CHAPTER 15

ERISA

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§ 15.1 ERISA "Stock Drop" Cases

§ 15.1.1 Five Years after Enron?

We live in a post-Enron world. When Enron stock plunged from $30.00 to a few pennies per share during 2001, a lot more than money was lost. Along with nearly all of the equity invested in one of America's most heavily capitalized corporations, went people's confidence in the integrity of their ERISA-regulated[1] retirement plans. All told, 11,000 Enron employees lost close to $1 billion in 401(k) plan savings.

Just as disappointed public shareholders bring federal securities fraud lawsuits when they suffer investment losses, so too do ERISA plan participants when they think plan fiduciaries have done bad things. Following Enron, similar "stock drop" ERISA cases allege that plan fiduciaries, like the Enron 401(k) plan fiduciaries, knew or should have known that company stock was not a prudent retirement plan investment, yet they allowed participants to accumulate it anyway.

Litigating cases involving a drop in the price of employer stock held by employee benefit plans is different from securities fraud lawsuits. In the words of the Supreme Court: "ERISA is a comprehensive and reticulated statute." *Nachman Corp. v. Pension Benefit Guaranty Corp.*, 446 U.S. 359, 361 (1980). There are different types of stock plans, different legal standards, different procedural considerations, and different types of discovery. As a result, the case law has developed in fits and starts.

Stock drop cases do, however, follow a familiar pattern. Company stock is offered as an investment vehicle in the company's retirement plan. The company stock price precipitously declines and retirement plan participants sue, alleging the plan's fiduciaries knew or should have known that employer stock was not a prudent investment option for the plan. *See e.g., In re WorldCom, Inc.*, 263 F. Supp.

1. Employee Retirement Income Security Act of 1974 ("ERISA").

2d 745 (S.D.N.Y. 2003); *Rankin v. Rots (Kmart)*; 278 F. Supp. 2d 853, 875-877 (E.D. Mich. 2003); *In re Dynegy Inc. ERISA Litigation*, 309 F. Supp. 2d 861 (S.D. Tex. 2004); *In re Enron Corp. Securities, Derivative & ERISA Litig.*, 284 F. Supp. 2d 511, 601 (S.D. Tex. 2003).

ERISA stock drop cases are often brought in tandem with lawsuits alleging securities law violations. The ERISA stock drop lawsuit has a certain sex appeal for plaintiffs' lawyers compared to class action securities litigation. While the Private Securities Litigation Reform Act of 1995 ("PSLRA") requires plaintiffs to plead fraud with particularity, and while the PLSRA stays all discovery pending resolution of the adequacy of the pleadings, ERISA does not. Most courts do not require ERISA plaintiffs to "plead fraud with particularity," when alleging a fiduciary breach under ERISA. *See, e.g. Pietrangelo v. NUI Corp.*, 2005 WL 1703200 at *9 (D.N.J Jul. 20, 2005) (declining to apply heightened pleading standard unless the fraudulent act itself is the alleged fiduciary breach); *In re Electronic Data Sys. Corp. ERISA Litig.*, 305 F. Supp. 2d 658, 672 (E.D. Tex. 2004) (heightened pleading does not apply unless plaintiffs plead breach of duty is part of a scheme to defraud.)

Three basic claims tend to populate most ERISA stock drop complaints: (1) the "why did you let me invest my money in your crummy stock?"—the imprudent investment claim; (2) the "why didn't you tell me the company stock was going to tank?"—the failure to disclose claim; and (3) "why didn't you monitor the bozos running our plan?"—the duty to monitor claim. The imprudent investment claim challenges the act of offering company stock as a plan investment when it was not prudent to do so. Theories of why it was imprudent to offer company stock include: knowledge of impending company collapse, knowledge of serious company mismanagement, and knowledge that the price of stock is inflated due to fraudulent activities. The failure to disclose claim is premised on the theory that plan fiduciaries made affirmative misrepresentations or did not disclose information that they knew would have a materially adverse affect on the price of stock. Courts have split on whether the failure to disclose claim runs afoul of securities laws. *Compare In Re McKesson HBOC Inc. ERISA Litigation*, 29 EBC 1229, 2002 WL 31431588 at *6 (N.D. Cal. Sept. 30, 2002), with *In re Enron Corp. Securities, Derivative & ERISA Litig.*, 284 F. Supp. 2d 511, 601 (S.D. Tex. 2003). Finally, the duty to monitor claim emanates from the idea that those who appoint plan fiduciaries have an independent duty to monitor and prevent their appointees from breaching any fiduciary duties owed to plan participants.

§ 15.1.2 The Requirement of Prudence

ERISA's "prudent man" standard requires plan fiduciaries to diversify plan investments so as to "minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so." ERISA § 404(a)(1)(C), 29 U.S.C. § 1104(a)(1)(c). However, Congress exempted fiduciaries of "eligible individual account plans", including 401(k) plans and ESOP's ("EIAP") from the diversification requirements of the prudent man standard. *See* ERISA § 404(a)(2),

29 U.S.C. § 1104(a)(2). Even though the statute says the diversification rule does not apply to these plans, courts have held that when the value of employee stock plummets, ERISA's prudence requirement may require EIAP fiduciaries to diversify investments.

§ 15.1.2.1 A Presumption of Prudence?

The Third Circuit in *Moench v. Robertson*, 62 F.3d 553 (3rd Cir. 1995), followed by the Sixth Circuit in *Kuper v. Iovenko*, 66 F.3d 1447 (6th Cir. 1995), adopted a prudence standard for EIAP fiduciaries, which states the law presumes an investment in employer stock is prudent. The presumption of prudence, however, can be overcome by showing that the fiduciary was asleep at the wheel (*i.e.*, they "abused their discretion") by holding on to the employer stock when prudent investors knew it was going to tank. *Moench*, 62 F.3d at 571. To overcome the presumption of prudence, a "plaintiff must show that the ERISA fiduciary could not have believed reasonably that continued adherence to the [plan's terms] was in keeping with the settlor's expectations of how a prudent trustee would operate." *Id.* In a 2004 decision, the Ninth Circuit indicated the *Moench* and *Kuper* court's "presumption of prudence" standard may have been wrong. *Wright v. Oregon Metallurgical Corp.*, 360 F.3d 1090 (9th Cir. 2004). The *Wright* Court stated that *Moench's* "intermediate prudence standard is difficult to reconcile with ERISA's statutory text, which exempts EIAP's from the prudence requirement to the extent it requires diversification." *Id.* at 1097. Nonetheless, the Ninth Circuit blinked. They did not specifically disavow *Moench* and *Kuper*. Instead, they noted that "the facts of this case do not necessitate that we decide whether the duty to diversify survives the statutory text of §1104(a)(2)" because "[p]laintiffs' prudence claim is unavailing under any existing approach." *Id.* at 1097–98. Holding that even if *Moench* applied, plaintiffs' allegations were insufficient to state a claim, the Court explained:

> The published accounts of [the company's] earnings and financial fundamentals during the relevant period, attached to the complaint, demonstrate that [the company] was far from the sort of deteriorating financial circumstances involved in *Moench* and was, in fact, profitable and paying substantial dividends throughout that period... Mere stock fluctuations, even those that trend downward significantly, are insufficient to establish the requisite imprudence to rebut the *Moench* presumption...

Id. at 1098-99.

Two notable 2005 stock drop decisions are reviewed below that further explore the *Moench* presumption with differing outcomes.

§ 15.1.2.2 In re McKesson HBOC, Inc. ERISA Litigation

In 2005, the Northern District of California found the presumption of prudence standard articulated in *Moench* to be wrong. It explained that "fiduciaries can-

not be liable for failing to divest an ESOP of company stock." *In re McKesson HBOC, Inc. ERISA Litigation,* 391 F. Supp. 2d 812, 825 (N.D. Cal. 2005). According to the *McKesson* court, section 404 of ERISA "prohibits claims against fiduciaries for failing to diversify an ESOP." *Id.* at 829.

Following the 1999 merger of McKesson Corporation and HBO & Company ("HBOC"), McKesson merged HBOC's retirement plan with its own and participants in the HBOC plan received 0.37 shares of McKesson HBOC stock for each HBOC share held in their account. The McKesson retirement plan contained an "ESOP component under which McKesson Corporation 'matche[s] up to the first 6% of each participant's salary-deferral contributions' and makes supplemental contributions based on an employee's age and length of service." *Id.* at 816. Within months of completing the merger of the two corporations, McKesson HBOC announced that HBOC had engaged in accounting improprieties and would be restating its prior years' earnings downward by hundreds of millions of dollars. After these announcements, McKesson HBOC's sudden stock drop predictably resulted in the filing of multiple securities and ERISA class action lawsuits. The consolidated ERISA action alleged that the McKesson Corporation Board of Directors and the McKesson HBOC Board of Directors breached their fiduciary duties by failing to sell the company stock held in the ESOP before the merger, failing to sell stock after the merger and by continuing to contribute stock to the ESOP as the stock value declined.

The *McKesson* court analyzed the plaintiffs' claims under *Moench, Kuper* and *Wright.* Applying these cases, the *McKesson* court created a two-pronged test to determine whether a plaintiff has stated a claim for breach of fiduciary duty based on an ESOP fiduciary's failure to divest a plan of company stock. *McKesson* at 829-33. If, as was the case in *Moench,* the plan does not mandate that all assets of the plan be invested in employer stock, then the presumption of reasonableness set forth in *Moench* applies - and can be overcome with a showing that the fiduciary abused its discretion by investing in employer securities. *Id.*; *Moench* at 571 (holding that plaintiffs may rebut the presumption by "show[ing] that the ERISA fiduciary could not have believed reasonably that continued adherence to the ESOP's direction was in keeping with the settlor's expectations of how a prudent trustee would operate."). This showing does not require that the employer became insolvent or that the stock became worthless. *See McKesson* at 823 ("Common sense suggests that plaintiffs can prove that fiduciaries behaved "unreasonably" in various ways."). *McKesson* at 830. If, on the other hand, the plan mandates that all assets of the ESOP be invested in employer stock, then the higher standard set forth in *Wright* applies, and a plan fiduciaries' decision to retain employer stock will not be found "imprudent" unless the stock became worthless. As the *McKesson* court explained "a different rule should apply when a plaintiff claims that an ESOP fiduciary imprudently failed to *violate the plan.*" *McKesson* at 831.

The *McKesson* court also addressed another issue on which courts have split: Can an ERISA fiduciary be held liable for failing to trade company stock held in the company retirement plan based on insider information? Whereas the *Enron* court answered "yes", the *McKesson* court answered "no".

The plaintiffs in *McKesson* argued that the plan fiduciaries should have divested the plan of company stock before publicizing HBOC's accounting irregularities. *McKesson* at 836. In dismissing the plaintiffs' claims, the court looked to *In re Enron*, 284 F. Supp. 2d 511 (S.D. Tex. 2003) and ultimately rejected *Enron's* suggestions for dealing with the tension between ERISA and the securities laws when a section 404 fiduciary learns material, non-public information that threatens to impair the company's stock value. According to the *Enron* court, plan fiduciaries in possession of material inside information have a duty to disclose that information to the public or to force others at the company to do so. *Id.* at 565-66. Rather than construe ERISA and securities laws to conflict, the *Enron* court held that "the statutes should be construed to require, as they do, disclosure by Enron officials and plan fiduciaries of Enron's concealed, material financial status to the investing public generally, including plan participants, whether 'impractical' or not, because continued silence and deceit would only encourage the alleged fraud and increase the extent of injury." *Id.* at 565.

In response to the *Enron* court's conclusion that plan fiduciaries "disclose the information to other shareholders and the public at large," the *McKesson* court noted that while this would comply with the securities laws, "it would severely harm plan participants; indeed, any such disclosure would immediately cause the company's stock price to drop." *McKesson.* at 837, *citing West v. Prudential Securities, Inc.*, 282 F.3d 935, 938 (7th Cir. 2002) ("few propositions in economics are better established than the quick adjustment of securities prices to public information"). In response to the idea that plan fiduciaries selectively disclose information to plan participants, the *McKesson* court reasoned that "there are strong countervailing policy considerations. Indeed, selective disclosure would benefit plan participants at the expense of general shareholders." *Id.* The *McKesson* court noted that ERISA fiduciaries are not exempted from securities laws and are not permitted to trade on inside information. *See* 29 U.S.C. § 1144; *McKesson* at 837 ("a fiduciary cannot be liable for failing to utilize material, non-public information."). Based on this reasoning, the Court concluded that "a fiduciary... cannot be liable for failing to diversify a plan when doing so would mean engaging in insider trading." *Id.* at 838.

The *McKesson* court also noted that the plaintiffs failed to explain how disclosure of accounting irregularities would have avoided any loss to the Plan. "Even if [the defendant fiduciary] had disclosed the accounting irregularities... [the company stock price] presumably would have taken the same precipitous plunge and any argument otherwise would be pure speculation." *Id.* at 837, n.25.] Finally, the Court noted that "participants do not need a remedy under ERISA to obtain relief for a fiduciary's false statements or omissions; indeed, they can invoke the securities laws." *Id.* The *Enron* court recognized both of these points as well stating:

> If the material information about Enron's precarious financial status had been made public by Enron officials and plan fiduciaries in accordance with their legal obligations and the prices of the stock dropped before the plan participants could make a profit or reduce a substantial loss, the damage to the plan participants would not be

> the fault of the plan fiduciary but of the underlying alleged fraudulent Ponzi scheme and the corporate officials who participated in it, concealed it, and against whom the plan would have a cause of action.

