Proskauer

The ERISA Litigation Newsletter

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Editor's Overview

Welcome to the inaugural issue of Proskauer Rose's ERISA Litigation Newsletter. Our goal is a modest, but we hope, helpful one: To provide monthly an analysis of ERISA cases and developments that may be of interest, or that may reflect emerging trends, including how they can impact you as an employer, plan fiduciary, plan administrator, trustee or plan service provider. We will be calling on our Proskauer colleagues, both litigators and compliance lawyers, to assist us in this task. It is thus with immense pleasure that we bring this service to you, and we look forward to bringing you our analysis of significant cases and developments in the months and years ahead. We hope you enjoy it!

This month's articles illustrate that ERISA litigation "follows the money." 401(k) plans have grown into the primary source of retirement income, so it should be little surprise that litigation involving 401(k) plans is front and center in the first two articles. The first looks at recent significant rulings in 401(k) fee litigation, and asks whether a tipping point has been reached similar to what occurred in employer stock litigation. The second article reports on the Supreme Court's recent remedy ruling in *LaRue*,in which the Court concluded that an individual can sue for "make whole" monetary relief regarding an alleged administrative snafu in handling his 401(k) account.

Continuing the money theme, the next article looks at the persistent signal, by at least a faction of the Supreme Court, that they want to review whether monetary remedies are available for individual claims of breach of fiduciary duty under ERISA § 502(a)(3). Although lower courts have uniformly said "no," this has never stopped the Court from ruling the other way, if it is so inclined.

Finally, the Newsletter addresses state and local governments' increased resort to "pay or play" mandates that seek to force employers to pay for (here's that pesky money theme again) a minimum level of health care benefits on behalf of their employees. Whether or not these efforts are viewed as good health care policy, these mandates challenge ERISA's protection — through its preemption provision — of the ability to administer a plan uniformly nationwide. Not surprisingly, there have been several significant ERISA preemption cases to date, with the Ninth Circuit seeming to chart a novel path.

Recent Developments in Fee Litigation: Has a Tipping Point Been Reached?

by Robert Rachal

"Fee litigation," which challenges the fees and expenses borne by 401(k) plans, is making a run at becoming the next major wave of ERISA fiduciary litigation. For example, as discussed in the "News Items of Interest" section below, a financial provider, New York Life, has recently agreed to pay $14 million on ERISA fee claims related to its mutual funds. Moreover, in several recent rulings, many courts have permitted fee claims to go forward, at least through the preliminary stage of the case. An illustrative case is *Charters v. John Hancock Life Ins. Co.,* 2007 WL 487407 (D. Mass. Dec. 21, 2007), which addressed what are known as "gatekeeper" claims brought against financial providers and their affiliates. These are claims based on the notion that financial providers or their affiliates are fiduciaries because they act as "gatekeepers" in screening the funds offered to the plan. *Charters* followed the current majority view in refusing to dismiss these claims at the motion to dismiss stage, reasoning that the provider's reservation of authority to substitute mutual funds for those selected by the plan fiduciary was sufficient to establish fiduciary status for purposes of a motion to dismiss. *Charters* also held that the plan fiduciary had standing to aggregate claims on behalf of the trustees of other plans, although the court noted that it was not deciding whether plaintiffs will ultimately meet the class action requirements of *Fed. R. Civ. P.* 23.

Two recent rulings in *Tussey v. ABB, Inc.* also supported gatekeeper claims, and claims against plan fiduciaries. In the class ruling, *Tussey v. ABB, Inc.,* 2007 WL 4289684 (W.D. Mo. Dec. 3, 2007), the court certified a class over a plethora of defense objections. One objection was that plaintiff had no constitutional standing, i.e., suffered no "injury in fact," for fees charged on funds in which plaintiff never invested. The court rejected this argument, substituting "the plan" for plaintiff to conclude the plan suffered an injury in fact if an investment option charged unreasonable fees. The court also rejected the notion that divergent interests among class members may defeat class certification, concluding that shared interests outweighed any divergence. Finally, the court read any affirmative defenses and reliance, causation and materiality elements out of the class certification analysis, reasoning that class typicality is determined based on defendant's actions, not on the basis of individualized defenses and issues raised against particular class members.

