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The ERISA Litigation Newsletter

May 2008

Editor's Overview

It seems only fitting that since last month's articles illustrated that ERISA litigation "followed the money," that we start off this month with a review of a decision on insurance coverage for plan sponsors and fiduciaries. The article takes us through a recent decision from the Seventh Circuit which reminds us all that late notice to the insurer and failure to seek consent from the insurer may preclude the ability to obtain any contribution towards a litigation settlement.

The second article discusses the Supreme Court's decision to grant *certiorari* in *MetLife v. Glenn*, No. 06 Civ. 923, a decision that may provide clarification on the appropriate standard of review that courts should apply to issues of plan interpretation, particularly where a conflict of interest exists and/or infects the decision-making process. In the same vein, the next article discusses recent challenges to discretionary clauses, *i.e.*, clauses that grant fiduciaries discretion in deciding benefit claims. While the Supreme Court is currently considering how to handle conflicts by the fiduciaries in *MetLife v. Glenn*, various state insurance regulators are – with some success – seeking to bar completely discretionary clauses in insured ERISA plans.

The next article reviews a stock-drop decision from the Seventh Circuit that provides common sense, but important, answers to the question of what an ERISA fiduciary should do when he or she is facing allegations that the company engaged in fraud.

We conclude with an article that discusses a recent decision from the Sixth Circuit involving retiree welfare benefit claims filed by unionized employees, which illustrates one of the many instances in which ERISA has not succeeded in creating a uniform body of law and, as a result, may prevent employers from successfully addressing rising healthcare costs.

Wake Up! Is It Time to Notify the Insurer?

by Russell L. Hirschhorn

The Seventh Circuit recently provided a stark reminder to ERISA plans and fiduciaries of the consequences resulting from the failure to timely notify the insurer of a potential litigation settlement. In *Federal Insurance Co. v. Arthur Andersen LLP*, 2008 WL 942640 (7th Cir. Apr. 9, 2008), the Seventh Circuit held that Federal Insurance Company ("Federal") was not obligated to contribute the policy limit of $25 million towards a settlement of pension claims by retirees who had worked for Arthur Andersen. In so holding, the Court determined that, contrary to the terms of the policy, Arthur Andersen did not "ask for the consent or even the comments of its insurers; it presented the deal to them as a *fait accompli*."

Following Enron's collapse, the accounting firm Arthur Andersen was indicted and, as a result, lost most of its clients. Arthur Andersen retirees found that their pension benefits were in serious jeopardy as the pension plan was unfunded. With the firm's collapse looming, retirees en masse demanded lump sum distributions, which created the equivalent of a run on a bank. Arthur Andersen told its retirees that it would continue monthly pension payments but would not honor any requests for lump sum distributions. Unsurprisingly, litigation ensued.

The first litigation was filed in March 2002. This suit alleged, among other things, that the retirees had been employees rather than partners, that ERISA therefore required retirement benefits to be funded through a trust, and that Arthur Andersen was liable for breach of this statutory duty. These claims potentially came within the scope of Arthur Anderson's insurance policies, such as the one issued by Federal. In May 2002, Arthur Andersen's insurance broker first informed Federal about the March 2002 litigation. The broker's letter stated that Arthur Andersen had retained a law firm to represent it; it did not ask Federal to provide a defense to the litigation, but did ask Federal to "confirm coverage" and contribute toward the cost of the lawyers' services. Federal replied within a week that it was reserving its rights, and requested a copy of the Arthur Andersen's partnership agreement (so it could evaluate the plaintiffs' claims) and a schedule of the lawyers' rates. Not until August 2002 did the broker provide Federal with the requested information as well as the news that the March 2002 litigation had been dismissed by plaintiffs, who planned to commence arbitration instead.

In September 2002, the broker told Federal that there was another litigation that had been filed two months earlier. This letter also did not request a defense from Federal, but did ask Federal to consent to the defense provided by Arthur Andersen's lawyers. In November 2002, Arthur Andersen proposed a compromise to all retirees and wrote to its insurers that it needed at least $75 million from them to fund a settlement and, in particular, asked Federal to pay the policy limit of $25 million. In response, Federal filed a lawsuit, seeking a declaration that it was not required to defend or indemnify Arthur Andersen because, unlike the first litigation, this litigation did not make any claim that Arthur Andersen acted negligently or breached any fiduciary duty. Rather, the new litigation only asserted that every retiree was entitled by contract to immediate distribution of retirement funds and Federal's policy excluded claims for retirement benefits due under contracts. Ultimately, Arthur Andersen settled with all retirees for an amount in excess of $260 million, a fraction of the outstanding retirement balances.