Enron, supra, at 565.

§ 15.1.2.3 *In re Polaroid ERISA Litigation*

During the late 1990s, the Polaroid Corporation "Instamatic" film system fell victim to digital photography. Burdened with declining sales and a heavy debt load, Polaroid filed for Chapter 11 bankruptcy protection. Within a month of the bankruptcy filing, in October 2001, Polaroid stock crashed to $.24 per share. At the time of the Polaroid bankruptcy, Polaroid employees participated in a retirement plan which contained both a 401(k) and ESOP component. The plan documents required the 401(k) component to include an employer matching contribution investment in the Polaroid Common Stock Fund. The plan documents also stated that the ESOP was to be invested primarily in Polaroid stock. Participants could not contribute directly to the ESOP, it was "free money" - a matching contribution funded exclusively by the company with Polaroid stock. Following its bankruptcy, Polaroid was sued for securities fraud and breaching its fiduciary duties under ERISA.

In *In re Polaroid ERISA Litigation,* 362 F. Supp. 2d 461 (S.D.N.Y. 2005), the three basic stock drop claims emerged: (1) breach of the fiduciary duty of prudence by continuing to offer Polaroid stock as an investment option; (2) breach of the duty to monitor appointed fiduciaries; and (3) breach of fiduciary duty for "failing to provide complete and accurate information regarding Polaroid stock and the soundness of Polaroid stock as [a] retirement plan investment to participants. *Id.* at 468.

The Polaroid defendants did what was expected. They responded to the Complaint by filing a motion to dismiss. In response to the prudent investment claim, Defendants argued that their discretionary authority to eliminate plan investments in Polaroid stock was constrained by the Plan documents, which required a common stock fund be offered as an investment option and that the ESOP portion of the plan be primarily invested in employer securities. In declining to dismiss this claim, the Court cited ERISA § 404(a)(1)(D), 29 U.S.C. § 1104(a)(1)(d), which commands ERISA fiduciaries "to obey Plan documents only to the extent they are consistent with other fiduciary duties." *Id.* at 473. "Thus, the fact that the Plan required investments in Polaroid stock does "not 'ipso facto relieve [Defendants] of their fiduciary obligations.'" *Id.* at 474, citing *Rankin v. Rotts,* 278 F. Supp. 2d 853, 879 (E.D. Mich. 2003). While the *Polaroid* Court also recognized the existence of the *Kuper* and *Moench* presumption "that the fiduciary's decision to continue to offer an investment in the employer's securities is reasonable and prudent" and that it was the plaintiff's burden to overcome the presumption, like the overwhelming majority of courts to face the issue, it was reluctant

to say this claim failed as a matter of law without reviewing any facts. The *Polaroid* Court reasoned it was also premature to dismiss the duty to monitor claim alleged against Polaroid CEO, Gary DiCamillo, who appointed the plan's fund managers and plan administrators, without examining the underlying facts.

§ 15.2 Cash Balance Plan Litigation

§ 15.2.1 Fatal Flaw?

A popular new form of employee pension benefit plan has been the subject of considerable controversy and litigation. The "cash balance" plan is a defined benefit plan that has many defined contribution-type features. For example, a cash balance plan provides participants with a hypothetical account balance that is credited each year with a percentage of the employee's pay and interest. Cash balance plans also tend to favor younger workers as the plans typically have a portability feature allowing employees to take their cash balance benefits with them as they move from job to job. Upon termination of employment or retirement, an employee can choose to receive his or her cash balance account as a lump sum or annuity. Unlike a traditional defined contribution account, the cash balance plan provides a participant with a defined and determinable benefit regardless of the performance of the stock market. Thus, the risk and possible reward of stock market performance remains with the employer, much like a traditional defined benefit plan. The benefits provided under the cash balance plan are also insured by the Pension Benefit Guaranty Corporation. Because of these "hybrid" attributes, the cash balance plan gained popularity during the 1990's. Most cash balance plans have been established by "converting" a traditional defined benefit plan. Cash balance conversions have been the subject of several recent contradictory court rulings.

§ 15.2.2 Age Discrimination Claims

Do cash balance plans discriminate against older workers? The typical age discrimination claim alleges the design of a cash balance plan is inherently age discriminatory because equal pay credits for younger workers have a longer period of time to earn interest and accrue benefits before retirement whereas the equal pay credits for older workers have less time to earn interest. In other words, the "Economics 101" concept of compounding interest to employee accounts, due to the time value of money, is discriminatory because older workers will work fewer years than younger workers. Defendants reply that this age discrimination logic is inconsistent with every other pension plan design and would even make 401(k) plans and Social Security benefits automatically age discriminatory. The simple

fact that an employee aged 55 years receives his pension benefit before an employee who is 25 years old should not make the pension plan age discriminatory.

In *Cooper v. The IBM Personal Pension Plan and IBM Corp.*, 274 F. Supp. 2d 1010 (S.D. Ill. 2003), a federal court ruled that the IBM cash balance plan violated ERISA's discrimination provisions based on plaintiffs' simplistic theory. The *Cooper* court found that the concept of compounding interest to employee accounts, taking into consideration the time-value of money, is discriminatory. Under the logic of *Cooper,* all cash balance plans violate ERISA. Other courts have rejected this analysis. *See Eaton v. Onan Corp.*, 117 F. Supp. 2d 812 (S.D. Ind. 2000) (the proper method for testing age discrimination is whether the rate of contributions to an employee's cash balance account is at least the same, if not greater for older workers.); *Campbell v. BankBoston,* N.A., 206 F. Supp. 2d 70 (D. Mass. 2002), aff'd, 327 F.3d 1 (1st Cir. 2003). *Tootle v. Arinc,* 222 F.R.D. 88 (D. Md. 2004).

In *Tootle,* the court ultimately found that the *Cooper* court got it wrong. It found that the reasoning in *Eaton* was more persuasive because the legislative history and statutory history of ERISA indicate that the goal was to protect workers only *after* they attain normal retirement age. Moreover, the court stated that even if the provision was intended to protect employees prior to normal retirement age, the method of calculating accrued benefits as an age-sixty-five annuity was not appropriate with regard to a cash balance plan. A better method of calculating benefits, the court noted, would be to treat cash balance plans like defined contribution plans and look at the balance of the individual's account, or examine the rate at which amounts are allocated and changes in an individual's account balance over time.

§ 15.2.2.1 Is Providing Smaller Accruals to Older Workers Discriminatory?

Critics of cash balance plans have also argued that converting a defined benefit plan to a cash balance plan disadvantages older workers, because the conversion usually results in lower future accrual rates for older participants. This is usually a result of "wear away". Although a conversion to a cash balance plan cannot result in the reduction of an accrued benefit under IRS Code § 411(d)(6) and ERISA §204(g), 29 U.S.C. 1054(g), a conversion may result in a period of time during which a participant's prior accrued benefits under the former plan exceed the benefits payable under the cash balance plan. This means that older workers in converted plans may find themselves working for years without earning any additional pension benefits. During the "wear-away" period, the benefits under the cash balance plan formula must catch-up with the benefits accrued under the traditional plan before additional amounts are credited.

§ 15.2.2.1.1 Register v. PNC Financial Services Group, Inc.

Plaintiffs alleged that the "wear away" feature of the PNC cash balance plan violates the "anti-backloading provisions" of ERISA § 204(b)(1)(B), 29 U.S.C.

§ 1054(b)(1)(B). In *Register v. PNC Financial Services Group, Inc.*, 2005 U.S. Dist. LEXIS 29678 (D. PA 2005), the court explained: "The anti-backloading tests prevent an employer from allowing minimal accrual of benefits in the initial years of employment to be followed by large benefit accruals as an employee nears retirement." *Id.* at *9. Because a "cash balance is calculated using a career pay history" the only test under ERISA § 204(b)(1)(B) applicable to a cash balance plan is the 133 1/3% test. *Id.* at *10. "A plan will fail this test if the value of the benefit an employee accrues in any one year is 33 1/3% greater than the value of the benefit accrued in any prior year of employment." *Id.* The plaintiffs argued that as a result of the conversion to a cash balance plan a number of employees whose accrued benefits were greater under the prior plan would not accrue any additional value until the benefits payable under the new plan exceeded those payable under the old plan. When the benefit under the new plan outpaced that under the old plan, plaintiffs argued the resumption of accruals would "inevitably be more than a third higher." The *Register* Court rejected this analysis by explaining:

> The test states that 'any amendment to the plan which is in effect for the current year shall be treated as in effect for all other plan years.' Once a plan amendment occurs only the new plan is taken into consideration when performing the test. Since the protected prior benefits under the old plan are disregarded, no wearaway of the benefit occurs. Plaintiffs do not allege that the cash balance plan, when viewed by itself, violates the 133 1/3% test. Therefore, Plaintiffs have failed to state a claim for relief.

Id. at *11-12; *accord Allen v. Honeywell Retirement Earnings Plan*, 382 F. Supp. 2d 1139, 1160 (D. Ariz. 2005) ("because plaintiffs' anti-backloading claim attempts to compare the unamended benefit formulas with the amended benefit formulas, plaintiffs fail to state a claim for relief.")

15.3 Top Hat Plan Litigation

15.3.1 Square Pegs and Round Holes

By definition, a top hat plan is unfunded and must be "maintained by an employer primarily for the purpose of providing deferred compensation for a select group of management or highly compensated employees." *See* 29 U.S.C. §§ 1051(2), 1081(a)(3), 1101(a)(1). Top hat plans are exempted from ERISA's funding, participation, vesting and fiduciary provisions. *Id.* Principles of contract law, as opposed to trust law or ERISA's fiduciary standards, are applied to determine the rights of participants in a top hat plan. *Eastman Kodak v. Bayer Corp.*, 369 F. Supp. 2d 473, 478 (S.D.N.Y 2005). One of the consequences of having an employee benefit plan deemed to be a "top hat" plan is that it is enforceable in federal court and subject to ERISA's broad preemption statutes. *Moore v. Raytheon Corp.*, 314 F. Supp. 2d 658, 663 (N.D. Texas 2004). Litigation over ben-

efits arising from participation in these specialized employee benefit plans often revolves around the determination of whether or not the employee benefit plan in dispute qualifies as a top hat plan.

§ 15.3.2 Top Hat v. Excess Benefit Plans (*Isko v. Engelhard Corp.*)

The plaintiff, in *Isko v. Engelhard Corp.*, 367 F. Supp 2d 702 (D. N.J. 2005), sued his former employer in state court alleging his benefits under the company's Excess Benefit Plan (the "EB Plan") had been incorrectly calculated. The company transferred the case from state court to federal court on the grounds that the EB Plan was an ERISA-regulated "top hat" plan. Isko responded by asking the federal court to send his case back to state court because the plan in dispute was an unfunded "excess benefit" plan. Excess benefit plans are not governed by ERISA. *See* ERISA § 4(b), 29 U.S.C. § 1003(b). Everyone agreed the EB Plan was unfunded. The only issues were whether or not the EB plan qualified as a top hat plan. "In terms of design, the difference between a top hat plan and an excess benefit plan is, in most circumstances, that the top hat plan can have multiple broad purposes, while an excess benefit plan has the sole purpose of avoiding the limitations imposed by §415 of the Internal Revenue Code." *Garratt v. Knowles*, 245 F.3d 941, 946 n.4 (7th Cir. 2001). Engelhard argued "that the Excess Benefit Plan does not satisfy the statutory definition of 'excess benefit' plan because it was not maintained solely for the purpose of providing benefits in excess of the limitations imposed by section 415 of the Internal Revenue Code." *Isko*, 367 F. Supp. 2d at 709. The Court found otherwise and sent the case back to state court. As the plain terms of the EB Plan stated that its sole purpose was to avoid the limitations of section 415, the federal courts have has no jurisdiction concerning a dispute over how benefits should be calculated in an excess benefit plan.

§ 15.3.3 How Low Can Salaries Go in a Top Hat Plan? (*Bakri v. Venture Mfg. Co.*)

Ms. Bakri was employed by Venture for twenty years. As the manager of logistics, her salary upon termination of employment was $51,165. She was also one of six participants in the Venture "New Deferred Compensation Plan" (the "Plan"). When her employment at Venture ended, she was denied benefits under the Plan and she brought suit alleging breaches of fiduciary duty of ERISA. *Bakri v. Venture Mfg. Co.*, 2005 U.S. Dist LEXIS 26076 (S.D. Ohio 2005). Venture defended against the claim by asserting that the Plan was a "top hat" plan and not subject to the provisions of ERISA under which Bakri sought relief. In examining whether or not the Venture Plan was a top hat plan, the Court looked not to the employer's intent to establish a top hat plan, but rather to the actual operation of the Plan.

Bakri argued against the Plan's top hat status by noting that she was not a manager or a highly paid executive. She supervised no one and was not well paid in comparison to "true" executives. However, the evidence showed that Bakri's salary fell in the mid-range of all Plan participants. The court, in rejecting her claim, reasoned: "The law does not require that the top officers be participants or that the participants supervise other employees. The law requires only that the plan be limited to cover only high level employees." *Id.* at *15. As the plan was a top hat plan, ERISA did not provide relief for the fiduciary claims asserted by Ms. Bakri.

