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Editor's Overview

July was abuzz with a number of interesting ERISA decisions out of the circuit and district courts. The Seventh Circuit, in *Fry v. Exelon*, took the opportunity to issue another decision of first impression related to cash balance plans, finding that normal retirement age need not be defined by reference to a specific age. While the decision's implications are broader than just for cash balance plans, its overall impact may be of limited value in light of a 2007 Treasury regulation that provides guidance on defining normal retirement age.

The Eastern District of Pennsylvania in *Johnson v. Radian Group* and the Central District of California in *In re Computer Sciences* continued the trend of favorable judgments for the defense in stock-drop actions. These cases concerned allegations related to the subprime mortgage crisis and alleged backdating of stock options, respectively. Despite the new theories of liability advanced, these courts were unwilling to allow plaintiffs' claims to proceed when plaintiffs could not meet the strict pleading and proof requirements required to make out "stock drop" claims.

An update on the *U.S. v. Jackson* litigation from the Fourth Circuit (previously reported on in our June 2008 newsletter) follows. In connection with defendants' petition for writ of *certiorari*, the Government admitted error in the Fourth Circuit's decision, stating that it agreed that unpaid employer contributions are not plan assets unless the plan documents provide otherwise. The issue is important since plan assets are afforded special protections both by ERISA and by criminal law.

July also brought with it several significant procedural rulings. The Second Circuit, in *Burke v. Price Waterhouse Coopers LLP Long Term Disability Plan*, ruled that an ERISA plan may provide a limitations period that is shorter than the most analogous state law and that the limitations period was triggered before a participant has fully exhausted his or her administrative remedies. In *Krolnik v. Prudential Ins. Co.*, the Seventh Circuit suggested ERISA cases should be treated as any other insurance dispute (including discovery and trial) when the plan fails to provide for abuse of discretion review. On state attempts to bar such discretionary clauses for insured products, the District of Utah in *Lucero v. Hartford Life and Accident Ins. Co.* "bucked the trend" and concluded that Utah's bar of these clauses was preempted by ERISA.

Finally, the rulings and decision of interest address a potpourri of decisions as well, including claims against an investment manager, class certification, standing, standard of review, statute of limitations, benefit accruals, top-hat plans and ESOP valuation issues.

Seventh Circuit Rules That "Normal Retirement Age" Need Not Be Defined By Reference To A Specific Age

By Russell L. Hirschhorn

In a matter of first impression among the Circuit Courts, the Seventh Circuit held in *Fry v. Exelon Corp. Cash Balance Pension Plan*, 2009 WL 1885485 (7th Cir. July 2, 2009), that a pension plan need not define "normal retirement age" by reference to a specific age, such as age 65. As explained below, however, plan sponsors should proceed with caution in defining normal retirement age in light of a 2007 Treasury regulation, which generally provides that a plan's "normal retirement age" must be "reasonably representative of the typical retirement age for the industry."

Thomas Fry left Exelon in 2003, at age 55, after working more than five years for the company. Upon departure, he received his account balance, but not interest credits through 2013 (when he will turn 65), discounted to present value at the Treasury rate, as he contended he should have received.

Prior to the enactment of the Pension Protection Act of 2006, a participant's cash balance account was required to start with the current balance and add any contractually promised interest through the employee's "normal retirement age," which then had to be discounted to obtain the present value of the lump sum at distribution. If the contractually promised rate was greater than the statutorily mandated discount rate, this often created what is called a "whipsaw," in which the discounted lump sum benefit is greater than the current account balance. Exelon's plan resolved this dilemma by providing that each employee's "normal retirement age" arrived after five years on the job. Because ERISA required the addition of interest (and discounting at the Treasury rate) only through each participant's "normal retirement age," the plan was able to avoid the entire adjustment process and distribute employees' account balances just as a defined-contribution plan would distribute the balance of an actual account.

The Seventh Circuit rejected Fry's contention that the plan's definition of "normal retirement age" was designed to work around the "augment-and-discount process" and was thus impermissible. In so ruling, the court held that ERISA does not require the "normal retirement age" to be the same for every employee; and that the age in the plan was "normal" insofar as it applied across the board to every participant in the plan. Furthermore, the court concluded that there was nothing in ERISA that required a pension plan's retirement age to track the actuarial tables.