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not ask for consent; "it presented the deal
to [Federal] as a *fait accompli*."

The Seventh Circuit concluded that the policy did not call for indemnity and that Federal need not contribute toward the settlement of the claims against Arthur Andersen. The Court observed that the policy defined as a covered loss any injury caused by negligence or a breach of fiduciary duty and, as explained above, the retirees were not injured that way; they were injured as a result of Arthur Andersen's business and legal difficulties. The Court also concluded that the policy lawfully excluded pension benefits. Thus, even if Arthur Andersen had a right to reduce or eliminate the benefits, as it contended, the fact remained that the settlement reflected the present value of the pension promises; it did not reflect damages for anyone's misconduct. Finally, the Court reasoned that Federal need not indemnify Arthur Andersen because the policy commits Arthur Andersen not to settle any claim for more than $250,000 without Federal's "written consent, which shall not be unreasonably withheld" and, as noted above, Arthur Andersen did not ask for consent; "it presented the deal to [Federal] as a *fait accompli*."

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For some things in life, the age-old adage “better late than never” may hold true. The Seventh Circuit’s decision reminds us all, however, that late notice may be tantamount to no notice when it comes to issues pertaining to insurance coverage. To avoid the risk of loss of coverage, plan fiduciaries and sponsors should take heed of the Seventh Circuit’s decision and ensure that they comply with the terms of applicable insurance policies, including its notification and consent requirements.

***MetLife v. Glenn*: Supreme Court Struggles to Determine Judicial Standard of Review for Benefit Determinations Made by “Dual Role” Administrators**

by Deidre A. Grossman

The United States Supreme Court’s decision in *Firestone v. Bruch*, 489 U.S. 101 (1989), is generally cited for the proposition that, where a plan document grants discretionary authority to a plan administrator to make benefit determinations, the decision to deny a benefit claim is reviewable under the “arbitrary and capricious” standard. The Court cautioned, however, that, if there is evidence that the administrator operated under a “conflict of interest” when rendering the determination, a less deferential standard may be appropriate. In dictum, the Court remarked that the “conflict must be weighed as a ‘facto[r] in determining whether there is an abuse of discretion.’”

In the wake of *Firestone*, courts struggled to give effect to this statement when considering two questions: (1) what facts and circumstances give rise to a finding of a conflict of interest; and (2) what effect should the finding of a conflict have on the court’s scrutiny of an administrator’s decision to deny benefits. With more employers insuring their benefits through third-party providers, the bulk of the decisions addressing both questions arose in the context of participant claims against insurance companies, where financial self-interest is alleged to have improperly motivated the administrator to deny a claim for benefits.

For decades, these two issues have divided, not only the circuit courts of appeals, but also panels within each circuit, leaving district courts with no workable standards, and thus to decide cases based on their unique facts. On January 18, 2008, the United States Supreme Court granted *certiorari* in *MetLife v. Glenn*, No. 06 Civ. 923, to address both questions. Oral argument was held on April 23, 2008.

On the issue of whether or not an insurer's dual role as administrator and payor of benefits, standing alone, gives rise to a conflict of interest, the majority of the Justices appeared to accept the notion that it does, although they appeared to recognize that whether or not the conflict "infects" the determination in question is a separate matter. "[C]onflicting interests' mean just that; you have conflicting interests. It doesn't mean you necessarily slide over into misconduct[,]" noted Justice Ginsberg. Justice Scalia agreed, commenting that "the conflict exists whether you . . . give it effect or not." Justice Souter suggested that a "potential" conflict, i.e., the structural conflict that exists by virtue of the dual role even without evidence of a taint, is not immaterial, and that "there's no reason that the law should be blind" to the "contrary tugs on the . . . individual or the . . . organization that has the dual responsibilities[.]" As for Justice Alito and Chief Justice Roberts, they queried whether or not, if the conflict must have played a role in the decision in order to alter the standard of review, this would raise the practical problem of a court being unable to determine the standard until it had examined the merits of the case and allowed discovery into the decision-making processes.