In the merits ruling, *Tussey v. ABB, Inc.,* 2008 WL 379666 (W.D. Mo. Feb. 11, 2008), the court let plaintiffs' prudence claims go forward against both the financial provider, Fidelity, and the plan sponsor. *Tussey* stands in sharp contrast to *Hecker v. Deere,* 496 F. Supp. 2d 967 (W.D. Wis. 2007), which dismissed similar claims. Both *Tussey* and *Hecker* agreed that revenue sharing payments are not required to be disclosed to participants, reasoning that general notions of ERISA fiduciary duties should not be construed to require such disclosures when the current regulations and statute do not. From this point forward, however, the rulings diverged. *Hecker* concluded that the ERISA § 404(c), 29 U.S.C. § 1104(c), defense barred these claims based on the notion the participants knew the total fees charged for each investment option, and thus could adjust their investment strategy in relation to fees charged. *Hecker* also noted that the funds had to set their fees to attract investors in the general marketplace; thus, it was implausible to assume they were all excessive. In contrast, *Tussey* rejected applying the Section 404(c) defense at the motion to dismiss stage, questioning whether participants were the "cause" of any loss from excessive fees. On the merits, *Tussey* concluded plaintiffs had set forth sufficient facts suggesting that the fees were in excess of those charged similar plans. *Hecker*, on the other hand, concluded that the fees charged were at market rates, and thus had to be set low enough to attract investors. Finally, *Tussey* concluded that the record-keeper may have been a fiduciary by playing a gatekeeping role in screening investment options offered to the plan fiduciary for its consideration. In contrast, *Hecker* concluded the same record-keeper was not a fiduciary because the plan fiduciary selected the investments to be offered by the plan.

* * *

With the notable exception of *Hecker*, the above cases illustrate the all too common judicial reluctance to dismiss claims at the preliminary stage. Preliminary rulings do not equal judgments on the merits, however. For example, as litigators, we note that class procedural rules cannot subvert the substantive requirements of the law. It is thus questionable whether reliance, causation and Section 404(c) defenses should be read out of the law in cases where defendants establish that the fee disclosures complied with the requirements of Section 404(c), yet participants knowingly bypassed low fee funds to invest in higher fee funds. Participants who have made this selection also may have a real divergence of interest with plaintiffs who are seeking to cut off these higher fee investment options; likewise, participants who choose low fee funds may not want to end the subsidization of administrative expenses often provided by the higher fee funds. Finally, the claim that plan fiduciaries routinely loaded up their participants with nothing but overpriced investment options seems questionable; in addition to not making much sense (just why would they do this to their employees?), it ignores the fact that the market for plan providers and investment products is highly competitive, and any provider that gets out of line on cost or performance is fair game for its competitors.

Unfortunately, however, the judicial caution in dismissing lawsuits at a preliminary stage is begetting further lawsuits, as illustrated by the fact that more experienced ERISA plaintiffs' counsel are investigating claims in this area and approximately 30 class action lawsuits have been filed to date. The U.S. Department of Labor has also weighed in on the appeal of the *Hecker* case, taking positions that would make dismissals at the preliminary stage difficult. In this environment, it is reasonable to assume there will be continued litigation, and that the safe practice is thus to work through and document the prudent processes followed in selecting and monitoring the plan providers and fund investment options offered.

U.S. Supreme Court Rules Monetary Relief Is Available For Claim Fiduciary Breach Caused Losses To An Individual's 401(k) Plan Account

by Robert Rachal and Russell L. Hirschhorn

On February 20, 2008, in *LaRue v. DeWolff, Boberg & Associates, Inc.*, 128 S. Ct. 1020 (2008), the Supreme Court concluded that a participant in a defined contribution pension plan may sue a fiduciary under ERISA § 502(a)(2), 29 U.S.C. § 1132(a)(2), when claiming that a fiduciary breach caused a loss of plan assets allocated to his 401(k) plan account. The Court determined that, when the plan at issue is a defined contribution plan, neither the number of participants affected nor the percentage of plan assets at issue is relevant. While this ruling expands the universe of ERISA fiduciary claims for which plaintiffs can potentially seek make-whole monetary relief, it also leaves several questions unanswered. In addition, Justice Roberts's concurring opinion may reignite the debate over the applicability of ERISA's exhaustion requirement to fiduciary breach claims.