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The Seventh Circuit's decision is the first of its kind to conclude that normal retirement age need not be defined by a specific age. The decision may, however, have limited application, since in 2007 the Treasury Department issued a regulation providing that a plan's "normal retirement age" must generally be "reasonably representative of the typical retirement age for the industry" 72 Fed. Reg. 28604, 28606 (May 22, 2007) *amending* 26 C.F.R. § 1.401(a)-1(b). It also bears mentioning that the problems caused by the "augment-and-discount process" have been eliminated by the PPA. Effective for distributions made after August 17, 2006, provided the plan uses an approved interest crediting method, a cash balance plan may simply pay the participant the balance in his or her cash balance account.

Defendants Acquire Favorable Judgments in Latest Round of Stock Drop Cases Involving Subprime and Stock Option Claims

By Robert Rachal and Nicole A. Eichberger

This July, courts addressed the validity of stock drop claims set against the current backdrop of corporate issues: alleged backdating of stock options and the subprime mortgage crisis. In this latest round of stock drop claims, courts continue the trend of judgment for defendants.

In *Johnson v. Radian Group, Inc.*, 2009 WL 2137241 (E.D. Pa. July 16, 2009), the district court granted defendants' motion to dismiss "stock drop" claims related to the subprime mortgage market. Radian provides mortgage insurance and financial products and services to financial institutions, including mortgage lenders. Radian and various individual defendants were sued over the offering of Radian common stock in Radian's Savings Incentive Plan. As a result of the deteriorating conditions of the subprime mortgage market and other investments, plaintiffs filed a class action lawsuit against the defendants alleging that the continued offering of Radian common stock was imprudent. In addition, the plaintiffs also alleged a breach of fiduciary duty to disclose, claiming that defendants misinformed the putative class members about the risks of investing in Radian common stock. In dismissing the prudent investment claim, the court held that the holdings in "*Moench* and *Edgar* stand for the proposition that short-term financial difficulties do not create a duty to halt or modify investments in an otherwise lawful fund that consists primarily of employer securities." With respect to the disclosure claim, the court stated that the fiduciary disclosures made with respect to the Radian stock fund satisfied ERISA's obligations. In dismissing the claims, the court also noted that no fraud was alleged. Although the court dismissed all the claims, it did so without prejudice and granted plaintiffs leave to file an amended complaint within thirty days of the court's order.

In *In re Computer Sciences Corp. ERISA Litig.*, 2009 WL 2156696 (C.D. Cal. July 13, 2009), the district court granted defendants' motion for summary judgment on "stock drop" claims related to the alleged backdating of stock options. On the day the SEC backdating investigation was disclosed, Computer Sciences' stock dropped 12%; however, most of this loss was recouped within the next two weeks. The court held plaintiffs' imprudence claim suffered from numerous defects, including that: plan investments are made over a long-term horizon; and eliminating a company's stock as an investment option would have been a "clarion call" to the investment world that the fiduciaries lacked confidence in the value of the stock, which would have risked a catastrophic drop in Computer Sciences' stock price. The court also held that plaintiffs had failed to provide adequate evidence of causation, as there were other announcements that may have caused all or part of the 12% drop, and Computer Sciences' stock price fluctuations were in line with the movement of a stock index of companies in Computer Sciences' business sector. On the disclosure claim, the court held that the disclosures on stock options (which later required a $68 million correction to non-cash compensation expense) were not material, as they were not the result of intentional wrongdoing. The court also found that plaintiffs had failed to show detrimental reliance on the inaccurate statements.

Computer Sciences and *Radian* signal that at least some courts will not provide a "market meltdown" pass for the latest genres of stock drop claims; rather, these cases must still meet the strict pleadings and proof standards of imprudence developed in the earlier jurisprudence.

Are Unpaid Employer Contributions to an ERISA Plan "Plan Assets"? Courts and Government Weigh In

By Deidre A. Grossman

The question of when an employer contribution to an ERISA plan becomes a "plan asset" is an important one, since plan assets are afforded special protections both by ERISA and by criminal law, namely 18 U.S.C. § 664, which imposes criminal liability for embezzlement or unlawful conversion of ERISA plan assets. As discussed below, the once divergent views of the courts and government appear to be becoming reconciled.