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The Justices appeared to struggle more with how the conflict should affect the judicial standard of review and posed many challenging questions on what the standard should be. Can a conflict require the reversal of a determination that, if rendered by an impartial administrator, would have been deemed reasonable? Should a district court weigh the conflict in advance of assessing the reasonableness of the decision and then only consider it as a "tie-breaker" in close cases? How much more scrutiny is required when there is a conflict? If the conflict is, as *Firestone* suggests, to be weighed as "a factor," how much should that factor weigh?

The Court's questions ran the gamut. Its decision may determine whether there will be a bright-line rule or a standard dependant on the facts and circumstances of each case. However, it could potentially leave litigants with no more certainty than they have had since *Firestone.*

ERISA Preemption & State Insurance Bars of Discretionary Clauses

by Charles F. Seemann III

In *Firestone Tire & Rubber Co v. Bruch*, 489 U.S. 101 (1989), the Supreme Court established that reviewing courts should apply a de novo standard of review to ERISA fiduciaries' decisions where the plan instruments are silent on the degree of discretion those fiduciaries possess. Since the *Firestone* decision, discretionary clauses – *i.e.*, provisions granting fiduciaries the discretion to interpret uncertain plan terms or make eligibility determinations – have become common in ERISA plans.

For years, discretionary clauses have been challenged by ERISA plaintiffs and consumer groups. State insurance regulators entered the fray in 2002, and appear to be succeeding in setting aside these clauses for insured plans. Significantly, the usual ERISA preemption defense appears to be giving way to a wave of state insurance regulation preventing insured ERISA plans from giving *Firestone* discretion to fiduciaries of insured plans. This article examines some recent case law on the preemption issue, and briefly considers what the future may hold for ERISA plans and the interpretive discretion of plan fiduciaries.

Prohibitions on Discretionary Clauses

The National Association of Insurance Commissioners (NAIC) adopted the "Prohibition on the Use of Discretionary Clauses Model Act" (Act) in 2002. Despite opposition from trade and industry groups, the Act's provisions have been implemented in a number of states, including California, Illinois, Maine, Minnesota, New York and Oregon. In addition, several insurance commissioners have unilaterally refused to approve discretionary clauses. The Act broadly disapproves of any proposed insurance form containing a discretionary clause, typically defined as any clause that: (i) provides an insurer with sole discretionary authority to determine eligibility for benefits under, or interpret the terms and provisions of, an insurance policy; and (ii) purports to give the insurer's determination or interpretation binding effect as to the policy holder. The prohibition has been applied to life, disability, health, and long-term care policies purchased as part of a benefits plan established and maintained under ERISA. In fact, it appears that the Act was purposefully designed to reach insured ERISA plans.

Opponents' reactions have been swift, but to date ineffective. For example, in California – where, in 2005, discretionary clauses were banned by regulation after the state legislature declined to adopt the Act – various trade associations asserted challenges on state-law grounds. Ultimately, however, these challenges failed, and by mid-2007, the last insurer resisting enforcement reached a settlement with California regulators.

ERISA Pre-Emption & the Act

Proponents of the Act contend that the Act eliminates unfairness and misleading policy language. Opponents argue that adequate protections already exist for participants and beneficiaries, since ERISA itself imposes stringent legal duties and procedural requirements on plan fiduciaries, including insurers wielding discretionary authority over benefits. Employers and plan sponsors also observe that the elimination of fiduciary discretion, *i.e.*, a process to which reviewing courts can defer to plan interpretations by plan fiduciaries, undermines their ability to control the scope of benefits to be provided by health care, life insurance and other fringe benefits. Opponents also observe that resources for paying plan benefits will be diminished or exhausted by the litigation costs incurred defending lawsuits by frustrated claimants.

These arguments plainly evoke major policy objectives underlying ERISA, such as the establishment of a uniform federal standard of benefit-plan regulation, and the promotion of voluntary plan sponsorship through cost control. In light of this, opponents of the Act have sought relief under ERISA § 514, 29 U.S.C. § 1114, which preempts state laws "insofar as they may now or hereafter relate to any [ERISA] plan." Significantly, however, ERISA § 514 also expressly "saves" from pre-emption "any law . . . which regulates insurance, banking, or securities."