Background and Lower Courts' Decisions

LaRue was a participant in his employer's 401(k) plan; the plan, by it terms, permitted him to direct his investments among a menu of investment options. LaRue alleged that the plan fiduciaries breached their fiduciary duties by failing to carry out his investment instructions, and that, as a result, his individual account balance was depleted by approximately $150,000. The district court dismissed LaRue's claim, concluding that his requested monetary relief did not constitute "appropriate equitable relief" under ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3).

On appeal, the Fourth Circuit Court of Appeals affirmed the district court's ruling on Section 502(a)(3), and also ruled that LaRue could not bring his claim under Section 502(a)(2), which authorizes a civil action by a participant, beneficiary or fiduciary to recover losses to the plan. Relying on the Supreme Court's decision in *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 140 (1985), the Fourth Circuit reasoned that recovery under Section 502(a)(2) "must 'inure to the benefit of the plan as a whole,' not to particular persons with rights under the plan," and that LaRue was seeking only personal recovery for losses to his account.

Supreme Court's Decision

Although the Court's grant of *certiorari* included the Section 502(a)(3) issue, this issue was not addressed, as the five-person majority opinion, authored by Justice Stevens, concluded that the case could be disposed of on Section 502(a)(2) grounds. On this issue, the Court acknowledged that the Fourth Circuit's decision was consistent with the Court's "plan as a whole" language in *Russell*, *supra*, but explained that the rationale for *Russell* supported LaRue's claim. *Russell* reasoned that ERISA § 409, 29 U.S.C. § 1109, which is enforced through Section 502(a)(2), was focused on protecting plan assets from losses caused by fiduciary breaches. The *LaRue* Court reasoned that the "plan as a whole" requirement makes sense when the claim involves a defined benefit plan because, in that context, participants are being protected from "default risk" if the plan were unable to provide the promised defined benefit. In contrast, in the defined contribution context (such as a 401(k) plan), losses to a few or even to one individual's account can result in the loss of benefits to a participant.

Applying this distinction, the Court held that although Section 502(a)(2) "does not provide a remedy for individual injuries distinct from plan injuries, that provision does authorize recovery for fiduciary breaches that impair the value of plan assets in a participant's individual account." The majority pointed out that, while the record below was unclear as to the size of LaRue's plan account, its holding would be no different whether LaRue's account included 1% or 99% of the plan's assets.

The two concurrences agreed that the Fourth Circuit erred. The concurrence of Chief Justice Roberts, joined by Justice Kennedy, is of particular interest because it stated that the Court's majority opinion did not decide whether this type of claim may be required to be brought as a claim for benefits under ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B). Chief Justice Roberts reasoned that when the right at issue arises under the plan terms, as it did here, then such a claim would appear to fall naturally under Section 502(a)(1)(B). Chief Justice Roberts was animated by the concern that, if this type of claim were nonetheless allowed to be pursued under Section 502(a)(2), it may bypass the safeguards of plan exhaustion and deference to plan administrators applicable to claims for benefits under Section 502(a)(1)(B). The majority opinion had made it clear that, in light of the posture of the case, it was not considering whether plan exhaustion or other defenses may apply to this claim.

* * *

The Court's ruling expands the potential ERISA fiduciary claims for which plaintiffs can seek make-whole economic relief. If plaintiffs can show that the breach caused a loss or diminution of plan assets allocated to an individual's 401(k) or other defined contribution account, the majority's opinion suggests that plaintiffs can seek recovery of that loss under Section 502(a)(2). This does not mean that all fiduciary breach claims can now be fit under Section 502(a)(2) however, as many claims do not involve losses of plan assets, or involve claims that the breach in effect helped the plan by causing the participant to lose benefits otherwise due from the plan. Finally, Chief Justice Roberts's concurrence opens the door to the possibility that, when the right at issue arises under the plan terms, not ERISA, these claims may be required to be brought subject to the rules and procedures applicable to claims for benefits under Section 502(a)(1)(B).

Will Equitable Relief Be Redefined . . . Again?

by Russell L. Hirschhorn

For several years now, there has been a faction on the U.S. Supreme Court that appears to be seeking the appropriate case in which to reevaluate the meaning of the phrase "appropriate equitable relief" under ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3). The Court may have found its case in *Amschwand v. Spherion Corp.*, 505 F.3d 342 (5th Cir. 2007), and is currently deciding whether to grant Amschwand's petition for *certiorari*. In fact, on March 3, 2008, the Supreme Court asked the U.S. Solicitor General for its opinion on the issue; based on the U.S. Department of Labor's longstanding public views, discussed below, it is expected that the Solicitor will argue that the Fifth Circuit's opinion was wrong and that *certiorari* should be granted.

