Proskauer

The ERISA Litigation Newsletter

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Editor's Overview

Given the importance of the new claims regulations issued under authority created by the Patient Protection and Affordable Care Act, this month's *Newsletter* leads off with a client alert that was previously published by Proskauer's Health Care Reform Task Force. Under the new regulations, group health plans and health insurance issuers (other than grandfathered health plans)must begin complying with new internal claims and appeals and external review procedures for plan years commencing on or after September 23, 2010.

Our other article this month, authored by Bridgit DePietto and Robert Rachal, provides insight on the decision in *Tibble v. Edison International*, which was the first "excessive fees" case to go to judgment following a trial. A federal district court in California concluded that defendants breached their fiduciary duty of prudence under ERISA § 404(a) by offering as investment options in the company's 401(k) plan retail share classes of mutual funds that were more expensive than institutional share classes, upon finding that there was no relative advantage to the retail funds that would justify the higher costs, nor was there evidence that the fiduciaries considered offering the less expensive institutional funds.

As always, be sure to review the section on *Rulings, Filings and Settlements of Interest*.

Healthcare Reform: Interim Final Regulations for Internal Claims and Appeals; External Review Processes for Group Health Plans and Health Insurance Coverage[1]

By Proskauer's Health Care Reform Taskforce

Group health plans and health insurance issuers (other than grandfathered health plans, which are discussed here: Healthcare Reform: Interim Final Regulations For Internal Claims and Appeals; External Review Processes For Group Health Plans and Health Insurance Coverage, must begin complying with new internal claims and appeals and external review procedures for plan years commencing on or after September 23, 2010. The new procedures were issued under authority created by the Patient Protection and Affordable Care Act (PPACA), in the form of interim final regulations jointly issued July 22, 2010, by the Department of Treasury's Internal Revenue Service, the Department of Labor's Employee Benefits Security Administration (EBSA), and the Department of Health and Human Services (HHS).[2] Unlike proposed regulations, interim final regulations are binding upon the effective date.[3] The agencies have requested comments regarding the new claims review procedures by September 21, 2010, but any changes to these procedures likely would be prospective only. Accordingly, plan sponsors will likely need to update their claims review procedures before their next plan year begins.

PPACA requires group health plans and health insurance issuers offering group or individual health insurance coverage to implement an effective internal claims and appeals process for the determination of benefit claims, and also requires the establishment of state and federal external review processes to review benefit claim denials. The new claims procedure regulations set forth separate, although similar, rules for group health coverage and individual health insurance coverage for internal claims and appeals, and standards for state and federal external review processes. The rules applicable to the internal claims and appeals for group health plans, both insured and self-insured, are addressed herein.

Existing Claims Procedures

EBSA has previously promulgated claims procedures designed to ensure "full and fair" review of claims under ERISA-covered plans by establishing procedures for the organized flow of information between plans and claimants.[4] For example, at the claimant's request, plans must provide all documents, records, and other information relied upon or generated during the consideration of a claim. The purpose of ERISA's internal review process is to reduce litigation and thereby reduce the cost of benefit claim disputes. Courts generally require claimants to exhaust internal administrative claims procedures as a prerequisite to seeking judicial review of their claims for benefits.

Obligations Imposed By the New Interim Final Regulations

The interim final regulations impose six new obligations on group health plans and issuers in addition to the existing EBSA claims procedures.

1. Broader Definition of "Adverse Benefit Determination"

The new regulations include a rescission of coverage within the definition of "adverse benefit determination," which broadens the claims that are subject to the claims procedures. Claim denials will be subject to the existing and new claims regulations if based upon a group health plan's determination that the individual is not eligible to participate in a plan, a benefit is not covered by the terms of a plan, the plan imposes a preexisting, source-of-injury, network, or other exclusion on otherwise covered benefits, or a benefit is experimental, investigative or not medically necessary or appropriate.[5] An adverse benefit determination includes both pre-service and post-service claims, and any rescission of coverage whether or not there is an immediate adverse effect on any particular benefit.

2. Urgent Care Claims Must Be Decided As Soon As Possible, But No Later Than 24 Hours

Plans must notify claimants of benefit determinations (whether adverse or not) regarding urgent care claims as soon as possible, but no later than 24 hours following receipt, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered under the plan. This requirement is a significant change from the existing EBSA regulations requiring a response within 72 hours. When a plan requires submission of additional information to review the claim, the claimant must be afforded a reasonable amount of time, but no less than 48 hours, to provide the requested information.