In a 2002 case that foreshadowed NAIC's efforts to undermine a deferential standard of review, the Supreme Court addressed ERISA's "savings clause." In that decision, *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002), the Court held that ERISA did not preempt an Illinois statute requiring independent review of disputes between a primary-care physician and an HMO. In so holding, the Court rejected arguments that the independent-review mechanism conflicted with ERISA's enforcement scheme by depriving the HMO of deferential review arising out of its interpretive discretion. The Court wrote:

> Not only is there no ERISA provision directly providing a lenient standard of review of benefit denials, but there is no requirement necessarily entailing such an effect even indirectly . . . . Nothing in ERISA . . . requires that these kinds of decisions be so "discretionary" in the first place . . . . [The statute] prohibits designing an insurance contract so as to accord unfettered discretion to the insurer to interpret the contract's terms. As such, it does not implicate ERISA's enforcement scheme at all, and is no different from the types of substantive state regulation of insurance contracts we have in the past permitted to survive preemption.

A year later, the Supreme Court broke with earlier precedent and established a new, more liberal framework for determining whether a given law was "saved" from ERISA preemption. In *Kentucky Association of Health Plans v. Miller*, 538 U.S. 329 (2003), the Court held that a state law regulated insurance, and was thus saved from pre-emption, where: (i) the law was specifically directed to the insurance industry; and (ii) the law substantially affects the risk-pooling arrangement between insurer and insured. Against this backdrop, insurers have challenged bans on discretionary clauses in Montana and Michigan, asserting that ERISA preempted those laws despite their relationship to insurance regulation.

In *Standard Insurance Co. v. Morrison*, No. 06 Civ. 47 (D. Mont. Feb. 27, 2008), a group disability insurer, Standard, challenged a Montana ban on discretionary clauses. Standard argued against the ban on multiple levels. Attacking the savings issue first, Standard asserted that the Montana ban was not "specifically directed" at insurance: according to Standard, the ban simply codified principles of general contractual law, since it purported to reinstate the general rule that contractual ambiguities are construed against the drafter. Standard also adduced expert testimony that the Montana ban did not affect risk-pooling arrangements, because risk-pooling occurs at the time of contracting, not when benefits determinations are made. Finally, Standard argued that the ban was preempted due to a conflict with ERISA's enforcement mechanisms.[1]

The district court rejected all of these arguments and dismissed Standard's lawsuit. In addressing the savings-clause issues, the court concluded that the Montana ban was directed at insurance because it minimized insurers' advantage, *i.e.*, a deferential standard of review. Relying on a distinction emphasized in the Supreme Court's *Miller* decision, the court found that the Montana ban "substantially affects" risk pooling – even if it does not actually spread risk – because it dictates the conditions under which an insurer must pay for the risks it assumes. The court also disposed of Standard's argument that the Montana ban conflicted with ERISA's enforcement mechanisms, noting that such conflicts arose only when state law purported to provide additional remedies to those afforded by ERISA. Since a successful claimant would only collect monies due under the terms of a plan, the court found no conflict between the Montana ban and ERISA's remedial scheme.

Two days later, another district court dismissed a challenge to Michigan's ban on discretionary clauses, in *American Council of Life Insurers v. Watters*, No. 07 Civ. 631 (W.D. Mich. Feb. 29, 2008). In *Watters*, several national trade associations representing group-health and group-life insurers challenged state insurance regulations disallowing discretionary clauses. Like the plaintiff in the *Morrison* case, the plaintiff groups in *Watters* argued that the Michigan ban conflicted with Congressional intent, and was not covered by ERISA's savings clause.

After finding these trade associations had standing to challenge the Michigan regulations, the *Watters* court dismissed the lawsuit. The court first addressed plaintiffs' contention that ERISA authorizes insurers to design plans which include fiduciary discretion. The court rejected this argument, relying in part on the passage from *Rush Prudential* (quoted above), and holding that insurers had no enforceable "right" to establish plans including discretionary clauses. The court went on to state that Michigan's ban was not subject to "conflict" preemption, because it did not establish any new causes of action or forms of ultimate relief. The court then turned to the saving clause issues. Using the *Miller* test applied in *Morrison*, the court held that the Michigan regulations plainly regulated insurance, because they regulated the terms insurers could insert into insurance contracts and regulated the insurer's ultimate ability to deny benefits. The court also observed that the regulations substantially affected the risk-pooling arrangement, because they would require insurers to pay more money in claims and incur more of the risk they have assumed. Based on this reasoning, the court dismissed the preemption challenge and sustained Michigan's ban on discretionary clauses. The court concluded by denying, as futile, the trade associations' request to amend their complaint.