The Department of Labor has consistently taken the position before the Supreme Court (and other courts) that the limitations imposed on equitable relief by *Mertens v. Hewitt Associates*, 113 S. Ct. 2063 (1993), and its progeny do not apply to claims brought against fiduciaries; rather, such limitations only apply to claims brought against *non*-fiduciaries. The lower courts have generally rejected this argument, and have read *Mertens* broadly. However, Justice Ginsburg's concurrence in *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004) suggested that at least some on the Court viewed this as an open issue:

> Recognizing that this Court has construed section 502(a)(3) not to authorize an award of money damages against a *non-fiduciary*, the Government suggests that the Act, as currently written and interpreted, may allow at least some forms of make-whole relief against a breaching fiduciary in light of the general availability of such relief in equity at the time of the divided bench . . . The Government's suggestion may indicate an effective remedy others similarly circumstanced might fruitfully pursue. Congress . . . intended ERISA to replicate the core principles of trust remedy law, including the make-whole standard of relief. I anticipate that Congress, or this Court, will one day so confirm.

More recently, in *LaRue v. DeWolff, Boberg & Associates, Inc.*, 128 S. Ct. 1020 (2008) (discussed above), Justice Ginsberg suggested during oral argument that the Section 502(a)(3) issue was not ripe in that case, notwithstanding that the Court granted *certiorari* on the issue. Many thought this was a signal that *LaRue* was not viewed as the appropriate case in which to address this issue, and the Court specifically declined to address the Section 502(a)(3) issue in its written opinion.

Amschwand may be the appropriate case. During Amschwand's medical leave for a bout with cancer that he did not survive, his employer, Spherion, switched insurance companies. The new insurer's (Aetna's) policy provided, in relevant part, that if an employee is ill or injured and away from work on the date any of his coverage would become effective, the effective date of coverage will not begin until the date he returns to work for one full day (the "Active Work Rule"). Aetna and Spherion, however, agreed that the Active Work Rule would be waived for employees, like Amschwand, who were not currently working full-time due to a medical condition that antedated the switch in insurance companies. Amschwand enrolled in Aetna's new plan and, to ensure his wife would have coverage upon his death, had multiple conversations with Spherion's human resources department. For reasons that the lower court noted were not explained by the parties, Amschwand was not among those who received coverage, despite being on disability leave when the policy took effect. Shortly after Amschwand's death in February 2001, his wife filed a claim with Aetna, only to be informed that because her husband had not satisfied the Active Work Rule, she was ineligible for benefits under the policy.

Despite what appeared to be highly sympathetic facts (all recounted in detail in the Fifth Circuit's opinion), the Fifth Circuit ruled that the widowed wife's claim must be dismissed because she had no remedy under Section 502(a)(3). The Fifth Circuit concluded that the lost policy proceeds sought by Amschwand were a form of make-whole damages, not equitable in derivation, but akin to the legal remedies of extracontractual or compensatory damages. As a result, the remedy sought was not typically available in courts of equity (as required by *Mertens*), and was unavailable under Section 502(a)(3).

* * *

It remains to be seen whether the Supreme Court will grant *certiorari* in *Amschwand v. Spherion Corp*. If and when the Court reaches the Section 502(a)(3) issue, the one thing that is certain is that its decision will be of great import. Among other things, if the Supreme Court grants *certiorari*, we could see the Court attempt to reconcile the remedies available depending on whether the plaintiff can couch the claim as impacting plan assets (and falling under Section 502(a)(2)) versus impacting only the plaintiff (and thus arising under Section 502(a)(3)). At a minimum, practitioners may be left scratching their heads as to why there are two different statutory provisions for fiduciary breach claims.

