CHAPTER **15**

ERISA

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CHAPTER 15

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§ 15.1 ERISA "STOCK DROP" CASE DEVELOPMENTS

§ 15.1.1 Alive And Kicking!

Six years after Enron, lawsuits continue to be routinely filed whenever the price of company stock in a 401(k) plan declines by more than 15%. "Heads I win, tails you lose," remains the mantra for many ERISA plaintiffs' lawyers following the economic implosions of Enron, Worldcom, Dynegy and others. The bad facts giving rise to the collapse of the 401(k) plan's company stock holdings in Enron resulted in an avalanche of civil lawsuits and an adverse district court decision. Aberrant behavior by a few executives at Enron mushroomed into a new ERISA litigation industry. Variations on the Enron theme soon emerged. Instead of the price of stock in a 401(k) plan going to zero as the basis for a lawsuit, later claims asserted temporary price fluctuations also provided a sufficient factual basis for asserting a breach of fiduciary duty. The more aggressive claims spawned more aggressive defenses. As a result of these new cases with more aggressive claims, the pendulum in the case law appears to be swinging back to the center. Some good news for plan fiduciaries emerged from the courts during 2006.

§ 15.1.2 Anatomy Of An ERISA Stock Drop Case

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. In the words of the Supreme Court: "ERISA is a comprehensive and reticulated statute." *Nachman Corp. v. Pension Benefit Guar. 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. 2d 745 (S.D.N.Y. 2003); *Rankin v. Rots (Kmart)*, 278 F. Supp. 2d 853, 875-77 (E.D. Mich. 2003); *In re Dynegy Inc. ERISA Litig.*, 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 ("PLSRA") 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 Elec. 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 the plan's participants the stock was certain to tank?" - the failure to disclose claim; and (3) "why didn't you supervise the bozos running our plan who let the company stock account go to zero?" - 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 Litig.*, 391 F. Supp. 2d 812 (N.D. Cal. 2005), with *In re Enron Corp. Secs., 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.

§ 15.1.3 Employer Stock And The Prudent Man Standard

By definition, an investment option concentrated in employer stock is not diversified. 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" ("EIAP"), including 401(k) plans and ESOP's 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 sell or discontinue a plan's investments in employer stock. "A fiduciary must comply with plan instruments only to the extent that they are consistent with the other provisions of § 1104, including the duties of loyalty and prudence." *In Re Xcel*

Energy, Inc., Secs., Derivative & "ERISA" Litig., 312 F. Supp. 2d 1165, 1181 (N.D. Minn. 2004).

§ 15.1.4 Must The Company Be On The Verge Of "Imminent Financial Collapse?"

A common defense to ERISA "stock drop" claims is that retirement plan investments in employer stock are presumed to be prudent unless the fiduciary had knowledge that the company was facing such dire consequences as to be on the brink of "impending collapse." This theory is consistent with the statutory text of ERISA quoted above. The origin of the "presumption of prudence" and "impending collapse" terminology is *Moench v. Robertson*, 62 F.3d 553 (3d Cir. 1995). In *Moench*, the court opined that the "precipitous decline" in company stock combined with an insider fiduciary's knowledge of "its" "impending collapse" and the fiduciary's own "conflicted status" might constitute the type of change in circumstances that was not anticipated by the settlor of the trust. Without these facts, a retirement plan fiduciary is entitled to a "presumption of prudence" when following the terms of a plan and allowing continued investment in employer stock. The *Moench* presumption is not universally accepted. Only the Third Circuit in *Moench*, followed by the Sixth Circuit in *Kuper v. Iovenko*, 66 F.3d 1447 (6th Cir. 1995), have adopted a prudence standard for ESOP fiduciaries, which states the law presumes an investment in employer stock is prudent.

The Ninth Circuit in *Wright v. Oregon Metallurgical Corp.*, 360 F.3d 1090 (9th Cir. 2004), expanded the application of the presumption of prudence to a stock bonus plan. In *Wright*, the court upheld the district court's grant of a motion to dismiss in favor of the plan's discretionary trustee on the ground that the plaintiffs had failed to allege any facts other than that the plan sponsor's stock price had declined in value. According to the court in *Wright*, the "[m]ere stock fluctuations, even those that trend downward significantly" are insufficient to rebut the presumption that the discretionary fiduciary had acted prudently in deciding to hold onto the stock. Instead, the plaintiffs had to allege, in addition to a decline in value, some evidence that the company was on the brink of collapse or undergoing serious mismanagement. Without such a showing, there could be no fiduciary breach claim against the discretionary trustee for deciding to hold the stock. According to the court, the danger in acting precipitously to dispose of the stock while it is declining in value is that such actions may trigger an even steeper sell-off and/or invite a lawsuit when the stock later appreciates.

Unfortunately, the majority of case law analyzing the *Moench* presumption has been generated in response to Rule 12(b)(6) motions to dismiss and there is no common thread as to the willingness of courts to apply the *Moench* presumption at the pleading stage. The rulings vary even between courts within the same circuit and district. *Compare Hill v. BellSouth Corp.*, 313 F. Supp. 2d 1361 (N.D. Ga. 2004) (declining to apply *Moench* presumption on a motion to dismiss) *with Pedraza v. The Coca-Cola Co.*, 2006 U.S. Dist. LEXIS 76212 (N.D. Ga. Sept. 29, 2006) (dismissing Complaint based on failure to plead facts which would overcome the *Moench* presumption.)

Although the *Moench* presumption is arguably based on a statutory exemption, most courts view it as an evidentiary standard and are reluctant to apply it when this defense is raised on a motion to dismiss. "There exists no uniform rule that a plaintiff must plead that the defendant company's viability was in jeopardy to state a claim for imprudent investment in company stock." *In re ADC Telecomm., Inc., ERISA Litig.*, 2004 U.S. Dist. LEXIS 14383 (D. Minn. 2004); *see also, Pa. Fed'n., Bhd. of Maint. of Way Emples. v. Norfolk S. Corp. Thoroughbred Ret. Inv. Plan*, 2004 U.S. Dist. LEXIS 1987 (E.D. Pa. Feb. 4, 2004) ("Although a drop in stock price and general weakness in the company's performance is not sufficient to win judgment on a breach of the duty of prudence, it is enough to survive a motion to dismiss."); *In re Xcel Energy, Inc. Sec., Derivative & ERISA Litig.*, 312 F. Supp. 2d 1165, 2004 WL 758990, at *8 (D. Minn. 2004) (declining to apply ESOP presumption on a motion to dismiss); *In re Elec. Data Sys. Corp. ERISA Litig.* ("EDS"), 305 F. Supp. 2d 658, 668-70 (E.D. Tex. 2004) (same); *Stein v. Smith*, 270 F. Supp. 2d 157, 171-72 (D. Mass. 2003) (same); *Rankin v. Rots*, 278 F. Supp. 2d 853, 879 (E.D. Mich. 2003) (declining to rely on the ESOP presumption because whether the defendants breached their fiduciary obligations required the development of the facts of the case, and plaintiff stated a claim in that respect); *In re Ikon Office Sol'ns, Inc. Sec. Litig.*, 86 F. Supp. 2d 481, 492 (E.D. Pa. 2000) (denying motion to dismiss because "it would be premature to dismiss [the complaint] without giving plaintiffs an opportunity to overcome the presumption"). *Hill v. BellSouth Corp.*, 313 F. Supp. 2d 1361 (N.D. Ga. 2004) (same).

A handful of other courts have taken a contrary view and applied the presumption of prudence at the motion to dismiss stage. *See e.g., In re Duke Energy ERISA Litig.*, 281 F. Supp. 2d 786 (W.D.N.C. 2003) (complaint not viable where dire circumstances or impending collapse not alleged); *In re McKesson HBOC, Inc. ERISA Litig.*, 391 F. Supp. 2d 812 (N.D. Cal. 2005) (allegations of inequitable conduct without brink of collapse insufficient to withstand motion to dismiss.); *In re Calpine Corp.* ERISA Litig. , 2005 U.S. Dist. LEXIS 9719 (N.D. Cal. Mar. 31 2005) (allegation of seriously deteriorating financial condition and genuine risk of inside self-dealing required to state claim); *Wright v. Oregon Metallurgical Corp.*, 222 F. Supp. 2d 1224 (D. Or. 2002), *aff'd*, 360 F.3d 1090 (9th Cir. 2004) (allegations of complaint insufficient to rebut *Moench* presumption.); *Pedraza v. The Coca-Cola Co.*, 2006 U.S. Dist. LEXIS 76212 (Sept. 29, 2006) (same).

Summary judgment, on the other hand, is a different animal. A recent case involving the merits of the three fiduciary duty breach theories casts significant doubt on their viability as to temporary stock drop claims when plaintiffs are put to their proof.

§ 15.1.5 A Temporary Stock Price Decline Is Not Enough - *In re Syncor ERISA Litig.*, 410 F. Supp. 2d 904 (C.D. Cal. 2006)

In June of 2002, Cardinal Health ("Cardinal") acquired Syncor International Corp. ("Syncor") in a stock-for-stock merger. In conducting its due diligence investigation in preparation for the merger, Cardinal uncovered potential illegal payments made by a

subsidiary of Syncor in Taiwan and China. Allegations were made that Syncor's subsidiary was bribing foreign doctors to use its services in order to increase its sales figures. Immediately following disclosure of the alleged bribery scheme, the price of Syncor stock dropped. As a result, the price of Syncor stock tumbled and the merger partners agreed that Syncor shareholders would receive .47 shares of Cardinal stock for each share of Syncor stock in the merger, rather than .52 shares as originally planned.

A number of participants in Syncor's ERISA Plan (the "Syncor Plan") then sued. They stated that their 401(k) plan accounts had been adversely affected by the resulting dip in the price of Syncor shares. The three standard issue fiduciary breach claims were asserted: (1) the bribery scheme was implemented by the highest levels of Syncor management, therefore, defendants knew or should have known that Syncor stock was not a prudent Plan investment; (2) defendants failed to adequately disclose what they knew to the Committee Members; and (3) defendants failed to properly monitor the Committee Members. *Id.* at 908. After examining witnesses in depositions and reviewing relevant documents, defendants filed a motion for summary judgment asking the court to throw plaintiffs' lawsuit out as the facts did not support plaintiffs' legal theories. The district court ultimately agreed.

The court concluded the defendants had not been imprudent and had not violated their fiduciary duties by failing to diversify Syncor stock in the Plan because the Plan mandated that employer-matching contributions be made in Syncor stock. The court next applied the *Moench* presumption in considering the question of whether the Plan's retention of Syncor stock was imprudent and concluded that to prevail on this type of claim:

> [a] plaintiff must demonstrate that the fiduciaries knew that the 'company's financial condition is seriously deteriorating and that there is a genuine risk of insider self-dealing.'

410 F. Supp. 2d at 910. The Syncor plaintiffs "failed to produce evidence that Syncor's financial condition, despite the international bribery scheme, deteriorated in any way." *Id.* at 911. The court was not convinced by the plaintiffs' argument that the drop in Syncor's stock price after public disclosure of the bribery scheme was sufficient to overcome the presumption requiring the court to assume the plan's fiduciaries' decision to retain company stock was reasonable. "Mere stock fluctuations, even those that trend downward significantly, are insufficient to establish the requisite imprudence to rebut the Moench presumption." *Id.* at 911. While the plaintiffs pointed to the alleged bribery scheme and the dip in Syncor's stock price as evidence of a financial impact, it was not enough. The defendants produced evidence showing plaintiffs' theory was baloney. Syncor demonstrated its international operations generated only about 6% of its overall revenues. Because the bribery scheme was limited to Syncor's international operations, it had almost no effect on Syncor's financial condition. Syncor stock outperformed both the NASDAQ index and the S&P 500 index during the class period. Numerous reports written by investment advisors concerning the disclosure of the bribery scheme continued to recommend retaining Syncor stock.

Plaintiffs' claims that the Board breached its fiduciary duty by failing to monitor the Committee Members or failed to provide them with accurate information regarding the true value of Syncor stock suffered a similar fate. The court explained that the plaintiffs' "duty to monitor" and "duty to inform" claims were derivative of their general "prudence" claim. Since the Committee Members committed no breach of fiduciary duty of prudence by retaining Syncor stock as a 401(k) plan investment, the Board committed no breach of fiduciary duty by failing to monitor the Committee Members or by failing to provide them with accurate information.

Thus, while falling company stock prices are rarely a pleasant experience, the developing case law appears to be trending towards the conclusion that a temporary drop in the price of employer stock held by a qualified retirement plan may not be reason enough to file a class action lawsuit.

§ 15.2 SUBROGATION LITIGATION

§ 15.2.1 Chasing Shadows – The Resurrection of Equitable Relief? *Sereboff v. Mid-Atlantic Med. Servs.*, 547 U.S. ____, 126 S. Ct. 1869 (2006)

Born again! So felt virtually every ERISA lawyer on May 15, 2006, when the U.S. Supreme Court announced its decision in *Sereboff v. Mid-Atlantic Med. Servs.*. Many of us lamented that collecting reimbursement claims for medical plans was a lost cause four years ago following the Supreme Court's decision in *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 122 S. Ct. 708 (2002). We had thought equitable relief under ERISA had been entombed by *Great-West* in the catacombs of ancient equity. It turns out we were wrong.

Before *Great-West*, ERISA-regulated medical plans could routinely enforce repayment provisions ("subrogation clauses") to recover the costs of plan benefits that were reimbursed by third parties. After *Great-West*, they could not. The health plan repayment clause works like this: 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 health plan, upon learning of the participant's good fortune in recovering from the other driver's auto insurance carrier, asks the participant to repay the medical plan. After all, is it really fair for the participant to recover twice for fixing his broken leg?

§ 15.2.2 *Great West*'s Long Shadow

Great-West's insistence that any recovery by the medical plan had to satisfy the strictures described by the ancient courts of equity mystified both the bench and the bar. The key problem for the plaintiff medical plan fiduciary in *Great-West* was that the

"restitution" it sought was not "equitable" relief under ERISA because it could not point to specific property it wanted to be restored. Here is what happened in *Great-West* - A medical plan's fiduciary filed a lawsuit in federal court to enforce the medical plan's repayment clause. The defendant, Janette Knudson, had been rendered a quadriplegic in a car accident. Janette filed a lawsuit in state court to recover from the car manufacturer and others and eventually negotiated a settlement for over $600,000. In the settlement agreement, she earmarked $13,000 to pay for the medical plan's claim of over $400,000 in medical plan benefits. The federal district court rejected the medical benefit plan's claim. On appeal, the medical benefit plan's fiduciaries argued that the relief they sought was "equitable" and "appropriate" under ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3). The Supreme Court disagreed, finding that the medical plan's attempt to recover money from the beneficiary for amounts recovered from the third party was not "equitable" and, thus, the remedy was unavailable under § 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*, 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.

The crux of the repayment problem for an ERISA-regulated medical plan is that the remedies available under ERISA's catchall provision (§ 502(a)(3)) are limited. While "equitable" forms of relief can be used, monetary relief is unavailable. *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 113 S. Ct. 2063 (1993). In *Great-West*, the Supreme Court explained that § 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 § 502(a)(3). *Mertens*, 508 U.S. at 255.

As the Supreme Court taught us twenty years ago, the menu of available relief under ERISA is limited:

> The six carefully integrated civil enforcement provisions found in § 502(a) of the statute as finally enacted, however, provide strong evidence that Congress did not intend to authorize other remedies that it simply forgot to incorporate expressly.

Massachusetts Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 146, 105 S. Ct. 3085, 3092 (1985).

ERISA's available enforcement provisions for plan participants and beneficiaries (set forth in ERISA §§ 502(a)(1)(B), 502(a)(2) and 502(a)(3)) are specific. Plaintiffs who want additional plan benefits can file suit under ERISA § 502(a)(1)(B). A participant who believes the plan's fiduciaries are liars, crooks or incompetent can sue the plan's fiduciaries to make the plan whole for losses under § 502(a)(2). Finally, there is a "catchall" provision under ERISA § 502(a)(3). This "kitchen sink" remedy 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." In *Great-West*, the Supreme Court ruled that medical plan fiduciaries seeking to enforce a medical plan's repayment clause against plan participants or beneficiaries must do so under ERISA's catchall provision § 502(a)(3).

A number of Circuit Courts of Appeals interpreted *Great-West* to mean the Supreme Court had closed the door to the enforcement of a medical plan's repayment provision. For example, in *Westaff (USA), Inc. v. Arce*, 298 F.3d 1164 (9th Cir. 2002), the Ninth Circuit provided an emphatic "hell no" to the question of whether a medical plan's repayment clause could be enforced in federal court. According to the Ninth Circuit, even where the ERISA-regulated medical plan asserts a right to particular property or funds held by the plan participant, the medical plan's demand for repayment of those funds is not within an ancient equity court's ghoulish definition of "equitable" relief. In *Westaff*, the parties had entered into a repayment agreement under which the medical plan would be entitled to recover all medical benefits paid from a third-party settlement. The participant recovered from the third party and then placed the recovered money into an escrow account pending resolution of the medical plan's claim for reimbursement. In an attempt to avoid the application of *Great-West*, the medical plan characterized its claim as one for equitable relief, and sought a declaratory judgment that it was entitled to these funds. Refusing to be tricked by word play, the Ninth Circuit clung to the literal holding of *Great-West*, finding that restitution was a legal remedy regardless of what the claim was called, and regardless of whether the specific money sought was identified by the plaintiff's medical plan. Accordingly, the medical plan's right to repayment of the medical benefits provided could not be enforced under ERISA.