§ 15.4 Defined Benefit Pension Plan Terminations

There are two ways to terminate a defined benefit pension plan: (1) the easy way; and (2) the hard way. Terminating a single-employer pension plan is governed by 29 U.S.C. § 1341, ERISA § 4041. Section 1341 states a single-employer pension plan may be terminated by an employer in: (1) a standard termination (the "easy way"); or (2) a (the "hard way") distress termination. The "easy way" requires formal advance notification and other governmental notification requirements. Most importantly, to qualify for an "easy way" termination, the pension plan must be fully funded. This means the plan must contain sufficient assets to cover all of its benefit liabilities. Only if all of these requirements are met may an employer terminate its plan under a standard termination. 29 U.S.C. §1341(b).

The hard way of terminating a single-employer plan is called a distress termination. As its name implies, a distress termination occurs when a plan is terminated without sufficient assets to cover all of its future benefit obligations. When a plan is terminated without sufficient assets, the Pension Benefit Guaranty Corporation ("PBGC") generally takes over as the plan trustee, including the obligation to pay benefits on behalf of the failed plan. When an employer in bankruptcy proceedings seeks a distress termination, the termination will not be allowed unless the bankruptcy court finds that the debtor will not be able to emerge from bankruptcy with the plan in place. *See* 29 U.S.C. § 1341©(2)(B)(ii)(IV).

In order to aid the PBGC in fulfilling its responsibilities and decrease the PBGC's potential exposure, the PBGC is also authorized to terminate a failing pension plan in certain circumstances. *See* 29 U.S.C. 1342(a)(4). However, unlike employer initiated terminations, the PBGC is not constrained by the terms of a union's collective bargaining agreement. *PBGC v. LTV Corp.*, 496 U.S. 633, 637-38 (1990). In fact, the PBGC need not even consult with a union before terminating a plan under section 1342. *Jones & Laughlin Hourly Pension Plan v. LTV Corp.*, 824 F.2d 197, 199-202 (2d Cir. 1987).

The complexities in terminating a pension plan were highlighted this year in the fight over how to terminate the United Airlines flights attendants' pension plan and in a dispute over whether PBGC must terminate *all* or only some plans of Kaiser Aluminum Corporation once the "hard way" criteria are met.

§ 15.4.1 Unfriendly Skies?

United Airlines filed a voluntary reorganization in December 2002 under Chapter 11 of the Bankruptcy Code. Nearly two years later, United began taking steps toward a distress termination of its defined benefit pension funds. On April 11, 2005, it filed a motion to reject its collective bargaining agreement with the Association of Flight Attendants ("AFA") under section 1113© of the Bankruptcy Code. United also sought a distress termination of the Flight Attendant Plan under 29 U.S.C. § 1341(c). While United's motions were pending, the PBGC and United reached a settlement. Under the terms of the settlement, the PBGC would acquire a "single unsecured claim for United's unfunded pension liabilities against United's bankruptcy estate" and $1.5 billion in securities under United's plan of reorganization to partially offset United's unfunded pension obligations. *In re: UAL Corp.*, 428 F.3d 677, 681 (7th Cir. 2005) The settlement agreement did not require the PBGC to terminate the Flight Attendant Plan. It did, however, call for the PBGC to evaluate whether or not the Flight Attendant Plan should be terminated pursuant to 29 U.S.C. § 1342. The settlement agreement was approved by the Bankruptcy Court in May 2005. In June 2005, the PBGC determined it was appropriate for the Flight Attendant Plan to be terminated, effective on June 30, 2005.

The AFA challenged the termination of the Flight Attendant Plan by appealing the Bankruptcy Court's approval of the settlement agreement to the United States District Court for the Northern District of Illinois and separately suing the PBGC in the United States District Court for the District of Columbia. After the Northern District of Illinois affirmed the Bankruptcy Court's ruling on July 21, 2005, the AFA appealed the decision to the Seventh Circuit Court of Appeals.

On November 1, 2005, the Seventh Circuit affirmed the district court's and the Bankruptcy Court's previous approval of the settlement agreement. *Id.* On appeal, the AFA advanced three arguments: (1) the Bankruptcy Court erred in approving the settlement agreement because the AFA was not a party to it; (2) by entering into the settlement agreement, United "trampled over the collective bargaining framework established by §§1113/1341 and, more generally, the Railway Labor Act, which governs relations between United and AFA." *Id.* at 683; and (3) the settlement impermissibly provided that for five years from the date it exits bankruptcy United will not establish any new pension plans, which has the effect of impermissibly modifying the current collective bargaining agreement. *Id.* at 684. The Seventh Circuit disposed of each argument in turn. As to the contention that the AFA should have been a party to the settlement agreement, the Court noted the "AFA... misapprehends the nature of what the agreement set-

tled." The settlement agreement did not settle United's §§1113©/1341© motion, which was withdrawn. Instead, the settlement agreement settled matters strictly between United and the PBGC and, importantly, did not specifically require the PBGC to terminate the Flight Attendant Plan. The settlement agreement only required the PBGC to evaluate possible termination under section 1342. In response to the AFA's second claim, the Court explained that collective bargaining rights of the parties were immaterial because "under §1342, PBGC can terminate a plan irrespective of a particular collective bargaining agreement...." *Id.* at 683. The Court called the AFA's third claim "entirely speculative" since the moratorium would end "no sooner than the fall of 2010" and the current collective bargaining agreement with the AFA becomes amendable on January 7, 2010. Thus, "The [collective bargaining agreement] does not call for a new plan to be established within what is now the moratorium period." *Id.* at 684.

Recently, the District Court for the District of Columbia found that the PBGC did not violate ERISA or the Administrative Procedure Act in its decision to terminate the Flight Attendant Plan. *Association of Flight Attendants v. PBGC*, D.D.C., No. 05-1036 (January 13, 2006). The District Court allowed the challenge to the PBGC decision under 29 U.S.C. § 1303(f)(4). The PBGC had considered the fact that it would lose the benefits of the settlement agreement with United in determining that its long run loss was reasonably expected to increase unreasonably, a standard for a PBGC termination under 29 U.S.C. § 1342. The court agreed with the AFA that it was improper for the PBGC to consider losses caused by matters independent of the Flight Attendant Plan, but determined that the PBGC had sufficient reasons, independent of the suspect rationale, to terminate the Plan. The plan was chronically underfunded, and potential losses to the PBGC were increasing at a rate of $3.3 million per month, therefore the court found the termination to be justified.

15.4.2 Does Passing the "Hard Way" Test Mean All Plans Can Be Terminated?

There is an ambiguity in the distress termination test for a company in bankruptcy proceedings that maintains more than one plan, as shown by a recent case involving Kaiser Aluminum Corporation. *PBGC v. Kaiser Aluminum Corp. et al.*, Civ. No. 04-145 (D. Del. March 23, 2004), *on appeal to 3rd Cir.* The applicable test requires the Bankruptcy Court to determinate that the debtor would not be able to emerge from bankruptcy under a plan of reorganization and continue in business unless the "plan" is terminated. *See* 29 U.S.C. § 1341©(2)(B)(ii)(IV). The PBGC takes the position that this determination should be made on a plan-by-plan basis, as the statute uses the word "plan", in the singular.

What happens when a debtor maintains several plans, and can emerge as a viable entity so long as some, but not all plans are terminated? Kaiser maintained several defined benefit pension plans of varying sizes, each applying to a differ-

ent population of employees. Kaiser sought to terminate four of these plans in a distress termination, however the PBGC did not believe that all four should be terminated, as Kaiser could emerge with smaller plans intact.

At the heart of the issue is the conflict between ERISA and the Bankruptcy Code. Section 1113 of the Bankruptcy Code deals with modification or rejection of collective bargaining agreements in bankruptcy proceedings. 11 U.S.C. § 1113. Under this section, debtors must ensure that a union proposal, "assures that all creditors, the debtor and all of the affected parties are treated fairly and equitably." 11 U.S.C. § 1113(b)(1). Is it equitable if one union employee loses his pension benefits because he participates in a larger, more heavily underfunded plan, while another maintains her benefits because the underfunding in her plan is smaller? The District Court for the District of Delaware apparently did not find such an outcome to be equitable. The District Court therefore upheld a Bankruptcy Court determination that all of Kaiser's defined benefit pension plans should be terminated, on the grounds that it would be contrary to the Bankruptcy Code, and therefore to Congressional intent, in the face of ambiguous language in ERISA where there are multiple pension plans. The PBGC has appealed this case to the Third Circuit Court of Appeals.

§ 15.5 Remedies

§ 15.5.1 What Is Plan-Wide Relief?

We all know that it is safe to say that lawyers, litigants and judges are all confused by this question. ERISA contains an exclusive civil enforcement scheme. *Ingersoll-Rand Co. v. McClendon,* 498 U.S. 133, 144 (1990). Class action plaintiffs usually invoke ERISA § 502(a)(2), 29 U.S.C. § 1132(a)(2) as the statutory basis for their fiduciary breach claims. Section 502(a)(2) states the Secretary of Labor, participants, beneficiaries and fiduciaries of employee benefit plans may bring a civil action for "appropriate relief under § 409". ERISA § 409, 29 U.S.C. § 1109, for its part, says:

> Any person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by this title shall be personally liable to make good to such plan any losses to the plan resulting from each such breach, and to restore to such plan any profits of such fiduciary which have been made through use of assets of the plan by the fiduciary, and shall be subject to such other equitable or remedial relief as the court may deem appropriate, including removal of such fiduciary ***

The reason this procedural question is important is—money. The Supreme Court previously ruled that fiduciary breach claims for individual relief are only entitled to equitable relief (no money damages). In a series of individual fiduciary

breach cases culminating in *Great-West Life & Annuity Ins. Co. v. Knudson,* 534 U.S. 204 (2002), the Supreme Court has made it clear that suits arising under ERISA § 502(a)(3) do not encompass money damages. The problem for plaintiffs' lawyers is the Supreme Court's decision in *Massachusetts Mutual Life Insurance Co. v. Russell,* 473 U.S. 134 (1985) appears to say that section 502(a)(2) authorizes only plan-wide relief for breaches of fiduciary duty. That is, claims brought under section 502(a)(2) must be brought on behalf of an employee benefit plan and, consequently, any recovery must be paid to the plan. *Id.* at 144. The Circuit Courts of Appeals have consistently followed this guidance and denied claims for individual relief brought pursuant to section 502(a)(2). However, there is a current controversy brewing over whether section 502(a)(2) can be used in cases involving 401(k) or other individual account plans.

Individual account plans are defined contribution plans "which provides for an individual account for each participant and for benefits based solely upon the amount contributed to the participant's account, and any income which may be allocated to such participant's account." ERISA § 3(34), 29 U.S.C. § 1002(34). Thus, any recovery on behalf of an individual account plan necessarily means a recovery to individual participant accounts. The issue which has recently troubled the courts is whether ERISA § 502(a)(2) or ERISA § 502(a)(3) should be used to obtain a recovery on behalf of a subset of individual account plan participants. For example, in the typical ERISA stock drop case, only those participants whose individual accounts held investments in employer stock would recover. Until recently, courts generally accepted the idea that section 502(a)(2) was a permissible enforcement mechanism for individual account plans. *See Kuper v. Iovenko,* 66 F.3d 1447 (6th Cir. 1995) (disallowing section 502(a)(2) claims for individual account plans "would insulate fiduciaries who breach their duty so long as the breach does not harm all of a plan's participants"). *In re CMS Energy ERISA Litig,* 312 F. Sup. 2d 898 (E.D. Mich. 2004) (rejecting argument that suit really sought relief to individual account plans.). Two recent cases have taken a fresh look at this controversy.

§ 15.5.1.1 Milofsky v. American Airlines, Inc.

The plaintiffs in *Milofsky v. American Airlines, Inc.,* 404 F.3d 338 (5th Cir. 2005), *vacated, rehearing en banc granted,* 418 F. 3d 429 (5th Cir. 2005) were pilots for a small airline acquired by American Airlines. As part of the acquisition, the pilots' retirement plan interests were transferred to the American Eagle 401(k) plan. The pilots sued American Airlines under section 502(a)(2) of ERISA alleging it had breached its fiduciary duties by misrepresenting certain aspects of the transaction and failing to transfer the pilots' accounts in a "timely and prudent manner." 404 F.3d at 341. The pilots alleged the actions of the fiduciaries resulted in losses to their individual accounts and sought actual damages to be paid to the plan but allocated among their individual accounts. The district court dismissed the action. It ruled the pilots lacked standing to sue under section 502(a)(2) and the pilots appealed the decision to the Fifth Circuit. The Fifth Circuit affirmed.

> In summary, plaintiffs lack standing because this case in essence is about an alleged particularized harm targeting a specific subset of plan beneficiaries, with claims for damages to benefit members of the subclass only, and not the plan generally. This is the kind of case that, under *Russell* and its progeny, falls outside §502(a)(2), despite the formalistic distinction that recovery from the suit would be paid into individual accounts and not directly to plaintiffs. Even though the complaint may allege that damage occurred to the plan as a whole, we agree with the district court when it saw the essence of the complaint as a claim decrying particularized harm to individual plaintiffs who seek only to benefit themselves and not the entire plan as required by §502(a)(2).