Pay or Play: State Mandated Health Care Laws

by Russell L. Hirschhorn[1]

It is no secret that, as a result of rising health care costs, the number of Americans without health care coverage continues to rise at alarming rates. According to some estimates, as many as 46 million Americans (nearly 16% of the total population) are uninsured. *See* http://www.census.gov/prod/2005pubs/p60-229.pdf. Individuals who do not receive health care coverage through their employment and/or who cannot afford to purchase their own are forced to turn to Medicaid and other government-funded forms of health care, which, in turn, increases the burden on taxpayers to subsidize the costs of providing health care. In an effort to curb these costs, state and local governments have introduced, and in some cases passed, legislation that requires employers to contribute their "fair share" toward the costs of providing health care benefits. Currently, twenty-eight states (*see* http://www.epionline.org) have introduced legislation that requires employers to: (i) pay for a minimum level of health care benefits for their employees; or (ii) pay an assessment to the government sponsoring the law. These laws not only increase the cost for employers doing business in these states, but also increase the burdens imposed on human resource personnel, often requiring additional reporting and disclosure requirements. Massachusetts, Maryland, Suffolk County, NY, and San Francisco, CA, are among those governments that have passed such legislation. Except for Massachusetts' legislation, all of them, as described below, have been challenged in the federal courts.

The Maryland Fair Share Health Care Fund

The Maryland Fair Share Health Care Fund Act ("Maryland Act"), 2006 Md. Laws 1, Md. Code Ann. Lab. & Empl. §§ 8.5-102, before being invalidated, as discussed below, required employers with 10,000 or more employees in Maryland to pay to the state the difference between what the employer spends on health care insurance for such employees and 8% (for profits) or 6% (for non-profits) of its total Maryland payroll. A covered employer that failed to make the mandatory payment was subject to a civil penalty of $250,000. The Maryland Act also imposed reporting requirements on covered employers along with penalties of $250 per day for noncompliance.

The Suffolk County Fair Share for Health Care Act

Recent developments:

Currently, twenty-eight states have introduced legislation that requires employers to: (i) pay a minimum level of health care benefits for their employees; or (ii) pay an assessment to the government sponsoring the law.

The Suffolk County Fair Share for Health Care Act (the "Suffolk County Act"), Suffolk County, N.Y., Reg. Local Law §§ 325-1 to 7 (2005), before being invalidated, as discussed below, required large supermarkets to contribute not less than $3 in health care costs for each hour their employees work, or pay a civil penalty to Suffolk County. The Suffolk County Act also imposed reporting requirements on covered employers and imposed penalties of up to $250 per day for noncompliance.

The San Francisco Health Care Security Ordinance

The San Francisco Health Care Security Ordinance ("San Francisco Act"), S.F. Cal., Admin. Code Chap. 14, §§ 14.1–14.8 (2007), requires employers with at least 100 employees to pay $1.73 per hour for full-time employees, and employers with 20 to 99 employees to pay a $1.17 per hour for full-time employees for their covered employees, or make payments to the city for the benefit of their covered employees. The San Francisco Act also imposes reporting requirements on covered employees, mandating that employers maintain "accurate records of health care expenditures," "proof of such expenditures" and annually report required information. The San Francisco Act imposes penalties of up to $1,000 per week per employee for noncompliance with the Act's disclosure requirements.

Challenges to Legislation

One of Congress's principal goals in enacting ERISA was to encourage voluntary employer-sponsored benefits by relieving plan administrators from compliance with multiple, and potentially conflicting, state laws. As such, ERISA § 514(a), 29 U.S.C. § 1144(a), preempts "any and all State laws insofar as they . . . relate to any employee benefit plan" governed by ERISA. Employers have argued, with some success, that the state mandated health care laws impermissibly regulate the administration of employee benefit plans and that they are therefore preempted by ERISA.

The preemption reasoning:

[N]o rational employer would choose to pay the state over increasing the benefits provided its employees.

In *Retail Indus. Leaders Ass'n v. Fielder*, 475 F.3d 180 (4th Cir. 2007), the Fourth Circuit held that Maryland's Act was preempted by ERISA because the Maryland Act effectively required covered employers to restructure their employee health insurance programs to provide the mandated minimum benefit, thus upsetting the uniform nationwide administration of benefits that is a "foundational policy" of ERISA. In so holding, the court reasoned that the "choice" between paying the state or increasing benefits to its employees was no choice at all because no rational employer would choose to pay the state over increasing the benefits provided its employees. In *Retail Indus. Leaders Ass'n v. Suffolk County*, 497 F. Supp. 2d 403 (E.D.N.Y. 2007), the district court followed *Fiedler's* analysis to conclude Suffolk County's Act was preempted by ERISA.

