Proskauer

The ERISA Litigation Newsletter

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Editor's Overview

This month, we feature two articles that discuss the accrual of statutes of limitations for ERISA claims, providing practical insight into reliance on the statutes to bar plaintiffs' claims. The first article discusses the Seventh Circuit's recent decision in *Thompson v. Retirement Plan for Employees of S.C. Johnson & Son, Inc.*, addressing the accrual of claims for benefits. The second article provides an overview of varying approaches among the Courts of Appeals regarding statutes of limitations applicable to breach of fiduciary duty claims.

As always, be sure to review the section on *Rulings, Filings, and Settlements of Interest*. The section includes a summary of a decision that will be discussed in depth in next month's Newsletter: *Bacon v. Stiefel Laboratories, Inc.*, 09-cv-21871-JLK, 2011 WL 2973677 (S.D. Fla. July 21, 2011), which denied certification of class claims alleging fraudulent misrepresentations in connection with the merger of an ESOP and 401(k) plan because individual reliance determinations would be required.

Seventh Circuit Confirms that Receipt of Benefit Distribution Can Trigger Statute of Limitations; Also Precludes Deference to Plan Administrator Where No Discretion Exercised[1]

Contributed by Amy R. Covert

The Seventh Circuit recently addressed two significant issues in *Thompson v. Retirement Plan for Employees of S.C. Johnson & Son, Inc.*[2] First, the Court held that a lump sum benefit payment can trigger the statute of limitations. In so ruling, the Court clarified that its prior ruling in *Young v. Verizon*,[3] that the statute of limitations did not begin to run until the plaintiff's formal claim for benefits was denied, was confined to the facts of that case. The Court also held that plan fiduciaries are entitled to no deference where they have exercised no discretion in interpreting the terms of the plan.

The statute of limitations ruling provides significant guidance on when a claim accrues, for statute of limitations purposes, which in turn depends on when a claim for benefits is deemed "repudiated." The deference ruling indicates that there are limitations on when the administrative process can serve as a vehicle for limiting judicial scrutiny of plan determinations.

Background

In 1998, S.C. Johnson & Son amended its ERISA plan to convert it from a traditional defined benefit plan into a "cash balance" plan. Although cash balance plans are formally classified as defined benefit plans, they function more like defined contribution plans in that they provide an account balance for each participant. However, that account balance is only a notional tool for calculating a retirement annuity, not an actual account containing money. Defendants – two retirement plans of S.C. Johnson – conceded that the amended plan unlawfully calculated the lump sum benefits that were available to participants at termination, in lieu of a retirement annuity, in that the payment was based on an amount equal to the amount in the cash balance account, rather than adjusted to include the present value of future interest credits that participants would have earned if they did not take the lump sum.

Plaintiffs, plan participants who had received lump sum distributions, filed suit in 2007. The parties cross-moved for summary judgment. Defendants argued that the statute of limitations barred plaintiffs' claims. The United States District Court for the Eastern District of Wisconsin held that Wisconsin's six-year contract limitations period applied. For purposes of the statute of limitations analysis, the district court divided the class into two groups: participants who received their lump sums within the six year limitations period, and those who received their lump sums more than six years before the lawsuit was filed. The district court held that the claims accrued when the plaintiffs received their lump-sum distributions, thereby rendering the claims of the first group timely and the claims of the second group untimely.

The District Court then considered the recovery to which the plaintiffs in the first group were entitled. Relying on *Conkright v. Frommert*,[4] the District Court determined that the plan defendants were entitled to deference in choosing the appropriate method to calculate damages. The district court selected a modified version of the plan defendants' proposed method.

Both parties appealed to the Seventh Circuit Court of Appeals on the issue of timeliness. The defendants argued that the district court was correct in ruling that the claims of plaintiffs in the second group were untimely because their lump sum distributions occurred over six years prior to the litigation; however, the defendants also argued that the claims of plaintiffs in the first group were untimely as well because all plan participants were informed of the relevant plan provisions in 1999, more than six years before suit was commenced. The plaintiffs argued that the court was correct to conclude that the first group had timely claims, but that the second group's claims should not have been barred because the receipt of a lump sum distribution was not a "repudiation" triggering the start of the statute of limitations clock. The parties also appealed whether the plan defendants' proposed method of recovery was entitled to deference and also presented for appeal the question of whether the district court or the parties should determine how future interest credits should be determined for purposes of the damages calculation.