The judgments in both *Watters* and *Morrison* are now on appeal.

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The Future of Discretionary Clauses

Unless one or both of these appeals yield a reversal, the trend appears to be an unfavorable one for insurance carriers administering group health, life and other insured ERISA plans. In the *Morrison* case, regulators presented evidence that when the claim denial results in a lawsuit, claimants recover benefits in 68 percent of lawsuits when a discretionary clause is absent, compared to a 28 percent rate of recovery when the plan gives the insurer discretion.

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The insurance bar of discretionary clauses will increase the incentive to go to self-funded plans for employers large enough to undertake this risk. Since ERISA § 514(b)(2)(B) exempts self-insured plans from insurance regulation, a self-funded format will permit larger plan sponsors to continue using fiduciary discretion as a means to control the scope of the benefits to be provided. In contrast, smaller employers may be forced into an unappetizing choice of paying higher premiums, or terminating employee-benefit programs they can no longer afford.

Pugh v. Tribune: A Fiduciary Roadmap for Handling Claims of Corporate Fraud

by Robert Rachal

In *Pugh v. Tribune Co.*, 2008 WL 867739 (7th Cir. April 2, 2008), the Seventh Circuit affirmed dismissal of claims that fiduciaries had breached their duties regarding an ESOP's investments in Tribune's stock. In so holding, the Seventh Circuit provided what are common sense, but important, answers to the question of what an ERISA fiduciary should do when he or she is facing allegations that the company engaged in fraud.

Pugh arose out of circulation fraud at a subsidiary of Tribune. Two newspapers at that subsidiary, Newsday and Hoy, had inflated their circulation figures so that they could charge higher rates to advertisers. In February 2004 several advertisers filed lawsuits alleging that Newsday and Hoy had overstated circulation. Shortly after the filing of these lawsuits Tribune launched an internal investigation while various government agencies also began an investigation. In June 2004, Tribune's investigation revealed that the circulation figures were overstated. In July 2004, Tribune set forth a $35 million reserve for the advertisers' lawsuits, which it increased by $45 to $60 million in September 2004. In the ERISA lawsuit, plaintiffs alleged that the fiduciaries breached their fiduciary duties by failing to prudently manage the investments in Tribune stock while this fraud was occurring. Specifically, plaintiffs alleged that the ERISA fiduciaries had a duty to investigate and to uncover the fraud at an earlier time.

The court rejected this duty to uncover claim and affirmed the dismissal of plaintiffs' claims. The court observed that "ERISA imposes no duty on plan fiduciaries to continuously operate operational affairs," reasoning instead that a duty to investigate only arises when there is some "red flag" of possible misconduct. Here, the red flag was the February 2004 advertiser lawsuit. In response, Tribune commenced an investigation that eventually ferreted out and disclosed the fraud. The court reasoned that the fiduciaries had no duty to commence an independent investigation in light of this, and that Tribune was entitled to a reasonable amount of time to investigate until it had a full story to disclose. As the court explained in dismissing the securities lawsuit:

> After the lawsuits were filed, the defendants had actual knowledge of accusations of fraud, not fraud itself. In February, they promptly commenced an investigation to discover whether the allegations were true. As the investigation continued and more information became available, the defendants disclosed it to the public, issuing press releases in June, July, and September. This is exactly what they should have done, and they did it within a reasonable time, especially considering that the perpetrators allegedly took pains to hide the fraud . . . Taking the time necessary to get things right is both proper and lawful. Managers cannot tell lies but are entitled to investigate for a reasonable time, until they have a full story to reveal.

The court also rejected the claim that the fiduciaries should have uncovered the fraud before the advertiser lawsuit, concluding that plaintiffs failed to allege any facts suggesting that any defendant was in a position to have been alerted to the risk of this circulation fraud prior to the lawsuit and subsequent investigation.

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Pughprovides a roadmap for how fiduciaries can lawfully comply with their fiduciary duties under the difficult circumstances in which a company is facing allegations of fraud or other misconduct.