In contrast, in *Golden Gate Res. Ass'n v. City and County of San Francisco*, No. 07 Civ. 17372, 2008 WL 90078 (9th Cir. Jan. 9, 2008), the Ninth Circuit issued a preliminary procedural ruling suggesting that it may conclude San Francisco's ordinance is not preempted. In granting the City's request for a stay of an adverse decision by the district court, the Ninth Circuit reasoned that the ordinance did not require any employer to adopt a benefit plan, but rather allowed the employer to either adopt or amend an existing ERISA plan, or make payments directly to the City. Thus, according to the Ninth Circuit, the ordinance did not impose an administrative burden of complying with conflicting directives on plan administrators. In so holding, the Ninth Circuit did not mention, much less seek to distinguish or refute, the earlier *Fielder* and *Suffolk County* rulings, which held that the only rational choice for an employer facing these "pay or play" mandates is to modify its benefits. Nor did the Ninth Circuit address the fact that one of ERISA's core concerns is to give employers flexibility in setting and modifying the level of health benefits provided nationwide. Justice Kennedy subsequently refused to grant an immediate petition for *certiorari*. The Ninth Circuit is currently scheduled to hold an expedited hearing on April 17, 2008 on the merits of this appeal.

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If “pay or play” mandates grow in popularity, the resulting impact on employers and plan administrators could be quite substantial. Employers that operate in multiple states may find themselves subject to conflicting state statutes that require them to pay varying amounts in employee benefits and/or penalties to the state. Similarly, plan administrators may be subjected to different state reporting requirements, creating confusion within the plan’s record-keeping procedures. As a result, some employers may find that it is economically and administratively easier to pay the “assessment” to the government than to try and comply with multiple states’ mandatory health care laws. Other employers may decide to challenge these statutes as preempted. Either way, through compliance or challenge, covered employers will be forced to address these “pay or play” statutes.

News Items of Interest

- A federal court approved a $14 million settlement in an ERISA suit against New York Life Insurance Co. The suit was brought by employees who accused the company of breaching its fiduciary duties by paying excessive investment management fees and expenses on New York Life funds offered to the plan. The case is *Mehling v. New York Life Insurance Co.,* No. 99 Civ. 5417 (E.D. Pa.)
- The U.S. Department of Labor filed an amicus brief in support of Plaintiffs-Appellants in the appeal of *Hecker v. Deere*, No. 07-3605 (7th Cir.). The Department of Labor argued that the district court erred in applying the ERISA § 404(c) defense to the selection of investment funds. The Department of Labor also argued that the district court rulings were too broad in holding that: (i) there was no general ERISA fiduciary duty to disclose revenue sharing payments; and (ii) the plan documents excluded fiduciary status for the plan’s record-keeper.
- The U.S. Supreme Court will consider whether the Fifth Circuit correctly ruled that the plan properly declined to treat a divorce decree as a waiver of the ex-spouse’s right to the plan funds, because the only exception to ERISA’s anti-alienation provision is a qualified domestic relations order, and a QDRO was not presented to the plan. The case is *Kennedy v. Plan Administrator for DuPont Savings and Investment Plan*, No. 07-636.
- In *Noe v. PolyOne Corp.*, No. 07-5068, 2008 WL 723769 (6th Cir. Mar. 19, 2008), the Sixth Circuit held, consistent with its previous case law, that language in collective bargaining and related agreements that tied eligibility for retiree health benefits to

eligibility for pension benefits exhibited an intent to vest the health benefits. In so holding, the court rejected the claim that the general durational clauses in the agreement were specific enough to preclude vesting in retiree medical benefits.

??? On February 4, 2008, the Internal Revenue Service issued Revenue Ruling 2008-7, which provides guidance on the application of ERISA's backloading rules for plans that have converted from a traditional defined benefit plan to a cash balance plan. The Ruling is designed specifically to address the potential backloading issues that can arise when plans use a "better of both" formula, since under such formulas a participant may accrue no incremental benefit for a period of time before the cash balance formula becomes the superior benefit. The Ruling resolves this issue by permitting plans to test for backloading under the new benefit formula without regard to the prior formula.

??? On March 21, 2008, the Internal Revenue Service published proposed regulations that would provide guidance relating to the application of section 4980F of the Code (ERISA §204(h)) to a plan amendment that is permitted to reduce benefits accrued before the plan amendment's applicable amendment date.

[1] Special thanks to Timothy Moriarty, an associate in Proskauer Rose's ERISA Litigation Group, for his assistance with drafting this article.

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