The Seventh Circuit's Ruling on the Statute of Limitations

The Seventh Circuit affirmed the district court's rulings on the statute of limitations. The Court of Appeals explained that "[t]he general federal common law rule is that an ERISA claim accrues when the plaintiff knows or should know of conduct that interferes with the plaintiff's ERISA rights" and explained further that "a claim to recover benefits under § 502(a) accrues upon a clear and unequivocal repudiation of rights under the pension plan which has been made known to the beneficiary."[5] Although noting it was a "close question," the Seventh Circuit rejected the defendants' argument that the statute of limitations ran from the time the participants received Summary Plan Descriptions (SPDs) and informational materials describing the benefit formula.[6] The court held that, while the SPDs and other informational communications "touch[ed] on" the lump-sum distribution issue, these materials were "inadequate to convey the crucial defect in the Plans: that early lump sum distributions would not be increased to reflect the present value of future interest credits continuing to age 65."[7] The court observed that while the SPDs told participants that they would cease to earn additional credits after receiving a lump sum, the SPDs failed to communicate that the lump sum benefit they would receive would not take into account the present value of these credits.[8]

Significantly, the court recognized that it is possible for generic plan communications to "prospectively repudiate unequivocally participant rights."[9] However, the court explained that, in this case, because of the "relative obscurity of the rights at issue, the fact that most of the Plans' references to lump-sum distributions offered only oblique guidance about the crucial flaw at issue . . . and the fact that the most illuminating statements were found in informal Plan newsletters as opposed to the more legally weighty SPDs," there was no clear and unequivocal repudiation of the plaintiffs' rights to future interest credits under ERISA.

The Seventh Circuit agreed with the district court that the claims of the second group were time-barred. It ruled that the receipt of the lump sum distribution constituted an "unequivocal repudiation of any entitlement to benefits beyond the account balance," because information circulars previously distributed "confirmed that after a lump sum distribution, no additional benefits would be forthcoming."[10] The court explained that the lump sum distributions served as the "final step" of a clear repudiation of the plaintiffs' right to something more. In so ruling, the court rejected the plaintiffs' argument that the lump-sum distributions did not start the statute of limitations clock because plaintiffs could not have understood their injury without seeing the full plan document. The court explained that to understand their injury, the plaintiffs needed to reference ERISA and the laws interpreting it, not the plan. The court noted that the fact that "[t]hose sources may be obscure," should not to be held against the defendants.

In concluding that claim accrued from receipt of the lump-sum distribution, the court distinguished its prior ruling in *Young v. Verizon,*[11] where the Seventh Circuit had found that the payment of a disputed lump-sum amount did not qualify as a "clear repudiation." The court explained that the "right that the lump-sum distribution needed to 'clearly repudiate' was very different in *Young.*" In that case, the fiduciaries had distributed benefits that were smaller than what the plan literally prescribed, due to a scrivener's error. In these circumstances, the court concluded that the mere distribution of the lump sum would not have placed the participant on notice that one of the factors in the plan's benefit formula was being ignored. In *Thompson*, by contrast, the court explained that, in order to place plaintiffs on notice of their claim, "the lump-sum distribution merely needed to show that participants would receive their account balance and no more." The court also explained that *Young* was not controlling because the plaintiff had exhausted the plan's internal remedies in that case, thereby furnishing an alternative accrual date (the date the plan finally denied her claim). In *Thompson*, the plaintiffs were "given a pass" on exhausting their claims and the court refused to allow the plaintiffs to "slip by with no accrual date."

The Seventh Circuit's Ruling on Deference Owed to Plan Administrator's Calculation of Damages

The Seventh Circuit rejected the defendants' argument that their methodology for calculating damages was entitled to deference under *Conkright v. Frommert*. In *Conkright* , the Supreme Court reiterated the policy set forth in *Firestone Tire & Rubber Co. v. Bruch* ,[12] that courts are to defer to plan fiduciaries' interpretation of plan terms and clarified that fiduciaries are not stripped of deference because of an initial improper interpretation.[13] The Seventh Circuit concluded that *Conkright* was not applicable because *Firestone* deference applied only to questions of plan interpretation and did not extend to design decisions. Because the fiduciaries did not exercise interpretive discretion over the projection rate for calculating future interest credits, the court concluded that *Conkright* and *Firestone* were inapplicable. The court thus reversed the district court ruling to the extent that it held that some deference was owed to the plan defendants' damages calculations and remanded the case for the district court to determine damages without deference to the plan's proposed methodology.