404 F.3d at 347.

§ 15.5.1.2 *In re Schering-Plough ERISA Litigation*—*Milofsky Revisited*

The Third Circuit faced the same issue in *In re Schering-Plough Corporation ERISA Litigation*, 420 F.3d 231 (3d Cir. 2005). The *Schering-Plough* plaintiffs were former employees who participated in the Schering-Plough Employees' Savings Plan (the "Plan"). One of the investment vehicles offered under the Plan was a Company Stock Fund consisting primarily of investments in Schering-Plough stock. Approximately 60% of the Plan's participants invested in the Company Stock Fund. In 2001, the price of Schering-Plough stock plummeted. The *Schering-Plough* plaintiffs filed a class action alleging breach of fiduciary duty pursuant to ERISA § 502(a)(2) on behalf of all Plan participants whose Plan accounts contained investments in Schering-Plough stock. The Defendants argued that Plaintiffs lacked standing to pursue their claims under section 502(a)(2) because that provision only allows participants to proceed in a representative capacity on behalf of the "plan as a whole", which meant seeking relief for all plan participants. The Schering-Plough Plaintiffs only sought relief on behalf of those participants who invested in the Company Stock Fund; thus, any recovery obtained would only benefit a subset, not all, of the Plan participants. The district court agreed and granted the defendant's motion to dismiss on the basis that "the consolidated complaint alleges only 'harm suffered by the individual Plan Participants and not the Savings Plan, and seeks relief measured by the harm to individuals and tailored for the benefit of individuals, and not the Savings Plan." *Id.* at 234. Plaintiffs timely appealed the district court's decision.

Judge Arthur Alarcon of the Ninth Circuit Court of Appeals, sitting by designation, ruled that "the Plaintiffs may seek money damages on behalf of the fund, notwithstanding the fact the alleged fiduciary violation affected only a subset of the savings plan's participants." *Id.* at 232. That the Plaintiffs had sufficiently alleged that the Plan as a whole had suffered losses was obvious: "the Plan held Schering-Plough stock as an asset and that asset was greatly reduced in value al-

legedly because of breaches of fiduciary duty." *Id.* at 235. The words of section § 409 allow the plan to recover "any losses" resulting from a breach of fiduciary duty, not just those losses that affect all participants. *Id.* Moreover, the fact that a plan is an individual account plan "does not preclude the Plan from having losses." *Id.* at 236. Individual account plan status simply means that "losses to the Plan may have resulted from decisions by individual participants, but that does not mean that those losses were not losses of the Plan." *Id* at 235.

The Third Circuit reconciled its decision with the Supreme Court's decision in *Russell* first by noting "the issue presented here was not before the Court."

> The [Supreme] Court did not hold in *Russell* that a subgroup of plan participants cannot file [a] derivative action on behalf of an ERISA employee benefits plan if the fiduciaries' alleged breach did not affect the investments of participants in other subgroups. That issue simply was not before the Supreme Court.

Id. at 241.

The Third Circuit went on to agree that Judge King's interpretation of *Russell* in her *Milofsky* dissent was correct. The Court concluded that while the Supreme Court's decision in *Russell* distinguishes between relief for individuals and relief for the plan, it does not "stand for the proposition that the 'plan as a whole' is synonymous with 'all participants of the plan....'" *Id.* at 240.

§ 15.6 Preemption

§ 15.6.1 Is Everything "Related To" Everything Else?

What is ERISA preemption? Ask any two ERISA lawyers and you will get two different answers. The basis for the supremacy of the ERISA statute over competing state laws is found in ERISA § 514(a), 29 U.S.C. § 1144(a). It states that the ERISA statute "shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan..." Whether a state law "relates to" an employee benefit plan has confounded the courts for three decades. Justice Scalia summed up his frustration concerning ERISA preemption as follows: "But applying the 'relate to' provision according to its terms was a project doomed to failure, since many a curbstone philosopher has observed, everything is related to everything else." *Calif. Div. of Labor Stds. Enforcement v. Dillingham Construction, N.A.*, 519 U.S. 316, 335 (1997) (Scalia, concurring). Further complicating the issue of preemption is the statutory exception for state insurance laws. ERISA § 514(b); 29 U.S.C. § 1144(b). Determining whether a state statute is an insurance law is, itself, another fine kettle of fish. *Kentucky Association of Health Plans v. Miller*, 538 U.S. 329 (2003).

§ 15.6.1.1 Penny/Ohlmann/Nieman, Inc. v. Miami Valley Pension Corp.

The result of ERISA's broad preemption provisions, combined with its limited available remedies, is that ERISA participants or fiduciaries who are harmed by a service provider's improper conduct are often left with no remedy. *See, e.g., Watkins v. Westinghouse Hanford Co.*, 12 F.3d 1517 (9th Cir. 1993). Whether an ERISA fiduciary may bring state law breach of contract and negligence claims against a service provider to an ERISA plan was addressed in *Penny/Ohlmann/ Nieman, Inc. v. Miami Valley Pension Corp.*, 399 F.3d 692 (6th Cir. 2005). Penny/Ohlmann/Nieman, Inc. ("PONI") sponsored three different retirement plans: (1) a defined benefit pension plan; (2) an employee stock ownership plan ("ESOP"); and (3) a savings plan. From 1970 to the present, Miami Valley Pension Corp. ("MVP") provided record keeping services for both the defined benefit plan as well as the ESOP. MVP also served as the broker of life insurance policies held by the defined benefit plan. National City Bank ("NCB") was the record keeper and trustee for the savings plan. In 1990 PONI terminated the defined benefit plan. All except one participant in the defined benefit plan chose to cash out the insurance portion of their benefits. The one employee who chose not to cash out his benefit was a "key employee" under Internal Revenue Code §416(i)(1). This key employee chose instead to roll the value of his insurance policy over into the Savings Plan. During 1998, it was discovered that the value of this insurance policy was incorrectly valued by NCB at one dollar ($1.00). When the insurance policy was correctly valued, it turned out the ESOP and Savings Plan were both in violation of the top-heavy limitations of the Internal Revenue Code for the period 1991-1998. Consequently, PONI was required to pay $177,087.17 in employer contributions, IRS fines and legal expenses as a result of the top-heavy error. PONI sued NCB and MVP alleging breach-of-contract and negligent misrepresentation. The district court dismissed PONI's state law claims against MVP and NCB on the grounds that the claims were preempted under section 514 (a) of ERISA. PONI appealed.

The Sixth Circuit found that the state law breach-of-contract and negligent misrepresentation claims against NCB, as trustee for the savings plan, were preempted. However, the company's claims alleged against MVP could proceed. The basis for the Court's holding was that MVP was a non-fiduciary service provider to the ESOP and defined benefit plan, whereas NCB functioned as an ERISA fiduciary to the savings plan. The Sixth Circuit observed, "where an ERISA plan's relationship with another entity is not governed by ERISA, it is subject to state law. *Id.* at 698. The district court had erred in its overly simplistic ruling that all state law claims against both NCB and MVP were preempted merely because they arose "out of obligations relating to the servicing of ERISA plans." *Id.* at 699. The Sixth Circuit noted: "the mere fact that an employee benefit plan is implicated in the dispute . . . is not dispositive of whether the [state law] claims are preempted." *Id.* Instead, courts are instructed to look at the nature of the services provided to

the ERISA plan and relationship of the service provider to the plan in order to analyze the issue of ERISA preemption. As a general rule, where "a service agreement or contract *separate and distinct* from the ERISA qualified plan served as the basis for the claim", ERISA does not preempt state law claims against non-fiduciary service providers. *Id.* at 699. However, where the contract at issue is the ERISA plan itself, ERISA preemption applies. Using this analytical framework, the Sixth Circuit found the state law claims against NCB arose out of its obligations as the trustee to the savings plan. Thus, the state law breach of contract and negligent misrepresentation claims were preempted because they inherently involved "a claim that a fiduciary breached the terms of the ERISA plan." *Id.* at 699. On the other hand, MVP did not function as an ERISA fiduciary and its services were governed by the terms of a separate contract with PONI. Therefore, the same state law claims the court found to be preempted as to NCB, were not preempted as to MVP because they were not "based on any rights under the plan; there is no allegation that any of the plan's terms have been breached. Nor is there any effort to enforce or modify the terms of the plan." *Id.* at 701.

§ 15.7 Retiree Medical Benefits

§ 15.7.1 When Is a "Lifetime" Not a Lifetime?

Congress passed ERISA in 1974, responding to a public outcry that many pension plan sponsors were either crooks, charlatans or worse. Determined to protect employees' retirement benefits, Congress devised "rules concerning reporting, disclosure and fiduciary responsibility" to keep plan sponsors on the up and up. *Shaw v. Delta Airlines,* 463 U.S. 85, 91, 103 S. Ct. 2890, 2896 (1983). Although Congress gave ERISA sweeping authority over all employee benefit plans, it left welfare plans (such as medical plans) largely unregulated.

One of ERISA's aims was to provide minimum standards and uniform federal regulation of employee benefit plans. To that end, Congress enacted a broad preemption clause that states that ERISA "shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan." To ensure the effectiveness of this provision, Congress expansively defined "state law." The primary advantage of ERISA preemption is that it allowed plan sponsors to create uniform employee benefit plans covering different employees in different states. *Shaw, supra,* at 105.

Pension plans under ERISA include retirement plans or other plans that defer the receipt of income to the termination of employment or beyond. *See* 29 U.S.C. § 1002(1). Welfare plans encompass medical, dental, vision, life, disability and every other benefit that is not related to "retirement." 29 U.S.C. § 1002(2)(A). While welfare benefits plans were left largely unregulated, pension benefits are subject to cradle to grave regulation, including vesting requirements, funding

mandates, non-discrimination tests and special rules concerning benefit accruals. See, *e.g.*, 29 U.S.C. §§ 1052, 1053, 1054 and 1082.

Welfare benefits such as medical benefits are the primary form of retiree medical benefits. These benefits usually do not vest unless the plan contract expressly so provides. 29 U.S.C. § 1051(1). Because employers are not legally required to vest welfare benefits such as retiree medical benefits "the intention to vest must be found in 'clear and express language' in plan documents." *Inter-Modal Rail Employees Ass'n v. Atchison, Topeka, & Santa Fe Ry. Co.*, 520 U.S. 510, 117 S. Ct. 1513 (1997).

Prior to the run up in retiree medical costs in the 1990s, many employers failed to properly articulate their power to amend or terminate their retiree medical plans. *See, e.g., Bland v. Fiatallis North America, Inc.*, 401 F.3d 779, 783 (7th Cir. 2005). However, with retirees living longer and because of the increasing costs of providing medical benefits, many employers concluded they could no longer afford their retiree medical benefit promises. *Id.*

§ 15.7.1.1 Bland v. Fiatallis North America, Inc. and Vallone v. CNA Financial Corp.

In two recent Seventh Circuit cases, retirees challenged their former employer's decision to reduce their retiree medical benefits. *Vallone v. CNA Financial Corp.*, 375 F.3d 623 (7th Cir. 2004); *Bland v. Fiatallis North America, Inc.*, 401 F.3d 779 (7th Cir. 2005). These decisions show that an employer's ability to unilaterally reduce benefits depends upon the answers to two questions: (1) Is there unambiguous plan language promising lifetime benefits? and (2) Does a clause in the plan reserving the employer's right to amend or terminate the promised benefits trump the promise of "lifetime" benefits?

For example, in *Vallone*, plaintiffs were two of 347 former employees of CNA Financial, who opted for an early retirement package. The package included a monthly Health Care Allowance ("HCA") benefit. *Id.* at 626. The retirees were told that the HCA benefit would be for their "lifetime." *Id.* at 626. Less than 10 years later, CNA changed its mind. Notice was sent to the retirees stating that their HCA benefits would be eliminated. *Id.* at 626. The plaintiffs sued to hold CNA to this promise of "lifetime benefits." They lost. The Seventh Circuit, in rejecting plaintiffs' appeal, explained that it started "from the premise that employers... are generally free under ERISA, for any reason at any time, to adopt, modify, or terminate welfare plans... [I]f ERISA welfare benefits vest at all, they do so under the terms of a particular contract." *Id.* at 632. "Given [the] presumption against the vesting of welfare benefits, silence indicates that welfare benefits are not vested." *Id.* at 632. Thus, a promise of "lifetime" benefits could be construed as "good for life unless revoked or modified," particularly where the plan documents contained a reservation provision allowing the employer to amend or terminate the plan at any time (a "reservation of rights" clause). *Id.* at 633.

Less than a year later, the Seventh Circuit looked at different retiree medical plan language and reached a different conclusion. In *Bland v. Fiatallis North America, Inc.*, 401 F.3d 779 (7th Cir. 2005), the retiree medical benefits were provided to employees in a plan that did not give the employer the express right to amend or terminate the plan. Many years later, in efforts to reign in the spiraling cost of these benefits, the company cut back on the benefits provided to existing retirees. The retirees sued claiming that their "lifetime" benefits were vested and could not be changed. The district court granted the company's motion for summary judgment, the retirees appealed, and the Seventh Circuit reversed.

Consistent with its holding in *Vallone,* the Seventh Circuit explained that where a plan is silent as to vesting, there will be a presumption against vesting. *Id.* at 784; citing *Rossetto v. Pabst Brewing Co., Inc.*, 217 F.3d 539, 541 (7th Cir. 2000); *Vallone v. CNA Financial Corp.*, 375 F.3d 623, 632 (7th Cir. 2004). However, "any positive indication of ambiguity, something to make you scratch your head" will defeat that presumption. *Id.* at 784. Like the plan documents in *Vallone,* the plan documents in *Fiatallis* promised "lifetime" benefits. *Id.* at 784. One plan document stated that "coverage remains in effect as long as you or your surviving spouse are living" *Id.* at 785. Another provided that "if a retired employee dies, the surviving spouse will have basic coverage continued for his or her lifetime at no cost." *Id.* Unlike *Vallone,* none of the plan documents contained an express reservation of rights clause. *Id.* With no express power to change, the company's ability to change the benefits was questionable, at best. The plan documents were not silent, but "merely somewhat vague." *Id.* 785. Thus, the Court concluded, the plaintiffs were entitled to a trial to determine whether the benefits were vested. *Bland,* 401 F.3d at 786-87.