Other Circuit Courts of Appeals interpreted *Great-West* to mean that so long as funds recovered from a third party are identified and have not been distributed, the medical plan may seek the "equitable" remedy of a constructive trust or equitable lien on those amounts. *Admin. Comm. of Wal-Mart Assocs. Health & Welfare Plan v. Willard*, 393 F.3d 1119 (10th Cir. 2004), *Bombardier Aerospace Employee Welfare Benefits Plan v. Ferrer, Poiret & Wansbrough*, 354 F.3d 348 (5th Cir. 2003).

§ 15.2.3 Justice Roberts' Elegant Solution

Because the federal courts of appeals were in complete disagreement as to whether a medical plan could enforce its repayment provisions, the U.S. Supreme Court entered the fray. *Sereboff v. Mid-Atlantic Med. Servs., Inc.*, 547 U.S. _____, 126 S. Ct. 1869 (2006). The Sereboffs had been involved in an automobile accident in California and had suffered injuries. The Mid-Atlantic plan had paid for the couple's medical expenses. The Sereboffs later filed a lawsuit in state court against several third parties and eventually settled for $750,000. Although Mid-Atlantic sent the Sereboffs' attorney several letters asserting a $75,000 lien on the anticipated proceeds from the lawsuit for the Mid-Atlantic plan's medical expenses, the Sereboffs' attorney never responded.

Mid-Atlantic filed suit in federal court in Maryland under ERISA § 502(a)(3), seeking to collect from the Sereboffs the $75,000 in medical expenses it had paid on their

behalf. Since the Sereboffs' attorney had already paid out the settlement proceeds to the Sereboffs, Mid-Atlantic sought a temporary restraining order and preliminary injunction requiring the Sereboffs to retain and set aside at least $75,000 from the settlement proceeds. The district court approved a stipulation by the parties to "preserve $75,000" of the settlement funds in an investment account until the court ruled on the merits of the case and all appeals, if any, were exhausted.

On the merits, both the district court and the Fourth Circuit Court of Appeals found in Mid-Atlantic's favor and ordered the Sereboffs to pay Mid-Atlantic $75,000, plus interest, with a deduction for Mid-Atlantic's share of the attorneys' fees and court costs the Sereboffs had incurred in state court.

Chief Justice Roberts, writing for a unanimous Supreme Court, ruled that enforcing a medical plan's repayment agreement qualifies as "equitable" relief under ERISA:

> The plan provides for payment of certain covered medical expenses and contains an 'Acts of Third Parties' provision. This provision 'applies when [a beneficiary is] sick or injured as a result of the act or omission of another person or party', and requires a beneficiary who 'receives benefits' under the plan for such injuries to 'reimburse [Mid-Atlantic]' for those benefits from 'all recoveries from a third party (whether by lawsuit, settlement or otherwise).' … The provision states that '[Mid-Atlantic's] share of the recovery will not be reduced because [the beneficiary] has not received the full damages claimed, unless [Mid-Atlantic] agrees in writing to a reduction.'

126 S. Ct. at 1872.

For Chief Justice Roberts, the medical plan acted properly by enforcing its repayment provision because it sought to enforce an equitable lien on the money the Sereboffs received:

> It [Mid-Atlantic] alleged breach of contract and sought money, to be sure, but it sought its recovery through a constructive trust or equitable lien on a specifically identified fund, not from the Sereboffs' assets generally, as would be the case with a contract action at law. ERISA provides for equitable remedies *to enforce plan terms*, so the fact that the action involves a breach of contract can hardly be enough to prove relief is not equitable; that would make § 502(a)(3)(B)(ii) an empty promise. This Court in *Knudson* did not reject *Great-West's* suit out of hand because it alleged a breach of contract and sought money, but because *Great-West* did not seek to recover a particular fund from the defendant. Mid-Atlantic does.

126 S. Ct. at 1874. (Emphasis in original.)

This holding indicates that because ERISA plans are in essence contracts, they can use equitable remedies to enforce their terms. To paraphrase the Supreme Court, an ERISA-regulated medical plan's contractual agreement for repayment can be enforced through "equity" under ERISA § 502(a)(3) by filing an action for an equitable lien or for a constructive trust. *Id.* Although the Sereboffs argued that the Supreme Court's decision in *Knudson* imposed a strict "tracing requirement" on all equitable actions to recover money, Justice Roberts decided that the Sereboffs were confused. Mid-Atlantic was suing on an "equitable lien imposed by agreement," not on an "equitable lien sought as a matter of restitution." *Id.* at 1875-76. Because Mid-Atlantic was suing on an "equitable lien imposed by agreement," there was no requirement that the money over which the lien is asserted be in existence when the contract containing the lien provision was executed. *Id.* at 1876. This means that for a medical plan fiduciary to recover in a subrogation claim, the plan document (usually a summary plan description) must state that in exchange for the payment by the plan for injuries caused by another, the participant must agree to repay the plan from any monies recovered from the third-party tortfeasor. Finally, the Supreme Court explained that because the action was for breach of contract enforced by an equitable lien, the "parcel of equitable defenses the Sereboffs claim accompany any such action are beside the point." *Id.* at 1877. An equitable remedy based on a contractual agreement was very different from a purely equitable claim, and in the words of the Court was not "a freestanding action for equitable subrogation." *Id.*

Whether *Sereboff* is the last word on the enforcement of a medical plan's repayment provisions remains to be seen. We do not yet know whether the plan provision entitled "Acts of Third Parties" is the only magic phrase required to create an equitable lien to fend off the ghouls of ancient equity. As all good lawyers know, facts matter. In *Sereboff's* case, the district court approved the parties' agreement to set aside $75,000 in an investment account until the case was resolved. Was *Sereboff* an easy case because Mid-Atlantic pursued $75,000 that was already identifiable and set aside in an investment account? What happens if there is no segregated investment account? Worse, can the medical plan recover if the participant hides the money or gives the money away?

§ 15.2.4 *Sereboff* Revisited

In two recent cases, the Eleventh Circuit - *Popowski v. Parrott* and *BlueCross BlueShield v. Carillo* (combined into one opinion) – revisited *Sereboff* and held that one type of reimbursement/subrogation provision could be enforced while another could not. 2006 U.S. App. LEXIS 21587 (11th Cir., Aug. 24, 2006). The plan's right to an equitable lien was upheld in *Popowski*, but rejected in *BlueCross BlueShield* ("*BCBS*"). A small difference in plan language compelled these different results:

> The subrogation and reimbursement provision in the United Distributors Plan claims a lien **"on any amount recovered by the Covered Person whether or not designated as payment for medical expenses."** PR1-1, Exh. G at 63. **The Plan further clarifies that "[t]he Covered Person… must repay to the Plan the *benefits paid on his or her behalf out of the recovery made from the third party or insurer*."** *Id.* (emphasis added). Thus,

> language essentially identical to the Supreme Court's characterization of the plan language in *Sereboff*, specifies both the fund (recovery from the third party or insurer) out of which reimbursement is due to the plan and the portion due the plan (benefits paid by the plan on behalf of the defendant). Unlike in *Knudson*, a significant portion of the funds specified went directly into the Parrotts' bank account and, thereby, was in their possession for purposes of this case. Thus, at the time they filed their suit, Popowski and the Commerce Group sought "not to impose personal liability on [Parrott], but to restore to the plaintiff[s] particular funds or property in [Parrott's] possession." *See Knudson*, 534 U.S. at 214, 122 S. Ct. at 714-15. Accordingly, we conclude that Popowski and the Commerce Group have stated a claim for "appropriate equitable relief" under § 1132(a)(3) and that the district court erred in dismissing the suit for lack of subject matter jurisdiction.

Id. at *14-15.

By contrast, the *BCBS* plan contained a contractual reimbursement provision:

> The subrogation and reimbursement provision in the Mohawk Plan, unlike that of the United Distributors Plan, claims a right to reimbursement "in full, and in first priority, for any medical expenses paid by the Plan relating to the injury or illness," *but does not specify that that reimbursement may be made out of any particular fund, as distinct from the beneficiary's general assets*. BCBS Letter Br., Exh. B; BR1-1 at 3. Instead, it makes receipt of "a settlement, judgment, or other payment relating to the accidental injury or illness" a trigger for the general reimbursement obligation. *Id.* Further, in requiring reimbursement "in full", it fails to limit recovery to a specific portion of a particular fund. Accordingly, we conclude that, because the Mohwak plan fails to specify that recovery come from any identifiable fund or to limit that recovery to any portion thereof, it fails to meet the requirements outlined in *Sereboff* for the assertion of an equitable lien for the purposes of 29 U.S.C. § 1132(a)(3). For this reason, we conclude that it was not error to dismiss BCBS's claims.

Id. at *15-16.

The way to properly establish an equitable lien under ERISA, according to the Eleventh Circuit, is to state "a claim that "allege[s] breach of contract and [seeks] money" but "[seeks] recovery through a constructive trust or equitable lien on a specifically identified fund" in the defendant's possession and control." *Id.* at *13. ERISA § 1132(a)(3) appears to require that the plan language generally identify the fund out of which recovery is sought, according to the Eleventh Circuit.

Other Circuit Courts have followed *Sereboff's* teaching that unless the amounts sought are in the defendants' possession, the relief will be legal, not equitable relief, under ERISA § 502(a)(3). *See, e.g., Larue v. Dewolff, Boberg & Assocs., Inc*., 450 F.3d 570, 576 (4th Cir. 2006) ("[T]he absence of unjust possession is fatal to an equitable restitution claim" brought under § 502(a)(3)."); *Donaldson v. Pharmacia Pension Plan*, 435 F. Supp. 2d 853 (S.D. Ill. 2006); *Moore v. Capitalcare Inc*., 2006 U.S. App. Lexis 22075 (D.C. Cir. Aug. 29, 2006); *Coan v. Kaufman*, 2006 U.S. App. Lexis 18444 at *35 (2d Cir., July 21, 2006). *Sereboff* has also been cited as establishing a requirement that the third party reimbursement provision specifically identify a particular fund, distinct from the beneficiaries' general assets, and a particular share of that fund to which the plan is entitled. *See, e.g., Dillards, Inc. v. Liberty Life Assurance Co. of Boston*, 2006 U.S. App. Lexis 18062 at *18 (8th Cir., July 19, 2006).

The game is not yet over. Disputes about a medical plan's subrogation language will continue. Although the Supreme Court's pragmatic approach to this problem in *Sereboff* has narrowed the playing field, the intensely factual nature of these disputes means ERISA lawyers will continue to chase the shadows of equitable relief for many years to come.

§ 15.2.5 Recovering Medical Plan Money When the Plan's Language Is Less Than Perfect

Sereboff has helped. A plan fiduciary who has a medical plan that creates an equitable lien on a participant's recovery from a third party can now enforce the plan's repayment clause under ERISA. What happens if the medical plan's repayment language does not create an equitable lien? Do the plan fiduciaries have a remedy? A recent pair of decisions has opened the door to enforce subrogation claims in state court as breach of contract claims.

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 § 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, Providence argued that the district court lacked removal jurisdiction over its breach of contract action because its state claim was not preempted by ERISA. The Ninth Circuit agreed. "In order to be removable to federal court, a claim concerning a plan governed by ERISA must be preempted by ERISA and must fall within the scope of ERISA's enforcement provisions." *Id.* at 1171. ERISA's preemption provision provides that ERISA supersedes "any and all State laws insofar as they… relate to any employee benefit plan…" *Id.* at 1171, ERISA § 514(a). The Court explained that while the phrase "relate to" should be read broadly, it also must be read practically, "with an eye toward the

action's actual relationship to the subject plan." *Id.* at 1172. The Court reasoned that "Providence is simply attempting, through contract law, to enforce the reimbursement provisions. Adjudication of its claim does not require interpreting the plan or dictate any sort of distribution of benefits. Providence has already paid ERISA benefits on behalf of the McDowells, and they are not disputing the correctness of the benefits paid." *Id.* at 1172. The Court concluded that because Providence's claim was "merely a claim for reimbursement based upon the third-party settlement, it does not 'relate to' the plan." *Id.* at 1172. The Court also concluded that Providence's breach of contract action failed the second requirement of removal jurisdiction because it did not fall within ERISA's civil enforcement provision. *Id.* at 1172. That is, Providence would not be entitled to relief under ERISA § 502(a)(3), which provides only "equitable" relief, not the ordinary damages (i.e. monetary relief) that Providence sought. *Id.* at 1172-73. Holding that Providence's breach of contract claim was not preempted by ERISA, the Ninth Circuit ordered the claim remanded to state court. *Id.* at 1173.

The Supreme Court of Oklahoma recently followed *Providence* in holding that Oklahoma courts have subject matter jurisdiction over an ERISA fiduciary's claim for legal relief. *Reeds v. Walker*, 2006 OK 43 (June 20, 2006). Noting that a claim which seeks relief that is "not authorized" by ERISA's civil enforcement scheme may stand outside the jurisdiction of the federal courts, the *Reed* court acknowledged that this is not the only possible legal consequence of the Supreme Court's holding in *Great-West*. "It is also possible that such a claim stands within the federal courts' jurisdiction, but fails to state a claim under federal law for which relief may be granted." *Id.* at 20. Noting that each interpretation has its adherents, and reluctant to "abdicate Oklahoman's cognizance over this state-law cause of action" with federal jurisdiction uncertain, the Supreme Court of Oklahoma held that "Oklahoma courts have subject matter jurisdiction over an ERISA fiduciary's claim for legal relief." *Id.* at 20 (citing cases).

Providence and *Reeds*, therefore, permit 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 Mut. Auto. Ins. Co.*, 140 Idaho 334, 342 (2004) (applying Idaho's "common fund" doctrine); *Hamm v. State Farm Mut. Auto. Ins. 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).

§ 15.3 RETIREE MEDICAL BENEFIT LITIGATION

§ 15.3.1 When Is A "Lifetime" Not A Lifetime?

Unlike most forms of pension benefits, welfare benefits, such as medical, dental, vision, life and disability benefits, are not required to vest. *See, e.g.*, 29 U.S.C. §§ 1052, 1053, 1054 and 1082; 29 U.S.C. § 1002(1); 29 U.S.C. § 1002(2)(A). Because such benefits are not legally required to vest, "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); 29 U.S.C. § 1051(1).

Prior to the run up in retiree medical costs in the 1990s, many employers failed to specify in their retiree medical plans that these benefits could be amended or terminated. *See, e.g., Bland v. Fiatallis N. Am., 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.* As employers make cutbacks in retiree medical benefits or eliminate those benefits entirely, the lawsuits brought by retirees claiming they were promised "lifetime" benefits continue to pour in.

Whether or not there is an agreement to vest retiree medical benefits turns on the language contained within the ERISA plan, its related documents, contemporaneous collective bargaining agreements, and the employer's conduct concerning these benefits. In many circuits, if the language in a collective bargaining agreement states retiree medical benefits are to be provided "during the term of the agreement," or can be otherwise amended or terminated, then the benefits are not vested. *District 29 UMW v. Royal Coal*, 768 F.2d 588 (4th Cir. 1985); *Rosetto v. Pabst Blue Ribbon*, 247 F.3d 539 (7th Cir. 2000); *Skinner v. NSTAR Elec.*, 499 F.3d 206 (1st Cir. 2006); *UAW v. Skinner Engine Co.*, 188 F.3d 130 (3d Cir. 1999); *Wise v. El Paso Nat. Gas*, 986 F.2d 929 (5th Cir. 1993); *Anderson v. Alpha Portland Indus*., 831 F.2d 1512 (8th Cir. 1988); *Chiles v. Ceridian Corp*., 95 F.3d 1505 (10th Cir. 1996); and *Jones v. American Gen. Life*, 370 F.2d 1065 (11th Cir. 2004). Moreover, "all courts agree that if a document unambiguously indicates whether retiree medical benefits are vested, the unambiguous language should be enforced." *UAW v. Yard-Man*, 716 F.2d 1476, 1479 (6th Cir. 1983). To reach a trier of fact in a few circuits on the issue of whether a retiree has received vested retirement benefits, a retiree does not have to point to unambiguous language in the labor contract to support a claim. "It is enough to point to written language capable of reasonably being interpreted as creating a promise on the part of the employer to vest the recipient's benefits." *American Fed'n of Grain Millers v. Int'l Multifoods Corp*., 116 F.3d 976, 980 (2d Cir. 1997) and *Yolton v. El Paso Tenn. Pipeline Co*., 435 F.3d 571 (6th Cir. 2006), *reh'g* and *reh'g* en banc denied (May 9, 2006), *petition for cert. filed*, 75 U.S.L.W. 3065 (U.S. Aug, 3, 2006) (No. 06-176). The courts are guided by general principles of contract interpretation. For instance, all courts agree that if a document unambiguously indicates

the employer promised that retiree medical benefits are vested, the unambiguous language should be enforced according to its terms. *American Fed'n of Grain Millers, supra*. The circuits disagree, however, as to the proper interpretation of documents containing ambiguous language. While all circuits will admit extrinsic evidence to elucidate ambiguities, they differ as to the burdens, presumptions, and thresholds that they apply.

