* affirmed the district court's dismissal on the grounds that the fiduciary paid benefits in accordance with the plan terms. One of the two plans at issue in *Faber* stated:

> Payment of a death benefit of $7,500 or more is made [into a bank account]. The death benefit amount is deposited in an interest bearing money market account and your beneficiary is provided with a checkbook to use for writing checks to withdraw funds. Other payment options are available. However, if the total death benefit is less than $7,500, a lump sum payment will be made.

The Court invited the Department of Labor to opine on the issue. The DOL stated that the fiduciary discharged "its ERISA fiduciary duties by furnishing beneficiaries a [settlement-option account] in accordance with plan terms and does not retain plan benefits by holding and managing the assets that back the [account]." According to the DOL, once the fiduciary "creates and credits a beneficiary's [settlement-option account] and provides a checkbook, the beneficiary has effectively received a distribution of all the benefits that the Plan promised," and "ERISA no longer governs the relationship between [the fiduciary] and the … account holder[]."

Relying heavily on the DOL, the Second Circuit affirmed. Because the fiduciary paid benefits in accordance with the terms of the plan, unlike the fiduciary in *Mogel*, where the plan did not require payment into a settlement-option account, the Court found the fiduciary was no longer acting as a fiduciary once it set up the account and credited it with the plan benefits. Distinguishing *Mogel*, the Second Circuit recognized that the First Circuit found for the plaintiff in that case because the fiduciary there had not paid benefits in accordance with the terms of the plan, while the fiduciary in *Faber* had.

The plan at issue in *Edmonson v. Lincoln Nat'l Life Ins. Co.*, 725 F.3d 406 (3d Cir. 2013), was a bit different. The plan stated:

> "[u]pon receipt of satisfactory proof of a Dependent's death while insured under this Policy, the Company will pay the amount of the Dependents [sic] Life Insurance in

> effect on the date of such death," and that "[a]ny benefits payable under this Policy will be paid immediately after the Company receives complete proof of claim."

So unlike the plan in *Mogel*, requiring the fiduciary to pay benefits as a lump-sum, and unlike the plans in *Faber*, requiring payment into a settlement-option account, the plan in *Edmonson* was silent with respect to method of payment. The plan only required immediate payment. On the fiduciary's claim form, however, the fiduciary stated that its "usual method of payment is to open a [settlement-option account] in the beneficiary's name." The plaintiff beneficiary submitted a claim for $10,000 in plan benefits. The fiduciary opened an account in plaintiff's name and sent her a draft book. Three months later, plaintiff withdrew the entire amount and the fiduciary paid her the interest owed.

Plaintiff sued under ERISA arguing the fiduciary breached its fiduciary duties by using a settlement-option account and investing the proceeds for its own profit. Plaintiff sought disgorgement of the fiduciary's profits. The court held that:

> [b]ecause the [plan] here is silent as to the form of payment, [the fiduciary] had discretion as to how to comply with its requirements, under its contractual obligations and, as we concluded above, under ERISA. Accordingly, [the fiduciary] fulfilled its obligation to pay [plaintiff] when it established the [account].

Yet again, *Edmonson* turned on whether the fiduciary paid benefits in accordance with the terms of the plan and recognizing the plan granted the fiduciary discretion to construe the plan, the court refused to reverse the benefit determination, much like it would have if applying the abuse of discretion standard of review to an adverse benefit determination under 29 U.S.C. §1132(a)(1)(B).

Similar to the plan in *Faber*, the plan in *Merrimon v. Unum Life Ins. Co.*, 758 F.3d 46 (1st Cir. 2014), required the plan fiduciary to make settlement-option accounts available to the beneficiaries of life insurance plan benefits. Even though the fiduciary in the case paid benefits into the accounts, the plaintiffs nevertheless sued for breach of fiduciary duties. The First Circuit recognized that "fiduciary duties relate principally to ensuring that monies owed to beneficiaries are disbursed in accordance with the terms of the plan." In *Merrimon*, the court concluded that the fiduciary did precisely that; paid benefits in accordance with the terms of the plan.

In denying defendant's motion for summary judgment on plaintiffs' breach of fiduciary duty claims, the court in *Owens v. Metropolitan Life Ins. Co.*, 210 F. Supp. 3d 1344 (N.D. Ga. 2016), concluded that because the plan there required payment of life insurance benefits in a lump sum, "the creation of the [settlement-option account] in [plaintiff's] name and delivery of a blank draftbook [sic] did not satisfy this requirement of the [plan]." In other words, the court in Owens found that the defendant breached a fiduciary duty by not adjudicating benefit claims in accordance with the plan terms.

In *Huffman v. Prudential Ins. Co. of Am.*, 2017 U.S. Dist. LEXIS 201440 (E.D. Pa. Dec. 6, 2017), the court granted plaintiffs' motion for summary judgment for breach of fiduciary duty. The fiduciary paid life insurance plan benefits into a settlement-option account. The court found for plaintiffs even though the plan's summary plan description ("SPD") required payment into the accounts. The plan, however, required payment in a lump sum. The court reasoned that because the SPD stated the plan governed when there were discrepancies between the plan and the SPD, the plan governed. Thus, because the plan required the fiduciary to pay plan benefits in a lump sum and it did not, the fiduciary breached its fiduciary duties.