A similar result occurred in *Asarco v. United Steelworkers of America,* 2005 U.S. Dist. LEXIS 20873 (D. Ariz. July 26, 2005), where the plaintiff/employer asked the Court for an order declaring that it had the right to modify its Health Plan and Prescription Drug Plan by increasing premiums, deductibles, and co-payment levels for retired employees. *Id.* at *6. The Court refused to do so, finding that the plan documents and governing collective bargaining agreements were "ambiguous and susceptible to multiple interpretations." *Id.* at *9. One plan document stated that benefits would continue "until the employee qualifies for Medicare." *Id.* at *9. Another stated that coverage "may continue for you, your spouse and eligible dependents as long as they remain eligible." *Id.* at 10. While later plan documents contained clauses reserving the employer's right to amend or terminate benefits, those clauses were not clearly contained in the original plan documents. *Id.* at *11-12.

Where a plan is simply vague as to how long retiree medical benefits will last, the presumption against vesting of retiree medical benefits may be enough. In *Senior v. NSTAR Electric and Gas Corp.*, 372 F. Supp. 2d 159 (D. Mass. 2005), NSTAR informed its retirees it would cease reimbursing Medicare Part B premiums paid by retirees who retired from the Company between 1973 and 1997. Retirees who were not sixty-five years of age as of April 1, 2003, were told they would

lose their dental benefits upon reaching age sixty-five. In the ensuing lawsuit, plaintiffs pointed to personalized summaries given to two individual plan participants, which stated that "the Company will reimburse you the cost of Medicare Part B." However, no mention was made in these summary statements about benefits vesting or how long Medicare Part B reimbursement would last. *Id.* at 165. The Court explained that given the "strong presumption against the [automatic] vesting of welfare benefits" the summary statements presented did not clearly state that benefits would vest, and could not demonstrate the plaintiffs were entitled to lifetime benefits. *Id.* at 166. In reaching its decision, the court considered, but ultimately discounted, testimony that plaintiffs were told Medicare Part B reimbursement would continue for their lifetime. *Id.* at 166. According to the court, plaintiffs' self-serving testimony was insufficient to overcome the actual words of the plan and the strong presumption against the vesting of welfare benefits. *Id.*

§ 15.7.2 The ADEA and Retiree Medical Benefits

§ 15.7.2.1 Erie County Retirees Ass'n v. County of Erie

For 30 years, the Age Discrimination in Employment Act of 1967 ("ADEA") 29 U.S.C. § 621, *et seq.* was viewed as prohibiting age discrimination in the workplace - not regulating employee plans. We thought the ADEA did not regulate retiree medical benefits because it did not mention employee benefits. This interpretation of the ADEA was central to a 1989 Supreme Court ruling that the ADEA did not prohibit discrimination in employee benefits. *Public Employees Retirement System of Ohio v. Betts,* 492 U.S. 158, 109 S. Ct. 256 (1989). In response to the Supreme Court's decision, Congress passed the Older Workers Benefit Protection Act of 1990 ("OWBPA"), which amended the ADEA to cover employee benefits. 29 U.S.C. §§ 621, 623, 626, 629, 630. Most employee benefit lawyers continued to believe employer-provided retiree medical benefits would not be affected by OWBPA because OWBPA's legislative history indicated that the prior employer practices of eliminating, reducing, or altering retiree medical benefits would remain lawful. Final Substitute: Statement of Managers, 136 Cong. Rec. S25353 (09/24/90); 136 Cong. Rec. H27062 (10/02/90). They were wrong.

In 1997, Erie County, Pennsylvania tried to control its rapidly rising medical plan costs by changing the benefits it offered under its retiree medical plan. Erie County's retiree medical plan (prior to 1997) provided all retirees with the same health benefits regardless of their Medicare eligibility status. The new plan divided the benefits by placing Medicare-eligible retirees in an HMO plan that coordinated its benefit payments with Medicare and placing the younger retirees in a hybrid point-of-service plan. The benefits received by the non-Medicare re-

tirees were better than the combined benefits provided by Medicare and the HMO to the Medicare eligible retirees. In 1999, six Medicare-eligible retirees (the "Erie County Six") sued, claiming that Erie County's actions violated the ADEA by providing them with inferior medical benefits because of their age.

The Erie County Six eventually won. The federal district court in Erie County first ruled in favor of Erie County, finding that retiree medical plans are not regulated by the ADEA. *Erie County Retirees Ass'n v. County of Erie*, 91 F. Supp. 2d 860 (W.D. Pa. 1999). However, the Third Circuit reversed. *Erie County Retirees Ass'n v. County of Erie*, 220 F.3d 193 (3rd Cir. 2000). In parsing the words of the ADEA statute, the Third Circuit found that its basic provision, Section 4(a), prohibits age discrimination "against any individual" with respect to the terms, conditions, or privileges of employment. With that, the Third Circuit held: 1) the ADEA applies to retirees and to retiree medical plans; and 2) that Erie County's retiree medical plan violated the ADEA, unless Erie County could meet either the equal benefit or the equal cost safe harbor tests under the ADEA. *Id.* at 213-14. Generally, the safe harbor rule requires a plan either to incur equal or greater costs in providing benefits to older workers, or to provide equal or greater benefits to older workers, when comparing either the costs or benefits to those provided for younger workers. The Third Circuit stated that Erie County could take into account the benefits provided by Medicare for purposes of applying the equal benefit safe harbor. On rehearing, the District Court found that Erie County's retiree medical plan did not meet the equal benefit or the equal cost safe harbor. *Erie County Retirees Ass'n v. County of Erie*, 140 F. Supp. 2d 466, 477 (W.D. Pa. 2001). Erie County eventually decided to reduce its benefits for all retirees to comply with the ADEA.

The federal government first embraced and then recoiled from the *Erie County* decision. In October 2000, the Equal Employment Opportunity Commission ("EEOC") issued an enforcement policy adopting the Third Circuit's 2000 ruling. However, a firestorm of criticism ensued. Employers, employees, and labor groups came to the conclusion that the Third Circuit's *Erie County* decision and the EEOC's new policy would have disastrous consequences. Instead of protecting retiree medical benefits, the EEOC's new policy would have the effect of reducing health coverage for retirees. In response to these comments, the EEOC rescinded its policy in August 2001 and announced that it was forming a task force to study the issue. In July 2003, as a result of the task force's recommendations, the EEOC reversed course. It proposed to create a regulatory exception to the ADEA, eviscerating the *Erie County* decision. The new exception would permit employers to provide employer-provided retiree medical benefits as before. It would be lawful to provide better benefits for non-Medicare eligible retirees and lesser benefits for older Medicare eligible retirees. In April 2004, the EEOC formally approved the proposed rule.

On February 4, 2005, AARP challenged the proposed EEOC rule in federal court. On March 30, 2005, a federal judge in Pennsylvania ruled that she was bound by the Third Circuit's prior ruling in *Erie County*. Judge Anita B. Brody explained:

> The Third Circuit has already decided that Congress intended for the provisions of the ADEA to apply when an employer reduces health benefits based on Medicare eligibility. An administrative agency, including the EEOC, may not issue regulations, rules or exemptions that go against the intent of Congress.

2005 WL 723991 (E.D. Pa. 2005).

The EEOC appealed the Pennsylvania ruling. Less than a month later, the U.S. Supreme Court in *Nat'l Cable & Telecomms. Ass'n v. Brand X Internet Servs.*, 2005 U.S. LEXIS 5018, 125 S. Ct. 2688 (2005) ("*Brand X*") granted federal government agencies more discretion to interpret their governing statutes than was previously thought. In *Brand X* the Supreme Court explained:

> Only a judicial precedent holding that the statute unambiguously forecloses the agency's interpretation, and therefore contains no gap for the agency to fill, displaces a conflicting agency construction.

125 S. Ct. 2700. The following day, the Pennsylvania District Court convened a conference call inviting the parties to address the impact of *Brand X* on the Court's decision. Two days later (on June 30, 2005) the EEOC moved for relief from judgment pursuant to Fed. R. Civ. P. 60(b). The Third Circuit remanded the case on July 13, 2005 to the District Court to consider the EEOC's motion for relief.

In its brief to the District Court, the EEOC argued that the Third Circuit's decision in *Erie County* did not consider whether 29 U.S.C. § 628 allows the EEOC to issue a regulation exempting from the ADEA benefit plans which would otherwise be considered age discrimination. The EEOC argued that *Erie County* did not preclude the Court from upholding the EEOC's newly promulgated regulation. The AARP, on the other hand, argued that there was no ambiguity in the words of the ADEA and thus, no ambiguity for the EEOC to fill.

On September 27, 2005, the District Court reversed its February 4, 2005 order, explaining:

> "*Brand X* held that a court's interpretation of a statute only bars an agency from interpreting that statute differently from the court if the court has determined the *only permissible* meaning of the statute. *See Brand X*, 125 S. Ct. at 2701. Because the Third Circuit's *Erie County* decision did not determine the *only permissible* meaning of the relevant provisions of the ADEA, under *Brand X*, I am not bound by Erie County in reviewing the EEOC's regulation."

September 27, 2005 Decision at page 3. (Emphasis in original).

So here we are, six years after the original *Erie County* District Court decision, in limbo about the effect (or non-effect) of the ADEA on retiree medical benefit plans. Employers with retirees within the jurisdiction of the Third Circuit (in Pennsylvania, New Jersey, the Virgin Islands and Delaware), may temporarily rejoice. The reborn EEOC exemption gives plan sponsors a workable approach in

dealing with retirees who are eligible for Medicare benefits. They should, however, remain cautious. An adverse Third Circuit ruling may yet again invalidate this new EEOC exemption. Employers elsewhere should also exercise caution, knowing that if the District Court's recent decision is upheld, other courts will likely be asked to decide whether the ADEA applies to retiree medical benefits and, if so, whether the EEOC's exemptive rule is valid.

§ 15.8 Subrogation Litigation

§ 15.8.1 Subrogation in the Ninth Circuit after *Great-West Life & Annuity Insurance Co. v. Knudson*

"Where do we go from here?" Three years after *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 122 S. Ct. 708 (2002), these words echo in the tortured logic employed by litigants and the courts as they try to put a legal Humpty Dumpty back together again. For ERISA lawyers, Humpty Dumpty is something called "subrogation." ERISA-regulated health plans normally include reimbursement clauses ("subrogation clauses") in order to recover the costs of plan benefits that are reimbursed by third parties. For example, a plan participant who breaks his leg in a car accident will have his medical plan pay to fix his leg. The participant will then sue to recover the costs of these same medical plan benefits (among other things) from the other driver's auto insurance carrier. The unanswered question is whether an ERISA-regulated health plan's fiduciaries can sue to enforce these reimbursement clauses.

While some federal courts (like the Ninth Circuit Court of Appeals) have made clear that health plan fiduciaries may not enforce claims to reimburse the health plan in federal court, a door has been set ajar to enforce subrogation claims in state court as breach of contract claims.

As the Supreme Court oft reminds us, the parsimony in ERISA remedies is no accident: "ERISA is a comprehensive and a reticulated statute." *Nachman Corp. v. Pension Benefit Guaranty Corp.*, 446 U.S. 359, 361 (1980). Accordingly, its enforcement provisions (set forth in ERISA §§ 502(a)(1)(B), 502(a)(2) and 502(a)(3)) are limited. Plaintiffs who want additional plan benefits can file suit under ERISA § 502(a)(1)(B) seeking benefits under the terms of the plan. A participant who believes all the plan's participants are being shortchanged can sue the plan's fiduciaries to make the plan whole for losses under section 502(a)(2). Finally, a "catchall" provision, ERISA § 502(a)(3) allows claims by participants, beneficiaries or fiduciaries "(A) to enjoin any act or practice which violates any provision of [ERISA] 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 [ERISA] or the terms of the plan." As it turns out, the courts have decided that medical plan fiduciaries seeking to enforce a medical plan's reimbursement clause against plan participants or beneficiaries must do so under ERISA's catchall provision Section 502(a)(3).

The nub of the problem for an ERISA-regulated plan is that the remedies available under ERISA's catchall provisions are limited. "Equitable" forms of relief can be used. However, monetary relief is unavailable. *Mertens v. Hewitt Associates,* 508 U.S. 248, 113 S. Ct. 2063 (1993). In *Great-West,* the Supreme Court explained that section 502(a)(3) only authorizes the use of "traditional" forms of equitable relief, *i.e.*, "those categories of relief that were typically available in equity (such as injunction, mandamus, and restitution, but not compensatory damages)." *Great-West Life,* 534 U.S. at 726; *Mertens,* 508 U.S. at 256. "[M]oney damages..., the classic form of legal relief" is unavailable under section 502(a)(3). *Mertens,* 508 U.S. at 255.