In our June 2008 issue of the *Newsletter* we reported on the Fourth Circuit's decision in *United States v. Jackson*, 524 F.3d 532 (4th Cir. 2008), where the court affirmed the convictions and sentences of certain company officers, including under 18 U.S.C. § 664 for failing to pay employer contributions to the company's pension plan. The affirmance turned on the circuit court's endorsement of the district court and government's positions that employer contributions become "plan assets" when they are due and owing, even if they are still housed in the corporate coffers. In so holding, the Fourth Circuit contended that it was agreeing with the Second Circuit, which it believed had held the same in *United States v. LaBarbara*, 129 F.3d 81 (2d Cir. 1997).

A few events followed. In connection with reviewing the defendants' petition for writ of *certiorari* in *Jackson*, the United States Supreme Court requested that the government address the plan asset question. In its brief, the Solicitor General admitted error in the position the government had originally advanced in *Jackson*, which the Fourth Circuit had adopted, and stated that, "after closer consideration of [the Department of Labor's] position on this issue" and other authorities, it agreed with petitioners' contention that "unpaid employer contributions are not 'assets' of an ERISA plan unless the plan documents provide otherwise." The Solicitor General went on to explain that, when contributions are owing, the plan has a "debt" or "chose in action" to collect the contributions, which *is* a plan asset; the unpaid contributions themselves, however, are *not*. A person may be liable under Section 664 if, for example, he or she unlawfully assigns to a third party the plan's right to collect its debt or, as in *LaBarbara* (which the Fourth Circuit appeared to have misconstrued), participates in a "double breasting scheme" designed to evade the employer's contribution obligation, thereby concealing from the plan its right to collect contributions. Because, unlike in *LaBarbara*, the defendants in *Jackson* had not embezzled or converted the plan's contractual right to the contributions in question, the Solicitor General agreed that there could be no liability under Section 664 and their convictions should be vacated. Thereafter the Supreme Court vacated the Fourth Circuit's decision in *Jackson* and remanded for reconsideration in light of the Solicitor General's brief. On July 1, 2009, the Fourth Circuit vacated the convictions and sentences of the defendants, but remanded to the district court to consider the government's position, contending that "the government's 'confession does not relieve [us] of the performance of the judicial function.'" *United States v. Jackson*, 2009 WL 1877466, at *2 (4th Cir. July 1, 2009).

In the meantime, the Second Circuit also had an opportunity to weigh in on the plan asset question in *In re Halpin*, 566 F.3d 286 (2d Cir. 2009), where it held that, for purposes of ERISA's fiduciary provisions, unpaid employer contributions are not plan assets until they are paid into the plan (in the absence of plan language providing "for some other result"). In *Halpin*, the plan asset claim was advanced by the trustees of an ERISA plan to which contributions were owed by a bankrupt employer. The trustees contended, during bankruptcy proceedings, that their debt could not be discharged because the unpaid contributions were plan assets and thus the company's president breached his fiduciary duties (thus making him personally liable) by causing the company to pay moneys to other creditors, rather than make contributions to the plan. The Second Circuit disagreed, adopting the DOL's position (including as set out in its amicus brief in *Halpin*) and drawing the distinction between "chose in action" and actual funds. It went on to explain that its holding was consistent with *LaBarbara*, since there the plan asset that had been concealed in violation of Section 664 was the plan's contractual right to collect employer contributions, not "any actual funds."

The Second Circuit closed with the following note (also made by the Solicitor General in its brief in *Jackson*):

> [I]f unpaid employer contributions were plan assets, the employer would automatically become an ERISA fiduciary once it failed to make the payments. As such, the employer would owe the plan undivided loyalty at the expense of competing obligations – some fiduciary – to the business, and to others such as employees, customers, shareholders and lenders, and an undifferentiated portion of the companies [sic] assets would be held in trust for the plan. It is difficult to envision how the proprietors could ever operate a business enterprise under such circumstances. It is highly unlikely – indeed inconceivable – that Congress intended such a result.