Pugh provides a roadmap for how fiduciaries can lawfully comply with their fiduciary duties under the difficult circumstances in which a company is facing allegations of fraud or other misconduct. Specifically, *Pugh* suggests that fiduciaries can rely on the corporate investigation and reporting process unless they had some reason to believe it was broken. In *Pugh*, the fiduciaries could reasonably rely on the fact that the company had commenced an investigation and timely reported the fraud as the facts were uncovered. While this seems like it ought to be obvious, that solution now has the blessing of a federal appellate court. In situations such as this, fiduciaries also should consider documenting how they worked through the process to decide whether it was reasonable to rely on what the company was doing to investigate and report any corporate wrongdoing.

So Much for the Uniform Body of Federal Benefits Law: Sixth Circuit Continues to Buck Trend on Law Governing Termination of Retiree Welfare Benefits for Unionized Employees

by Myron D. Rumeld and Kevin Pflug

Notwithstanding the Congressional intention when enacting ERISA to create a uniform national body of law governing benefits claims (*see Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990)), there are numerous instances in which the law governing such claims will differ among jurisdictions. One such instance is with respect to retiree welfare benefit claims filed by unionized employees. As the Sixth Circuit's recent decision in *Noe v. PolyOne Corp.*, No. 07 Civ. 5068, 2008 WL 723769 (6th Cir. March 19, 2008) confirms, that Circuit continues to chart a different path than other circuits on this issue.

Whereas most circuits have generally permitted employers to terminate retiree benefits upon the expiration of a collective bargaining agreement, absent explicit language in the agreement guaranteeing lifetime benefits, the Sixth Circuit continues to create a presumption favoring lifetime benefits. As a result, participants bringing claims for retiree benefits stand a dramatically better chance of prevailing in the Sixth Circuit than anywhere else in the country.

Factual Background

In *Noe*, a group of retirees (and a beneficiary) from a division of B.F. Goodrich Co. ("BFG"), which later became PolyOne Corp. ("PolyOne"), brought suit under LMRA § 301, alleging that Polyone breached employee agreements when it reduced the level of medical coverage available to retirees and their surviving spouses. Although the collective bargaining agreements negotiated on behalf of the plaintiffs did not address retiree health benefits, a Memorandum of Understanding extended to them the terms of certain "Agreements on Employee Benefit Programs" ("EBA's") that BFG had negotiated with other unions representing employees working at locations outside Kentucky. The EBAs provided retiree health benefits to "[e]mployees who retire and who are eligible under this Agreement for a pension (other than a Deferred Vested Pension)." Eligible retirees were not required to contribute toward health insurance premiums, were reimbursed for Medicare Part B, and paid only $1.00 for prescriptions.

Plaintiffs continued to receive post-retirement medical benefits pursuant to the EBA's, or their successor agreements, until March of 2006 when Polyone ceased paying Plaintiffs' Medicare Part B premiums, began requiring Plaintiffs to contribute towards their insurance premiums, and introduced much higher co-pays.

The District Court's Decision

The district court for the Western District of Kentucky granted summary judgment for Polyone and dismissed the claims. In so ruling the court acknowledged that, in *UAW v. Yard-Man, Inc.*, 716 F.2d 1476 (6th Cir. 1983), the Sixth Circuit had held that "retiree benefits are in a sense 'status' benefits which, as such, carry with them an inference that the parties likely intended those benefits to continue as long as the beneficiary remains a retiree" *Noe v. Polyone Corp.*, No. 06 Civ. 170, 2006 WL 3759601, at *2 (W.D. Ky. Dec. 19, 2006). Nevertheless, based on the court's subsequent ruling in *Yolton v. El Paso Tenn. Pipeline Co.*, 435 F.3d 571, 579 (6th Cir. 2006), the district court determined "that despite the language of *Yard-Man*, courts are to apply ordinary principles of contract interpretation when determining whether the parties to a CBA intended employee health benefits to vest."

Applying this standard to the agreements at issue in *Noe*, the district court held that the EBA's contained no language that "specifically vests retiree health benefits" and that "[i]n fact, the language seems to suggest the opposite." The district court cited the language in the agreements that stated that the company would provide medical benefits "for the duration of the agreement." It also pointed to what it characterized as the "express durational limits" of the agreement, which stated that "[u]pon termination, this agreement shall terminate in all respects except that the benefits provided by it shall be extended for ninety (90) days following such termination."