3. Additional Criteria to Ensure A Claimant Receives A Full and Fair Review

In addition to complying with the existing EBSA claims procedures, group health plans must provide a claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the plan in connection with the claim. This information must be provided sufficiently in advance to allow a claimant time to respond prior to the adverse benefit determination. Further, any new rationale for denying a claim on appeal or review must be disclosed to the claimant sufficiently in advance to allow the claimant time to respond prior to the adverse benefit determination on appeal or review.[6]

4. New Criteria to Avoid Conflicts of Interest By Decision Makers

The new regulations mandate additional precautions to ensure that claims and appeals are decided independently and impartially. Accordingly, plans cannot hire, promote, or terminate claims reviewers based on the likelihood that an individual will support a denial of benefits. For example, bonuses based on the number of claims denied are strictly forbidden. Similarly, a plan cannot contract with a medical expert based on the expert's reputation for outcomes in contested cases rather than the expert's professional qualifications.

5. New Notice Standards

Notices to individuals must be provided in a "culturally and linguistically appropriate manner." Depending on the number of non-English speaking plan participants, written communications may be required in their native language. In addition to the existing notice standards under EBSA's claims procedures, group health plans must provide:

> (a) information identifying the claim involved, including the date of service, the health care provider, the claim amount, the diagnosis code, the treatment code, and the corresponding meaning of those codes;
>
> (b) the reason(s) for the adverse benefit determination that includes the denial code and its corresponding meaning and a description of the plan's standard, if any, that was used to deny the claim; and, for notices of final internal adverse benefit determinations, the description must include a discussion of the decision;

(c) a description of available internal appeals and external review processes, including how to initiate an appeal; and

(d) contact information for any applicable office of health insurance consumer assistance or ombudsman established under PPACA to assist individuals with the internal claims and appeals and external review processes.

6. Strict Adherence Required for Deemed Exhaustion of Internal Claims and Appeals Procedures

If group health plans do not strictly adhere to all requirements of the internal claims and appeals process, claimants will be deemed to have exhausted the internal claims and review process regardless of whether the plan substantially complied with these requirements or any error committed is "de minimis." This is a different standard than the one applied under EBSA regulations. Accordingly, non-compliance with the new claims procedures could turn a claimant into a plaintiff empowered to seek external review or immediate judicial review of the benefit denial. Moreover, claims that fail to follow procedures established by regulation are deemed denied on review without the exercise of discretion by an appropriate fiduciary. The regulations take the view that this could lead a court to apply a de novo standard of review rather than an arbitrary and capricious standard of review.

In addition to imposing these new obligations on plans, the interim final regulations require that group health plans provide continued coverage pending the outcome of an internal appeal under the existing EBSA claims procedures, which generally provide that an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review. However, the existing claims procedures allow a plan to notify a participant in advance that benefits will be limited and do not require additional formal notice that the approved course of treatment is coming to an end.[7]

The new claims procedures require group health plans to provide an effective external review process by Independent Review Organizations ("IROs"), by requiring plans to provide information to IROs regarding final adverse benefit determinations. The new claims procedures set forth standards for state external review processes and provide an outline of the federal external review process, the final details of which will be forthcoming. Most claims under self-insured ERISA-covered plans will be subject to the federal external review process because of ERISA's broad preemption provision. For plans providing health insurance coverage that is subject to a state external review process, these plans will not need to comply with the federal external review process if the state external review process meets the minimum consumer protection in the National Association of Insurance Commissioners Uniform Health Carrier External Review Model Act, upon which the federal external review process will be based. Decisions by IROs under the external review processes will be binding on the plan and claimant, except to the extent other remedies are available under state or federal law.

***Tibble v. Edison International*: District Court Finds After Trial That It Was a Breach of Fiduciary Duty to Offer Retail Rather Than Institutional Share Classes of Certain Mutual Funds**[8]

By Bridgit DePieto and Robert Rachal

As 401(k) plans have grown into the primary source of retirement income for many employees, the fees paid by such plans have come under increasing scrutiny by Congress and the U.S. Department of Labor. In addition, since the fall of 2006, more than thirty class action complaints claiming breaches of fiduciary duties under Employee Retirement Income Security Act (ERISA) related to fees and expenses have been filed against some of the nation's largest companies, the officers of those companies, the members of their 401(k) plan committees, and the service providers to both small and large plans.