§ 15.3.2 Retiree Medical Case Developments The Unbreakable Promise

As my sixteen-year-old son likes to say, "stuff happens." 2006 was a "stuff happening" year for retiree medical benefits. The retiree medical benefit story begins innocently enough many years ago when an employer's cost of providing medical benefits was a pittance. Little cost meant little worry and many employers did not think twice about promising their faithful employees "lifetime" medical benefits. Unfortunately, things changed. Medical care improved and people lived longer. While these developments are wonderful in themselves, they are economically disastrous when played out over many years and thousands of lives. Medical breakthroughs and technological innovations cost a lot of money. While medical premiums for active employees skyrocketed, the premiums for the medical care of retirees (who often live well into the shipwreck of old age) went into hyperspace. Things got worse. In 1990 the Financial Accounting Standards Board ("FASB") announced that all public corporations would have to fess up to their shareholders about their retiree medical promises. FAS 106. Beginning in 1993 a corporation would be required to report on its financial statement the actuarial value of the total projected accrued costs of an employee's retiree medical benefits. General Motors announced on February 1, 1993 that it was taking a $23 billion dollar charge on its financial statement to reflect the current value of its retiree medical obligations. Further compounding these problems was an increasingly competitive global economy. For example, car parts made for generations in the Rust Belt were now being manufactured by low-cost producers whether they were located in Taipei or Timbuktu. It is little wonder that employers began to rethink their position on retiree medical benefits. Since these promises were in legal documents like summary plan descriptions or collective bargaining agreements, lawyers were called in to assist with this endeavor. When employers took action to change retiree medical plans, litigation frequently ensued. Enter *Yard-Man*.

§ 15.3.3 Litigating Collectively Bargained For Retiree Medical Benefit Disputes

Whether or not an employer has the right to change medical benefits for retired employees turns on what that employer has promised them. Retiree medical benefit disputes are complicated because an employer's agreement to provide medical benefits is regulated by the Employee Retirement Income Security Act of 1974 ("ERISA") and (in the case of collectively bargained for retiree medical arrangements) by § 301 of the Labor Management Relations Act ("LMRA").

When a collective bargaining agreement expires, an employer is ordinarily free to modify or terminate any retiree medical benefits provided under that collective bargaining agreement. In *Litton Fin. Printing Div. v. NLRB*, 501 U.S. 190 (1991), the Supreme Court explained that the layoff of ten factory workers after the expiration of a collective bargaining agreement was not subject to the expired contract's grievance and arbitration procedure:

> As with the obligation to make pension contributions in *Advance Lightweight Concrete Co.*, other contractual obligations will cease, in the ordinary course, upon termination of the bargaining agreement. Exceptions are determined by contract interpretation. Rights which accrued or vested under the agreement will, as a general rule, survive termination of the agreement.

Id. at 207.

Further complicating this area is the fact that bargaining for retired employees is a permissive, rather than a mandatory, subject of collective bargaining (because retired employees are no longer members of the bargaining unit). *Allied Chem. & Alkali Workers v. Pittsburg Plate Glass Co.*, 404 U.S. 157 (1971). The law has developed differently in each circuit. A large part of the Midwest, including Ohio, was retiree friendly from the start. Cases in the Circuit Courts of Appeal are all over the lot about how to deal with retiree medical benefit disputes. For example, the Seventh Circuit's en banc decision in *Bidlack v. Wheelabrator Corp.*, 993 F.2d 603, 606-07 (7th Cir. 1993), established that an employee's entitlement to retiree medical benefits are presumed not to be vested. The Sixth Circuit has ruled, on the other hand, that retiree medical benefits are presumed to vest. *Maurer v. Joy Techs., Inc.*, 212 F.3d 907, 915-16 (6th Cir. 2000). Two Circuit Courts insist there be express language used to vest retiree medical benefits. *Int'l Union, UAW v. Skinner Engine Co.*, 188 F.3d 130, 139-47 (3d Cir. 1999); *Gable v. Sweetheart Cup Co.*, 35 F.3d 851, 855 (4th Cir. 1994). Three Circuit Courts make no presumptions. *Deboard v. Sunshine Mining & Refining Co.*, 208 F.3d 1228, 1240-41 (10th Cir. 2000); *Joyce v. Curtiss-Wright Corp.*, 171 F.3d 130, 134-35 (10th Cir. 1999); *Barker v. Ceridian Corp.*, 122 F.3d 628, 634-38 (8th Cir. 1997); and *Int'l Ass'n of Machinists & Aerospace Workers v. Masonite Corp.*, 122 F.3d 228, 231-32 (5th Cir. 1977). Simply put, whether collectively bargained for retiree medical benefits vest will be determined as a matter of federal common law under § 301 of the Taft-Hartley Act, 29 U.S.C. § 185, as interpreted by the federal circuit where the case is litigated.

One of the earliest Circuit Court of Appeals decisions to consider collectively bargained for retiree medical benefits was perceived as announcing the following rule:

> Retiree benefits are in a sense 'status' benefits which, as such, carry with them an inference that they continue so long as the prerequisite status is maintained. Thus when the parties contract for benefits which accrue upon achievement of retiree

> status, there is an inference that the parties likely inferred those benefits to continue as long as the beneficiary remains a retiree.

UAW v. Yard-Man, Inc., 716 F.2d 1476, 1482 (6th Cir. 1983).

The facts in *Yard-Man* are familiar: The company tells the union it is shutting down a factory and will end the payment of retiree medical benefits on the last day of the collective bargaining agreement. The union sues claiming the retiree medical benefits were "lifetime" benefits that cannot be terminated. *Id.* at 1478. The company responds that the contract is clear—no retiree benefits outlive the termination of the union contract. In *Yard-Man* the key provision of the contract in dispute stated:

> When the former employee has attained the age of 65 years then:
> 1. The Company will provide insurance benefits equal to the active group benefits…for the former employee and his spouse.

Id. at 1480.

The Sixth Circuit found this language to be ambiguous: "The language 'will provide insurance benefits equal to the active group' could reasonably be construed, if read in isolation, as either solely a reference to the nature of retiree benefits or as an incorporation of some durational limitation as well." *Id.* Due to this ambiguity, the Sixth Circuit said that to determine "whether retiree insurance benefits continue beyond the expiration of the collective bargaining agreement depends upon the intent of the parties." *Id.* at 1479. It then detailed seven rules courts should use to examine extrinsic evidence to divine the parties' intent: 1) traditional rules for interpreting contracts should be applied consistent with federal labor policies; 2) the court should first look to the explicit language of the contract for clear manifestations of intent; 3) explicit language should be viewed in the light of the context which give rise to its inclusion; 4) each contract provision should be interpreted as part of an integrated whole; 5) the contract's terms should be construed so as to render none nugatory and avoid illusory promises; 6) where ambiguities exist, the court may look to other words and phrases in the contract for guidance; and 7) the court should review the interpretation ultimately derived from its examination of the language, context and other indicia of intent for consistency with federal labor policy. *Id.* at 1479-80.

The mischief in *Yard-Man*'s reasoning is the way in which it points to the use of extrinsic evidence before examining the actual words of the contract. By pre-supposing and inferring an "intent to vest" retiree medical benefits, *Yard-Man* made the express words of almost every contract ambiguous. The "inference of vesting" shifted the burden of proof to the employer to disprove that it vested retiree medical benefits.

After considering the evidence, the *Yard-Man* court ruled that retiree medical benefits were intended to outlive the collective bargaining agreement's life. *Id.* at 1482-83. Having indicated it favored the vesting of retiree medical benefits, a plague of plaintiffs' cases descended upon the federal district courts within the Sixth Circuit. Within

a short time, some Sixth Circuit cases began to expand this "rule": "This court has recognized that normally retiree benefits are vested." *Policy v. Powell Pressed Steel Co.*, 770 F.2d 609, 613 (6th Cir. 1985), *cert. denied*, 475 U.S. 1017 (1986); *but see Int'l Union, United Auto., Aero. & Agric. Implement Workers v. Cadillac Malleable Iron Co.*, 728 F.2d 807, 808 (6th Cir. 1984) ("There is no legal presumption based on the status of retired employees.").

§ 15.3.3.1 *Yolton v. El Paso Tenn. Pipeline Co.*

While the vitality of the *Yard-Man* inference has waxed and waned within the Sixth Circuit over the past twenty years, in its most recent decision, *Yolton v. El Paso Tenn. Pipeline Co.*, 435 F.3d 571 (6th Cir. 2006), *reh'g* and *reh'g* en banc denied (May 9, 2006), *petition for cert. filed*, 75 U.S.L.W. 3065 (U.S. Aug, 3, 2006) (No. 06-176), the Sixth Circuit appears to have finally killed off the *Yard-Man* inference:

> **This Court has never inferred an intent to vest benefits in the absence of either explicit contractual language or extrinsic evidence indicating such an intent.** Rather, the inference functions more to provide a contextual understanding about the nature of labor-management negotiations over retirement benefits. That is, because retirement health care benefits are not mandatory or required to be included in an agreement, and because they are 'typically understood as a form of delayed compensation or reward for past services' it is unlikely that they would be 'left to the contingencies of future negotiations.' *Yard-Man*, 716 F.2d at 1481-82 (citations omitted). If other contextual factors so indicate, *Yard-Man* simply provides another inference of intent. **All that *Yard-Man* and subsequent cases instruct is that the Court should apply ordinary principles of contract interpretation.**

Id. at 580 (emphasis added).

Applying "ordinary principles of contract interpretation," coupled with the instruction that courts are never to infer an intent to vest benefits, brings the Sixth Circuit's approach to collectively bargained for retiree medical benefits much closer to the views of the other Circuits The *Yolton* court effectively ruled it is the plaintiff's burden to prove an employer intended to vest retiree medical benefits.

Though the *Yard-man* inference may be losing its footing, the Sixth Circuit remains a favorable forum for retirees. Despite rejecting the inference, the Court in *Yolton* upheld a grant of a preliminary injunction in favor of plaintiffs/retirees, holding that they were likely to succeed on the merits of their claim that they were entitled to fully funded lifetime health care benefits. The Court reached this holding despite language in collective bargaining agreements arguably limiting health benefits to the term of the collective bargaining agreements.

The plaintiffs in *Yolton* were retirees and surviving spouses of retirees of J.I. Case Co. ("Case"). In 1994, Case was spun off of Tenneco (its former parent company) and renamed Case Equipment. Tenneco remained liable for post-retirement health and life insurance benefits for retirees who retired on or before July 1, 1994. After Tenneco merged with El Paso Nation Gas in 1996, El Paso quickly acted to pass along some costs of retiree medical benefits to retirees. In 1997, El Paso sent letters to the plaintiffs informing them that they would be required to contribute $56 per month for health coverage beginning April 1, 1998. In August of 2002, retirees' share of the health care premiums were raised to $290 per month. In January 2003 premiums were again increased to $501 per month. The retirees filed suit seeking an injunction to prevent El Paso from continuing to charge them for health coverage. The District Court granted the plaintiff's motion for preliminary injunction, concluding that the plaintiffs were likely to succeed on their claim that the defendants were obligated to provide fully paid, lifetime health care benefits. The defendants appealed. On appeal, the Sixth Circuit affirmed.

The Sixth Circuit explained that, unlike pension plans, "there is no statutory right to lifetime health benefits." *Id.* at 578. Therefore, "[i]f lifetime health care benefits exist for the plaintiffs, it is because the UAW and the defendants agreed to vest a welfare benefit plan." *Id.* "If a welfare benefit has not vested, after a CBA expires, an employer generally is free to modify or terminate any retiree medical benefits that the employer provided pursuant to that CBA." *Id.* at 578 (internal quotes omitted). The Court explained that "[w]hether the benefits vest depends upon the intent of the parties." *Id.* However, "Courts can find that rights have vested under a CBA even if the intent to vest has not been explicitly set out in the agreement." *Id.*

Though the Court did not rely on the *Yard-man* inference, the results it reached cast a retiree-favorable spin on the evidence. The collective bargaining agreement in effect provided that the insurance plan (under which retiree health benefits were provided) "will run concurrently with [the CBA] and is hereby made part of this Agreement." *Id.* at 580. The defendants argued that this durational clause made explicit that health insurance benefits were not vested, and that those benefits would run only as long as the collective bargaining agreement. Thus, every time a CBA expires, the company would be free to modify benefits. The Court rejected this argument, finding that, when read as whole, the plan's durational language should only be read to affect future retirees. Thus, "someone who retired after the expiration of a particular CBA would not be entitled to the previous benefits, but is rather entitled only to those benefits newly negotiated under a new CBA." *Id.* at 581.

The Court also relied on language in the CBA relating to pension benefits which similarly provided that "[t]he pension plan agreed to between the parties will run concurrently with this agreement and is hereby made part of this Agreement." Since it was undisputed that the pension benefits were vested, and since the same durational language was used in reference to health benefits and pension benefits, the Court reasoned that health benefits should be understood to vest under the agreement. *Id.* at 581. The court also looked outside the four corners of the agreement to the behavior of the parties to conclude that the retirees would likely prevail on their claim.

§ 15.3.3.2 Seventh Circuit: *Barnett* and *Cherry* Follow *Vallone* and *Bland*

The Seventh Circuit has recently considered several cases in which retirees challenged their former employer's decision to reduce their retiree medical benefits. Two cases decided in 2006 clearly articulate the standard in the Seventh Circuit under which these types of cases will be decided.

In *Barnett v. Ameren Corp.*, 436 F.3d 830 (7th Cir. 2006), the plaintiffs were retired employees of defendant Ameren Corporation ("Ameren") who argued that they were entitled to receive retiree medical benefits from their former employer for their entire lives. Their employer, on the other hand, argued that it was only obligated to provide retiree medical benefits through the term of the governing collective bargaining agreement. The relevant governing documents did not explicitly specify how long benefits would continue. The plaintiffs pointed to language regarding "vesting" service as evidence of ambiguity.

The plaintiffs admitted that the governing documents did not unambiguously create a lifetime entitlement to health-care benefits. Instead, the plaintiffs argued that latent and patent ambiguities in the governing documents entitled them to a trial on the merits. Without such an ambiguity, Ameren would be entitled to summary judgment, because "absent an ambiguity, the agreements are at best silent on the issue of the duration of the health-care benefits, which triggers the presumption that benefits expire with the agreement." *Id.* at 833.

The Court explained:

> Unlike pension benefits, ERISA does not require the vesting of health-care benefits. If they vest at all, they do so under the terms of a particular contract. Therefore, as harsh as it may sound, in the absence of a contractual obligation employers are generally free… for any reason at any time, to adopt, modify or terminate welfare plans. If a CBA or other governing document provides for health-care benefits for retirees, but is silent on the issue of whether or not those benefits exceed the life of the agreement, then in this circuit the presumption is that the benefits expire with the agreement.

Id. at 832-33 (internal citations omitted).

The Seventh Circuit rejected the plaintiffs' argument that the terms "vested" and "vesting" contained in the governing benefits created an ambiguity as to the duration of benefits. The Court explained:

> Contractual provisions must be read in a manner that makes them consistent with each other…. Accordingly, we have held that, when "lifetime" benefits are granted by the same contract

> that reserves the right to change or terminate the benefits, the "lifetime" benefits are not vested. The reason for such a holding is that benefits described as "lifetime" are not really vested when the same contract also reserves the right to revoke them, because the only proper construction of the two seemingly conflicting provisions is that the "lifetime" benefits are "good for life unless revoked or modified."

Id. at 833 (internal citations omitted).

The Court did not indicate whether the governing documents reserved to Ameren the right to amend or terminate the plan. However, one of the documents stated that the company would "take such action as may be necessary to modify and to continue *for the life of the Labor Agreement*" the provisions of the health-care plan. *Id.* at 834 (emphasis added by Court). According to the Court, this "explicit limitation" as to the duration of the health-care benefits eliminated any ambiguity as to the terms "vested" and vesting." Finding no ambiguity, latent or patent, the Seventh Circuit upheld the district court's grant of summary judgment in favor of Ameren.

In *Cherry v. Auburn Gear, Inc*., 441 F. 3d 476 (7th Cir. 2006), the Seventh Circuit held that a statement in governing documents which specifically limits benefits to the "period of this agreement" is a reservation of rights clause which has the effect of clarifying that a promise to provide "lifetime" benefits does not extend beyond the term of the agreement. *Id.* at 484. In *Cherry*, retired former employees of Auburn Gear sued when Auburn Gear terminated their retiree medical benefits. The plaintiffs argued that they had been promised "lifetime" benefits while the defendant argued that the promise of benefits terminated with each collective bargaining agreement – typically every three years. The Seventh Circuit cited with approval the District Court's recital of the standards for interpreting an retiree medical plan agreement as follows:

> 1. If a collective bargaining agreement is completely silent on the duration of health benefits, the entitlement to them expires with the agreement, as a mater of law (that is, without going beyond the pleadings), unless the plaintiff can show by objective evidence that the agreement is latently ambiguous, that is, that anyone knowledgeable about the real-world context of the agreement would realize that it might not mean what it says. This is the *Bidlack* presumption and its latent-ambiguity rebuttal
> 2. If the agreement makes clear that the entitlement expires with the agreement, as by including such a phrase as "during the term of this agreement," then, once again, the plaintiff loses as a matter of law unless he can show a latent ambiguity by means of objective evidence….
> 3. If there is language in the agreement to suggest a grant of lifetime benefits, and the suggestion is not negated by the agreement read as a whole, the plaintiff is entitled to a trial…

> 4. If the plaintiff is entitled to a trial by reason of either a patent or a latent ambiguity, the normal rules of evidence will govern the trial…

Id. at 481-82.

Since the collective bargaining agreement promised benefits only "during the period of this agreement" no patent ambiguity existed and the employer was entitled to summary judgment unless the retirees could show a latent ambiguity by means of objective evidence. Rejecting the plaintiffs' argument that a latent ambiguity existed, the Court held that evidence suggesting "alternative *interpretations* of the contract [are] insufficient to reveal an ambiguity." *Id.* at 484-85 (emphasis in original).