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With these recent pronouncements, the courts and the government appear to have restored the sound distinction between the "chose in action" that lies in the hands of a plan's trustees to collect unpaid contributions, and plan assets in the hands of a delinquent employer. As noted above, the distinction is an important one for employers contributing to ERISA plans. Although the fiduciaries of an ERISA plan continue to have a full legal arsenal for compelling payment of contributions from delinquent employers, in the absence of plan language to the contrary, employers are unlikely to face criminal or fiduciary liability if they are late in making employer contributions to their plans.

Second Circuit Concludes Claim Was Time-Barred Before Expiration of the Limitations Period

By Russell L. Hirschhorn

The Second Circuit, in *Burke v. Price Waterhouse Coopers LLP Long Term Disability Plan*, 2009 WL 1964972 (2d Cir. July 9, 2009), ruled that, consistent with New York State law, an ERISA plan may provide a limitations period that is shorter than the six-year breach of contract statute of limitations and, perhaps more importantly, the limitations period may be triggered before a participant has fully exhausted his or her administrative remedies.

Following the exhaustion of Burke's short-term disability benefits, Burke received long-term disability benefits. Burke's long-term disability benefits were subsequently terminated, however, because Burke's doctor failed to timely submit information supporting proof of loss in response to a request by Hartford that the information be provided by May 12, 2003. On June 10, 2003, Burke appealed the termination and submitted additional information. Hartford denied the appeal on October 1, 2003 and informed Burke she could bring a civil action. On September 25, 2006, Burke filed a suit in federal court.

The court first observed that there was no dispute that the plan's three-year limitations period was valid and enforceable. Next, the court noted that the plan required a claimant to bring suit no more than three years after proof of loss is required to be furnished to Hartford. The court concluded that this plan provision was enforceable and held that the limitations period began to run on May 12, 2003, the last date on which Hartford required proof of loss to be submitted. In so ruling, the court rejected plaintiff's argument that the limitations period should not have commenced until October 1, 2003, the date on which she had fully exhausted her claim. The court also rejected plaintiff's argument that the plan could sit on a claim for lengthy periods, and thus "run-out" the limitations period, because the regulations state that a claim is deemed denied if not decided within a specified time period.

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The Second Circuit's decision is consistent with several other circuits that have ruled on the issue. It remains to be seen whether the Second Circuit's decision will be applied more broadly and courts become more willing to conclude that the limitations period was triggered before a plaintiff has fully exhausted his or her administrative remedies.

***Krolnik v. Prudential Insurance Company of America*: When Discretion Is Gone . . . Is There Full Blown Federal Discovery?**

By Yolanda D. Montgomery and Michael D. Spencer

A recent decision by Judge Easterbrook in *Krolnik v. Prudential Inc. Co. of America*, 2009 WL 1838298 (7th Cir. June 29, 2009), illustrates the importance of including *Firestone* "discretionary" language in plan documents. In *Firestone v. Bruch*, 489 U.S. 101 (1989), the Supreme Court held that when a plan document confers discretionary authority on a plan administrator to make benefit determinations, the decision of the plan administrator will be reviewed under the abuse of discretion standard. The court's review is generally limited to the administrative record that was before the plan administrator, subject to the potential for limited discovery on whether conflicts influenced the plan administrator's decision.

Different rules apply, however, when the plan fails to confer discretionary authority. Under *Firestone*, if the plan document fails to grant such authority, the court will review the decision to deny benefits *de novo*. In *Krolnik*,Judge Easterbrook addressed the scope of discovery and the nature of the district court's review when the plan fails to grant discretionary authority.

Plaintiff sued in *Kronlik* to recover disability benefits that were terminated because of plan language limiting payments to two years if the disability is caused, even in part, by a mental illness. Plaintiff proposed to take discovery on his medical and mental condition; however, Prudential opposed, arguing that the suit should be resolved on the administrative record. The district court agreed and barred all discovery on medical questions, stating that the costs of conducting the discovery outweighed its benefits. Plaintiff then provided the district court with several affidavits from physicians describing his condition and prognosis, which the district court struck from the record. The district court, applying *de novo* review to Prudential's decision to deny benefits, granted summary judgment in favor of Prudential relying on the plan language and the administrative record.