The district court rejected plaintiffs' argument that the agreements vested retirees with medical benefits because they linked eligibility for healthcare benefits to eligibility for pension benefits, which are vested. The court found that the tie in to pension eligibility merely defined who could qualify for retiree medical benefits in the first place, not the duration and vesting of these benefits.

The Sixth Circuit's Analysis – General Limitation Language is Not Enough

The majority opinion was premised on the principle that a court may find vested rights under a CBA even if the intent to vest has not been explicitly set out in the agreement.

In a 2-1 ruling, the Sixth Circuit vacated the district court's decision, and ruled that the district court erred in concluded that the agreements indicated an intent to vest the plaintiff's health benefits. The majority opinion was premised on the principle that a court "may find vested rights under a CBA even if the intent to vest has not been explicitly set out in the agreement."

Applying this principle, the court determined that the language in the agreements did not preclude a finding that the parties intended to vest retirees with health benefits, because "there is no language specifically stating that retiree health benefits expire upon termination of the agreement." The court found that the limitation language "speaks generically of all benefits for all employees" and that this general limitation language "does not constitute a specific durational clause under our precedent."

The court also found, contrary to the district court, language linking eligibility to retiree medical benefits with eligibility for pension benefits evidences an intent to vest medical benefits. The court reasoned that "[s]ince retirees are eligible to receive pension benefits for life, the act of tying retiree health benefits to pension eligibility indicates that the parties intended that the company provided lifetime health benefits as well."

The Concurring and Dissenting Opinion

A concurring and dissenting opinion by Judge Sutton, who stated that he would not rule for either party as a matter of law, pointed out that the majority's ruling differed sharply from the law in the Third, Fourth, Seventh, and Eighth Circuits, which have created "a presumption against vesting because a company's unchangeable promise to pay healthcare benefits for life is a significant and unusual one – particularly when it arises from a three-year contract." (Citing *UAW v. Skinner Engine Co*., 188 F.3d 130, 140 (3d Cir. 1999); *Gable v. Sweetheart Cup Co.*, 35 F.3d 851, 855 (4th Cir. 1994); *Bidlock v. Wheelabrator Corp*., 996 F.2d 603, 606-07 (7th Cir. 1993); *Anderson v. Alpha Portland Indus., Inc.*, 836 F.2d 1512, 1517 (8th Cir. 1988)). Judge Sutton also noted the First Circuit has not adopted a presumption and interprets retiree healthcare agreements no differently that other collectively bargained contracts. (Citing *Senior v. NSTAR Elec. & Gas Corp.*, 449 F.3d 206, 218 (1st Cir. 2006)).

Judge Sutton took issue with the majority's rational and argued that the majority has created an "omnipresent presumption" under which "[u]nless a company can point to explicit language in the relevant agreement stating that 'retiree benefits' terminate at a particular date or do not vest, the benefits seem to vest as a matter of law." Judge Sutton argued that the Sixth Circuit should not apply "an in-between inference-not quite a presumption in favor of vesting," but instead should either declare that the inference has become a presumption in order to "spare future panels, the district courts and litigants the confusion the inference has created – or abandon the inference altogether."

Petition for Rehearing *En Banc*

On April 3, 2008, PolyOne filed a petition for rehearing en banc. The ERISA Industry Committee filed an amicus brief in support of Polyone's petition for rehearing *en banc*, arguing, *inter alia*, that the panel's decision conflicts with Congress's clear intent that health and welfare plans not vest by operation of law.

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The implications of the Sixth Circuit's ruling, and its application of a different legal standard than the standard used elsewhere, is evident from the majority opinion's comment that "rising healthcare costs and foreign competition have certainly placed corporations such as PolyOne in a difficult economic position." Employers seeking to address these concerns by reducing retiree health care costs may be unable to do so in the Sixth Circuit if they previously entered into collective bargaining agreements providing retiree benefits without an explicit duration clause. To make matters worse, if they entered into parallel agreements in multiple jurisdictions, they may lack the ability to eliminate or reduce benefits anywhere by virtue of the agreements entered into in the Sixth Circuit.