Barnett and *Cherry* cite to and rely upon several prior Seventh Circuit cases involving retiree medical claims, including *Vallone v. CNA Fin. Corp.*, 375 F.3d 623 (7th Cir. 2004) and *Bland v. Fiatallis N. Am., Inc.*, 401 F.3d 779 (7th Cir. 2005). Both of these cases provide good examples of when the Seventh Circuit will and when it will not find that benefits are for a "lifetime."

In *Vallone v. CNA Fin. Corp.*, 375 F.3d 623 (7th Cir. 2004), retired former employees of CNA Financial sued when ten years after accepting an early retirement package which included a monthly Health Care Allowance ("HCA") benefit, CNA discontinued that benefit. The retirees had been told that the benefit would be for their "lifetime." The district court granted summary judgment to CNA and the Seventh Circuit affirmed. In rejecting plaintiffs' appeal, the Court 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.

One year later, in *Bland v. Fiatallis N. Am., Inc.*, 401 F.3d 779 (7th Cir. 2005), the Seventh Circuit reached a different result based on two important facts. In *Bland*, the retiree medical plan in question did not give the employer the express right to amend or terminate the plan. Therefore, the court found that a grant of "lifetime" benefits was ambiguous and the plaintiffs were entitled to a trial on the issue of whether they were entitled to benefits for life. The Court's holding in *Bland* was consistent with its holding in *Vallone*. 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. 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. Unlike *Vallone*, none of the plan documents contained an express reservation of rights clause. *Id.* The plan documents were not silent, but "merely somewhat vague." *Id.* at 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. The holding in *Bland* demonstrates how important a plan's reservation of right's clause can be in these retiree medical cases.

§ 15.3.3.3 Second Circuit: *Bouboulis v. Transp. Workers Union of Am.*

In *Bouboulis v. Transp. Workers Union of Am.*, 442 F.3d 55 (2d Cir. 2006), the plaintiffs were retirees receiving medical benefits under a union plan affiliated with the Transport Workers Union of America (TWU). When the union eliminated health insurance benefits for the retirees if they received health insurance benefits elsewhere, the plaintiffs filed suit under ERISA. In dismissing the plaintiffs' claim for benefits under ERISA § 502(a)(1)(B), the district court considered two documents – the SPD for the plan and a letter to retirees which the plaintiffs claimed were part of the plan and promised "lifetime" benefits. On appeal, the Second Circuit affirmed. The Court held that in the Second Circuit, in order for benefits to vest for life the plan documents must contain "specific written language that is reasonably susceptible to interpretation as a promise to vest the benefits." *Id.* at 60. Neither the plan documents, nor a letter, which the plaintiffs argued should be considered a plan document, contained such language.

The Circuit Court's decision was based, in part, on the fact that the SPD itself was silent as to vesting of lifetime benefits. The SPD listed two circumstances under which benefits may be terminated – ceasing employment and death. The plaintiffs argued that, because they were already retired, the only applicable termination event was death, and that it was reasonable to infer that lifetime benefits were being promised. *Id.* at 61. The plaintiffs also cited to the requirement in ERISA § 1022(b) that an SPD contain, among other things, "circumstances which may result in disqualification, ineligibility, or denial or loss of benefits." *Id.* at 61. The Court rejected the notion that silence implies vesting, stating that "the absence of such language alone cannot create a promise to vest." *Id.* at 61.

The Court also considered and rejected the plaintiffs' argument that a separate letter provided to the retirees, which provided that "upon the death of a participant (whether active or retired), insurance coverage will continue to the participant's spouse for the remainder of his/her life," required the union to continue retiree medical benefits until the retirees' death. *Id.* at 61. According to the Court, even if the letter was binding on the defendants, "it contains no language that affirmatively operates to create a promise to vest benefits for the Retirees." *Id.* at 62. The Court interpreted the letter as a promise of lifetime benefits to spouses of retirees (upon a covered retiree's death) but not a promise of lifetime benefits to the retirees themselves. *Id.* at 62-63.

§ 15.4 CASH BALANCE PLANS: BACK TO THE FUTURE?

As the old saying goes, "the more things change, the more they stay the same." 2006 was just that kind of year for cash balance plans. There are two ways to make a pension

promise. You can specify how much you are going to contribute (a defined contribution plan) or you can specify the amount the employee will be paid at retirement (a defined benefit plan). A "cash balance" plan is a variation on the defined benefit plan theme. It combines the transparency of knowing to the dollar what is in your 401(k) account with the requirement that the employer fund these retirement benefits as it if were a traditional pension. Put simply, a cash balance plan is funded like a defined benefit plan but looks to most participants like a defined contribution plan. A cash balance plan typically provides participants with a hypothetical account balance that is credited each year with a percentage of the employee's pay and interest. Younger workers are favored by cash balance plans because these plans normally 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 and were, for the most part, established by "converting" a traditional defined benefit plan.

Recent attacks on cash balance plans are based on the idea that these plans discriminate against older workers. Plaintiffs allege the design of a cash balance plan is inherently age discriminatory because equal pay credits for younger workers have a much longer period of time to earn interest and accrue benefits before retirement. 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.

§ 15.4.1 Uneasy Balance

The issue providing the most mileage for the ERISA plaintiff's bar has been the metaphysical question of what the rate of benefit accrual means for cash balance plans. ERISA prohibits age discrimination in benefit accruals under defined benefit pension plans by providing, "the rate of an employee's benefit accrual may not be reduced, because of the attainment of any age." 29 U.S.C §1054 (b)(1)(H), ERISA §204(b)(1)(H). The district court decision in *Cooper v. The IBM Personal Pension Plan and IBM Corp.*, 274 F. Supp. 2d 1010 (S.D. Ill. 2003) (which gave credence to this theory), involved older participants in the IBM cash balance plan. As participants nearing retirement age, they alleged the homogenized interest rate for all benefit accruals violated ERISA § 204(b)(1)(H)'s anti-age discrimination provision. *Id.* This ERISA provision states that a defined benefit plan may neither cease an employee's benefit accrual, nor reduce the rate of an employee's accrual of benefits, because the employee has reached a particular age.

While finding all of the IBM Pension Plan terms were age neutral and provided the same credits per annum to all covered employees, the district court nonetheless ruled that since younger employees receive more interest over time than similarly situated older employees due to compounding interest and the time value of money, the Plan terms discriminated against older employees. *Id.* at 638. The district court arrived at this conclusion by interpreting the phrase "rate of an employee's benefit accrual" found in § 204(b)(1)(H) to mean "what the employee takes out [of his plan] on retirement," not what he puts into his plan. *Id.* at 638. Under the logic of the district court decision in *Cooper*, all cash balance plans violate ERISA.

It turns out, the district court's age discrimination theory in the *Cooper* case was wrong. The Seventh Circuit ruled in *Cooper v. IBM*, 457 F.3d 636, 643 (7th Cir. 2006), that "the phrase 'benefit accrual' reads most naturally as a reference to what the employer puts in to a cash balance plan (either in absolute terms or as a rate of change)." *Id.* at 639. Judge Easterbrook explained:

> Here, as so often, it is essential to separate age discrimination from other characteristics that may be correlated with age. That was the Supreme Court's point in *Hazen Paper*: wages rise with seniority (and thus with age) at many employers, but distinctions based on wage level (in order to reduce a payroll) do not 'discriminate' by age. … A plaintiff alleging age discrimination must demonstrate that the complained-of effect is actually on account of age. One need only look at IBM's formula to rule out a violation. It is age-neutral. …
>
> … Like a defined-contribution plan, a cash-balance plan removes the back-loading of the pension formula; older workers (accurately) perceive that they are worse off under a cash-balance approach than under a traditional years-of-service-times-final-salary plan. But removing a feature that gave extra benefits to the old differs from discriminating against them. Replacing a plan that discriminates against the young with one that is age-neutral does not discriminate against the old.

The *Cooper* court determined that the anti-age discrimination provisions in both ERISA § 204(b)(1)(H)(i), dealing with defined benefit plans, and 204(b)(2)(A), dealing with defined contribution plans, both say the same thing – they prohibit an employer from stopping allocations or accruals to the plan or changes in their rate on account of age. The common sense rules described in these statutory provisions are centered on how allocations are made to an employee's account, rather than the annual rate of withdrawal at retirement. *Id.* at 639. To hold otherwise "treats the time-value of money as age discrimination." *Id* at 638. "Nothing in the language or background of § 204(b)(1)(H) suggest that Congress set out to legislate against the fact that younger workers have (statistically) more time left before retirement, and thus a greater opportunity to earn interest on each year's retirement savings." *Id.* at 639. Applying this interpretation, the

court held that the IBM Plan terms are age-neutral, reversed the district court decision, and entered judgment in favor of IBM. *Id.* at 642-43.

The Seventh Circuit recognized that older workers may ultimately receive less benefits under the IBM cash balance plan than they would have under a traditional defined benefit plan, but refused to hold that a change in older worker's expectations amounted to age-discrimination.

> [O]lder workers accurately perceive that they are worse off under a cash-balance approach than under a traditional years-of-service-times-final-salary plan. But removing a feature that gave extra benefits to the old differs from discriminating against them. Replacing a plan that discriminates against the young with one that is age-neutral does not discriminate against the old. . . . That the change disappointed expectations is not material. An employer is free to move from one legal plan to another legal plan, provided that it does not diminish vested interests. . . .

Id. at 642*; citing Lockheed Corp. v. Spink*, 571 U.S. 882 (1996).

§ 15.4.2 New Legislative Protection

After six months of wrangling, Congress passed the Pension Protection Act of 2006, Pub. L. No. 109-280 (the "Act") in August, which included provisions that confirmed the legitimacy of cash balance plans, on a prospective basis. Just one week before the Act was passed, the Seventh Circuit Court of Appeals reversed the district court decision that helped create the firestorm of age-discrimination claims against cash balance plans. *Cooper v. IBM*, 457 F.3d 636, 643 (7th Cir. 2006). The Act addresses several of the nettlesome issues that have troubled cash balance plan sponsors, including: (i) rate of benefit accrual; (ii) interest (iii) conversions; (iv) the "whipsaw" effect; and (v) vesting. However, much to the dismay of beleaguered cash balance plans sponsors, the new law does not address cash balance plans implemented before June 29, 2005. This means that plans existing before June 29, 2005, are still in litigation "play."

The Pension Protection Act of 2006, for its part, follows the Seventh Circuit's decision in *Cooper*. It clarifies that after June 29, 2005, cash balance plans will not violate the age-discrimination provisions of ERISA or the parallel age discrimination provisions found in the Internal Revenue Code and ADEA, provided a participant's "accrued benefit" as of any date, is equal to or greater than that of any similarly situated younger individual who is or could be a participant in the plan.

Just when we thought it was safe to go back into the cash balance water, the Southern District of New York rekindled the age discrimination debate. *In re J.P. Morgan Chase Cash Balance Litig.*,____ F. Supp. 2d____, 2006 WL 3063424 (S.D.N.Y 2006), the court paid lip service to the Seventh Circuit's decision in *Cooper* before observing that New York was not Illinois. District court decisions in the Second Circuit were divided as

to whether cash balance plan terms violate ERISA's anti-age discrimination provisions. The *J.P. Morgan* court found that cash balance plans do, in fact, discriminate on the basis of age. *Id.* at *4. Like other courts that had reviewed the issue, the *J.P. Morgan* court focused on the definition of the phrase "rate of an employee's benefit accrual" found in § 204(b)(1)(H)(i) and whether it "refers to the employer's contribution to the plan (inputs) or the employee's retirement benefit (outputs)." *Id.* The court stated that the "rate of an employee's benefit accrual' refers to the outputs from the Plan," which distinguishes defined benefit plans from defined contribution plans, where employees are promised an "input." *Id.* at *6. It reasoned that the "binary regulatory framework" governing defined benefit and defined contribution plans "compels differing treatment for the two plans," and thus makes the phrase "unambiguous." *Id.*

§ 15.5 TOP HAT PLAN LITIGATION

A top hat plan is an unfunded non-qualified retirement plan that is usually only offered to executives. The term "unfunded" does not mean money cannot be set aside to fund these deferred compensation promises to executives. Rather, "unfunded" in this case, means any money put aside must remain part of the company's general assets and subject to the claims of the company's general creditors. The importance of the plan being "non-qualified" is that it frees these top hat arrangements from the shackles of the Internal Revenue Code. For example, neither the Code's non-discrimination rules nor its funding requirements nor its vesting standards apply. The ERISA statute defines a "top hat" plan as an unfunded, non-qualified retirement plan "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). Properly constituted, these 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 and obligations 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. Tex. 2004). Litigation over benefits 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.

§ 15.5.1 Top Hat Plans Are Not Excess Benefit Plans

Excess benefit plans are not top hat plans. They provide additional retirement benefits to employees whose benefits under the employer's qualified pension plan are limited by the caps on pension benefits set forth in Internal Revenue Code § 415. Participation in an excess benefit plan is not limited to a select group of management or highly compensated employees, as is participation in a top hat plan. Instead, excess benefit plan participation is open to any employee whose qualified retirement plan benefits are limited by Internal Revenue Code § 415. One important difference between top hat

plans and excess benefit plans is that excess benefit plans are completely exempted from ERISA. 29 U.S.C. §1003(b)(5).

§ 15.5.2 State Or Federal Court?

Whether a benefit plan is a "top hat" or "excess benefit plan" is important. A claim against a top hat plan is enforceable in federal court, while a claim against an excess benefit plan belongs in state court. For example, in *Hutchinson v. Crane Plastics Mfg. Ltd.*, 2005 U.S. Dist. LEXIS 43628 (2006), plaintiff Hubert Hutchinson brought an action against Crane Plastics for a breach of contract based on Crane's failure to pay benefits due from his deferred compensation account. Mr. Hutchinson brought his case in Ohio state court. Citing ERISA, Crane Plastics removed the case to the United States District Court for the Southern District of Ohio. Hutchinson then sought to remand on the basis that the court lacked jurisdiction because the Crane Plastics Company LLC Compensation Deferral Plan (the "Deferral Plan") was an "excess benefit plan" exempt from ERISA coverage. Defendants argued the Deferral Plan was "not an excess benefit plan because it was not established for the sole purpose of avoiding the limitations of §415 of the Internal Revenue Code." *Id.* at *10.

The court explained, "whether a plan meets the requirements for the 'excess benefit plan' exemption may be determined through an examination of the surrounding circumstances and an analysis of the stated purpose of the plan as determined by its plain language." *Id.* at *12. "In addition, the labels which an employer places on a plan, while subject to some consideration, are not controlling on the issue of whether the plan is an ERISA plan." *Id.* at *19-20. The Deferral Plan's language stated it was intended "to enhance the career remuneration of key management and highly compensated employees" and participation was restricted to individuals meeting these qualifications. Moreover, the plan made no reference to limitations of § 415. Although another provision of the plan stated "it is the intention of the Sponsor and the Employers that the Plan be exempt from the provisions of Title I of [ERISA]" the court interpreted this language as an expression by the drafters "that the vesting, funding and fiduciary provision of Title I would not apply to the Plan, which is consistent with a top hat plan". The court concluded that the Deferral Plan was a top hat plan governed by ERISA, therefore Mr. Hutchinson's state law breach of contract claim was preempted and removal to federal court was appropriate.

§ 15.5.3 A Clerk Is Not A "Key Employee"

Many courts have applied a three factor test in order to determine whether an employee benefit plan qualifies as a "top hat" plan. Two of the factors are statutory: (1) the Plan must be unfunded; and (2) it must be "maintained by an employer for the purpose of proving deferred compensation for a select group of management or highly compensated employees". 29 U.S.C. §§ 1051(2), 1081(a)(3), 1101(a)(1). The Department of Labor has also indicated, through Advisory Opinion letters, that courts should look to a third factor: "whether the employees participating in the alleged top hat plan have sufficient influence within the company to negotiate compensation agreements that will

protect their interests where ERISA provisions do not apply." *Guiragoss v. Khoury et al.*, 444 F. Supp. 2d 649, 658-59 (E.D. Va. 2006); citing DOL Opinion 90-14A.

Top hat plans that do not qualify as top hat plans are an employer's worst nightmare. They become *de facto* qualified retirement plans that are retroactively subject to the minimum funding vesting, minimum participation and other rules found in the Internal Revenue Code. Suzanne Guiragoss is a case in point. She was a sales clerk at Khoury Brothers Jewelers in Virginia. Although she was not an officer of the company, she eventually obtained "keyholder" status, which meant she was given a key to the store and was entrusted to open and close the store. A year after joining the company Ms. Guiragoss was invited to join the Khoury Bros. Deferred Compensation Plan (the "Deferred Plan"). The Deferred Plan was presented to each employee as an individual agreement, however, each of the individual agreements were identical in form. Under the terms of the Deferred Plan, it was unfunded and Khoury Bros retained sole discretion to credit or not credit money to participant accounts. Ms. Guiragoss understood that 50% of her bonuses would be credited to her deferred compensation account. Two years later, Khoury Bros began offering a 401(k) plan to its employees and Ms. Guiragoss became the only participant under the Deferred Plan. After ten years of employment, Ms. Guiragoss learned that almost no money had been credited to her . She then filed an action in federal court claiming breach of fiduciary duty, breach of co-fiduciary duty and seeking injunctive relief, as well as two state law claims for breach of contract and common law fraud. Khoury argued that the Deferred Plan was a top hat plan and thus exempt from ERISA's fiduciary and funding requirements.