The Seventh Circuit, per Judge Easterbrook, reversed. Judge Easterbrook noted that if abuse of discretion review had applied, Prudential's decision to deny benefits would have been sustained easily. Citing *Firestone*, Judge Easterbrook held that since the plan document did not contain discretionary language, however, the court is required to make an independent decision of the benefit determination. Judge Easterbrook found that the term "*de novo* review" is misleading because, in his view, the court should not "review" the plan administrator's decision; rather, it should take the facts and evidence and independently decide for itself where the truth lies. Judge Easterbrook noted that just as in insurance litigation, evidence is essential in ERISA benefits litigation if the court is to fulfill this fact-finding function. However, Judge Easterbrook did note that there may be times when the administrative record is ample enough to fulfill this mission, and discovery of duplicative evidence may be limited to avoid undue burden or expense as defined under *Fed. R. Civ. P.* 26(c)(1).

Applying these rules, Judge Easterbrook held there was no justification for the district court's refusal to admit the affidavits that plaintiff procured at his own expense. Rather, to make an independent decision, the district court was obligated to consider all of the medical evidence, including the evidence supplied by plaintiff. If there remained a material dispute after reviewing the paper record, Judge Easterbrook noted that trial would be required, including the plaintiff's right to cross examine the physicians whose reports underlie Prudential's decision.

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Krolnik illustrates the potential costs to plans when a plan document fails to confer discretionary authority to a plan administrator to make benefit determinations. Although *Krolnik's* facts and holding are narrow (*i.e.*, the affidavits tendered must be accepted and considered), the reasoning is broad, as it suggests that instead of sitting in review of the plan administrator's decision *de novo*, the courts should independently decide the claim based on the evidence adduced through the federal discovery process. Such an expensive way to resolve benefit disputes drives up the costs of benefits for all, and provides strong reason for adding discretionary clauses to benefit plans whenever feasible. However, the option of adding discretionary clauses (and thus lowering benefit costs) may not always be available. As discussed in our next article, several states have sought to ban discretionary clauses in insured plans, with most attempts successful to date.

Bucking the Trend, District Court Finds That Utah's Attempt to Bar Discretionary Clauses Is Preempted By ERISA

By Charles Seemann III

The May 2008, April 2009 and June 2009 issues of the *Newsletter* reported on recent court decisions addressing ERISA preemption of state attempts to prohibit discretionary reviews of benefit claims in insured plans. Prior decisions addressing the issue had uniformly treated state regulation of discretionary clauses as exempt from preemption under ERISA's "savings" clause, which permits state-level regulation of insurance.

One court has bucked that trend, finding that Utah's regulation on discretionary clauses was preempted by ERISA. In *Lucero v. Hartford Life and Accident Ins. Co.*, 2009 WL 2170048 (D. Utah Jul. 17, 2009), the court addressed benefits claims by Cherise Lucero, a participant in a long-term disability plan administered by defendant Hartford. After terminating her employment in May 2004, Lucero applied for disability benefits, claiming that her physical disability (pain and fatigue) resulted from stress, depression, anxiety and post-traumatic stress disorder. Two physician statements accompanying the application stated these mental conditions caused Lucero to be unable to work, and one of these also indicated Lucero suffered from fibromyalgia. A third physician's statement indicated that Lucero was "healthy" by September 2004, opining that Lucero did not suffer from fibromyalgia. Hartford initially granted Lucero's claim for disability benefits. After investigating the claim, however, Hartford terminated Lucero's benefits in November 2005, citing the plan's 12-month limitation on disability benefits for mental illness and the lack of objective evidence of physical impairment. In 2006, Hartford denied Lucero's disability claim based on physical impairment, determining that Lucero did not have a physical disability as defined in the plan.

After exhausting administrative appeals, Lucero filed suit. Lucero asserted that her disability claim should be reviewed under a *de novo* standard, arguing that Utah Insurance Rule 590-218 permitted discretionary clauses only insofar as they relate to the scope of materials that a court may consider in reviewing a benefits decision. The Court rejected this argument, relying on an earlier decision that "scope of review" and "standard of review" were synonymous. The court thus held that the "arbitrary and capricious" standard still applied, even under the terms of the Utah rule.