In the first “excessive fees” case to go to judgment following a trial, *Tibble v. Edison Int’l*, 2010 WL 2757153 (C.D. Cal. July 8, 2010), the U.S. District Court for the Central District of California addressed whether defendants breached their fiduciary duties under ERISA by offering as investment options in the company’s 401(k) plan more expensive retail share classes of mutual funds rather than the cheaper institutional share classes. The court concluded that defendants breached their fiduciary duty of prudence under ERISA § 404(a) because, under the facts of this case, there was no advantage offered by the more expensive retail funds and there was no evidence that the fiduciaries considered offering the less expensive institutional funds.

Background Facts

Edison International (Edison) is the parent company of Southern California Edison Company (SCE), which sponsors the Edison 401(k) Savings Plan (Plan). The Plan is a defined contribution plan and an “eligible individual account plan,” as those terms are defined by ERISA. The Southern California Edison Company Benefits Committee (Benefits Committee) is the Plan administrator. The Board of Directors of SCE and Edison delegated the authority to select and monitor the Plan’s investment options to the Edison International Trust Investment Committee (TIC). The TIC, in turn, delegated certain investment responsibilities to the TIC Chairman’s Subcommittee (Sub-TIC), which focused on the selection of specific investment options. SCE’s Investments Staff provided information and recommendations to the TIC and Sub-TIC (Investment Committees) regarding which investment options to maintain or replace, and monitored and evaluated the funds’ performance and fees.

The issues remaining for trial related to issues raised by “revenue sharing,” a process in which mutual funds pay fees to providers, such as a plan’s recordkeeper, for services they provide when the plan’s assets are invested in the mutual fund. Revenue sharing is paid out of a mutual fund’s 12b-1 fees used to fund distribution of its shares, and is part of the overall fees charged the investors in that mutual fund. Here, since at least 1997, the Plan document provided that SCE would pay the cost of administering the Plan, not the Plan participants. Hewitt Associates (Hewitt) was the Plan’s recordkeeper. When the Plan was amended in 1999 to add retail mutual funds, Hewitt already had contracts with certain mutual fund companies whereby Hewitt received a portion of the “revenue sharing” to pay for its recordkeeping services. As a result, when the retail mutual funds were added to the Plan, the revenue sharing payments received by Hewitt were applied to reduce Hewitt’s recordkeeping charges to SCE.

Procedural History

Plaintiffs, current or former employees and participants in the Plan, filed a class action complaint on August 16, 2007, against several different Edison entities and individuals, all of whom were alleged to have been Plan fiduciaries during the relevant time period. Plaintiffs sought to recover damages pursuant to ERISA for alleged financial losses suffered by the Plan as well as injunctive and other equitable relief based on alleged breaches of defendants' fiduciary duties.

Plaintiffs brought a laundry list of claims, alleging prohibited transactions and fiduciary breaches related to the administrative and investment fees paid by the Plan. After dismissing all but two claims against defendants in two separate summary judgment opinions last year, the court held a three-day bench trial to address: (1) whether defendants breached their duties of loyalty and prudence when they invested in the retail share classes rather than the institutional shares classes of six mutual funds; and (2) whether defendants breached their duty of prudence by requiring participants to pay excessive investment management fees for the Money Market Mutual Fund.

Retail vs. Institutional Share Classes

Duty of Loyalty Claim. ERISA's duty of loyalty requires a fiduciary to discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries. ERISA § 404(a)(1)(A), 29 U.S.C. § 1104(a)(1)(A). Under ERISA, a conflict of interest alone is not a breach. Instead, to prevail on a claim for breach of the duty of loyalty, a plaintiff must show "actual disloyal conduct."

At trial, plaintiffs claimed that, when deciding to invest in the retail share classes rather than the cheaper institutional share classes of the six mutual funds at issue, defendants breached their duty of loyalty because they were improperly motivated by a desire to capture more revenue sharing for the Plan sponsor, SCE, even though doing so increased the investment fees paid by the Plan participants. Plaintiffs argued that by doing so, defendants put the interests of SCE in offsetting the record-keeping costs to Hewitt above the interests of the Plan participants in paying lower mutual fund fees.