Proskauer's Perspective

The Seventh Circuit's decision in Thompson is significant because it recognizes that claims for benefits under ERISA can accrue, for statute of limitations purposes, well before a participant files a formal claim for benefits. While other courts have already recognized that the limitations period can run upon a "repudiation" of rights that occurs before a formal administrative claim is filed,[14] this ruling helps clarify that adequate notice can constitute a repudiation for these purposes. By narrowing and distinguishing the court's prior ruling in *Young v. Verizon*, the decision confirms that a benefit distribution can start the statute of limitations clock running. The decision also recognizes that, in appropriate circumstances, plan communications can also commence the running of the limitations period. The court's ruling and rationale thus may present opportunities for defendants to bar claims that are brought at the time a participant retires, but are based on events that took place many years earlier, as to which the evidence has become stale. At a minimum, the decision would oblige participants to bring their claims within a reasonable period after their benefit payments commence, thus preventing suits that are belatedly brought at the behest of plaintiffs' attorneys based on newly discovered legal theories.

The deference ruling, on its face, would also appear to be potentially significant for ERISA litigators, in that it purports to carve out a category of cases in which the defendant-friendly arbitrary and capricious standard of review would not apply because the plan administrator exercised no discretion. We suspect, however, that there will be relatively few circumstances in which plan administrators will be found to have exercised no discretion at all in rendering benefit determinations.

Do You Know What It Means To Know? Actual Knowledge and ERISA Section 413[15]

Contributed by Aaron A. Reuter

Statutes of limitation restrict the time period in which a plaintiff can bring a claim. These rules are designed to prevent a plaintiff from sleeping on his or her cause of action for an unreasonably extended period of time because the resulting delays can often result in unfairness and prejudice to a defendant who, with the passage of time and the loss of evidence, may lose the ability to mount an effective defense. Above, we discussed the Seventh Circuit's decision in *Thompson v. Retirement Plan for Employees of S.C. Johnson & Son, Inc.,* which provided significant guidance on when an ERISA claim for benefits accrues for statute of limitations purposes. In this article we discuss the statute of limitations governing breach of fiduciary duty claims under ERISA.

While ERISA does not provide a limitations period for benefit claims, a claim for breach of fiduciary duty is governed by ERISA § 413, 29 U.S.C. § 1113. Section 413 provides that a claim for breach of fiduciary duty must be brought within the earlier of six years from the date of the last action that constituted a part of the alleged breach or violation, or three years after the earliest date that the plaintiff had actual knowledge of the alleged breach or violation.[16]

Whereas the three-year period acts as a traditional statute of limitations, in that it runs from the date of actual knowledge of the claim, the six-year period acts as a statute of repose: it provides for a strict deadline, which may not be tolled, and is tied to the fixed date in time when the last act of the alleged breach or violation occurred. These two provisions work in conjunction with each other, providing a balanced approach that allows a plaintiff three years to file an action from the date that he or she acquires actual knowledge of the claim, as long as that date is within six years of the alleged breach or violation.

ERISA does not define actual knowledge and, as a result, the courts have been left to establish their own approaches to determine whether and when a plaintiff has actual knowledge of the alleged breach or violation sufficient to begin running the three-year limitations period. This rule has been applied differently among the circuits: some courts define actual knowledge as when a plaintiff knows the facts and events that underlie an alleged breach or violation, while other courts define actual knowledge as knowledge of those facts and events plus an understanding that those facts support some sort of legal claim under ERISA.[17] A third group of courts that, for the most part, appears to fall into one of the aforementioned categories, claims to apply hybrid approaches based on fact-driven inquiries.

The Permissive Approach

The Third Circuit follows a permissive approach, requiring that in order for a plaintiff to have actual knowledge for purposes of the three-year limitations period, the plaintiff must have knowledge of all the material facts necessary to understand that a claim exists *and* also knowledge that those facts give rise to an actual claim under ERISA.[18] Under this approach, the Third Circuit does not require plaintiffs to have met with their lawyer or have a complete understanding of their rights under ERISA, but they must know that a fiduciary has breached its obligations under the statute. This differs from the conservative approach described below, which does not require a plaintiff to understand that a legal claim exists.

The Fifth Circuit's definition of actual knowledge is similar to the Third Circuit's, requiring that a plaintiff have knowledge of all the material facts needed to know that a claim exists *and* also knowledge that those facts support a claim for breach of fiduciary duty under ERISA.[19] For example, for a plaintiff to have actual knowledge, he or she would have to know that a plan was governed by ERISA and that a fiduciary acted in such a way as to give rise to a legal claim. This more lenient approach favors plaintiffs as it postpones the start of the three-year limitations period under ERISA § 413 until a plaintiff understands that he or she has a cause of action under ERISA.

The Conservative Approach

Following a markedly more conservative approach, the Sixth Circuit only requires that a plaintiff have knowledge of the relevant facts of a transaction or actions giving rise to a violation to start the three-year limitations period.[20] The Sixth Circuit specifically declined to follow the more permissive approach adopted by the Third and Fifth Circuits and does not define actual knowledge to include a plaintiff's understanding that the known facts support a legal claim under ERISA.