The court also held that even if Utah's rule applied to limit discretion in review of benefit claims, it was preempted. The parties agreed the Utah rule was specifically directed at entities engaged in the business of insurance. Departing from the cases decided in other jurisdictions, however, the *Lucero* court held that the rule was not "saved" from preemption because it did not substantially affect the risk-pooling arrangement between insurers and insureds. In reaching this conclusion, the court described risk pooling as "the means by which insurers cover individuals of all risk levels across a variety of adverse event probabilities." Under this view, the court found the Utah rule was not saved from preemption:

> [T]he Utah Rule applies only to the administrative function of interpreting the insurance plan's terms and judicial review of the use of that administrative function. The Court, therefore, finds that the Utah Rule does not substantially affect the risk pooling arrangement because it is unrelated to either the risk of adverse events occurring or their potential magnitude . . . . [T]he Court find[s] that the requirements of the Utah Rule cannot be applied to the Plan, [and] that the Plan's discretionary authority clause is effective.

Applying the arbitrary and capricious standard, the court sustained Hartford's denial of benefits, because Hartford collected information from Lucero and her physicians, and through its own independent review. On this record, the court found Hartford reasonably concluded that there was no objective evidence of physical impairment that would permit Lucero to receive disability benefits past the 12-month limit for mental illness. Similarly, the court found that that Hartford did not act arbitrarily when it gave less weight to Lucero's subjective claims of physical pain associated with fibromyalgia.

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As noted in previous reports, a trend toward *do novo* review of all benefits decisions threatens the ability of insured plans to control costs. While larger employers have the option of implementing self-insured plans, a surge in insurance costs may force smaller employers to choose between onerous premiums and the abandonment of benefits plans. The *Lucero* decision holds out hope that ERISA preemption will prevent state regulators from impairing the discretionary features of benefit plans. If *Lucero* is followed in other jurisdictions, its reasoning also may help stop a trend that still threatens to make benefits program costs-prohibitive for smaller employers.

Rulings, Filings and Settlements of Interest

- In *Trustees Local 464A United Food & Commercial Workers Pension Fund v. Wachovia Bank*, 2009 WL 2152074 (D.N.J. July 14, 2009), the trustees sued the plan's investments managers that were responsible for an individually managed fixed income account. The trustees claim the fixed income fund lost 50% of its value ($60 million) in 2008 because of its heavy concentration in mortgage backed securities (MBSs) and collateralized mortgage obligations (CMOs). The court denied the investment managers' motion to dismiss, concluding that the trustees stated a claim of imprudence by alleging that the investment managers continued to invest in MBSs and CMOs after warnings of problems in the mortgage and credit markets began to appear in early 2007. The court also held that, in light of the economic climate at the time and the stated conservative investment aims of the fund, the trustees stated a claim for breach of the duty to diversify by alleging that approximately 31% of the fund's portfolio was invested in CMOs in November 2008, after the credit crisis began.
- In *Tibble v. Edison Int'l*, (C.D. Ca. Jun. 30, 2009), the district court granted plaintiffs' motion for class certification in a case where plaintiffs alleged various breaches of ERISA fiduciary duties stemming from "an arrangement whereby Edison received offsets from retail mutual funds" to cover the costs and fees of the plan's record-keeper. First, the court rejected defendants' claim that there was no typicality, holding that "the effect of the Supreme Court's ruling in *LaRue* is to expand the scope of individuals who can bring actions against plan fiduciaries" and "§ 502(a)(2) does not provide for a remedy for individual differences distinct from plan injuries." In addition, defendants' attack on the adequacy of the named plaintiffs for failing to have sufficient knowledge of the case ("puppets of class counsel") was rejected because the named plaintiffs had a general understanding of the issues involved. Finally, the court held that certification pursuant to *Fed. R. Civ. P.* 23(b)(1)(A) was appropriate to prevent prejudice to defendants because plaintiffs sought equitable

remedies, including removal of trustees. Rule 23(b)(1)(A) states that a class action can be maintained if prosecuting separate actions would create a risk of "inconsistent and varying adjudications . . . that would establish incompatible standards of conduct for the party opposing the class." The court reasoned that the possibility of other plaintiffs seeking similar remedies risked inconsistent courses of conduct being imposed on the defendants.