The court concluded that plaintiffs failed to make the requisite showing based on testimony from members of the Investments Staff that they never considered revenue sharing when making recommendations to the Investment Committees to add or replace mutual funds, never discussed revenue sharing at any of the meetings with the Investment Committees, and were never instructed to consider revenue sharing in their analysis of whether or not to recommend a certain fund. The court's conclusion also was based on its finding that the mutual fund selections from 2002 to 2008 evidenced a pattern that was flatly inconsistent with a desire to capture more revenue sharing for SCE. In fact, the evidence established that more often than not defendants chose to replace an existing mutual fund with one offering less revenue sharing, one with no revenue sharing at all, or one that resulted in no net change in the amount of revenue sharing received by SCE. Because plaintiffs failed to establish that defendants made fund selections with an eye toward increasing revenue sharing or put the interests of SCE above those of the Plan participants, the court dismissed plaintiffs' duty of loyalty claim.

Duty of Prudence. ERISA's duty of prudence requires a fiduciary to act with the care, skill, prudence and diligence that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims. ERISA § 404(a)(1)(B), 29 U.S.C. § 1104(a)(1)(B). ERISA's prudence requirement is generally comprised of two components – "procedural prudence" and "substantive prudence." The former refers to the process involved in making decisions for a plan, whereas the latter refers to the merits of the decision made by the fiduciary. The prudence requirement focuses on the fiduciary's conduct in arriving at the decision, not on its results, and asks whether a fiduciary employed appropriate methods to investigate and determine the merits of a particular decision. However, the failure to investigate alone cannot sustain an action for damages where the investment decision nonetheless was objectively prudent. This means that even if a fiduciary failed to conduct a sufficient investigation before making a decision (procedural prudence), he is insulated from fiduciary liability if a "hypothetical prudent fiduciary" would have made the same decision anyway (substantive prudence).

In addressing plaintiffs' prudence claims, the court divided its analysis between those investments selected before August 17, 2001, and those investments selected after August 17, 2001. With regard to the three mutual funds — the William Blair Fund, the PIMCO Fund, and the MFS Total Return Fund — that were added to the Plan in July 2002, plaintiffs argued that the initial decision to invest in the retail share classes constituted a breach of defendants' duty of prudence. At the time of the initial investment decision, both retail and institutional share classes were available for all three funds. The only difference between the share classes was that the retail share classes charged higher fees to the Plan participants. The higher fee for each fund was attributable to the 12b-1 fees that served as a source of revenue sharing to SCE.

The court first examined whether defendants engaged in a thorough investigation of the merits of the funds at the time the funds were added to the Plan. The evidence presented at trial established that defendants never considered or evaluated the different share classes for the three funds. The court found that the Investments Staff recommended adding the retail share classes of these three funds without considering whether the institutional share classes offered greater benefits to the Plan participants. Thus, the court concluded that defendants did not conduct a thorough investigation.

Having found that defendants failed to adequately investigate these three funds selected in 2002, the court then examined whether, in light of the facts that an adequate and thorough investigation would have revealed, investing in the retail share classes of these funds was objectively prudent. Based on the evidence presented at trial, the court concluded that had defendants considered the institutional share classes when adding these funds in 2002 and weighed the relative merits of the institutional share classes against the retail share classes, defendants would have realized that the institutional share classes offered the same investment at a lower cost to the Plan participants. The court also found that had the defendants asked, the mutual funds would have waived any minimum investment requirements for their institutional share classes. In so ruling, the court found credible the testimony of both plaintiffs' *and* defendants' experts that such waivers were commonly granted to plans of this size (the Plan had over $1 billion in total assets). In light of these facts, the court found a prudent fiduciary acting in a like capacity would have invested in the institutional share classes. Thus, the court held that defendants violated their duty of prudence when selecting the retail share classes for these funds.

With regard to the three mutual funds — Janus, Allianz, and Franklin — that were added to the Plan before August 16, 2001, the court ruled in an earlier summary judgment decision that the initial selection of these funds was outside the applicable statute of limitations period. Thus, at trial plaintiffs switched tacks, arguing it was imprudent to continue to invest in these funds after August 2001. After a lengthy analysis, the court found that there was nothing occurring after August 2001 that would have required the fiduciaries to reevaluate the available share classes and fee structure of these funds.

Excessive Investment Management Fees

The second claim presented at trial was whether defendants breached their duty of prudence by charging participants excessive investment management fees to invest in the Money Market Fund. The evidence at trial established that, when selecting the fund, defendants researched and compared the fees of four comparable funds; defendants reviewed the comparable funds (including fees) of seven candidates that responded to a request for proposal for the trustee business; defendants consistently monitored the fund's performance net of fees, which revealed that the fund performed consistently well (net of fees) throughout 1999 to 2008; defendants periodically reviewed the reasonableness of the fees for the fund; the fund's fee was reduced in 2005 and 2007; the fund's fees were periodically reduced as the Plan's assets in the fund increased; and defendants conducted an extensive review of the fund in 2008.