The Seventh Circuit has also defined actual knowledge for the purpose of ERISA § 413 as knowing the "essential facts of the transaction or conduct constituting the violation," without requiring "a potential plaintiff to have knowledge of every last detail of a transaction, or knowledge of its illegality."[21] Because neither the Sixth nor Seventh Circuits require that the plaintiff have knowledge that a legal claim exists under ERISA or otherwise, the three-year period for purposes of ERISA § 413 could start running much earlier in these circuits than it would under the approach applied in the Third and Fifth Circuits.

The Ninth Circuit has stated that actual knowledge requires that a plaintiff have knowledge that a fiduciary committed a breach, not just knowledge of the transaction itself.[22] The Ninth Circuit declined to equate knowledge of a transaction that is not illegal on its face with actual knowledge of an alleged breach of fiduciary duty for the purposes of triggering ERISA's three-year statute of limitations period. Instead, the Ninth Circuit requires that a plaintiff have actual knowledge of the act by the fiduciary that constitutes the breach before the limitations period will begin to run. The Ninth Circuit does not, however, require that a plaintiff understand that a cause of action exists under ERISA.

The Eleventh Circuit has determined that actual knowledge requires more than knowledge "that something was awry"[23] – a plaintiff must have "specific knowledge of the actual breach of duty upon which he sues" before the statute of limitations period will begin to run.[24] Nevertheless, like the Sixth, Seventh, and Ninth Circuits, the Eleventh Circuit does not require that the plaintiff know that those facts support a legal claim under ERISA.

The "Hybrid" Approach

The D.C. Circuit was one of the first circuit courts to consider the meaning of actual knowledge for the purpose of ERISA § 413. While it did not develop a specific approach like other circuit courts to later consider the issue, the D.C. Circuit did provide helpful guidance by concluding that the disclosure of a transaction that is not prohibited under ERISA cannot provide a plaintiff with actual knowledge of an underlying violation.[25] Subsequently, the Second and Eighth Circuits both agreed with the D.C. Circuit's analysis that knowledge of a transaction that is legal on its face will not serve to trigger the running of the three-year limitations period.

More recently, the First Circuit stated its belief that the differences between the aforementioned approaches were exaggerated, and that, were there actually a circuit split on the issue, the First Circuit would find itself in the middle.[26] The First Circuit took more of a hybrid approach, concluding that, while "*facts* cannot be attributed to plaintiffs who have no actual knowledge of them," a plaintiff has actual knowledge for the purposes of ERISA § 413 when he or she knows the "essential facts of the transaction or the conduct constituting the violation."[27] In so doing, the First Circuit noted that actual knowledge must be distinguished from the concept of constructive knowledge, which Congress removed from ERISA § 413 in 1987, and that the inquiry is one that must be flexible, allowing a court to take into account the factual scenario at issue. The First Circuit would find that a plaintiff had actual knowledge for purposes of ERISA § 413 if he or she knew the essential facts of the transaction or the conduct constituting the violation; and, like the Sixth, Seventh, Ninth, and Eleventh Circuits, the First Circuit does not require that a plaintiff understand that a legal claim exists under ERISA to begin running the three-year limitations period.

Refusing to develop a “hard and fast definition,” the Fourth Circuit adopted a fact-intensive, hybrid approach that is similar to the one developed by the First Circuit.[28] The Fourth Circuit was similarly concerned with the 1987 amendment to ERISA § 413 that replaced constructive knowledge with the current actual knowledge requirement, and agreed with the First Circuit that actual knowledge of facts cannot be attributed to a plaintiff who has no knowledge of them. Thus, the Fourth Circuit concluded that actual knowledge exists when a plaintiff knows the essential facts of a transaction or the conduct that constituted the violation.[29] How the approach adopted by the First and Fourth Circuits falls in the “middle” or differs from the conservative one adopted by the Sixth, Seventh, Ninth, and Eleventh Circuits is somewhat unclear because neither court requires, like the Third and Fifth Circuits do, that a plaintiff have an understanding that a legal claim exists under ERISA.

The Second Circuit follows a more lenient hybrid approach, requiring that a plaintiff have knowledge “of all material facts necessary to understand that an ERISA fiduciary has breached his or her duty or otherwise violated” ERISA.[30] While the Second Circuit does not require that the plaintiff have knowledge of the relevant law, a plaintiff must have knowledge of the material facts necessary to constitute a claim under ERISA, which might include expert opinions or an understanding of the harmful consequences.[31] Furthermore, the Second Circuit will not find actual knowledge where a plaintiff only has knowledge of a transaction that is not, on its face, “inherently a statutory breach of fiduciary duty.”[32] Thus, the Second Circuit’s approach appears to be a slightly more conservative variation of the one promulgated by the Third and Fifth Circuits, requiring that a plaintiff have some understanding that a breach or violation has occurred, not just knowledge of the underlying facts.