???In *Harris v. Amgen, Inc.*, 2009 WL 2020785 (9th Cir. July 14, 2009), the Ninth Circuit joined other circuits in holding that a former participant in a defined contribution plan has standing to assert an ERISA claim, even after he had voluntarily withdrawn his assets from his plan account. The court reasoned this was a claim for benefits that allegedly would have been in the plaintiff's account but for the alleged breach of fiduciary duty from knowingly purchasing and retaining artificially inflated stock. The court distinguished *Kuntz v. Reese*, 785 F.2d 1410, 1411 (9th Cir. 1986), which had found no standing, as involving a claim on a defined benefit plan in which the plaintiff had admittedly received all the benefits he was due. Also, the court allowed the claim to proceed under § 502(a)(2), rejecting the contention that it must be brought under § 502(a)(1)(B).

???In *Holland v. Int'l Paper Co. Ret. Plan*, 2009 WL 2050688 (5th Cir. July 16, 2009), the Fifth Circuit discussed the post-*Glenn* standard of review for a denial of benefits. Applying *Glenn*, the Fifth Circuit abandoned its "sliding scale" approach while observing that much of its "sliding scale" precedent remained compatible with *Glenn* to the extent that precedent reflects the use of a conflict as a factor that would alter the relative weight of other factors. The court explained that the appropriate weight to give the conflict depends on the facts, including the conflict's impact on the benefits determination, and the employer's attempts to reduce potential bias and promote accurate determinations. Here, the employer's use of a trust to fund the plan reduced any potential conflict, as did its other efforts to promote accurate determinations, which included using an independent medical advisor. The Fifth Circuit concluded the conflict was not a significant factor to be considered and reversed the district court's award of benefits, which had applied "a modicum less deference" due to the conflict.

???In *Bamgbose v. Delta-T Group, Inc.*, 2009 WL 1940928 (E.D. Pa. July 6, 2009), plaintiff alleged that defendant, a recruitment and placement company, misclassified workers as independent contractors to evade FLSA overtime requirements and to deny ERISA protected employee benefits. The court determined that plaintiff's ERISA claims were time-barred. With respect to plaintiff's denial of benefits claim, the court stated that "the statute of limitations begins to run when a plaintiff discovers or should have discovered the injury that forms the basis of the claim." The court observed that events "other than the

denial of a claim may trigger the statute of limitations by clearly alerting the plaintiff that his entitlement to benefits has been repudiated." The court held that the independent contractor agreement plaintiff signed in 1999 clearly placed him on notice that he was not entitled to any employee benefits; thus, plaintiff should have brought a claim within four years of signing the agreement (the most analogous Pennsylvania rule had a four year statute of limitations). With respect to plaintiff's breach of fiduciary duty claim, the court ruled that ERISA's three year limitations period did not apply because plaintiff did not have "actual knowledge" of the breach in 1999. "Actual knowledge" is knowledge "not only of the events constituting the breach or violation but also that those events supported a claim of breach of fiduciary duty," *i.e.* "constructive knowledge is not sufficient." However, the court applied ERISA's six year limitations period to bar plaintiff's claims because "the last action which constituted a part of the [alleged] breach" occurred in 1999 (when plaintiff signed the independent contractor agreement), and plaintiff failed to file suit until 2009.

??? In *Sznewajs v. U.S. Bancorp,* 2009 U.S. App. LEXIS 15392 (9th Cir. July 13, 2009), plaintiff filed a claim for benefits under a top-hat plan. She contended that she was entitled to benefits because she was married to Sznewajs at the time he left U.S. Bancorp and, therefore, she was designated Sznewajs's beneficiary at the time of his "retirement." The plan administrator rejected plaintiff's interpretation of "retirement," determining that "retirement" was the commencement of the payment of benefits, not the time employment with the company ended. Thus, the plan paid Sznewajs' second wife, rejecting plaintiff's application for benefits. The Ninth Circuit held that the plan's determination would be reviewed under the abuse of discretion standard. In so ruling, the court observed that although certain circuits have carved out an exception for top-hat plans, whereby they review decisions under a *de novo* standard of review, the court determined that "importing 'de novo' language into the standard of review simply because the plan involved is a top-hat plan would create unnecessary confusion." Using the abuse of discretion standard of review, the court concluded that the plan was ambiguous with respect to the term "retirement" and the plan's determination that "retirement" began when benefits became payable, not at the time the employee terminated employment with the company, was not unreasonable or made in bad faith.

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