The court further concluded that even if defendants' process for monitoring and negotiating the fees for the Money Market Fund were somehow deficient, a hypothetical prudent fiduciary would have made the same investment decision based on the undisputed evidence that the fees were well within the reasonable range of fees charged by comparably performing money market funds. The court also noted that the fact that another money market fund charged lower fees does not mean that investment in the Money Market Fund was imprudent. "Where the undisputed evidence establishes that the Money Market Fund significantly outperformed its market benchmarks net of fees for 9 years, and . . . at most, two money market funds charged lower fees than the Money Market Fund . . . while several others charged comparable or even higher fees during the same period, Plaintiffs cannot meet their burden of showing that investment in the Money Market Fund was imprudent."

Damages and Other Relief Awarded

Due to certain errors in plaintiffs' damages calculations, the court was unable to calculate with accuracy the exact amount of damages. The court ordered plaintiffs to submit revised damage calculations to identify and measure the difference in investment fees between the retail share classes included in the Plan and the less expensive institutional share classes that were available but not selected for the Plan. The court also held that had the Plan fiduciaries not invested in the more expensive retail share classes, the Plan participants would have had more money invested and therefore would have earned more money over the course of time (lost investment opportunity), and in calculating their damages from lost investment opportunity, plaintiffs should use the returns of the funds in which the assets actually are (and have been) invested. Finally, to the extent any of the three funds at issue continued to be invested in retail share classes and cheaper but otherwise identical investments are available in the institutional share classes of those same funds, the court ordered defendants to take steps to remedy the situation consistent with the court's order to eliminate future damage to the Plan participants.

Proskauer's Perspective

Edison's ruling on retail mutual funds appears to be driven by the particular facts of this case. Specifically, based on the court's factual findings, there was absolutely no advantage offered by the more expensive retail share classes of the mutual funds, nor was there any fiduciary process or analysis in the record indicating that any fiduciary looked at whether they should have considered the cheaper institutional share classes. The *Edison* court did not rule that retail funds were somehow intrinsically imprudent, and in fact the court suggested that participant familiarity with funds and the availability of more public information on a fund (both often common advantages offered by retail mutual funds) can, at least in some instances, make those funds a superior choice.

Finally, *Edison* illustrates that it may be worthwhile for plan sponsors to consider structuring their plans so that the plan's administrative costs are borne by the plan, not the plan sponsor. Such a structure can lessen or eliminate claims of conflicts when revenue sharing is used to effectively lower a plan's administrative expenses.

Rulings, Filings and Settlements of Interest

- ???In *Borrero v. United HealthCare of New York, Inc.*, 2010 WL 2652456 (11th Cir. July 6, 2010), healthcare providers (and their representative organizations) alleged

state law claims against United HealthCare for failing to pay them the agreed upon rate contained in the subscriber agreements rate for services. The Eleventh Circuit held that these claims were preempted by ERISA because at least some of the allegations were dependent on ERISA, and that a prior litigation asserting claims under RICO did not preclude this litigation from proceeding.

- In *Kenseth v. Dean Health Plan, Inc.*, 2010 WL 2557767 (7th Cir. 2010), the Seventh Circuit concluded that issues of fact precluded a finding of summary judgment in favor of defendants on claims that the plan breached its fiduciary duty by providing a plan participant with an ambiguous summary of her insurance benefits, by inviting her to call its customer service representative with questions about coverage but failing to inform her that the information provided to her did not bind the Plan, and by failing to advise the participant of alternative channels to pursue in order to obtain a definitive determination of coverage in advance of her surgery. The court also ruled that the district court should, on remand, determine whether there is any appropriate equitable relief available to plaintiff.

- In *Mack v. Kuckenmeister*, 2010 WL 2853881 (9th Cir. July 22, 2010), the Ninth Circuit held state courts have jurisdiction to determine whether domestic relations orders (DROs) are qualified domestic relations orders (QDROs) and thus concluded that a Nevada court's determination in a divorce proceeding that a DRO was a QDRO was binding in federal court. The Ninth Circuit's holding conflicts with the DOL's guidance, which provides that federal courts have exclusive jurisdiction to determine whether a domestic relations order is a QDRO. *See DOL's FAQs About Qualified Domestic Relations Orders* ("Who determines whether an order is a QDRO?"), at http://www.dol.gov/ebsa/faqs/faq_qdro.html.