Finally, in defining actual knowledge for the purposes of ERISA § 413, the Eighth Circuit declared that it would adopt a hybrid approach. The Court stated that it "agreed with the interpretation developed with substantial unanimity by [its] sister circuits," that a plaintiff must have actual knowledge of the material facts to be aware that a claim exists.[33] The Eighth Circuit approved of the D.C. Circuit's reasoning that the disclosure of a transaction that is not facially a breach or violation would not serve to create actual knowledge on the part of a potential plaintiff. Thus, the Eighth Circuit noted that the "nature of the alleged breach is critical to the actual knowledge issue."[34] The Court opined that where a fiduciary commits a breach by making, for example, an imprudent investment, a plaintiff would have to have more knowledge than simply being aware that the transaction had occurred. Instead, a plaintiff would need to have some understanding of how the investment was selected to trigger the start of the three-year limitations period. Conversely, the Eighth Circuit stated that where a fiduciary engages in a prohibited transaction, a plaintiff's knowledge of the transaction itself would constitute actual knowledge for the purposes of ERISA § 413's three-year statute of limitations period.

Proskauer's Perspective

Even though the First Circuit characterized the circuit split as exaggerated and the Eighth Circuit declared that the circuit courts were substantially in agreement in their interpretation of actual knowledge, the differences between the conservative and permissive approaches can significantly impact the outcome of motions to dismiss on statute of limitations grounds.

Allowing the tolling of the three-year limitations period until plaintiffs understand that the facts they already know would support a claim under ERISA, as required by the Third and Fifth Circuits, seems to reach beyond the intent of the statute. ERISA § 413 does not specifically require such extensive understanding by a plaintiff, and the lenient standard may allow plaintiffs to escape the three-year period by arguing simply that they did not understand there was a legal claim available under ERISA to redress an alleged breach or violation of which they already had knowledge. The more conservative approach adopted by the majority of the circuit courts promotes a more objective standard because it is easier to determine when facts are communicated to a plaintiff than when a plaintiff realizes he or she had a claim under ERISA.

Given the disparity among the approaches of the circuit courts, plaintiffs bringing fiduciary breach claims may engage in forum-shopping as a means to avoid application of the three-year rule or the more onerous interpretations of that rule. It is hoped that the issue of when a fiduciary breach claim accrues eventually makes its way to the Supreme Court, since only then will there be an opportunity to develop a uniform rule for actual knowledge that could be applied consistently throughout the courts.

Rulings, Filings, and Settlements of Interest

Affordable Health Care Act:

- In *Thomas More Law Center v. Obama*, 10-2388-cv, 2011 WL 2556039 (6th Cir. June 29, 2011), the Sixth Circuit Court of Appeals affirmed the district court's decision, holding that the Affordable Care Act's minimum coverage provision, which requires that all applicable individuals maintain minimum essential heath insurance coverage or pay a fine, was constitutional pursuant to Congress's power to regulate interstate commerce. Applying the rational basis test, the court concluded that Congress had a rational basis to conclude that an individual's choice not to purchase health insurance "substantially affected interstate commerce," and therefore, the provision was facially constitutional. Additionally, the court found that failure to regulate such activity would undermine the effectiveness and intent of the Act's regulatory scheme. In so holding, the court rejected the plaintiffs' argument that Congress was impermissibly regulating "inactivity," stating that "far from regulating inactivity, the minimum coverage provision regulates individuals who are, in the aggregate, active in the health care market." For a more detailed discussion of this case and related cases currently before other Appellate Courts, please see the June issue of our *Newsletter*.

ESOP Litigation:

- In *Bacon v. Stiefel Laboratories, Inc.*, 09-cv-21871-JLK, 2011 WL 2973677 (S.D. Fla. July 21, 2011), the district court refused to certify a class action lawsuit where plaintiffs alleged that defendants tricked them into selling back their shares of company stock at a significantly undervalued price during a merger of the company's ESOP and 401(k) plans so that the defendants could, shortly thereafter, sell the company at a drastically higher price per share. The court refused to certify the class because the individual determinations by each plaintiff in response to these statements would have varied based on each plaintiff's needs. This case will be the topic of a feature article to appear in the September issue of the *Newsletter*.