A medical plan sought repayment pursuant to a reimbursement clause in *Great-West Life* from a plan participant under section § 502(a)(3). The Plan filed suit to enforce its rights. The medical benefit plan lost. On appeal, the medical benefit plan's fiduciaries argued that the relief they sought was "equitable" and thus was "appropriate" under section § 502(a)(3). The Supreme Court disagreed, finding that the medical plan's attempt to impose personal liability on the beneficiary for amounts recovered from the third party was not "equitable" and thus, the remedy was unavailable under section § 502(a)(3). The Supreme Court left open the possibility of an equitable remedy "where money or property identified as belonging in good conscience to the plaintiff could clearly be traced to particular funds or property in the defendant's possession." *Great-West Life,* 534 U.S. at 213. In that situation, the medical plan plaintiffs could seek restitution in equity in the form of a constructive trust or an equitable lien. *Id.* at 213.

§ 15.8.1.1 Providence Health Plan v. McDowell and Canfora v. Coast Hotels and Casinos, Inc.

Great-West Life has baffled the courts. Some circuits allow medical benefit plan fiduciaries to bring claims for reimbursement where an identifiable corpus of money can be identified. *See, e.g., Mid Atlantic Medical Services, LLC v. Sereboff,* 407 F.3d 212 (4th Cir. 2005) (allowing imposition of constructive trust over specifically identifiable settlement funds under section § 502(a)(3)); *Admin. Comm. of the Wal-Mart Assoc. Health & Welfare Plan v. Willard,* 393 F.3d 1119 (10th Cir. 2004) (same); *Bombardier Aerospace Employee Welfare Benefits Plan,* 354 F.3d 348 (5th Cir. 2003) (same); *IBEW-NECA Southwestern Health & Benefit Fund v. Gurule,* 337 F. Supp. 2d 845 (N.D. Tex. 2004) (same); *Mank v. Green,* 323 F. Supp. 2d 115 (D. Me. 2004) (same). In these circuits, a "constructive trust" or "equitable lien" may be imposed on the identifiable funds and, accordingly, is

seen as an appropriate equitable remedy under *Great-West Life.* Other courts, such as the Ninth Circuit have deemed claims for reimbursement not to be a form of equitable relief even if funds are traceable to a defendant. *Westaff (USA) Inc. v. Arce,* 298 F.3d 1164 (9th Cir. 2002), *cert. denied,* 537 U.S. 1111, 123 S. Ct. 901 (2003). This has meant, until recently, that plans seeking to enforce subrogation clauses in the Ninth Circuit have experienced that "left out" feeling of having no way to enforce these agreements.

However, there is some good news from the Ninth Circuit. We have recently been taught that a medical plan's reimbursement provisions are not necessarily an ERISA problem. In *Providence Health Plan v. McDowell,* 385 F.3d 1168 (9th Cir. 2004), *cert. denied,* 2005 U.S. LEXIS 2978, 125 S. Ct. 1735 (2005), an ERISA-regulated medical plan brought a state law contract claim seeking reimbursement under a subrogation clause contained in the plan. The case was removed to federal court and dismissed on the basis of ERISA preemption. The plan then filed a second suit for specific performance of the subrogation provision under section § 502(a)(3). The district court dismissed the second suit, holding that "Providence was in reality seeking monetary relief despite couching its request in equity." The plan appealed both dismissals. On appeal, the Ninth Circuit held that the plan's state lawsuit for breach of contract claim was not preempted by ERISA, and should not have been dismissed. The Court's decision relied, in part, on the absence of any remedy available to the plan under section § 502(a)(3). *Id.* at 1172-73. The Ninth Circuit remanded the case to state court. *Id.* at 1173.

Providence, thus, permits a medical plan's reimbursement claims to be enforced in state court, using the principles of contract law. Enforcement of subrogation provisions in state court includes its own challenges. Some states have highly developed common law doctrines such as the "common fund" doctrine, which may reduce a plan's recovery by attorney fees incurred by the insured while pursing the third party recovery, and the "make whole" doctrine, which may reduce an insurance plan's recovery if the insured has not been "made whole" for her injury. *See, e.g., Boll v. State Farm Mutual Automobile Insurance Co.,* 140 Idaho 334, 342 (2004) (applying Idaho's "common fund" doctrine); *Hamm v. State Farm Mutual Automobile Insurance Co.,* 151 Wn.2d 303 (2004) (dissent applying Washington's common fund doctrine); *Swanson v. Hartford Ins. Co. of the Midwest,* 2002 MT 81 (2002) (applying Montana's "make whole" doctrine).

Until recently, Nevada state law seemed to bar reimbursement claims brought by insurance companies against their insureds. *See Maxwell v. Allstate Ins. Co.,* 102 Nev. 502, 506 (1986) (holding a workers' compensation subrogation clause unenforceable as against public policy). However, the Nevada Supreme Court's recent opinion in *Canfora v. Coast Hotels and Casinos, Inc.,* 121 P. 3d 599, 2005 WL 2665801 (Nev. Oct. 20, 2005), made clear that subrogation clauses are enforceable and can be enforced according to their terms. *Id.*

§ 15.8.2 Can a Subrogation Clause Be Enforced?

Mid Atlantic Medical Services, LLC v. Sereboff

It is a toss up. The Fourth, Fifth, Seventh, and Tenth Circuits agree that reimbursement clauses in ERISA-regulated medical plans can be enforced where the monies to pay the reimbursement can be clearly traced to particular funds. *Mid Atlantic Medical Services, LLC v. Sereboff,* 407 F.3d 212 (4th Cir. 2005), *Bombardier Aerospace Employee Welfare Benefits Plan v. Ferrer, Poirot and Wansbrough,* 354 F.3d 348 (5th Cir. 2003); *Administrative Committee of the Wal-Mart Stores, Inc. Associates Health & Welfare Plan v. Varca,* 338 F.3d 680 (7th Cir. 2003); and *Administrative Committee of the Wal-Mart Associates Health & Welfare Plan v. Willard,* 393 F.3d 1119 (10th Cir. 2004). In *Sereboff, Varca* and *Ferrer,* the beneficiaries' attorneys had accepted payment from the tortfeasors on behalf of their clients and placed the funds into accounts over which the beneficiaries had constructive possession. In each of these cases, the courts ruled that the fiduciaries were seeking "equitable relief" under section § 502(a)(3). In *Willard,* an ERISA fiduciary sought to enforce a subrogation clause against the beneficiary through imposition of a constructive trust on settlement proceeds received from a third-party tortfeasor. The district court allowed the fiduciary to intervene and deposit a portion of the settlement proceeds equivalent to the medical expenses into the court's registry. On appeal, the Tenth Circuit agreed that the fiduciary's effort to secure imposition of an actual lien fell within the ambit of section 502(a)(3). Meanwhile, courts in the Sixth and Ninth Circuits have ruled that the enforcement of subrogation rights is legal in nature, even where the beneficiary possesses that recovery in an identifiable fund. *Qualchoice, Inc. v. Rowland,* 367 F.3d 638 (6th Cir. 2004); *Westaff (USA) Inc. v. Arce,* 298 F.3d 1164 (9th Cir. 2002). On November 28, 2005, the U.S. Supreme Court stepped in to resolve this split between the circuits. It has agreed to review the Fourth Circuit's decision in *Sereboff.* 2005 U.S. Lexis 8573 (Nov. 28, 2005).

§ 15.8.3 Requiring a Written Reimbursement Agreement in Advance of Subrogation Payments Does Not Violate ERISA

§ 15.8.3.1 Kress v. Food Employers Labor Relations Association

Mr. Kress, a participant in Giant Foods' medical benefit plan, was injured when his car was rear-ended. The Summary Plan Description states the plan would advance participants' accident-related expenses on the condition that the participant and their attorney sign a subrogation agreement to reimburse the plan "before all others" from any third-party recovery. *Kress v. Food Employers Labor Relations Association,* 391 F.3d 563, 565 (4th Cir. 2004). Mr. Kress agreed to these

terms and received $1500 from the plan. However, his attorney refused to sign. As a result, the plan denied Mr. Kress' claim for accident-related benefits. Once Mr. Kress' benefits were denied, he no longer qualified as an active participant and his dependents' benefits were also terminated.

Mr. Kress sued, arguing that the plan's summary plan description did not, and legally could not, require his attorney's signature on an agreement as a condition precedent for subrogation payments. The district court granted summary judgment to the plan, finding that the summary plan description did require exactly that. Mr. Kress appealed.

In *Kress*, the Fourth Circuit Court of Appeals affirmed a provision in an ERISA plan which conditioned payment of benefits on the participant and the participant's attorney's agreement to reimburse the plan if there was a recovery from a third party. The sole question before the Fourth Circuit was whether the plan could legally condition payment of benefits on Mr. Kress' attorney's agreement to the plan's subrogation clause. The Court of Appeals held that because the self-funded medical plans Summary Plan Description stated that it would advance funds "only as a service to you" that reimbursement must come from "any recovery" and that "acceptance of benefits" connoted an agreement to reimburse, in full, from any "settlement, judgment, insurance or other payment." Reimbursing medical expenses as the result of a third-party accident was not even covered by the plan nor was the Giant Foods' medical plan required to offer reimbursement for these injuries under ERISA. Affirming the district court's holding, the appellate panel reasoned: "[s]ince circuit law interpreting ERISA plainly permits a plan to recoup any advance it has made to a participant before an attorney makes a claim on a subsequent award, we see no reason to impede a plan from requiring pre-commitment to this state of affairs. Congress placed no restrictions in ERISA on reimbursement provisions." *Id.* at 569. To the Court, "[t]he addition of an attorney signature requirement is a difference of degree, not of kind" and did not violate ERISA. *Id.* at 569.

The Court rejected Mr. Kress' argument that the SPD did not describe the specific terms of the subrogation agreement and was therefore so ambiguous as to be unenforceable. *Id.* 567-68. The Court ruled that the phrase in the SPD stating that the plan would be paid "in full" was sufficient to indicate that the plan's claim for reimbursement would take priority over any other claims - including a claim for attorneys' fees. *Id.* at 568.

Mr. Kress also argued that the subrogation agreement violated ERISA since it would allow the plan to benefit from litigation proceeds without sharing in litigation expenses. *Id.* at 568. The Fourth Circuit noted that ERISA "does not mandate any minimum substantive content for [welfare benefit] plans ... ERISA neither requires a welfare plan to contain a subrogation clause nor does it bar such clauses or otherwise regulate their content." *Id.* at 568-69. The subrogation agreement and the SPD both established an "unqualified right to reimbursement." *Id.* at 569. Thus, the Court held that "[a]bsent some provision in the SPD or Agreement for fees, the Fund's priority is paramount - it must recover before all others." *Id.* at 569.

Finally, the Court rejected Mr. Kress' arguments that the plan's policy wo discourage litigation by forcing attorneys to bear the costs of litigation. *Id.* at As the Court noted, the purported unfairness "is nothing more than comm place economic calculus." Id. at 570. A plan's subrogation rules "obviously m the payment of fees more or less likely, and prudent attorneys would factor th rules into their calculus" in determining whether to take a case on a continge basis. *Id.* Finally, according to the Court:

> Policy arguments such as these all go to the economic judgment of the Fund, should be directed to its trustees, or to Congress, rather to the federal courts... If Fund concludes that is subrogation rules are too severe and that they harm, rat than help, its bottom line, it may choose to alter them. In all events, ERISA does make that choice for it.

Id. at 570.

§ 15.9 ERISA § 510 litigation

§ 15.9.1 Saying "Discrimination" and Proving Are Two Different Things

§ 15.9.1.1 Isbell v. Allstate Insurance Company

"I will sue." The three most dreaded words spoken in any exit interview seem naturally blurt out when employees are informed that the company has decid to terminate them as employees but may allow them to continue working as i dependent contractors if they sign a release of all claims. During 2000, Allsta Insurance Company terminated Ms. Isbell, as well as its entire 6,400 employe agent sales force. *Isbell v. Allstate Insurance Company*, 418 F.3d 788 (7th Cir. 200 Ms. Isbell, like all other terminated agent-employees, was given four options: (retain her book of business and continue as an independent contractor for Al state; (2) retain her book of business for the purpose of selling that book to a approved agent; (3) terminate her relationship with Allstate and receive 1 months of severance pay; or (4) terminate her relationship with Allstate and re ceive up to 13 weeks of severance pay. *Id.* at 791. All but the fourth option re quired Ms. Isbell sign a release of claims against Allstate. *Id.* Ms. Isbell selecte option (4) and sued Allstate for discrimination, retaliation, and violation of sec tion § 510. *Id.* at 792. Ms. Isbell lost at the trial court and appealed. *Id.*

Section 510 section makes it "unlawful for any person to discharge... a par ticipant or beneficiary for exercising any right to which he is entitled under th provisions of an employee benefit plan... or for the purpose of interfering wit

the attainment of any right to which such participant may become entitled under the plan..." 29 U.S.C. § 1140. To prove a violation of section 510, the employer must be shown to have intended to deprive an employee of his plan rights; *Schweitzer v. Teamsters Local 100,* 413 F.3d 533, 537 (6th Cir. 2005); *Lindemann v. Mobil Oil Corp.,* 141 F.3d 290, 295 (7th Cir. 1998). No violation will arise where the deprivation was simply the consequence of a decision that had the incidental effect of affecting an employee's benefits. *Lindemann v. Mobil Oil Corp.,* 141 F.3d 290, 295 (7th Cir. 1998). 'The plaintiff must ultimately show that a desire to frustrate attainment or enjoyment of benefits rights contributed toward the employer's decision" *Teumer v. General Motors Corp.,* 34 F.3d 542, 550 (7th Cir. 1994).