After examining each of the three factors determinative of top hat status, the court concluded the Khoury Bros. Deferred Plan was not a top hat plan. Although it was indisputably unfunded, the plan was not limited to a select group of employees. The employees that had participated in the plan "were neither management nor highly compensated employees". When Mr. Guiragoss became a participant in the plan, she was being paid $7.75 an hour. 444 F. Supp. 2d at 663. Khoury's portrayal of the importance of Guiragoss's "keyholder" status was simply brushed aside: "assigning to a sales clerk the responsibility of opening and closing a store is not sufficient, by itself to establish that Guiragoss was a high-level employee with managerial responsibilities." *Id.* at 663. The court also found that the third factor weighed decidedly against top hat plan status. "A jewelry store sales clerk does not possess the bargaining clout to craft a favorable pension agreement that will protect her interests. . . ." *Id.* at 664. In fact, "Guiragoss is precisely the type of employee that ERISA's substantive provisions are intended to protect." *Id.*

§ 15.6 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. 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 distress termination (the "hard way"). 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. 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 § 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 again this year in the ongoing fight over how to terminate the United Airlines flights attendants' pension plan.

§ 15.6.1 The Return Of Friendly Skies?

During 2006, United Airlines finally emerged from the Chapter 11 bankruptcy it filed in 2002. Arguably, the biggest casualties from United's bankruptcy were its pension plans. Nearly two years after its bankruptcy filing, 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 § 1113(c) 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 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 settled." The settlement agreement did not settle United's §§1113(c)/1341(c) 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 § 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.

During 2006, the United States District Court for the District of Columbia upheld the PBGC's termination of the Flight Attendant Plan. *Ass'n of Flight Attendants-CWA v. Pension Ben. Guar. Corp.*, 2006 U.S. Dist. LEXIS 1318 (D.D.C. January 13, 2006). In evaluating the PBGC's termination decision the court agreed with AFA that PBGC's reliance on the settlement agreement to justify termination was contrary to § 1342. *Id.* at 24. Section 1342(a)(4) grants the PBGC the authority to terminate a pension plan when the "possible long-run loss [to PBGC] with respect to the plan may reasonably be expected to increase unreasonably if the plan is not terminated." 29 U.S.C. § 1342 (a)(4). The court concluded that "long-run loss …with respect to the plan" did not include benefits to the agency distinct from the financial health of the plan. *Id.* at 25.

However, the court upheld the PBGC's decision due to other valid bases for termination. Given that the PBGC confronted a high probability of termination of the plan under § 1342(a)(1) or a § 1341 distress termination with a resulting loss of $3.3 million per month, the court concluded that it was in PBGC's best interest to initiate involuntary termination as soon possible. *Id.* at 29. In addition, the court found the PBGC's reliance on § 1342(a)(2), which permits the agency to terminate if it determines that " the plan will be unable to pay benefits when due" was reasonable in light of rising oil prices, United's failure to seek an IRS waiver, and a shift in legal precedent. *Id.* at 41.

§ 15.7 DISTRESS TERMINATIONS OF DEFINED BENEFIT PLANS

§ 15.7.1 The Big Picture Rule For Terminating Collectively Bargained Pension Plans

The Third Circuit Court of Appeals provided needed clarity to an ambiguity in the distress termination rules for a company in bankruptcy that wants to terminate more than one collectively bargained pension plan. Terminating a pension plan requires the Bankruptcy Court to determine 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(c)(2)(B)(ii)(IV). The PBGC takes the position that deciding whether to terminate a pension plan 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 pension plans and can emerge as a viable entity so long as some, but not all, of its pension plans are terminated? ERISA and the Bankruptcy Code conflict on this issue. 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 pension plan, while another maintains her benefits because the underfunding in her pension plan is smaller? In *PBGC v. Kaiser Aluminum Corp. et al.*, 2005 U.S. Dist. LEXIS 5106 (D. Del. 2005) the District Court for the District of Delaware ruled that decisions to terminate pension plans are to be made by aggregating the pension plans.

Kaiser Aluminum Corporation maintained several defined benefit pension plans of varying sizes, each covering a different population of employees. Kaiser filed for relief under Chapter 11 of the Bankruptcy Code in February 2002. As part of their re-organization, Kaiser requested that the Bankruptcy Court approve the termination of all six pension plans under the reorganization test. The Bankruptcy Court applied the test to all six plans in the aggregate and concluded that their termination was required for Kaiser to emerge from Chapter 11. The PBGC appealed the Bankruptcy Court's decision arguing that it should have applied the reorganization test on a plan-by-plan basis. Under this approach, the PBGC contended that some of Kaiser's plans would not fulfill the test and could not be terminated. The District Court upheld the 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**.** ***Id.***

In affirming the District Court's decision, the Third Circuit noted that the reorganization test could not be rationally applied on a plan-by-plan basis unless a court makes basic assumptions about the order in which the plans should be considered and the status of the other plans that the employer is seeking to terminate. *In re Kaiser Aluminum Corp*., 456 F.3d 328 (3d Cir. 2006). The Third Circuit considered such an approach

essentially unworkable. It further held that a plan specific approach would result in inequitable consequences as it would require the bankruptcy courts to give preference to similarly situated workers without a principled basis to make such a determination. *Id.* at 331. Absent a clear congressional mandate to the contrary, the court declined to impose upon the bankruptcy courts an approach that would conflict with their tradition of fairness. *Id.* The court also rejected the PBGC's arguments based on legislative history, deference to its administrative interpretations, and public policy. *Id.* 345-54.

§ 15.8 ERISA DISCRIMINATION CLAIMS

ERISA § 510 prohibits any person from discriminating or retaliating against a participant or beneficiary for exercising his rights under ERISA or under the terms of an employee benefit plan. It also prohibits the "interference with the attainment of any right to which the participant may become entitled." Section 510 applies to both pension and welfare benefits. *See Inter-Modal Rail Employees Ass'n v. Atcheson, Topeka & Santa Fe Ry. Co.*, 520 U.S. 510 (1997). A cause of action arising under ERISA § 510 is enforceable under § 502(a)(3), which allows individuals to seek "appropriate equitable relief" for violations of ERISA.

§ 15.8.1 The Remedy Conundrum

Suits alleging a violation of ERISA § 510 have typically sought such remedies as reinstatement and back pay, front pay, or recovery of lost benefits. However, the Supreme Court's decisions in *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 262, (1993) and *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002) require a reconsideration of the equitable relief available for § 510 violations. In *Mertens*, the Supreme Court announced that recovery under § 502(a)(3) was limited to those remedies "typically available in equity (such as injunction, mandamus, and restitution) but not compensatory damages." *Mertens*, 508 U.S. at 256. The Supreme Court narrowed the scope of potential equitable remedies available § 502(a)(3) even further in *Great-West*, by instructing courts to examine the basis of the plaintiff's claim in order to determine whether the relief sought was legal or equitable in nature, and questioning, in a footnote, the equitable nature of back pay awards in Title VII cases. *Great-West*, 534 U.S. at 218 n.4. Following *Great-West*, courts that have considered the issue have held that back-pay, front pay, compensatory damages and additional benefits are foreclosed by the Supreme Court's decision in *Great-West*. *See e.g., De Pace v. Matsushita Elec. Corp. of Am.*, 257 F. Supp. 2d 543, 563 (E.D.N.Y. 2003).

In *Pelosi v. Schwab Capital Markets*, 2006 U.S. Dist. LEXIS 85237 (S.D.N.Y. Nov. 17, 2006), plaintiff Vincent Pelosi learned first hand what the Supreme Court's decisions in *Mertens* and *Great-West* meant for his § 510 claim. In mid-2004 Schwab announced its intention to sell its wholly owned subsidiary, Schwab Capital Markets ("SCM"), to UBS. At the time, Pelosi was senior vice-president of SCM with an anticipated total annual compensation of approximately $1.4 million. Under the Charles Schwab Severance Pay Plan (the "Plan"), Pelosi was entitled to severance benefits if he

suffered a "job elimination" as a result of the sale. *Id.* at *4. Although Pelosi was offered a new job, he considered the offer to be non-comparable, since the new position offered to him guaranteed only 10% of his previous salary and contained a restrictive non-compete provision. *Id.* Upon receiving the offer, Pelosi notified Schwab that he believed the offer to be non-comparable and inquired about his severance benefits. According to Pelosi, he was then informed that unless he accepted the position, UBS would deem Pelosi to have accepted the offer and would terminate his employment for failure to report to work. *Id.* at *5. At this point Pelosi considered his employment terminated and formally made a claim for benefits under the Plan which was denied. *Id.* at *6. Pelosi sued alleging wrongful denial of benefits pursuant to ERISA § 502(a)(1)(b), discrimination under ERISA § 510, common law breach of fiduciary duty, and tortious interference.

In support of his § 510 claim, Pelosi alleged that in order to avoid paying his substantial severance, Schwab, SCM and UBS conspired to offer him a non-comparable position. As a remedy Pelosi sought the payment of compensation for an amount equal to 12-months severance pay, plus COBRA premium payments, and other benefits. *Id* at *19. Defendant's moved to dismiss Pelosi's ERISA claim on the ground that Pelosi failed to state a claim under § 510 because he was offered continued employment. *Id.* at *17. Although the court recognized case law which held, "[g]enerally, an offer of continued employment, even if deemed inadequate, and which would preclude severance rights, is incompatible with a discrimination claim under ERISA § 510" it noted that under some situations the position offered to the eligible employee would amount to discrimination. *Id.* at *17-18. However, the court held that it need not decide whether the facts alleged in this particular complaint would sustain an ERISA § 510 claim because the complaint sought relief not afforded by § 510. *Id.* at *19. Pelosi argued that the relief sought was properly characterized as restitution — a historically equitable remedy. Unfortunately for Pelosi, the Supreme Court in *Great-West* held that "for restitution to be in equity, the action generally must seek not to impose personal liability on the defendant but to restore to the plaintiff particular funds or property in the defendant's possession . . . almost invariably. . . suits seeking . . . to compel the defendant to pay a sum of money to the plaintiff are suits 'for money damages. . . ." *Great-West*, 534 U.S. at 210. Consequently, "Pelosi's ERISA § 510 claim [sought] precisely the type of remedy the Supreme Court rejected as impermissible under ERISA § 502(a)(3)" and on this basis was dismissed. *Pelosi*, at *21.

In *Hicks-Wagner v. Qwest, Inc*., 2006 U.S. Dist. LEXIS 83238 (D.N.M. Nov. 15, 2006), Plaintiff Ann Hicks-Wagner was also denied the remedies she sought under ERISA § 510. On January 9, 2003, Ms. Hicks-Wagner underwent heart surgery and applied for short-term disability for a period of ten weeks. Although her request was approved for only six weeks, she was absent from the time of her surgery until she was terminated in May. *Id.* at *5. On May 19, 2003, a Qwest labor relations manager sent Ms. Hicks-Wagner a letter informing her that her absence was unexcused and that she would be terminated if she did not return to work or request a leave by May 22, 2003. The letter also explained different leave options available to her. Ms. Hicks-Wagner never returned to work or requested a formal leave of absence, therefore, on May 23, 2003 she was terminated. *Id.* at* 6. She commenced an ERISA § 510 action arguing that

Qwest terminated her because she was disabled and that her termination affected her eligibility and access to disability benefits. *Id.* at *3. She sought damages in the form of lost benefits, lost wages, and mental, emotional, and psychogical distress. *Id.* at *14.

Among the grounds upon which Quest moved for summary judgment on Ms. Hicks-Wagner's § 510 claim was that she did not seek a remedy available under § 510. The Court explained that Ms. Hicks-Wagner was, in reality seeking ERISA benefits, however she could not do so because she brought her claim under § 510 and not ERISA § 502(a)(1)(b). Section 502(a)(1)(b) is the ERISA civil enforcement provision that authorizes a participant to bring a civil action "to recover benefits due." Because a § 510 discrimination claim is enforceable only through § 502(a)(3), Ms. Hick's remedies for a violation of § 510 are limited to the remedies available under § 502(a)(3). Citing *Great-West*, the court agreed that the remedies sought by Ms. Hicks-Wagner — lost benefits, back pay, front pay, damages for mental, emotional and psychological distress and punitive damages — were not "appropriate equitable relief" and granted summary judgment to Defendant Quest on this issue.

§ 15.8.2 Only Employees Can Allege Discrimination Under § 510

Joseph Bennett worked for Prudential Insurance Company of America from 1959 to 1980, when he voluntarily left the company. When Mr. Bennett became eligible to receive a pension under Prudential's Traditional Retirement Plan in November 2004, he contacted Prudential requesting a lump-sum payment. Prudential advised him that his benefits could not be paid in a lump-sum because such a distribution is available only if the total accrued benefit is less than $5,000, or if an additional retirement benefit was granted as a result of an involuntary separation from service.

Bennett brought a claim under ERISA § 510 on the theory that in 2002 Prudential offered its then current employees the option of transferring from the Traditional Retirement Plan to another plan which permitted all participants to elect a lump-sum payment. *Bennett v. Prudential Ins. Co. et. al*., 2006 U.S. App. LEXIS 21138 *9 (3d Cir. 2006). Because that option was not available to him, he claimed he was the victim of discrimination in violation of ERISA § 510. *Id.* In affirming the district court's order dismissing Mr. Bennett's claims the Third Circuit Court of Appeals rejected his discrimination argument holding that "suits for discrimination under § 510 are limited to actions affecting the employer-employee relationship" and that "Prudential's 2002 offer of a lump-sum payment to its then current employees did not change its relationship with retirees, such as Bennett." *Id.* at 10.

§ 15.9 ERISA PREEMPTION: IS EVERYTHING RELATED TO EVERYTHING ELSE?

As we all know, ERISA was designed to provide a uniform federal scheme of employee benefit plan regulation. By making ERISA the paramount law of employee benefit

plans, Congress sought to avoid the piecemeal regulation of employee benefit plans, to prevent conflicts between federal and state regulators and sought to encourage the formation of employee benefit plans. *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co*., 514 U.S. 645, 656-57, 115 S. Ct. 1671 (1995). Sounds simple enough. Yet, figuring out what federal regulation of employee benefit plans means has been very difficult.

The text of ERISA's preemption provision states: "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan. . . ." "State law" is broadly defined to include "all laws, decisions, rules, regulations, or other State action having the effect of law . . ." ERISA §§ 514(a) and (c), 29 U.S.C. §§ 1144(a) and (c). Those who find this language unwieldy should take heart from the U.S. Supreme Court which has criticized the ERISA preemption clause as not exactly "a model of legislative drafting." *John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank*, 510 U.S. 86, 99, 114 S. Ct. 517 (1993).

Whether a state law "relates to" an employee benefit plan has universally confounded the courts. Nonetheless, on numerous occasions the Supreme Court has attempted to provide guidance by confronting the text of ERISA's preemption clause head on. In *Shaw v. Delta Air Lines, Inc*., the Supreme Court explained that a state law relates to an employee benefit plan if it: (1) has a connection with a plan; or (2) refers to a plan. 463 U.S. at 96-97. In *California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, the Court further explained a law "has a . . . reference to" a plan where the law "acts immediately and exclusively upon ERISA plans, . . . or where the existence of ERISA plans is essential to the law's operation . . . " 519 U.S. at 325. On the other hand, if the law "functions irrespective of . . . the existence of an ERISA plan," it does not make reference to an ERISA plan so as to be preempted. 519 U.S. at 328.

§ 15.9.1 Pay Or Play?

On January 12, 2006, Maryland became the first state to enact a law mandating that employers with 10,000 or more employees ("10K employers") spend a minimum percentage of payroll on health-care costs or pay a certain amount into the state Medicaid fund. The Maryland law is titled the "Fair Share Health Care Fund Act" ("Fair Share") and went into effect on January 1, 2007. The new Maryland statute establishes a Fair Share Fund and subjects 10K employers to a health-care payroll assessment that supports the operations of the Maryland Medicaid program. The amount assessed for the Fair Share Fund is to be the difference between 8% of the 10K employer's payroll costs (6% of payroll for nonprofit entities) and the amount spent on health-care insurance costs, if the latter amount is lower. The legislative history to the Fair Share Act shows there are three employers in Maryland with more than 10,000 employees: Giant Food, Wal-Mart, and Johns Hopkins University. Only Wal-Mart has health insurance costs low enough to be subjected to the payroll assessment.

Opponents of Maryland's Fair Share legislation point out that this law directly conflicts with ERISA, which provides for a uniform national employee benefit law. "Fair Share" supporters argue that the law does not place requirements directly on employee

benefit plans but instead regulates employer conduct. Employers can either "pay" into the state fund or "play," by providing medical plan benefits to their employees.

§ 15.10 A BRIEF HISTORY OF ERISA PREEMPTION

Prior to the passage of ERISA, states were free to regulate the terms of employer-provided medical plans. At the time ERISA was enacted, however, most states had not done so. Indeed, when Congress passed ERISA in 1974, skyrocketing medical plan costs were not yet on the radar. Instead, Congress was responding to a public outcry that arose during the 1960s and 1970s 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.

The ERISA statute divides employee benefit plans into two worlds: (1) pension benefit plans; and (2) welfare benefit plans. Under ERISA, pension plans were defined to include retirement plans or other plans that defer the receipt of income to the termination of employment or beyond. Welfare plans included everything else, such as medical, dental, vision, life insurance, disability, and virtually any other employee benefit that is not related to "retirement." Congress established a uniform set of rules for "conduct" to be used in connection with all employee benefit plans. While the "content" of welfare benefit plans was left largely unregulated, pension benefits are subject to cradle-to-grave regulation, including vesting requirements, funding mandates, nondiscrimination tests, and special rules governing benefit accruals. This means that most welfare benefit plans, such as insured and self-funded medical, dental, disability, or vision plans, are subject to almost no content requirements under ERISA. While all employee benefit plans, including medical plans, are subject to reporting, disclosure, and fiduciary responsibility provisions, insured and self-funded medical plans are subject to few substantive content requirements.