Notwithstanding the relatively large number of ERISA cases that have already reached the Supreme Court, this issue should eventually get the Court's attention as well. In the meantime, employers with operations nationwide should be aware that courts in different circuits apply different interpretive standards to language in collective bargaining agreements providing for retiree medical benefits, and, if they have employees in the Sixth Circuit, will wish to carefully craft their agreements to expressly reserve the right to amend or terminate provisions on retiree welfare benefits.

Rulings, Filings and Settlements of Interest

- On April 22, 2008, the Second Circuit became the latest Court of Appeals to hear arguments on the legality of cash balance plans and whether such plans comply with ERISA's age discrimination rules. The cases *are Hirt v. The Equitable Retirement Plan for Employees, Managers and Agents*, No. 06 Civ. 47457, and *Bryerton v. Verizon Communications, Inc.*, No. 07 Civ. 1680.
- On March 27, the Department of Labor filed an amicus brief in *Golden Gate Rest. Ass'n v. San Francisco* (9th Cir., No. 07-17370), arguing that the employer health care spending requirements imposed by the San Francisco's Health Care Security Ordinance are preempted by ERISA. The DOL requested that the Ninth Circuit reinstate the injunction barring implementation of the ordinance that was imposed by the district court. In support of its request, the DOL argued that the employer spending requirements in the Act had a prohibited connection with ERISA plans and is thus preempted. For a more thorough discussion of the issues related to this amicus brief click here.
- Following on the heels of the Supreme Court's decision in *LaRue v. DeWolf Boberg & Assoc., Inc.*, 128 S. Ct. 1020 (2008) (click here for a discussion of the LaRue

decision), the Seventh Circuit rejected defendants' argument that plaintiffs could not pursue fiduciary breach claims associated with the investment in overvalued company stock by a defined contribution plan under Section 502(a)(2). See *Rogers v. Baxter Int'l, Inc.*, No. 06 Civ. 3241, 2008 WL 867741 (7th Cir. Apr. 2, 2008). Judge Easterbrook took this occasion to note his skepticism of the validity of claims based on the argument that the stock was "overpriced". In light of the fact that pension plans pursue a prudent "buy-and-hold" strategy, Judge Easterbrook suggested it would be difficult for plaintiffs to prove that plan fiduciaries are required to allow or prevent investments for blocks of weeks or months at a time when company stock is overpriced. Judge Easterbrook also did not appear persuaded by plaintiffs' alternative argument that defendants should not have allowed investment in Baxter's stock at any time, since it was allegedly always overvalued, because: (i) it amounted to an assertion that pension fiduciaries have a duty to outsmart the stock market; or (ii) it could be read to required defendants to use inside-information in their roles as fiduciaries, which he expressed skepticism as to whether this could be lawful.

- In *In re Radioshack Corp. ERISA Litig.*, No. 08 MD 1875, 2008 WL 1808329 (N.D. Tex. Mar. 31, 2008), the court dismissed plaintiffs' claim that the plan fiduciaries imprudently allowed plan participants to invest in company stock. After concluding the *Moench* presumption of prudence may be applied at the pleading stage, the court determined that plaintiffs could not overcome that presumption by alleging mere stock fluctuations, even those that trend downward significantly. With the some good came some bad, however. The court allowed plaintiffs' fiduciary breach claims associated with the selecting and maintaining of Putnam Funds to proceed. On this claim, the court concluded it was inappropriate to resolve on a motion to dismiss allegations that plaintiffs' choice of funds was too limited, and that the Putnam Funds charged excessive fees.
- In *Livick v. The Gillette Co.*, 2008 WL 174225 (1st Cir. Apr. 17, 2008), the First Circuit affirmed dismissal of a participant's breach fiduciary duty claim, concluding that there was no fiduciary act performed in connection with a human resource representative providing an inaccurate benefit estimate. The court reasoned that that the provision of an estimate was a ministerial function, and it interpreted the Department of Labor's regulation, 29 C.F.R. § 2509.75-8, as providing that fiduciary responsibility does not attach to the hiring, retention or monitoring of those performing non-fiduciary functions.

[1] Under ERISA, “conflict” preemption differs from statutory or “complete” preemption, and is not subject to ERISA’s savings provisions for insurance laws. Conflict pre-emption applies to state laws that purport to duplicate, supplement or supplant the remedies provided under ERISA. *See*, *e.g.*, *Aetna Health, Inc. v. Davila*, 542 U.S. 200, 209 (2004).

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