- In *Taylor v. ANB Bancshares, Inc.*, No. 5:08-cv-05170-RTD (W.D. Ark. July 14, 2011), the district court preliminarily approved a $2 million settlement agreement in a class action lawsuit where in ESOP participants alleged that the fiduciaries breached their duties under ERISA by continuing to invest the plan's assets in company stock when they allegedly knew that the company was severely undercapitalized. The ESOP suffered significant losses of virtually all of its assets when the company was closed by the Federal Office of the Comptroller of the Currency and the Federal Deposit Insurance Corporation was appointed as a receiver.

Equitable Relief Post *Amara*:

- The Secretary of Labor filed an amicus brief in support of the reversal of the decision in *Kenseth v. Dean Health Plan, Inc.*, No. 08-00001 (W.D. Wis. Feb. 14, 2011), arguing that the district court erred in denying a plan participant payment of medical expenses that she was told defendant's plan covered. The district court held that plaintiff's claim failed because the payment sought was not "appropriate equitable relief" under ERISA § 502(a)(3). The Secretary argued that the district court erred in applying law relating only to non-fiduciaries. According to the Secretary, this law was inapplicable here because plaintiff's claim was against a plan fiduciary over the terms of the plan, and, as such, was the kind of claim that, before the merger of law and equity, plaintiff could have brought only in a court of equity, not a court of law. The Secretary argued, based on the Supreme Court's ruling in *CIGNA Corp. v. Amara*, 131 S.Ct. 1866 (2011), that ERISA fiduciaries who breach their fiduciary duties are subject to the make-whole remedy of surcharge, as well as other equitable monetary awards such as estoppel and reformation under ERISA § 502(a)(3). The Secretary concluded that the ruling in *Amara* effectively overruled the district court's holding in *Kenseth*, and therefore equitable remedies should be awarded to the participant.
- In *Biglands v. Raytheon Employee Savings and Investment Plan*, No. 1:10cv351, 2011 WL 2709893 (N.D. Ind. July 12, 2011), a participant sued the plan and its administrator challenging the denial of a claim for benefits arising in connection with the distribution of an estate for which plaintiff was the executrix. Biglands alleged both a claim for the benefits under ERISA § 502(a)(1)(B) and a claim under § 502(a)(3) seeking to establish a constructive trust and a surcharge equal in amount to the benefits claim. Citing a long line of precedent, the court held that when a claimant asserts both a claim for benefits and a claim for equitable relief based on the same injury, the latter claim must be dismissed. In so ruling, the court rejected Biglands's argument that the Supreme Court's recent decision in *CIGNA Corp v. Amara*, 131 S. Ct. 1866 (2011), "changed the landscape of § 502(a)(3) claims by expanding the reach of" fiduciary breach claims. In addition to noting that *Amara*'s

discussion of equitable remedies was mere *dicta*, the court found the decision distinguishable on its facts, as the *Amara* plaintiff had no claim under § 502(a)(1)(B).

Retiree Benefits:

- In *Quesenberry v. Volvo Trucks N. Am. Retiree Healthcare Benefit Plan*, --- F.3d ----, No. 10-1491, 2011 WL 2675923 (4th Cir. July 11, 2011), the Fourth Circuit affirmed a ruling that Volvo's changes to retiree health benefits violated the LMRA and justified a permanent injunction. The Court determined that Volvo's obligations continued after the expiration of the governing collective bargaining agreement (CBA), even though the CBA stated the coverage at issue would continue "for the duration of this Agreement." In so ruling, the court relied upon the fact that although the "coverage" section of the CBA had a durational limit, the separate "cost" section did not. Rather, the "cost" section included a negotiated mechanism that allowed Volvo to charge retirees a premium in excess of agreed limits only if the trust created for above-cap costs was expected to be depleted within a year and Volvo and the union engaged in unsuccessful negotiations to agree on benefits reductions. Because these "cost" conditions could not be satisfied, the court held, Volvo could not unilaterally modify the benefits. The district court's ruling that the changes also violated ERISA was not considered on appeal because the appeals court had ruled in the retirees' favor on the LMRA claim.
- In *NewPage Wis. Sys. Inc. v. United Steel, Paper & Forestry, Rubber, Manuf., Energy Allied Indus. & Serv. Workers Int'l Union, AFL-CIO/CLC*, --- F.3d ----, No. 10-2887, 2011 WL 2684910 (7th Cir. July 12, 2011), the Seventh Circuit held there was federal jurisdiction over an action by an employer and its plan seeking a declaratory judgment that changes to the retiree health plan did not violate ERISA. In reversing the district court, the court held there was jurisdiction because there would be federal jurisdiction over a "mirror-image" action, with the same issues, if filed by plan participants under ERISA §§ 502(a)(1) and (a)(3). The court ruled that jurisdiction does not depend on whether the relief sought is available under ERISA. In so holding, the court overruled *Newell Operating Co. v. United Auto. Workers*, 532 F.3d 583 (7th Cir. 2008), which held that jurisdiction was lacking for a similar suit because the declaratory judgment sought remedies that would not be "appropriate equitable relief." The employer also sought a judgment that its changes did not violate the LMRA, but the district court held there was federal jurisdiction over those claims and that ruling was not on appeal.
- In *Maytag Corp. v. Int'l Union, United Auto., Aerospace, and Agric. Implement Workers of Am.*, No. 4:08-cv-00291 (S.D. Iowa July 22, 2011), the court ruled that, after Whirlpool purchased Maytag, it could unilaterally reduce retiree medical