One of ERISA's fundamental purposes is to encourage the formation of employee benefit plans. Congress further explained that ERISA is meant to govern the "operation and administration" of employee benefit plans. To this end, ERISA is designed to provide a single, uniform federal scheme so as to avoid a multiplicity of regulation and to prevent conflicts between federal and state regulatory systems. ERISA thus served to replace a patchwork scheme of state regulation of employee benefit plans with a uniform set of federal regulations. To protect ERISA's primary goal of providing minimum standards and uniform federal regulation of employee benefit plans, Congress enacted a broad preemption clause. When Congress enacted ERISA in 1974, it expressly preempted "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" and broadly defined "State law" to include "all laws, decisions, rules, regulations, or other State action having the effect of law …." "State" is defined by ERISA as "a State, any political subdivision thereof, or any agency or instrumentality of either which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by ERISA." The primary advantage of the supremacy clause found in the ERISA statute (also referred to as the preemption provision") is that it has allowed plan sponsors to create uniform employee benefit plans covering different employees in different states. How did

the ERISA statute come to dominate the operation and administration of employee benefit plans? The short answer is "supremacy." Our system of government divides power between state and federal governments. Questions about how power is divided are resolved, for the most part, by the United States Constitution's Supremacy Clause. It states: "This Constitution, and the laws of the United States, . . . shall be the supreme law of the land. . . ." Federal law generally supersedes state law where the two laws conflict or where Congress has otherwise indicated its desire to oust state regulation. Without uniform federal interpretation, employee benefit plans could be required to keep records in some states but not in others, to provide different benefits in different states, to decide benefit claims in different ways, and to comply with different standards of conduct in administering employee benefit programs. Obviously, the inefficiency caused by a "patchwork" of state-by-state regulation might lead large, national employers with employee benefit plans to provide the lowest common denominator of benefits, or might even discourage those employers from offering any employee benefit program at all. The Supreme Court has criticized ERISA's preemption provision for not being "a model of legislative drafting." Notwithstanding this criticism, the Supreme Court has consistently described ERISA's preemption provision as "conspicuous for its breadth." The boundaries of ERISA's preemptive reach have been the subject of a series of differing Supreme Court interpretations. Given the difficulty in applying the expansive preemption language found in ERISA to real-world problems, the Supreme Court has issued no less than 24 important ERISA preemption decisions over the course of the last 25 years. These Supreme Court ERISA preemption decisions (written by different judges during different decades) show the Court's evolving views on this issue.

Most of the Supreme Court's ERISA preemption cases have revolved around what the "relates to" standard means. Justice Scalia summed up his frustration with this ERISA preemption standard as follows: "But applying the 'relate to' provision according to its terms was a project doomed to failure, since, as many a curbstone philosopher has observed, everything is related to everything else." Further complicating the issue of ERISA preemption is its exemption from state insurance laws. Determining whether a state statute is an insurance law is, itself, an almost metaphysical endeavor.

§ 15.10.1 MARYLAND'S FAIR SHARE ACT

On February 7, 2006, the Retail Industry Leaders Association ("RILA") filed a complaint for declaratory and injunctive relief in the USDC for the District of Maryland. Among the challenges to the statute was ERISA Preemption. The parties filed cross-motions for summary judgment on the issue and numerous *amici curiae* weighed in, including, such ERISA heavyweights as the Chamber of Commerce of the United States of America, the Society for Human Resource Management, and the National Federation of Independent Business Legal Foundation.

Proponents of the Fair Share Act argued that it was not preempted by ERISA because the law did not affect any ERISA-regulated plan. Moreover, the Fair Share Act operates as a generally applicable tax or "economic incentive" in an area of traditional state regulation — the provision of health services. In support of their arguments, proponents relied upon a trilogy of Supreme Court cases, which they contend radically changed the landscape of ERISA preemption by redefining the "relate to" standard: *New*

York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. 514 U.S. 645 (1995), *De Buono v. NYSA-ILA Med. and Clinical Servs. Fund*, 520 U.S. 806 (1997) and *California Div. Of Labor Standards Enforcement v. Dillingham Constr.*, 519 U.S. 316 (1997).

In *Travelers*, the Court held that a New York law requiring hospitals to collect surcharges from patients covered by a commercial insurance company, but not from patients insured by a Blue Cross/Blue Shield plan, was not preempted. The Court explained that where federal law bars state action in fields of traditional state regulation, it has operated on "the 'assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress." *Id.* at 655. In *De Buono*, the Court found that a state imposed tax on hospital gross receipts from fees paid by patients, which "target[ed] the "health care industry" as a whole, had no connection with ERISA plans and was therefore not preempted. 520 U.S. at 814. The law upheld in *Dillingham* was a California law governing prevailing wages for public works projects involving apprenticeship programs.

On the other hand, RILA argued that the Fair Share Act was nothing more than a state imposed benefit mandate. Such benefit mandates have been consistently found to be preempted by ERISA. As explained by the Supreme Court, under ERISA "the private parties, not the Government, control the level of benefits." *Alessi v Raybestos*, 451 U.S. 504, 511 (1981). Whether a state can mandate health plan coverage was decided over 25 years ago by the Supreme Court. *See Standard Oil Co. of Cal. v. Agsalud*, 633 F.2d 760 (9th Cir. 1980) *aff'd* 454 U.S. 801 (1981). In *Agsalud*, the question presented was whether Hawaii's Comprehensive Prepaid Health Care Act enacted in 1974 ("Hawaii Act") requiring employers to provide all employees with comprehensive prepaid health care plan coverage was preempted by ERISA. *Id.* at 763. The Hawaii Act, like Maryland's Fair Share Act, included certain reporting requirements that differ from those in ERISA. *Id.*; *see* also, Md. Code Ann., Lab. & Empl. tit. § 8.5-102 to 8.5-105.

RILA also noted that the mandates of the Fair Share Act are analytically indistinguishable from those that were addressed by the Supreme Court in *District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125, 129-31 (1992). There the Court expressly stated that laws requiring employers to provide benefits based upon state-mandated levels are preempted by ERISA. *Greater Wash. Bd. of Trade*, 506 U.S. at 126-27.

In a 32-page Opinion issued July 19, 2006, the district court agreed with RILA. *Retail Leaders Ass'n v. Fielder*, 435 F. Supp. 2d 481 (D. Md. 2006). Relying heavily on the Supreme Court's decision in *Egelhoff v. Egelhoff*, 532 U.S. 141, 532 U.S. 141, 146 (2001), the district court focused on the ERISA goal of uniformity and found the Fair Share Act had a "connection with" an ERISA plan. The district court also determined that the Fair Share Act was an impermissible state imposed benefit mandate, "My finding that the Act is preempted is in accordance with long established Supreme Court law that state laws which impose employee health or welfare mandates on employers are invalid under ERISA." 435 F. Supp. 2d at 495. The district court was critical of the State of Maryland's reliance on *Travelers, De Buono, and Dilliham* stating these cases "lie at the periphery of

ERISA analysis, not (as does the Fair Share Act) at its core." *Id.* The State of Maryland promptly appealed the district court's decision.

The fate of the Fair Share Act is currently in the hands of the Fourth Circuit Court of Appeals. No matter the outcome, it is very likely that the Supreme Court will be asked if Maryland can make Wal-Mart "pay or play."

§ 15.11 REMEDIES

§ 15.11.1 Yesterday's Problem?

Can a 401(k) plan participant whose account has lost value due to one particular investment (usually employer stock) file a breach of fiduciary duty lawsuit on behalf of the entire plan (even though many plan participants' accounts do not hold any employee stock)? During 2005 and 2006, two Courts of Appeals answered emphatically "yes." ERISA's exclusive civil enforcement scheme, *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 144 (1990), spawned our confusion. 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 (aka 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) and *Sereboff v. Mid-Atlantic Med. Servs., Inc.*, 126 S. Ct. 1869 (2006), 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 *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134 (1985) appears to say that § 502(a)(2) authorizes only plan-wide relief for breaches of fiduciary duty. That is, claims brought under § 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 § 502(a)(2). However, there is a current controversy brewing over

whether § 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 § 502(a)(2) was a permissible enforcement mechanism for individual account plans. *See Kuper v. Iovenko*, 66 F.3d 1447 (6th Cir. 1995) (disallowing § 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. Supp. 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.

§ 15.11.2 *Milofsky v. American Airlines, Inc.*

The plaintiffs in *Milofsky v. American Airlines, Inc.*, 404 F.3d 338 (5th Cir. 2005), *vacated, reh'g 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 § 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 § 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.

On March 2, 2006 the Fifth Circuit en banc revisited its decision in *Milofsky v. American Airlines, Inc*. and reversed. The Fifth Circuit, in a two-paragraph opinion, explained that the plaintiffs, "a subset of participants in the [Plan], are entitled to further development of their breach of fiduciary duties claims, brought under ERISA §§ 502(a)(2) and 409(a)…" *Milofsky v. American Airlines, Inc*., 442 F.3d 311, 313 (5th Cir. 2006) (en banc).

§ 15.11.3 *In Re Schering-Plough ERISA Litig. - Milofsky* Revisited

The Third Circuit faced the same issue last year in *In re Schering-Plough Corp. ERISA Litig.*, 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 § 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 Third 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 allegedly because of breaches of fiduciary duty." *Id.* at 235. The words of § 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.

§ 15.12 OTHER COURTS AGREE

District Courts from outside the Third and Fifth Circuits have followed the holdings of *Milofsky* and *Schering-Plough*, confirming that a plaintiff, even though he is seeking to represent less than 100% of plan participants, has standing to sue for breach of fiduciary duty under ERISA § 502(a)(2).

In *DiFelice v. US Airways, Inc*., 235 F.R.D. 70 (E.D. Va. 2006), the plaintiff was an employee of US Airways and participant in the US Airways 401(k) plan. Following a thwarted merger attempt in early 2001 and the terrorist attacks of September 11, 2001, US Airways declared bankruptcy in August 2002. DiFelice, whose 401(k) plan account was nearly 100% invested in the Company Stock Fund, lost close to $243,000. DiFelice brought a lawsuit against the defendants under ERISA § 502(a)(2) on behalf of a proposed class of plan participants whose accounts held shares of the Company Stock Fund between August 2001 and August 2002. US Airways challenged the plaintiff's standing to sue, arguing that ERISA § 502(a)(2) provides relief only in a representative capacity for losses suffered by the plan. The court rejected US Airways' argument and allowed DiFelice to proceed under § 502(a)(2). The court explained:

> A retirement plan, like the plan at issue here, is nothing more than an aggregation of its participant's individual accounts, and therefore any loss to the plan will have caused a loss to some or all of the plan's individual accounts. It follows that any recovery through a suit on behalf of a plan pursuant to 502(a)(2) will redound to the ultimate benefit of those participant's individual accounts affected by the fiduciary's

> breach . . . This fact does not defeat a participant's standing to bring a suit under ERISA on behalf of the Plan.

Id. at 76.

Similarly, in *Rogers v. Baxter*, 417 F. Supp. 2d 974 (N. D. Ill. 2006), the court held that a class of plan participants who held employer stock in their 401(k) plan accounts could bring a claim for breach of fiduciary duty under ERISA § 502(a)(2). Mr. Rogers alleged that the defendants allowed and encouraged investment in Company stock when they knew or should have known it was an imprudent investment. After the company disclosed that it had inflated financial projections and restated its financials to correct improper accounting methods, the value of Baxter stock fell. Rogers filed suit on behalf of two plans which offered Baxter stock as a plan investment. The defendants argued that Rogers' claim was necessarily brought on behalf of a subset of plan participants and that any claim under ERISA § 502(a)(2) must be brought on behalf of the plan as a whole. The Court rejected the defendants' argument.

In reaching its holding the District Court discussed the decisions in *Milofsky* and *Shering-Plough*. The court also noted that while the Seventh Circuit has not yet addressed the issue, dicta in some cases could be viewed as supporting the "whole plan" interpretation. *Id.* at 982 (citing cases). The court also cited to a single case out of the Northern District of Illinois which suggests that claims on behalf of individuals or subgroups of an ESOP could not be brought under ERISA § 502(a)(2). *Id.* at 982, citing *Jackson v. Kroch's & Brentano's, Inc*., 1993 WL 243295 at *3 (N.D. Ill. June 20, 1993). Nonetheless, the court decided to follow the holding in *Milofsky* and *Shering Plough*, rather than the older Seventh Circuit cases cited. The court explained that "this interpretation best effectuates Congress's intent in passing the ERISA statute, which was to provide a high degree of protection to any and all plan participants from fiduciary abuse." *Id.* at 982; *see also Woods v. Southern Co.*, 396 F. Supp. 2d 1351, 1362-63 (N.D. Ga. 2005) (allowing a claim to proceed under ERISA § 502(a)(2) on behalf of a subset of plan participants).

At least one case decided after *Milofsky I* and before *Milofsky II* held that plaintiffs seeking relief under ERISA § 502(a)(2) did not have standing to sue on behalf of a subset of plan participants. *Fisher v. J.P. Morgan Chase & Co*., 230 F.R.D. 370 (S.D.N.Y. 2005). In *Fisher*, the court dismissed the plaintiffs' claims under ERISA § 502(a)(2) holding that because "plaintiffs seek to recover for personalized injuries, they lack standing, because this case in essence is about an alleged particularized harm targeting a specific subset of plan beneficiaries . . . only, and not the plan generally." *Id.* at 376.

§ 15.13 *LARUE v. DEWOLFF* – TESTING THE LIMITS OF *SCHERING-PLOUGH*

After *Schering-Plough*, both plaintiff and defense counsel may wonder where the line will be drawn. Can a single participant, alleging losses to the plan, seek relief under

502(a)(2)? At least in the Fourth Circuit, the answer to this question is "No." In *Larue v. Dewolff, Boberg & Assocs., Inc*., 2006 U.S. App. Lexis 20260 (Aug. 8, 2006), the Department of Labor, in an amicus brief to the court, attempted to extend the holding of *Schering-Plough* to allow relief under ERISA § 502(a)(2) to individual plan participants. The Fourth Circuit rejected the Secretary's argument.

Larue involved a single plaintiff who sought to recover for an individual loss. Indeed, Mr. Larue did not allege a "loss to the plan," but only to his "interest in the plan." *Id.* at *3. As stated by the Fourth Circuit, the Secretary's position was that Mr. Larue should be permitted to bring a claim under ERISA § 502(a)(2), because any "purely individual claim that bears any legal relationship to a plan inures to the benefit of that plan." *Id.* at *4. The Court explained that the Secretary's position "would necessarily transform every purely individual claim for breach of fiduciary duty into a "plan loss." "Such an expansive view of fiduciary liability would lead to its own parade of horribles, a parade that Congress refused to countenance." *Id.* at *4.

According to the Court, the Secretary's position was at odds with the statutory text as well as the Supreme Court's interpretation of that text. The Secretary's interpretation of the remedies available under § 502(a)(2) would "deprive of all meaning the careful distinction Congress drew between plan remedies in § 502(a)(2), and individual remedies in §§ 502(a)(1) and (a)(3)." *Id.* at *7. Moreover, the Secretary's interpretation was not required by any of the recent cases allowing a cause of action for a "subset" of plan participants. The Third Circuit's holding in *Schering-Plough*, the Sixth Circuit's holding in *Kuper v. Iovenko*, the Fifth Circuit's holding in *Milofsky*, and the Seventh Circuit's holding in *Steinman v. Hicks*, were each reached on the grounds that the lawsuits were brought by a subset of plan participants – not single individuals. *Id.* at *9. The Fourth Circuit further distinguished the facts and holding of *In re Schering-Plough Corp. ERISA Litig.*, explaining that the Third Circuit "held only that where plaintiffs alleged that "the Plan suffered significant losses" and requested that fiduciaries "make good to the Plan the losses to the Plan," they need not "seek[] to recover for all plan participants allegedly injured by the breach." *Id.* at *8.

§ 15.14 *PFAHLER V. NATIONAL LATEX CO.* – COURT RULES ERISA § 502(A)(2) DOES NOT PROVIDE RELIEF FOR PARTICIPANTS IN A DEFUNCT PLAN

In *Pfahler v. National Latex Co.*, 405 F. Supp. 2d 839 (N.D. Ohio 2005), the court considered the following question:

> Because any recovery for a breach of fiduciary duty claim brought on behalf of a plan must go to that plan, can plaintiffs bring a derivative action on behalf of a plan which is no longer operating?

Id. at 842.

The plan in question in *Pfahler* was a welfare plan and the damages sought by the plaintiffs included unpaid claims, claims paid by plan participants after the plan ceased operating, retiree medical expenses, and monies paid into the plaintiffs' flexible spending accounts. *Id.* at 844, n.7. In rejecting the plaintiffs' argument that they should be permitted to sue under ERISA § 502(a)(3) the court reasoned that the plaintiffs were not "trying to recover damages suffered by the [Plan], but rather are attempting to recover benefits and contributions they are allegedly owed by the now defunct [Plan]." *Id.* at 844. The court's holding was based largely on the nature of the claims. However, the court noted that "while the defunct nature of a plan may not necessarily represent an absolute obstacle to derivative actions on its behalf, it makes plaintiffs' attempt to recover for their own personal losses even more transparent." *Id.* at 845. The court did, however, reject the defendants' argument that derivative actions may never be maintained on behalf of defunct ERISA plans, holding that their reliance on shareholder derivative actions "lack[ed] persuasive force." *Id.* at 845, n.8.

§ 15.15 NEW DEVELOPMENTS – SEPTEMBER 11 FOR 401(k) PLAN SERVICE PROVIDERS?