Violation of section § 510 can be shown either directly or indirectly. *Isbell,* 418 F.3d at 796. Direct evidence is evidence "which, if believed, requires the conclusion that [the intent to interfere with plan benefits] was at least a motivating factor in the employer's actions." *Schweitzer,* 413 F.3d at 537. Since Ms. Isbell presented "no direct or circumstantial evidence that Allstate eliminated the employee-agent position for the purpose of depriving her (and the other employee agents) of her pension and health care benefits," Ms. Isbell was required to proceed under the "indirect method." *Isbell* at 796. Proving a violation of section § 510 using the indirect method involves a burden shifting analysis ala *McDonnell Douglas Corp. v. Green,* 411 U.S. 792, 93 S. Ct. 1817 (1973). *Id.* at 796. Under the *McDonnell Douglas* analysis, Ms. Isbell was required to show "that [she] (1) belongs to the protected class; (2) was qualified for [her] job position; and (3) was discharged or denied employment under circumstances that provide some basis for believing that the prohibited intent to retaliate or to prevent the use of benefits was present." *Id.* at 796 (internal quotations omitted). Under the *McDonnell Douglas* analysis, the burden would then shift to Allstate to produce evidence that it had a legitimate business reason for its adverse employment action. *McDonnell Douglas Corp. v. Green,* 411 U.S. at 802-03; *see also Schweitzer v. Teamsters Local 100,* 413 F.3d 533, 537 (6th Cir. 2005) (explaining the three steps). If the defendant shows a legitimate business reason for its action, the inference of discriminatory motive is dispelled and the burden shifts back to the plaintiff to show that the defendant's articulated reason is merely a pretext. *Id.* at 803.

However, rather than shift the burden back to Ms. Isbell to show that the "legitimate, nondiscriminatory reason" given by Allstate was mere "pretext" the Seventh Circuit simply concluded its analysis. According to the Seventh Circuit's reasoning, once Allstate gave a legitimate business reason for its decision "Allstate was entitled to summary judgment." *Isbell* at 796.

§ 15.9.1.2 Schweitzer v. Teamsters Local 100

In *Schweitzer v. Teamsters Local 100,* 413 F.3d 533 (6th Cir. 2005), the Sixth Circuit ruled that Mr. Schweitzer failed to present a prima facie case under section § 510. Mr. Schweitzer presented a letter written by his former employer's attorney, which "lists the cost of maintaining Schweitzer's health and welfare benefits

as one reason for Schweitzer's termination." *Id.* at 537. He also presented an affidavit, written by a former business agent for Mr. Schweitzer's former employer. That affidavit recounted a conversation with the treasurer of Schweitzer's former employer in which the treasurer stated that Schweitzer had been let go "because Local 100 did not want to pay Schweitzer's health, welfare and pension benefits." *Id.* at 538. The Sixth Circuit held that that this evidence was not "enough to support a prima face case under § 510 of ERISA." *Id.* at 539. The Court reasoned: "the mere fact that [an employee's] termination would save [the employer] money in pension costs ... is not sufficient to prove the requisite intent" in making a prima facie case under § 510." *Id.* at 539.

§ 15.10 Severance Plan Litigation

§ 15.10.1 No Warning?

Braden v. LSI Logic Corp.

Can a severance plan's calculation of benefits offset WARN Act payments without violating either ERISA or the WARN Act? The court in *Braden v. LSI Logic Corp.*, 340 F. Supp. 2d 1066 (N.D. Cal. 2004), answered, "yes." It ruled that offsets for WARN Act payments are permissible.

The WARN Act prohibits employers from closing a facility without first providing affected employees with sixty days written notice of such closing or layoff. 29 U.S.C. § 2102(a). An employer who fails to provide timely notice is liable to each aggrieved employee "for back pay for each day of violation." 29 U.S.C. § 2104(a)(1)(A). An employer's liability under section 2104(a)(1)(A) may be reduced by "any voluntary and unconditional payment by the employer to the employee that is not required by any legal obligation." 29 U.S.C. § 2104(c).

Ms. Braden was among over 100 former employees of LSI Logic whose employment was terminated on November 18, 2001 when LSI Logic shut down a facility in Santa Clara, California. All affected LSI employees were notified on September 19, 2001 of the impending layoff. The employees were told that they would receive their regular pay and benefits for the following sixty days, but would be relieved from all job duties during that time. *Id.* at 1068. The employees were also informed that they may be eligible for benefits under the LSI Logic Severance Plan. *Id.*

The LSI Logic Severance Plan, a welfare benefit plan covered by ERISA, stated that it was "intended to satisfy, where applicable, the obligations of the Company under the [WARN] Act." *Id.* at 1069. The Severance Plan provided eligible employees with benefits based on a formula of years worked and base salary. In addition, the critical portion of the plan provided:

> Should the termination of your employment be deemed to be covered by the WARN Act, the severance benefits above shall be considered to be payments required by that

> Act. Accordingly, any payments under this Plan shall be reduced dollar-for-dollar by payments required pursuant to the *WARN Act, and* all other benefits otherwise provided by this Plan will be offset by benefits required pursuant to the WARN Act.

Id. at 1070. (Emphasis in original). In calculating severance benefits payable to the laid off employees, LSI Logic offset severance benefits otherwise payable by the pay and benefits each employee received during the 60-day period between September 19, 2001 and November 18, 2001. Ms. Braden and several of her fellow terminated employees filed suit against LSI Logic for violating the terms of the severance plan and for violating the WARN Act.

Ms. Braden relied on two cases in support of her claims: *Local Joint Executive Bd. of Culinary/Bartender Trust Fund v. Las Vegas Sands, Inc.*, 244 F.3d 1152 (9th Cir. 2001) and *Ciarlante v. Brown & Williamson Tobacco Co.*, 143 F.3d 139 (3rd Cir. 1998). The employer in *Las Vegas Sands* had tumbled into trouble by failing to provide the 60-days notice required under the WARN Act. The Sands' employees noticed and sued for the full 60-days of back pay and benefits. The Sands argued that it should be permitted to reduce its liability for back pay and health benefits by amounts paid to the employees pursuant to severance agreements entered into after the employees were given notice of their termination. The severance agreements at issue provided for payment of wages and benefits to employees on the condition that they not quit before the date of closure. The court ruled that these agreements created a legal obligation to pay the severance amounts. Since the Las Vegas Sands had a pre-existing legal obligation to pay the severance amounts, those payments could not be reconstituted as "voluntary and unconditional payments," and thus could not be used to offset the 60-days of pay and benefits required under the WARN Act.

A similar result was reached in *Ciarlante* when the employer again failed to give the 60-day notice of a layoff required by the WARN Act. The affected employees again sued for back pay and benefits. The employer again argued that the back pay owed pursuant to the WARN Act should be reduced by severance amounts paid pursuant to the employees' existing ERISA benefit plan. The court again rejected the employer's argument stating that the company was already legally obligated to make the severance payments regardless of the work the terminated employees performed.

Las Vegas Sands and *Ciarlante* stand for the proposition that an employer may not create offsets to WARN Act payments after the fact. In both cases, the employers tried to offset the back pay and benefits required by the WARN Act by amounts the employer was already legally obligated to pay. By contrast, in *Braden*, the employer structured its severance plan benefit formula to offset WARN payments from severance payments otherwise payable. As a result, LSI Logic was not *legally obligated* to pay both the severance amounts and WARN Act payments. *See, e.g., Tobin v. Ravenswood Aluminum Corp.*, 838 F. Supp. 262 (S.D.W.VA. 1993). Since LSI Logic provided 60-days notice prior to terminating its employees, and since the LSI Logic severance plan explicitly reduced severance benefits otherwise payable by amounts paid pursuant to the WARN Act, the Court held that neither ERISA nor the WARN Act were violated. *Braden*, 340 F. Supp. at 1073-

1076. The moral to this ERISA story is to make sure your ERISA severance plan says what you mean.

§ 15.11 Long-term disability

§ 15.11.1 California Department of Insurance

A nettlesome problem emanating from ERISA has haunted both the plaintiffs' bar and the California Department of Insurance. The problem is under what circumstances should a court reviewing a denied claim for employee benefits substitute its own judgment for that of the plan's administrator?

Why, one may ask, is there confusion? Well, this problem began in 1989, when the U.S. Supreme Court decided that courts reviewing a participant's denied claim for employee benefits had been far too deferential to claims decisions made by plan administrators. In *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 109 S. Ct. 948 (1989), the Supreme Court announced that a plan administrator's interpretation of the terms in an employee benefit plan would be subject to "Judge Judy" review—called "de novo" review by lawyers—because the court gives no presumption of correctness to a plan administrator's decision to grant or deny a claim for benefits. In other words, like Judge Judy on television, the reviewing court will make the call as to whether the participant is entitled to employee benefits under the plan's terms.

The Supreme Court explained in *Firestone*, however, that if a plan contains special language giving the administrator the power to construe the plan's terms and to determine who is eligible for benefits, then the administrator's decision would be deferred to under the "abuse of discretion" standard of review. *Id.* at 115.

The degree of deference under the abuse of discretion standard is most commonly referred to by the familiar description that the administrator's reading will be upheld unless it is "arbitrary and capricious." The meaning of those words has been fleshed out further in several cases. For example, in *Pokratz v. Jones Dairy Farm*, 771 F.2d 206, 209 (7th Cir. 1985), the court stated that the standard calls for "the least demanding form of judicial review of administrative action: Although it is an overstatement to say that a decision is not arbitrary or capricious whenever a court can review the reasons stated for the decision without a loud guffaw, it is not much of an overstatement."

Other reviewing courts, such as the court in *Cuddington v. Northern Ind. Pub. Serv. Co.*, 33 F.3d 813, 817 (7th Cir. 1994), have extracted from earlier case law a less colorful but more helpful standard: "If the trustee makes an informed judgment and articulates an explanation for it that is satisfactory in light of the relevant facts, i.e., one that makes a 'rational connection' between the issue to be decided, the evidence in the case, the text under consideration, and the conclusion reached, then the trustee's decision is final."

§ 15.11.2 Attempts to Prohibit the Use of Magic Words in Long-Term Disability Plans

Over the past few years, a debate has raged within California regarding the inclusion of "discretionary clauses" in long-term disability insurance plans. The California Department of Insurance ("DOI") has ruled that these clauses giving the administrator the power to construe and interpret the plan and to determine who is eligible for benefits are improper features in an insured LTD plan. To the DOI, requiring a court to review benefit decisions "for an abuse of discretion" rather than de novo violates the California Insurance Code. Allowing insurance companies (acting as ERISA plan administrators) to make the call as to whether an LTD claimant is goldbricking seems, to the DOI, to render the promise of benefits illusory. Courts facing this dispute have taken every position possible - from outright rejection of the DOI's reasoning to an overzealous retroactive application of the DOI's position. What follows is a brief summary.

A review for "abuse of discretion" is obviously deferential. For example, in the Third Circuit, under this "highly deferential standard," "a plan administrator's interpretation of a plan may be disturbed only if it is without reason, unsupported by substantial evidence or erroneous as a matter of law." *Courson v. Bert Bell NFL Player Retirement Plan,* 214 F.3d 136, 142 (3d Cir. 2000); *see also Daniels v. Anchor Hocking Corp.*, 758 F. Supp. 326, 331 (W.D. PA 1991) ("[U]nless the decision was not rational, we must uphold the administrator's decision."). Similarly, the Ninth Circuit has held that "even decisions directly contrary to evidence in the record do not necessarily amount to an abuse of discretion." *Taft v. The Equitable Life Assurance Soc'y,* 9 F.3d 1469, 1473 (9th Cir. 1993); *see also Zavora v. Paul Revere Life Ins. Co.*, 145 F.3d 1118 (9th Cir. 1998) ("An ERISA administrator is entitled to substantial deference... [so long as it has] some reasonable basis for its decision denying benefits.").

Rowe v. Planetout Partners and Unum Life Insurance Co.

In late 2003, the plaintiff in an ERISA long-term disability case, *Rowe v. Planetout Partners and Unum Life Insurance Co.*, No. C 03-1145 (N.D. Cal.), requested an opinion letter from the DOI as to whether discretionary clauses in disability insurance policies were "appropriate under California law." In response to that request, the DOI opined that discretionary clauses in insurance contracts and the resulting "abuse of discretion review" granted to insurers making payment of benefits contingent on the "unfettered discretion of the insurer" this seemed to nullify the promise to pay, and made the contract potentially illusory. (*Id.*). Thus, the DOI concluded that discretionary clauses "render the insurance contract 'fraudulent or unsound insurance'" within the meaning of the California Insurance Code. (See DOI letter dated Feb. 26, 2004).

The following day, the DOI, whose job it is to review and either approve or disapprove disability insurance policies sold in California, issued a Notice to Withdraw Approval to all disability insurers doing business in California. The Notice conditionally withdrew the DOI's prior approval of eight disability insurance policies issued by five insurers because the policies contained discre-

tionary clauses. The Notice also ordered all insurers offering disability insurance in California to submit a list of insurance policy forms currently offered to California insureds which contained discretionary clauses.

One month later, the DOI responded to the *Rowe* court's request for clarification of its prior letter opinion and the Notice to Withdraw Approval. (March 24, 2004 letter). In its second letter to the court, the DOI explained that it had begun disapproving insurance policies containing discretionary clauses as early as 1996, but that there may be certain policies on the market containing those clauses. The DOI further explained that its Notice to Withdraw Approval would be effective prospectively only and would preclude insurers from further sales of the particular policies listed in the Notice. Policies already sold would not be affected - including the policy at issue in *Rowe*.