benefits because the union and its members had failed to meet their burden of showing that the relevant collective bargaining agreements demonstrated that the company intended to vest retiree benefits. Citing Eighth Circuit precedent, the court held that vesting is not to be presumed, but rather must be proved by a preponderance of the evidence that the employer agreed to vesting. In so ruling, the court relied on the CBA's duration provisions and blanket reservation of rights, a plan cap on lifetime benefits, and a bargaining history that showed benefits were modified over the years.

Failure to Exhaust Administrative Remedies:

- In *Angevine v. Anheuser-Busch Companies Pension Plan*, No. 10-2832, 2011 WL 2936354 (8th Cir. July 22, 2011), the Eighth Circuit affirmed the district court's dismissal of plaintiff's claim for benefits for failing to exhaust administrative remedies. Plaintiff claimed that an email informing employees they were not entitled to an early retirement benefit enhancement served as a repudiation of his right to such a benefit, thus rendering exhaustion futile. The court disagreed, reasoning that, while an ERISA claim accrues as a result of a clear repudiation known to a beneficiary, statutory accrual is a separate question from whether the judicially created exhaustion requirement is excused. The court found that plaintiff failed to demonstrate with certainty that pursuing administrative remedies under the plan would have been futile because he did not attempt to pursue administrative remedies and the plan administrator had not denied similar claims. The court also found that even if the email provided plaintiff with an indication of the outcome of pursuing an administrative remedy, the email alone did not show with certainty that the administrator would have denied plaintiff's claim.

Administrator's Conflict of Interest:

- In *Blankenship v. Metropolitan Life Ins. Co.*, --- F.3d ---, No.10-10717, 2011 WL 2567788 (11th Cir. June 30, 2011), the Eleventh Circuit reversed and remanded a long-term disability benefits ruling in plaintiff's favor, holding that the district court placed too much weight on the administrator's conflict of interest. The court noted that a structural conflict of interest – where administrators both make eligibility decisions and pay benefits – is "an unremarkable fact in today's marketplace," and that the burden remains with plaintiff to show that the conflict rendered a denial of benefits arbitrary and capricious. The court determined that the administrator's conflict of interest was counter-balanced by inconsistent reports from the participant's own physician about the gravity of his injuries. The court further rejected the notion that the large size of the claim – over a half million dollars – was enough to be a dispositive factor in the context of a plan administrator whose

annual revenues exceeded $50 billion. Considering the conflict as one factor in the analysis of the reasonableness of the administrator's decision, the court determined that the denial of benefits should be upheld.

SPD Violation:

- In *Weitzenkamp v. Unum Life Insurance Co. of America*, No. 10-3898, 2011 WL 2675247 (7th Cir. July 11, 2011), the Seventh Circuit reversed the district court's decision and held that the plan administrator could not rely on a plan's self-reported symptoms limitation to deny benefits because the limitation was not included in the summary plan description (SPD). Self-reported symptoms are those that cannot be verified by medical tests (headaches, pain, soreness, etc.) and can only be described by a patient to his or her doctor. The Seventh Circuit reasoned that the SPD violated ERISA § 102(b) because it did not include the plan's eligibility requirements for participation and benefits.

Interest Due on Lump-Sum Payments:

- In *Stephens v. US Airways Group, Inc.*, 10-7100-cv, 2011 WL 2739851 (D.C. Cir. July 15, 2011), the D.C. Circuit held that because the US Airways Pension Plan paid participants their lump-sum payments 45 days later than the day on which participants would have received their first checks had they selected the annuity payment option under the plan, participants were entitled to interest. The court reasoned that "a pension plan could not satisfy ERISA by correctly calculating an actuarially equivalent lump sum, then delaying payment of that sum indefinitely." The court also determined that the delay was "unreasonable," ruling that while the plan took 21 business days to calculate the lump-sum payments, the remaining delay was not the result of any administrative necessity. Accordingly, the court remanded the case to the district court to calculate the appropriate amounts due.