On September 11, 2006, a St. Louis, Missouri, law firm, Schlichter, Bogard and Denton ("Schlichter") filed a number of lawsuits against fiduciaries of large ERISA plans based on allegedly excessive undisclosed service provider fees paid by those plans. The complaints allege that the plans' fiduciaries breached their fiduciary duties under ERISA by allowing excessive service charges to be made against participant 401(k) accounts and by failing to disclose those charges to participants and to the Department of Labor (the "DOL") as required by ERISA.

The plaintiffs seek to set aside "excessive" investment-related fees paid by 401(k) plans to service providers found in revenue-sharing arrangements between plans, mutual funds, and record keepers. The plan fiduciaries named as defendants include the boards of directors for Lockheed Martin Corp., General Dynamics Corp., United Technologies Corp., Bechtel Group, Caterpillar Inc., Exelon Corp. and International Paper Company. Together, these seven 401(k) plans have more than 400,000 participants, and the value of the plans range from approximately $3 billion to $15 billion, according to published reports. The seven putative class action lawsuits are pending in Illinois, California, Connecticut and Missouri.

Schlichter's complaints target what the plaintiffs view as the most certain way to protect 401(k) plan returns — *i.e.* reducing the fees and expenses attributable to participants' accounts. According to the plaintiffs and the DOL, the significance to a plan participant of defraying plan expenses may be as great as the significance of choosing well-performing investments. On its website, the EBSA (the agency of the DOL responsible for enforcement of ERISA's fiduciary liability provisions) offers the following example of how plan-related fees can impact the account of a 401(k) plan participant:

> Assume that you are an employee with 35 years until retirement and a current 401(k) account balance of $25,000. If

> returns on investments in your account over the next 35 years average seven percent and fees and expenses reduce your average returns by .5%, your account balance will grow to $227,000 at retirement, even if there are no further contributions to your account. If fees and expenses are 1.5%, however, your account balance will grow to only $163,000. The one percent difference in fees and expenses would reduce your account balance at retirement by 28%.[1]

Using these assumptions, the reduction in value to plan accounts in a plan with 10 participants over the same 35 year period would be $640,000 — in a plan with 100 similarly situated participants, the number would be $6,400,000.

The complaints filed by Schlichter allege that the use of "revenue sharing" payments to plan service providers caused the plans to overpay for services and also disguised the amounts actually paid for any particular service. An example of a revenue sharing arrangement given in one of the complaints is where a plan pays a mutual fund provider a set fee for investing in the mutual fund, which is in excess of the amounts the investment advisor will actually charge. The excess is then shared with other plan service providers. The result is that service providers may receive both "hard dollar" payments and some portion of revenue sharing payments. According to the lawsuits, revenue sharing payments constitute payments above and beyond what a service provider would actually charge for the service provided. According to Schlichter, this practice is not disclosed to Plan participants or government regulators and makes it difficult or impossible to track what the Plan is paying for any one category of service or to any one service provider. In some of the lawsuits, Schlichter alleges that the plan fiduciaries could have recouped the revenue sharing amounts but failed to do so — leading the plans to pay unreasonably high amounts for plan services. The fiduciaries' failure to act prudently or disclose these hidden fees to participants was, according to Schlichter's complaints, a breach of fiduciary duty.

Another allegation common to several of Schlichter's complaints is that plan fiduciaries are hiding administrative expenses by paying those fees through a master trust rather than through the plan directly. For example, the complaint filed against Bechtel alleges that the Bechtel Plan indirectly paid millions of dollars for various services, including record-keeping, investment advisory, investment management, and administration services, through the Master Trust, 99% of the assets of which are Bechtel Plan assets. According to the plaintiffs, amounts paid through the Master Trust were not accounted for as Plan expenses and were not disclosed to Plan participants, despite the fact that they were charged to the Plan, and indirectly reduced the balance in the participants' Plan accounts. The Plan administrators are alleged to have affirmatively misled Plan participants by telling them that the Plan incurred only $33,257 in recordkeeping expenses and no other administrative expenses when in reality the Plan was simply paying Plan expenses through the Master Trust.

Additional allegations found in Schlichter's lawsuits include: (1) that the plans were charged excessive administrative and investment management fees for investment in the

[1] Available at http://www.dol.gov/ebsa/publications/401k_employee.html.

company stock fund; (2) that plans paid fees based on "actively managed funds" when those funds were in fact simply index funds; (3) that the plans failed to negotiate and receive discounted rates from a wholly-owned service provider; and (4) that settlor expenses were inappropriately charged to the plans.

Each of these excessive service fee lawsuits assert violations of the fiduciary duty of prudence and the fiduciary duty to only pay for the reasonable expenses of the plan. ERISA § 404(a)(1)(A) and (B). The plaintiffs seek to recoup losses to the plan under ERISA § 502(a)(2) and "appropriate equitable relief" under ERISA § 502(a)(3). Each of the complaints is brought as a putative class action, and seeks a jury trial — a remedy usually unavailable under ERISA. *See Thomas v. Oregon Fruit Products Co*., 228 F.3d 991, 995-97 (9th Cir. 2000) (collecting cases).

§ 15.15.1 *Haddock v. Nationwide Fin. Servs., Inc*.

Schlichter's lawsuits appear to have been spawned by *Haddock v. Nationwide Fin. Servs., Inc*., 419 F. Supp. 2d 156 (D. Conn. 2006). In *Haddock*, the trustees of an ERISA plan brought an action against Nationwide, an insurance company retained by the plans to select the investment options offered to plan participants. According to the plaintiffs, Nationwide received "revenue-sharing" payments from its selected mutual funds "based on a percentage of the assets that Plans and participants invested in the mutual funds through Nationwide." *Id.* at 162. The plaintiffs alleged that these "revenue-sharing" fees were paid in exchange for offering the mutual funds as investment options to the Plans and participants and that Nationwide's retention of these "revenue-sharing" payments constituted a breach of fiduciary duty and prohibited transactions under ERISA. Nationwide moved for summary judgment on all counts and the Court denied the motion.

The Court recognized that in order for the plaintiffs to succeed on their claims they would need to show that Nationwide was acting as a fiduciary to the plans and that Nationwide was dealing with "plan assets." The Court held that a reasonable fact finder could hold in the plaintiffs' favor on both issues. The Court explained: "Although Nationwide does not invest the pension contributions in particular mutual funds, Nationwide does exercise some control over the selection of mutual funds that are available for the Plans' and participants' investments." *Id.* at 166. "Nationwide may be a fiduciary to the extent that it exercises authority or control over plan assets by determining and alternating which mutual funds are available for the Plans' and participants' investments." *Id.* at 166. Applying a two-prong functional test, the court also concluded that Nationwide may have been dealing with "plan assets." The Court held that "plan assets" include items a defendant holds or receives: (1) as a result of its status as a fiduciary or its exercise of fiduciary discretion or authority; and (2) at the expense of plan participants or beneficiaries." *Id.* at 170. The plaintiffs alleged that Nationwide received payment from mutual funds in exchange for offering the funds as an investment option to the Plans and participants, *i.e*., as a result of its fiduciary status or function, and there was evidence to support this claim. *Id.* at 170. In addition, the Trustees alleged that the payments were made at the expense of the Plan participants or beneficiaries. Specifically, the plaintiffs alleged that the mutual funds set the fees they charged Plans and participants "to cover not only the fees they would have normally charged but also the amount of the

revenue-sharing payments they had to make to Nationwide." *Id.* at 170. Based on these findings, the Court held that a reasonable fact finder could hold, based on the evidence, that Nationwide breached its fiduciary duties to the plans. Plaintiffs' prohibited transaction claims also survived Nationwide's motion for summary judgment. *Id.* at 171.

The Schlichter lawsuits are peculiar because they question the reasonableness of the service provider fees and arrangements to an ERISA-regulated 401(k) plan. Whether a plan fiduciary was procedurally prudent is a facts and circumstances question. *Donovan v. Mazzola*, 916 F.2d 1226 (9th Cir. 1983). It is doubtful that the potential economic exposure in these cases is very significant as Plaintiffs do not seek to invalidate service fees, but to moderate them.

§ 15.16 CLAIMS FOR ERISA PLAN BENEFITS

§ 15.16.1 The Ninth Circuit's New Standard Of Review For Denied Claims: *Abatie v. Alta Health & Life Ins. Co.*

On August 15, 2006, the Ninth Circuit performed an about face — reversing eleven years of case law applying the highly deferential "abuse of discretion" review to a plan administrator's decision to deny benefits, despite the plan administrator's apparent conflict of interest. In the context of ERISA benefit claim litigation a "structural conflict of interest" exists when, for example, an insurer acts as both the plan administrator and the funding source for payment of benefits. Until now, structural conflicts of interest would not affect the deferential "abuse of discretion" review granted by a court in the Ninth Circuit to the plan administrator's decision. In order to receive the heightened "*de novo*" review, the participant was required to present "material, probative evidence, beyond the mere fact of the apparent conflict, tending to show that the fiduciary's self-interest caused a breach of the administrator's fiduciary obligations to the beneficiary." *Atwood v. Newmont Gold Co.*, 45 F.3d 1317, 1323 (9th Cir. 1995). All of this changed with the Ninth Circuit's decision in *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955 (9th Cir. 2006) (en banc).

Dr. Abatie was a radiologist for Santa Barbara Medical Foundation Clinic for over 20 years when, in November 1992 he took a medical leave of absence after developing non-Hodgkin's lymphoma. Shortly after taking leave from the Clinic, Dr. Abatie applied for and received disability benefits. Dr. Abatie never returned to work and received permanent disability benefits beginning in 1993. From September 1998 through April 2000, Dr. Abatie experienced a partial remission but, in June 2000, he died. After his death, his widow filed a claim for life insurance benefits with Alta Health & Life Insurance Company ("Alta"). Under the life insurance policy at issue, in order for Dr. Abatie to have continued coverage after his employment ended, he was required to request a "waiver of premium application" and provide the insurer with proof of total disability within 12 months of becoming totally disabled. He was also required to demonstrate evidence of continuing total disability. Several months after Dr. Abatie's death, the Clinic wrote to Alta, the insurance provider, stating that "due to administrative error, the waiver

of premium application was not filed." Despite the error, the Clinic sought retroactive coverage for Dr. Abatie. *Id.* at 960. Alta denied the claim for life insurance benefits in March 2001 on the ground that Dr. Abatie had not submitted proof of his total disability within 12 months of becoming totally disabled. Ms. Abatie filed suit. After discovery revealed evidence that the Clinic may in fact have submitted a "waiver of premium application" on Dr. Abatie's behalf, all parties agreed to stay the hearing in order to allow Alta to review its prior denial.

On review, Alta again denied Ms. Abatie's claim for benefits concluding that there was insufficient evidence to prove the Clinic had submitted a waiver of premium application for Dr. Abatie. In addition, Alta stated for the first time that it was denying coverage because there was insufficient evidence in the record that Dr. Abatie had remained totally disabled from the time he left work until his death, as required under the policy. The parties resumed litigation in court. *Id.* at 961. After the district court held that Alta had not abused its discretion in denying Ms. Abatie's claim for benefits, Ms. Abatie appealed. On appeal, the Ninth Circuit reversed.

In *Abatie*, the Ninth Circuit presented a revamped method for reviewing denied benefit claims. According to this new method, the "abuse of discretion" review applies whenever an ERISA plan grants discretion to the plan administrator. However, when a conflict of interest exits, the "abuse of discretion" review must be made with "skepticism," with the conflict of interest being weighed more or less heavily depending on the conflict's "nature, extent, and effect on the decision-making process . . ." *Abatie*, 458 F.3d at 967. Along with this new analysis of the review applicable to conflicted decision makers, the Court also addressed: (1) what language in an ERISA plan is sufficient to confer an "abuse of discretion" review (there are no "magic" words and the use of the word "discretion" not mandatory); (2) what evidence a Court may consider in determining whether a conflict exists (Court may look beyond the administrative record); (3) what evidence a Court may consider in reviewing the claim on its merits under the "abuse of discretion" review (Court is limited to administrative record); and (4) what effect procedural violations have on the Court's review and on the evidence the Court may consider (effect varies by severity of violations).

§ 15.16.2 Why the About-Face?

§ 15.16.2.1 *Firestone Tire & Rubber Co. v. Bruch*

The ERISA statute does not specify the standard of review that courts should apply when a plan participant challenges a denial of benefits, so the courts have stepped in to fill this gap. In 1989, the Supreme Court addressed the standard of review that courts must apply in reviewing ERISA cases in which plan administrators have denied benefits. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 109 S. Ct. 948 (1989). *Firestone* is the only Supreme Court opinion directly clarifying the nature of court review in an ERISA case. In *Firestone*, 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." In the Ninth Circuit, this has often meant that courts would uphold an administrator's decision so long as it was "grounded on *any* reasonable basis." *Jordan v. Northrop Grumman Corp. Welfare Benefit Plan*, 370 F.3d 869, 875 (9th Cir. 2004).

In *Firestone*, the Supreme Court also held that if a benefit plan gives discretion to an administrator or fiduciary who is operating under a possible conflict of interest, that conflict must be weighed as a "factor" in determining whether there is an abuse of discretion.

§ 15.16.3 Treatment of Conflicted Plan Administrators Among the Circuit Courts

The Circuits have rendered differing interpretations of how a plan administrator's conflict of interest should affect a court's review. For example, in the Second Circuit, a plan participant bears the burden of proving that the administrator was influenced by a conflict of interest. However, once such influence is shown, the court reviews the administrator's decision *de novo*. *See Sullivan v. LTV Aerospace and Defense Co.*, 82 F.3d 1251, 1259 (2d Cir. 1996). In the Eleventh Circuit, if a conflict of interest is present, the plan administrator still receives abuse of discretion review, but "the area of discretion to which deference is paid must be confined narrowly to decisions for which a conflicted fiduciary can demonstrate that it is operating exclusively in the interests of the plan participants and beneficiaries." *Brown v. Blue Cross & Blue Shield, Inc.*, 898 F.2d 1556 (11th Cir. 1990), *cert. denied*, 498 U.S. 1040, 111 S. Ct. 712 (1991). Many of the Circuits have applied a "sliding scale" approach under which the presence of a conflict of interest means the administrator's decision will be given "intermediate scrutiny." *See, e.g., Pinto v. Reliance Std. Life Ins. Co.*, 214 F.3d 377, 379 (3d Cir. 2000); *Stratton v. Dupont de Nemours & Co.*, 363 F.3d 250 (3d Cir. 2004) (applying the abuse of discretion standard of review "diminished perhaps to a slightly less deferential standard because of the slight conflict of interest."); *Lasser v. Reliance Std. Life Ins. Co.*, 344 F.3d 381 (3d Cir. 2003); *Ellis v. Metropolitan Life Ins. Co.*, 126 F.3d 228 (4th Cir. 1997); *Fought v. Unum Life Ins. Co. of Am.*, 379 F.3d 997, 1004 (10th Cir. 2004); *Baker v. Metropolitan Life Ins. Co.*, 364 F.3d 624 (5th Cir. 2004) (reviewing the administrator's denial of benefits with "less than full deference" because of conflict).

§ 15.16.4 Pre-*Abatie* Rule in the Ninth Circuit – *Atwood v. Newmont Gold Co.*

Prior to its decision in *Abatie*, the Ninth Circuit followed an all or nothing approach as set forth in *Atwood v. Newmont Gold Co*., 45 F.3d 1317, 1323 (9th Cir. 1995). In *Atwood*, the Ninth Circuit held that the existence of a structural conflict of interest did not necessarily alter the standard of review. *Atwood*, 45 F.3d at 1322-33. Instead, the participant was required to present "material, probative evidence, beyond the mere fact of the apparently conflict, tending to show that the fiduciary's self-interest caused a breach of the administrator's fiduciary obligations to the beneficiary." *Id.* at 1323. If the participant did so, the burden shifted to the administrator to prove that the conflict of interest did not affect its decision to deny benefits. If the administrator could not meet the burden, the court would review its decision *de novo*. If, on the other hand, the participant could not produce evidence that the conflict actually caused a breach of the fiduciary's obligations, or if the plan administrator was able to show that its decision was not affected by the conflict, the administrator's decision would be reviewed for an abuse of discretion. No "sliding scale" or "intermediate standard" would apply.

§ 15.16.5 The New Rule

In *Abatie*, the Ninth Circuit concluded that its prior decision in *Atwood* ignored the basic rule set forth in *Firestone* — i.e. that "Plans granting discretion to the administrator receive abuse of discretion review for their decisions denying benefits, while plans that do not confer discretion on the administrator have their decisions reviewed de novo." *Id.* at 966. The Ninth Circuit also concluded that *Atwood* ignored the Supreme Court's requirement that a conflict of interest which exists when a plan administrator also acts as its fiduciary must be weighed as a "factor" in the abuse of discretion review. *Id.* at 966. Finally, the Ninth Circuit held that *Atwood* incorrectly placed on plan participants the burden of producing evidence of the plan administrator's motives, evidence that an ERISA plan participant is much less likely to possess than the plan administrator. *Id.* at 967.

Under the new rule announced in *Abatie*, a conflict of interest must be weighed as a factor in the abuse of discretion review on a case-by-case basis. *Id.* at 968. "A district court, when faced with all the facts and circumstances, must decide in each case how much or how little to credit the plan administrator's reason for denying insurance coverage. An egregious conflict may weigh more heavily (that is, may cause the court to find an abuse of discretion more readily) than a minor, technical conflict might." *Id.* at 968. The court explicitly rejected the "sliding scale" approach articulated by several other Circuits, noting that "in any given case, all the facts and circumstances must be considered and nothing 'slides,' so we find the metaphor unnecessary and potentially confusing." *Id.* at 968.