- In *Walker v. Monsanto Co. Pension Plan*, 2010 WL 2977304 (7th Cir. July 30, 2010), the Seventh Circuit held that Monsanto's cash balance plan did not violate ERISA's age discrimination provision. In an effort to standardize the early retirement options under the plan, the plan calculated the opening balance of each employee's account by crediting each account with an amount equal to the lump sum value of the employee's accrued benefit at the time of conversion from a traditional defined benefit plan, discounted by 8.5% per year for each year he or she was younger than age 55 at the time of the conversion. Each year that passed after the conversion, an 8.5% credit would be added to a participant's account balance until the employee reached age 55. Plaintiffs claimed that this formula reduced employees benefit accruals on the basis of age because the benefit accruals ceased at the attainment of age 55. The Seventh Circuit ruled that the 8.5% interest discounts and credits are not benefit accruals because they "never chang[ed] the accrued benefit at normal retirement age but reduc[ed] the benefit if the employees choose to receive payment early."

- In *Tomlinson v. El Paso Corp.*, No. 04-cv-02686 (D. Col. July 26, 2010), the district court held that El Paso's conversion to a cash balance pension plan and its implementation of a wear-away provision did not discriminate on the basis of age in violation of the ADEA. In so ruling, the court resolved the last outstanding claim in an almost six-year-long litigation over the conversion.
- In *In re JPMorgan Chase Cash Balance Litig.*, No.06 Civ. 0732 (S.D.N.Y. July 15, 2010), the district court approved a settlement between JPMC and approximately 100,000 participants, resolving the employees' claims that the company violated ERISA by backloading benefits and failing to provide adequate notice of its plan's conversion from a traditional defined benefit plan to a cash balance plan. The settlement requires the company to provide to class members the assistance of a financial planner over a one-year period and granted reimbursement of plaintiffs' costs and expenses in the amount of $600,000, but not attorneys' fees.
- In *Buus v. WaMu Pension Plan*, No. 07 Civ. 00903 (W.D. Wash. July 27, 2010), the district court preliminarily approved a settlement of a claim that WaMu failed to notify participants that its plans' conversion to cash balance plans decreased their benefit accrual rate. The settlement provides that WaMu will pay $20 million to plaintiffs and $4.1 million to plaintiffs' attorneys.

In *Metro. Life Ins. Co. v. Jenkins*, 2010 WL 2898302 (D. Del. July 20, 2010), an interpleader action brought by MetLife to determine the proper beneficiary of a life insurance policy, the court determined that the decedent "substantially complied" with the terms of the policy when he completed and signed his pension application changing the beneficiary of his life insurance policy from his wife to his aunt, even though the signature on the application was not notarized. The court ruled that although there was language in the SPD that required notarization, it was not apparent that the actual pension application required notarization and the fact that the completed application was accepted by the decedent's employer "demonstrate[d] substantial compliance with the requirements necessary to change the life insurance beneficiary." Additionally, the court dismissed a breach of fiduciary duty counterclaim brought by the decedent's wife that challenged the propriety of MetLife's decision to file the interpleader action instead of simply awarding the benefits to her, noting that a "stakeholder who is permitted to bring an interpleader action cannot be liable for a breach of fiduciary duty, based on its failure to choose between the two adverse claimants."

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[2] Nearly identical regulations are published at 26 C.F.R. § 54.9815-2719T (IRS), 29 C.F.R. § 2590.715-2719 (EBSA), and 45 C.F.R. § 147.136 (HHS).

[3] The IRS issued temporary regulations, which are likewise binding on the effective date but will expire in three years if final regulations are not issued before then.

[4] 29 C.F.R. § 2560.503-1.

[5] Rescissions of coverage must also comply with recently promulgated regulations restricting rescissions, which are discussed here: Health Care Reform: Interim Final Regulations Released for Preexisting Condition Exclusions, Lifetime and Annual Limits, and Patient Protections.

[6] The regulation's preamble notes that these criteria are consistent with the EBSA's current interpretation of its existing claims procedures regulations and also acknowledged that its interpretation has not been enforced by some courts.

[7] *See* 29 C.F.R. 2560.503-1(f)(2)(ii).

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Related Professionals

Russell L. Hirschhorn
Partner