QDROs:

- In *Brown v. Continental Airlines, Inc.*, --- F.3d ---, No.10-20015, 2011 WL 2780505 (5th Cir. July 18, 2011), the court held that plans may not obtain restitution under ERISA Section 502(a)(3) of lump-sum pension benefit payments issued pursuant to a qualified domestic relations order (QDRO) upon a later determination that the participant engaged in a "sham" divorce solely to obtain the benefits. Continental alleged that several pilots, worried that the company's financial troubles would result in less then full payment of benefits at retirement, divorced their spouses to trigger immediate benefit payments to them under the terms of the plan and the QDROs. The court noted that ERISA § 206(d)(3) limits the DRO qualification determination to whether the state court decree calls for benefit payments outside

the terms of the plan. The court then rejected Continental's expanded reading of § 206, concluding that plan administrators may not question the good faith intent of participants submitting DROs for qualification.

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[2] Nos. 10-CV-3917, 10-CV-3918, 10-CV-3988 & 10-CV-3989, 2011 WL 2463550 (7th Cir. June 22, 2011).

[3] *Young v. Verizon's Bell Atlantic Cash Balance Plan*, 615 F.3d 808 (7th Cir. 2010).

[4] 130 S.Ct. 1640 (2010).

[5] 2011 WL 2463550, at *4 (internal citation and quotation omitted).

[6] *Id.* at *10.

[7] *Id.*

[8] *Id.*

[9] *Id*. at *12.

[10] *Id*. at *12-13.

[11] 615 F.3d 808 (7th Cir. 2010).

[12] 489 U.S. 101 (1989).

[13] 130 S. Ct. 1640 (2010); 2011 WL 2463550 at *7.

[14] *See, e.g., Miller v. Fortis Benefits Insurance Co*., 475 F.3d 516, 522-23 (3d Cir. 2007) (holding that action for underpayment of long-term disability benefits accrued upon initial receipt of erroneously calculated award); *Redmon v. Sud-Chemie Inc. Retirement Plan for Union Employees*, 547 F.3d 531, 539-40 (6th Cir. 2008) (finding that action accrued after participant's death, when plan stopped making payments, rather than when widow later received formal denial of survivor benefits); *Union Pacific Railroad Co. v. Beckham*, 138 F.3d 325, 331-32 (8th Cir.), *cert. denied*, 119 S.Ct. 56 (1998) (finding that claim accrued on date of successor's acquisition of predecessor even though participants did not file action formally challenging claim denial until later date).

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[16] In the case of fraud or concealment, an action may not be commenced later than six years after the date of discovery of the alleged breach or violation.

[17] The Tenth Circuit has not considered what constitutes actual knowledge for the purposes of ERISA § 413. The only district court in the Tenth Circuit that has considered the issue in depth declined to adopt a standard, instead finding that, under any approach, the plaintiff clearly had actual knowledge of the alleged breach of fiduciary duty. *See Midgley v. Rayrock Mines, Inc.*, 374 F. Supp. 2d 1039, 1049 (D. N.M. 2005).

[18] *Koert v. GE Group. Life Assurance Co.*, 231 F. App'x 117, 121 (3d Cir. 2007).

[19] *Babcock v. Hartmarx Corp.*, 182 F.3d 336, 339 (5th Cir. 1999).

[20] *Brown v. Owens Corning Investment Review Committee*, 622 F.3d 564, 570 (6th Cir. 2010).

[21] *Rush v. Martin Petersen Co.*, 83 F.3d 894, 896 (7th Cir. 1996).

[22] *Waller v. Blue Cross of California*, 32 F.3d 1337, 1341 (9th Cir. 1994).

[23] *Fetterhoff v. Liberty Life Assurance Co.*, 282 F. App'x 740, 742 (11th 2008).

[24] *Id.*

[25] *Fink v. National Savings & Trust Co.*, 772 F.2d 951, 957 (D.C. Cir. 1985).

[26] *Edes v. Verizon Communications, Inc.*, 417 F.3d 133, 141 (1st Cir. 2005).

[27] *Id.* at 142 (emphasis in original).

[28] *Browning v. Tiger's Eye Benefits Consulting*, 313 F. App'x 656, 661 (4th Cir. 2009).

[29] *Id.*

[30] *Caputo v. Pfizer, Inc.*, 267 F.3d 181, 193 (2d Cir. 2001).

[31] *Id.*

[32] *Id.*

[33] *Brown v. American Life Holdings, Inc.*, 190 F.3d 856, 859 (8th Cir. 1999).

[34] *Id.*