Apparently, the presence or absence of certain evidence will increase or decrease the level of skepticism with which a court should view a conflicted administrator's decision. For example, the level of skepticism may be low "if a structural conflict of interest is unaccompanied . . . by any evidence of malice, or self-dealing, or of a parsimonious claims-granting history." *Id.* at 968. On the other hand, the court's level of

skepticism may be higher if, for example, "the administrator provides inconsistent reasons for denial, fails adequately to investigate a claim or ask the plaintiff for necessary evidence, or has repeatedly denied benefits to deserving participants by interpreting plan terms incorrectly or by making decisions against the weight of evidence in the record." *Id.* at 968-69 (internal citations omitted).

The Court recognized that its new approach would place the responsibility on the district courts to determine how much weight to give to any specific piece of evidence. The Ninth Circuit was not troubled by this, likening the process to a determination, during a bench trial of "how much weight to give to a witness' testimony in the face of some evidence of bias." *Id.* at 969. Indeed, the Ninth Circuit held that district courts are "well equipped to consider the particulars of a conflict of interest, along with all of the other facts and circumstances, to determine whether an abuse of discretion has occurred." *Id.* at 969.

Under its case by case approach, plan participants will no longer be required to demonstrate a "serious conflict of interest" in order to avoid a straight "abuse of discretion" review. Instead, even without such a showing, plaintiffs "will have the benefit of an abuse of discretion review that always considers the inherent conflict when a plan administrator is also the fiduciary, even in the absence of "smoking gun" evidence of conflict. *Id.* at 969. In every case, plan administrators will be encouraged to produce evidence showing that any conflict did not influence its decision making process – in order to show that it has not abused its discretion. Examples of such evidence given by the Court include evidence that the plan "used truly independent medical examiners or a neutral, independent review process; that its employees do not have incentives to deny claims; that is interpretations of the plan have been consistent among patients; or that it has minimized any potential financial gain through structure of its business…" *Id.* at 969, n.7.

§ 15.16.6 No "Magic" Words Necessary to Receive "Abuse of Discretion" Review

In its single nod to plan administrators, the Ninth Circuit confirmed that it would read the terms of ERISA plans generously to confer "discretion" on the plan administrator even where the word "discretion" appears nowhere in the plan. *Id.* at 963. According to the Court, there are no "magic" words that conjure up discretion on the part of the plan administrator. *Id.* at 963. A plan should be considered to grant discretion if the administrator has the "power to construe disputed or doubtful terms" in the plan or if the administrator has "the power to interpret plan terms and to make final benefits determinations." *Id.* at 963. Only where a plan's terms are limited to identification of the party to pay benefits and administer the plan will *de novo* review apply. Examples of such provisions include those which state "[t]he carrier solely is responsible for providing the benefits under this Plan"; "[t]he carrier will make all decisions on claims"; and "the review and payment or denial of claims and the provision of full and fair review of a claim denial pursuant to [ERISA] shall be vested in the carrier." *Id.* at 964. In the present case, the plan bestowed on the administrator "the responsibility to interpret the terms of the plan and to determine eligibility for benefits." The fact that the plan nowhere explicitly gave the plan "discretion" in these endeavors was of no consequence to the court. *Id.* at 965.

§ 15.16.7 District Court Permitted to Consider Evidence Outside of the Administrative Record in Determining Weight to Give Conflict of Interest

In the Ninth Circuit, as in most Circuits, a district court reviewing a plan administrator's decision under the "abuse of discretion" standard is limited to the administrative record. *See e.g., Jebian v. Hewlett-Packard Co. Emple. Benefits Org. Income Prot. Plan*, 349 F.3d 1098, 1110 (9th Cir. 2003) ("While under an abuse of discretion standard our review is limited to the record before the plan administrator, this limitation does not apply to *de novo* review."). This typically means that plaintiffs litigating claims for benefits under an ERISA plan are not entitled to additional discovery, so long as the abuse of discretion review applies. According to the new standard of review announced by *Abatie*, a district court may consider evidence outside the record when deciding how much weight to give a conflict of interest under the abuse of discretion standard. *Id.* at 970. According to the Court, "the district court may, in its discretion, consider evidence outside the administrative record to decide the nature, extent, and effect on the decision-making process of any conflict of interest; the decision on the merits, though, must rest on the administrative record once the conflict (if any) has been established, by extrinsic evidence or otherwise." *Id.* at 970.

The Court considered its holding in this respect consistent with its prior holding in *Tremain v. Bell Indus., Inc*., 196 F.3d 970, 976-77 (9th Cir. 1999), in which the district court was permitted to consider evidence beyond that contained in the administrative record to determine whether a conflict of interest exists that would affect the appropriate level of judicial scrutiny. *Abatie*, 458 F.3d at 970.

§ 15.16.8 Effect of Procedural Violations on the Court's Review

Ordinarily, an administrator's failure to comply with ERISA's procedural requirements does not alter the standard of review applicable to the administrator's decision. *Gatti v. Reliance Std. Life Ins. Co*., 415 F.3d 978, 985 (9th Cir. 2005). However, sometimes a plan administrator may violate the procedural requirements so substantially that its decision cannot be considered an exercise of discretion. In these rare cases, "[w]hen an administrator engages in wholesale and flagrant violations of the procedural requirements of ERISA, and thus acts in utter disregard of the underlying purpose of the plan as well," the decision of the administrator is reviewed *de novo*. *Id.* at 971. *De novo* review is justified in these cases on the ground that the administrator is only entitled to deference when the administrator exercises discretion that the plan grants as a matter of contract. "Because an administrator cannot contract around the procedural requirements of ERISA, decisions taken in wholesale violation of ERISA procedures do not fall within an administrator's discretionary authority." *Id.* at 971-72.

More often, a plan administrator may make some procedural errors during the claims review and appeal process but those errors are not so severe as to undermine the administrator's exercise of discretion. In these instances, the Ninth Circuit in *Abatie* held that a procedural irregularity, like a conflict of interest, is a matter to be weighed in

deciding whether an administrator's decision was an abuse of discretion. *Id.* at 972. "When an administrator can show that it has engaged in an "ongoing, good faith exchange of information between the administrator and the claimant," the court should give the administrator's decision broad deference notwithstanding a minor irregularity. . . . A more serious procedural irregularity may weigh more heavily." *Id.* at 972 (internal citations omitted). According to the *Abatie* Court, failure to follow ERISA's procedural requirements may also justify a court's consideration of evidence outside the administrative record. *Id.* at 972-73.

Applying its newly minted rules to Ms. Abatie's claims, the Ninth Circuit concluded that Alta's inclusion of a second basis for denying Ms. Abatie's claim for benefits in its decision on review was a violation of the procedural requirements of ERISA. *Id.* at 971, 974. Alta originally denied Plaintiff's claim for life insurance benefits because it concluded that no waiver of premium application had been submitted on behalf of Dr. Abatie. Later, in its final denial of Plaintiff's claim, Alta continued to rely on that reason, but also added a second reason — that Plaintiff had provided insufficient evidence to show that Dr. Abatie had remained totally disabled from the time he left work at the Clinic until his death. *Id.* at 974. According to the Court, "[w]hen an administrator tacks on a new reason for denying benefits in a final decision, thereby precluding the plan participant from responding to that rationale for denial at the administrative level, the administrator violates ERISA's procedures." *Id.* at 974. The Court reached this conclusion despite the fact that Alta would have denied the claim based on the first reason alone. The Court held that Alta's procedural violation must be weighed by the district court in deciding whether Alta abused its discretion. *Id.* at 974.

§ 15.17 ERISA CLASS ACTION ISSUES

§ 15.17.1 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).

§ 15.17.1.1 *In Re ADC Telecomm., ERISA Litig.*

The complaint *In re: ADC Telecomm., ERISA Litig.*, 2005 U.S. Dist. LEXIS 20224 (D. Minn. Sept. 15, 2005), alleged that defendant ADC breached its fiduciary duties to

participants of the ADC Retirement Savings Plan (the "Plan") by allowing participant contributions and Plan assets to be invested in ADC stock. The plaintiffs alleged that ADC knew or should have know investment in ADC stock was imprudent due to non-public accounting irregularities and operational problems at ADC. Plaintiff James Carnahan was proposed as class representative and brought a motion to certify a class of ADC employees and former employees who participated in the Plan and invested in ADC stock during the class period.

The defendant conceded that the requirements of numerosity and commonality were met, but challenged Mr. Carnahan's claim that he satisfied the requirements of typicality and adequacy contained in Rule 23(a)(3) and (a)(4). The basis of the defendant's challenge to Mr. Carnahan's adequacy as a class representative lay in actions Carnahan took while employed by ADC. While employed by ADC, Mr. Carnahan posted an internal memorandum from ADC's CEO on a Yahoo! internet message board relating to ADC. The memo previewed future company actions, commented on the effect of reduced spending in the telecommunications industry, and predicted cost reductions. After discovering the post, ADC terminated Carnahan for violation of its Business Conduct Policy. Carnahan admitted during his deposition that he violated company policy. Nonetheless, following his termination Carnahan hired an attorney to consider the possibility of filing a suit against ADC for age discrimination and slander. He did not ultimately proceed with that lawsuit. The defendant argued that Mr. Carnahan's actions posed "issues of forthrightness and credibility" which undermined his adequacy as a class representative. The Court agreed, holding that "Carnahan's past actions could subject him to a vigorous cross-examination which would be disadvantageous to other class members." *Id.* at *13.

In addition to Mr. Carnahan's unique behavior with respect to ADC, Mr. Carnahan's deposition testimony suggests that he lacked a basic understanding of the claims alleged in his complaint. The defendant used this evidence to attack Mr. Carnahan's typicality. Mr. Carnahan apparently stated in his deposition that he was not making a "prudence" claim and admitted that "he did not feel Plan participants should have had the choice to invest in ADC stock during the class period." *Id.* at *8. Similarly, while the Complaint apparently alleged misrepresentations by the defendant with respect to ADC stock, Mr. Carnahan "was unable to identify specific statements by ADC he believes were misrepresentations." *Id.* at *8. According to the defendant, since Mr. Carnahan was not making a "prudence" claim and could not identify any misrepresentations made by ADC, his claims were not "typical" of the class he proposed to represent. The Court agreed with the defendant, concluding that Carnahan's admissions during his deposition made him a "dubious class representative." *Id.* at *9. The Court gave the plaintiffs 30 days to propose an alternative class representative. *Id.* at *13.

§ 15.17.1.2 *In Re Polaroid ERISA Litig.*

Courts are not always terribly demanding of putative class representatives. In *In Re Polaroid ERISA Litig.*, 2006 U.S. Dist. LEXIS 70867 (S.D.N.Y. Sept. 29, 2006), the Court found that Mr. Powers, a putative class representative, was "adequate" under Rule 23(a)(4) despite bigoted behavior and the fact that he destroyed documents before his

deposition. The defendants argued that Mr. Powers could not adequately represent minorities, women or Jews because of offensive statements he had made about those groups in an internet chat room. *Id.* at *33. The Court acknowledged Mr. Powers' bigoted statements, but did not agree that the plaintiff's remarks were sufficient to render him an inadequate class representative. The Court explained: "While Powers' bigoted remarks are repugnant to this Court, there is no evidence that he has ever discriminated against minorities, women or Jews in the course of his employment or business affairs, and his interests are aligned with the other members of the class in seeking to maximize recovery on behalf of the Plan." *Id.* at *33. The Court was more troubled by Powers' destruction of documents relevant to the action — behavior which could give rise to unique defenses. However, the Court concluded that "based on a review of Powers' deposition transcript, it appears that the need for document retention during litigation has been clarified for him and that he understands his need to comply." *Id.* at *34. Reassured, the Court granted Mr. Powers' motion to serve as class representative. *Id.* at *34.

§ 15.17.2 Must the Named Class Representative Exhaust Administrative Remedies Before Filing Suit? – *Spivey v. Southern Co.,* 427 F. Supp. 2d 1144 (N.D. Ga. 2006)

The short answer is "yes." A court-developed doctrine requires ERISA participants to first have their claims reviewed by the Plan Administrator before they are allowed to file suit. Courts uniformly impose such a requirement in claims for benefits brought under ERISA § 502(a)(1)(B). The question of whether one must exhaust administrative remedies when bringing an action to assert rights granted by ERISA itself is generally unsettled. The circuits are split as to whether exhaustion is required for a fiduciary breach. Some circuits require exhaustion of all claims. *See, e.g., Lindemann v. Mobil Oil Corp*., 79 F.3d 647 (7th Cir. 1996); *Communications Workers of Am. v. AT&T Co*., 40 F.3d 426, 432 (D.C. Cir. 1994); *Dale v. Chicago Tribune Co*., 797 F.2d 458 (7th Cir. 1986); *Mason v. Cont'l Group, Inc*., 763 F.2d 1219 (11th Cir. 1985); *Kross v. Western Elec. Co*., 701 F.2d 1238, 1245 (7th Cir. 1983). Other circuits do not, reasoning that plan fiduciaries have no expertise in interpreting statutory rights. *See, e.g., Milofksy v. American Airlines, Inc.,* 442 F.3d 311, 313 (5th Cir. 2006); *Richards v. General Motors Corp*., 991 F.2d 1227 (6th Cir. 1993); *Gavalik v. Cont'l Can Co.*, 812 F.2d 834, 849-50 (3d Cir. 1987); *Fujikawa v. Gushiken*, 823 F.2d 1341 (9th Cir. 1987); *Amaro v. Cont'l Can Co*., 724 F.2d 747, 752 (9th Cir. 1984). In *Amato v. Bernard*, 618 F.2d 559, 568 (9th Cir. 1980), the Ninth Circuit first announced the exhaustion rule, citing the legislative history and the text of ERISA. It explained that, as a matter of policy, federal courts had the authority to enforce the exhaustion requirements in suits arising under ERISA. *Id.* at 567-68.

The Eleventh Circuit followed the Ninth Circuit's reasoning in *Amato* and ruled that plaintiffs must exhaust the pension plan's administrative remedies before bringing fiduciary beach claims, *Mason v. Cont'l Group, Inc*., 763 F.2d 1219, 1226-27 (11th Cir. 1985):

> Administrative claim-resolution procedures reduce the number of frivolous lawsuits under ERISA, minimize the cost of dispute resolution, enhance the plan's trustees' ability to carry out their fiduciary duties expertly and efficiently by preventing premature judicial intervention in the decisionmaking process, and allow prior fully considered actions by pension plan trustees to assist courts if the dispute is eventually litigated.

Mason, 763 F.2d at 1227.

The requirement that an individual exhaust the ERISA plan's administrative remedies before filing suit recently derailed a 401(k) "stock drop" class action. The complaint in *Spivey v. Southern Co.*, 427 F. Supp. 2d, 1144 (N.D. Ga. 2006) was originally filed in June 2004 by Mr. Woods. Through his 401(k) plan account, Mr. Woods, and many other plan participants, held stock in Southern Co.'s defunct, subsidiary - Mirant Corporation. After the value of the Mirant stock held in his 401(k) plan account dropped from $47 to $0.25 per share, Mr. Woods filed suit, claiming that the defendants should have been aware of "scandalous and unlawful activities taking place within the former Southern Co. subsidiary" and should have divested the Southern Co. Plan of that stock.

Mr. Woods died during 2005. He was replaced by Mr. Spivey as the named plaintiff in this putative class action. Mr. Spivey, however, had failed to file a claim concerning the drop in price of his Mirant shares with the Southern Company Plan Administrator. The defendants successfully filed a motion for summary judgment seeking dismissal of Mr. Spivey's case for failure to file a claim with the Plan Administrator before filing suit.

The terms of the Southern Plan required all claims to be exhausted:

> No legal action to recover benefits or enforce or clarify rights under a Plan can be commenced until you have first exhausted the claims and review procedures provided under the Plan.

Id. at 1151.

Mr. Spivey argued that the administrative remedies provided by the plan only applied to claims for benefits under ERISA § 502(a)(1)(B), not claims for breach of fiduciary duty under ERISA § 502(a)(2) or (a)(3). The Court rejected Mr. Spivey's arguments:

> The Eleventh Circuit . . . 'appl[ies] the exhaustion requirement to both ERISA claims arising from the substantive provisions of the statute, and ERISA claims arising from an employment and/or pension plan agreement.' What is more, in at least two reported cases, the Circuit either enforced or acknowledged a participant's duty to exhaust prior to bringing 'statutory' claims where the language of the relevant plan, like here, could be

> read as limiting the administrative process to claims for benefits.

Id. at 1151, *citing Mason v. Cont'l Group, Inc.*, 763 F.2d 1219, 1226-27 (11th Cir. 1985); *Curry v. Contract Fabricators Inc. Profit Sharing Plan*, 891 F.2d 842, 845 n.3 (11th Cir. 1990).

Mr. Spivey's alternative arguments against application of the "exhaustion" requirement suffered the same fate. For example, Mr. Spivey argued that the language requiring exhaustion of plan remedies was not part of the SPD. The Court found attaching the claim procedure to the SPD was permitted by Department of Labor Regulations and that Mr. Spivey did not dispute that he was in possession of the relevant documents. Finally, Mr. Spivey argued that language in the Plan (stating that a participant claiming a misuse of Plan funds "may seek assistance from the U.S. Department of Labor or file suit in federal court") bestowed upon participants the right to immediately pursue such claims without first seeking administrative relief. *Id.* at 1153. The Court also rejected this argument, and explained that the cited language was required boilerplate constituting nothing more than a "generic description of participants' rights" under ERISA. *Id.* at 1154.

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.

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