How *Varity* and Its Progeny Should Impact Settlement-Option-Account Litigation

Every single one of these cases turned on whether the fiduciary paid benefits in accordance with the plan. But not every one of these plaintiffs prevailed on his or her claim for breach of fiduciary duty under 29 U.S.C. §1132(a)(3). In some of the cases, where the court found the defendant fiduciary failed to pay benefits in accordance with plan terms, *e.g.*, the lump-sum cases, the court found a breach. In the other cases, where the court found the fiduciary paid benefits in accordance with the terms of the plan, *e.g.*, the mandating-payment-into-a-settlement-option-account cases and the immediate-payment cases, the court found no breach.

Typically, plaintiffs complaining of an improper benefit determination, *e.g.*, improper payment or improper denial of benefits, will file suit under 29 U.S.C. §1132(a)(1)(B) to remedy their injury. Arguably, however, as the court in *Rochow* warned, every improper determination constitutes a breach of fiduciary duty, because the fiduciary is obligated to adjudicate claims in accordance with the terms of the plan. But because 29 U.S.C. §1132(a)(3) is a catchall and plaintiffs seeking to remedy an improper benefit determination would have a viable cause of action under 1132(a)(1)(B), relief under 1132(a)(3) is unavailable to plaintiffs seeking to remedy the breach.

And that is how the courts should be deciding the settlement-option-account cases. As in *Korotynska*, the plaintiffs' first alleged injury in these cases is that the fiduciaries failed to pay benefits properly, *i.e.*, in accordance with the terms of the plan. And as in *Rochow*, the plaintiffs' second alleged injury, the profits the fiduciary earned on the funds in the accounts, is indistinguishable from the injury allegedly arising from the improper payment of benefits, because plaintiff's "loss remained exactly the same irrespective of the use made by [the fiduciary] of the withheld benefits," even if the defendant fiduciary profits from investing the retained funds. Thus, because these beneficiaries claimed that the plan fiduciary did not pay benefits in accordance with the terms of the plan, they should have brought their actions under 29 U.S.C. §1132(a)(1)(B) to enforce their rights under the plan. So under the reasoning of *Varity*, *Rochow*, *Ogden*, *Korotynska*, and their progeny, because the plaintiffs in these cases had viable claims for benefits under 29 U.S.C. §1132(a)(1)(B) to enforce their rights under the plan, even if they do not ultimately prevail in or even assert a claim under §1132(a)(1)(B), their claims under 29 U.S.C. §1132(a)(3) should have failed as a matter of law. Accordingly, because the plaintiffs should have sued under §1132(a)(1)(B), the courts should not be entertaining the claims under §1132(a)(3).

So what would one of these suits under 29 U.S.C. §1132(a)(1)(B) look like? Hypothetically, a group life insurance beneficiary submits to a plan fiduciary a claim for benefits under an ERISA plan. The plan requires a lump-sum payment of benefits and may, or may not, grant the fiduciary discretionary authority to construe the plan. But instead of issuing a check to the beneficiary, the fiduciary establishes a settlement-option account and sends a draft book to the beneficiary. If the beneficiary objects to this method of payment, he or she would potentially need to exhaust the plan's administrative remedies before filing suit and request a check from the fiduciary. The fiduciary could reverse and simply shut down the account and issue the check, which would certainly be the cleanest and least costly outcome, or not.

If the beneficiary chooses not to object to the fiduciary, but instead decides to run into court and file suit, the fiduciary could move to dismiss on failure-to-exhaust-administrative-remedies grounds. A court would likely grant the motion in one form or another, because the exhaustion requirement is a universal principle in ERISA litigation and a prerequisite to filing suit, though there is a question given the crux of the dispute, *i.e.*, the method of payment, whether ERISA's notice requirements; thus, the exhaustion requirement would be implicated. *See*, *e.g.*, *Pompano v. Michael Schiavone & Sons, Inc.*, 680 F.2d 911 (2d Cir. 1982) (court affirmed pension committee's determination regarding method of payment when pension plan granted committee authority to make such determinations). Perhaps at that point the court would remand and allow the beneficiary to object directly to the fiduciary. And then, again, the fiduciary could reverse, or not.

But what if the fiduciary decides not to reverse? It looks at the facts and the plan language, considers whether the beneficiary already depleted the account, or simply concludes payment via bank account satisfies the plan's lump-sum-payment requirement. The beneficiary could decide at that point whether to pursue in court his or her request for a check. If the plan grants the fiduciary discretionary authority, the court's review, depending on the jurisdiction, of course, would be for an abuse of discretion. (Courts would review these determinations *de novo* if the plan does not grant discretionary authority or if a state ban on discretionary clauses applies.) There likely would be little, if any, discovery. The court's review would be limited to the administrative record compiled by the fiduciary. The court would affirm the determination to pay plan benefits via settlement-option account, unless the beneficiary could show the determination was unreasonable, an uphill battle for sure. If the court determines the fiduciary abused its discretion, or incorrect under *de novo* review, then the fiduciary would decide whether to appeal. If it decided to accept the court's judgment, it would issue a check, presumably less any funds already taken out of the account by the beneficiary, possibly pay prejudgment interest, and likely reimburse the beneficiary for his or her attorneys' fees.

Varity's principle is well-established in ERISA litigation: A court should dismiss a claim for breach of fiduciary duties if the plaintiff has a viable claim for benefits or some other remedy under ERISA and the multiple alleged injuries are in reality indistinguishable from each other. The principle should apply neatly in the settlement-option-account-litigation context where the plaintiffs do not allege a separate injury or a discrete wrong beyond the alleged improper benefit-payment determination. Accordingly, defendants in these cases should assert *Varity* and its progeny as an independent basis to defeat plaintiffs' claims for breach of fiduciary duty.

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