Firestone v. Acuson Corp. Long Term Disability Plan

In *Firestone v. Acuson Corp. Long Term Disability Plan*, 326 F. Supp. 2d 1040 (N.D. Cal. 2004), the plaintiff employee sought to overturn the defendant insurer's decision to terminate his benefits. The plaintiff argued that the insurer's decision should be reviewed de novo because the grant of discretion in the plan violated the California Insurance Code, as opined in the DOI's February 26, 2004 letter. *Id.* at 1050. The court rejected the plaintiff's argument and granted summary judgment in the defendant's favor. The Court reasoned that California Insurance Law did not "confer upon beneficiaries such as Firestone the right to 'reform the nature of his policy and obtain benefits for which he never bargained by engaging courts to second-guess the Commissioner's approval of the policy." *Id.* at 1050. "Once the Commissioner has approved a plan, an otherwise valid policy is a binding contract until the Commissioner revokes his approval." *Id.* at 1050. The insurance plan in question was not one covered in the DOI's Notice to Withdraw Approval. The Court noted that the plaintiff's only potential remedy was to seek a writ of mandamus compelling the commissioner to withdraw her approval of the applicable policy. *Id.* at 1051. Finally, the Court held that even if the Commissioner were to revoke approval of the policy, "such a revocation operates only prospectively and not retrospectively." *Id.* at 1051.

Horn v. Provident Life & Accident Insurance Company

In another recent case, *Horn v. Provident Life & Accident Insurance Company*, 351 F. Supp. 2d 954 (N.D. Cal. 2004), Mr. Horn, like the plaintiff in *Firestone*, argued that the grant of discretion to the insurer contained in his disability plan should be rendered void as in violation of the California Insurance Code. The Court noted the similarity of Mr. Horn's argument to the argument previously brought and rejected in *Firestone*. However, the Court noted that Mr. Horn made an additional argument, not made in *Firestone*, that there was no evidence defendant's policy had ever been reviewed or approved by the DOI. Adopting the reasoning of the Texas Supreme Court, the Northern District of California held that in the absence of evidence that the DOI approved the policy, the Court must "undertake an independent inquiry into whether that clause is void as contrary to public policy." *Id.* at 961. The Court declined to find the insurance policy in violation of public policy—including public policy articulated in California In-

surance laws. The Court rejected the reasoning set forth in the DOI's February 26, 2004 letter, stating that the "letter is so lacking in the 'the power to persuade' that the court need only accord it the respect that it is due—that is to say, very little." *Id.* at 962. Ultimately, the Court found that the insurance policy did not violate public policy and was enforceable. *Id.* at 964-65. The insurer's decision in *Horn* would be reviewed for an abuse of discretion.

§ 15.12 ERISA Class Action Issues

§ 15.12.1 Got Adequacy?

Why do plaintiffs' lawyers plead ERISA stock drop cases as class actions? Fiduciary breach claims under ERISA are, after all, derivative in nature. A typical ERISA plaintiff alleges the plan's fiduciaries did bad things and he or she is suing to "make the plan whole for any losses." ERISA § 409(a). So why do ERISA plaintiffs' lawyers invariably intone they are bringing a class action? The short answer is "greed." Bringing a case as a single plaintiff to "make the plan whole for any losses" usually results in potential legal fees equal to the hours of work expended by the plaintiff's lawyer. *Cann v. Carpenters' Pension Trust Fund*, 989 F.2d 313 (9th Cir. 1993). Bringing a class action, on the other hand, allows the lawyer to share in the spoils of victory. As a class action lawyer, he or she can petition the court for a percentage of the total "common fund" recovery. *Brytus v. Spang & Co.*, 203 F.3d 238, 245 (3d Cir. 2000).

Ogden v. AmeriCredit Corp.

The problem with class actions for plaintiffs' lawyers is that the procedure for certifying a class is often costly and complicated. Among the requirements to bring a class action is that the plaintiff be an "adequate" class representative. *Ogden v. AmeriCredit Corp.*, 225 F.R.D. 529 (N.D. Tex. 2005), demonstrates that less is not more when it comes to class certification. In *Ogden*, the Northern District of Texas denied Ms. Ogden's Motion for Class Certification and granted the defendants' Cross Motion to Deny Class Certification because it found that Ms. Ogden was not an adequate class representative.

The facts in *Ogden* are all too familiar. Ms. Ogden was a former employee and a participant in the AmeriCredit 401(k) Plan. *Id.* at 530. Through the 401(k) Plan, Ms. Ogden received shares of AmeriCredit stock in the form of "three" matching contributions to her plan account. *Id.* at 530. In 2003, AmeriCredit issued two press releases indicating that it was changing its accounting practices and that it would be reporting a loss for the most recent fiscal quarter. *Id.* at 530. Following those press releases, the price of AmeriCredit stock collapsed. Ms. Ogden then sued. *Id.* at 530. She alleged that the defendants breached their fiduciary duties by: (1) encouraging participants to invest in AmeriCredit Stock; and (2) by failing to timely disclose material, non-public information about the stock which

caused participants to purchase or remain invested in AmeriCredit Corp. stock when it was imprudent to do so. Following discovery, Ms. Ogden moved for class certification. She lost.

The Court ruled that Ms. Ogden's deposition testimony showed that she did not understand who did the bad things she complained of, or how they did them. Ms. Ogden was not sure whether AmeriCredit Stock was an investment option in the AmeriCredit 401(k) Plan; nor could she explain what bad things T. Rowe Price did that were a breach of fiduciary duty; nor could she identify a single action taken by T. Rowe Price to inflate the price of AmeriCredit Stock. *Id.* at 533-34. That Ms. Ogden relied excessively upon her counsel was self-evident. *Id.* at 534-35. Instead of being able to describe the facts that supported her Complaint, Ms. Ogden was only able to direct her questioners to find the answer in the wording of the Complaint. *Id.* at 534-35. The court also noted that though Ogden relied on her counsel to come up with her allegations, she had done no research regarding the suitability of her attorneys. *Id.* at 535. Ogden initiated her relationship with her attorneys in response to a solicitation by them, had not contacted or spoken with any other attorneys regarding her claims, and had not given her counsel any instructions as to their representation. *Id.* at 535. The Court also noted that, during her deposition, Ms. Ogden's attorney "repeatedly made lengthy and argumentative objections ... [which] often, directly or indirectly, either informed Ogden of what her response should be or attempted to explain Ogden's lack of ability to respond to the question posed." *Id.* at 535, n.7. The Court noted that: "A competent class representative should be able to appear at and participate in a deposition without such extensive involvement by her attorney." *Id.* The Court explained that while a class representative may rely on her counsel for some information, she must know more than that she was involved in a "bad business deal."

Ultimately, the Court concluded: "[c]onsidering all of the evidence weighing against Ogden's adequacy — her lack of knowledge and understanding, her level of reliance on counsel, and her failure to demonstrate her willingness and ability to proceed as class representative ... she cannot sustain the burden placed on her in Rule 23(a)(4)." *Id.* at 537.

§ 15.12.2 Why Do I Care? (*In re Administrative Committee ERISA Litigation*)

A question all federal judges eventually ask litigants at some stage of a proceeding confirms that you'd better have a personal stake in the outcome of an ERISA case before you file suit.

Mr. Ingle was a disgruntled former employee of Emery Worldwide Airlines. *In re Administrative Committee ERISA Litig.*, 2005 WL 3454126 (N.D. Cal. Dec. 16, 2005). He was also a former participant in two 401(k) plans offered by Emery Worldwide Airlines ("EWA"). He alleged that from August 12, 2001 through October 15, 2001, the two 401(k) plans had been improperly frozen. According to

Mr. Ingle, plan participant could not alter the investment mix in their plan accounts to dispose of CNF stock (stock of EWA's parent company), could not withdraw funds from their plan accounts, could not borrow money from the funds in their accounts and could not access their account balances or statements over the telephone or internet. *Id.* at *1. By the end of the "freeze," participants' accounts had allegedly declined in value, in large part because of a decline in the value of CNF stock held in their plan accounts. *Id.* at *1. Mr. Ingle sued EWA, CNF, the plans, the plan administrators, and the plans' trustees for breach of fiduciary duty under section § 502(a)(2). After discovery, Mr. Ingle moved for certification of a class defined as "all persons who were furloughed on August 12, 2001, and who were also participants in or beneficiaries of the Retirement Plans at any time between August 12, 2001, and October 16, 2001." *Id.* at *3.

ERISA only allows a short list of people to sue. "A participant, beneficiary, or fiduciary" may bring a civil action for breach of fiduciary duty." ERISA § 502(a)(2); *Id.* at *4. ERISA defines "participant" as "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." ERISA § 3(7), 29 U.S.C. § 1002(7). The Supreme Court in *Firestone Tire and Rubber Co. v. Bruch,* 489 U.S. 101 (1989), refined that definition, holding that the term "participant" is naturally read to mean either "employees in, or reasonably expected to be in, currently covered employment," or former employees who "have ... a reasonable expectation of returning to covered employment" or who have a "colorable claim" to vested benefits. *Id.* 117-18. In order to establish that he or she "may become eligible" for benefits, a claimant must have a colorable claim that: (1) he or she will prevail in a suit for benefits, or that (2) eligibility requirements will be fulfilled in the future... . A former employee who has neither a reasonable expectation of returning to covered employment nor a colorable claim to vested benefits, however, simply does not fit within the [phrase] 'may become eligible.' *Id.* at 117-18.

Mr. Ingle took full distribution of the amounts remaining in his plan accounts in January 2002. *Id.* at *5. His lawsuit was filed in August 2003. The defendants argued that because Mr. Ingle was no longer a participant in the plans by the time he filed his lawsuit, he did not have standing to assert claims on his own behalf or on behalf of any proposed class members. *Id.* at *5. The court agreed. At the time Mr. Ingle's lawsuit was filed, Mr. Ingle was a former employee of EWA. *Id.* at *5. Therefore, he would only qualify as a plan participant if he had "a reasonable expectation of returning to covered employment or [had] a colorable claim to vested benefits." *Id.* at *5. The court concluded that because EWA had ceased operations in December 2001 "Ingle did not have a reasonable expectation of returning to covered employment. And because he had taken a full distribution of money in his 401(k) account in January 2002, he did not have a colorable claim to vested benefits: his benefits under the Plans had already been distributed to him in full." *Id.* at *5. Without a reasonable expectation of returning to covered employment or a colorable claim to vested benefits, "Ingle was not a participant in the ERISA plan at the time he filed suit. He therefore lacked standing to bring a claim under § 1132." *Id.* at *6.

Mr. Ingle argued that he met an exception to the standing requirement set forth in cases such as *Amalgamated Clothing & Textile Workers Union, AFL-CIO v. Murdock,* 861 F.2d 1406, 1418 (9th Cir. 1988) and *Perigo v. Hoffer,* 354 F. Supp. 2d 1145, 1147 (E.D. Cal. 2005). The court disagreed. In *Amalgamated Clothing,* the Ninth Circuit held that a former plan participant could sue for breach of fiduciary duty because to preclude him from suing would be to allow the fiduciary to benefit from its scheme to personally profit from the breach. Similarly, in *Perigo,* the Eastern District found that a former plan participant had standing to seek disgorgement of ill-gotten gains that had accrued to defendant as a result of breaches of fiduciary duty. Since Mr. Ingle failed to allege facts showing "ill-gotten profits" made by defendants as a result of the alleged "freeze" on participant accounts, the court found that he did not meet the exception set forth in these cases. *Id.* at *6.

The court also rejected Mr. Ingle's request that another plan participant be permitted to seek to represent the proposed class. Because Mr. Ingle had not *lost* standing, but, rather, had never had standing, the appropriate result was dismissal of his case. *See Lierboe v. State Farm Mutual Automobile Ins. Co.,* 350 F.3d 1018, 1020-21 (9th Cir. 2003); *Foster v. Center Township of LaPorte County,* 798 F.2d 237, 244-45 (7th Cir. 1986).

Though not argued by the parties, the court noted that Mr. Ingle may also lack standing to bring a claim under section § 502(a)(2) since he was apparently seeking recovery for himself and the other individual members of the class, rather than the plan as a whole. *Id.* at *8, fn.6. Remedies for alleged fiduciary breaches under ERISA must inure to the benefit of the entire plan or to all plan participants; damages may not be pursued on behalf of a single beneficiary or a narrow class of beneficiaries. *Massachusetts Mut. Life Ins. Co. v. Russell,* 473 U.S. 134, 139-144, 105 S. Ct. 3085, 3088-91 (1985); *Parker v. BankAmerica Corp.,* 50 F.3d 757, 768; (9th Cir. 1995); *Horan v. Kaiser Steel Retirement Plan,* 947 F.2d 1412, 1417-18 (9th Cir. 1991) ("Plaintiffs fail to present a fiduciary breach claim if the only remedy sought is for their own benefit, rather than for the benefit of the Plan as a whole"). Mr. Ingle's proposed class included a narrow subset of plan participants - *i.e.* only persons who were participants in or beneficiaries of the plans at any time between August 12, 2001, and October 16, 2001, and furloughed on August 12, 2001. Anyone not a participant between August 12, 2001 and October 16, 2001 or not furloughed on August 12, 2001, was excluded. Based on these facts, the court indicated it could have concluded that Mr. Ingle was not suing on behalf of the plans as a whole and thus did not have standing to sue under section § 502(a)(2).

The views set forth herein are the personal views of the authors and do not necessarily reflect those of the law firm with which they are associated.