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The ERISA Litigation Newsletter

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Editor's Overview

This month, we examine two recent circuit court opinions. First, we highlight the Seventh Circuit's decision in *Loomis v. Exelon*, Nos. 09-4081 and 10-1755, 2011 WL 3890453 (7th Cir. Sept. 6, 2011), and evaluate more closely that circuit's treatment of the issues raised in the 401(k) excessive fees cases, which will likely guide the adjudication of future claims in the Seventh Circuit, and possibly elsewhere.

Second, we discuss the Tenth Circuit's opinion in *Tomlinson v. El Paso Corp*., No. 10-1385, 2011 U.S. App. LEXIS 16525 (10th Cir. Aug. 11, 2011), which addressed important disclosure issues under ERISA Sections 102 and 204(h) that arise when employers convert traditional defined benefit plans to cash balance plans. The Tenth Circuit's opinion also addresses whether, post-*Amara*, a plaintiff asserting an ERISA Section 502(a)(3) claim based on a summary plan description (SPD) disclosure violation must prove that he detrimentally relied upon the defective SPD or that he suffered actual harm caused by the ERISA violation.

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

Déjà Vu – the Seventh Circuit Again Rules in an Excessive Fee Case, Expanding on *Hecker v. Deere*, and Taking a Leading Role in the Field[1]

Contributed by Stacey Cerrone

There has been no shortage of so-called "excessive fee" cases: cases that address breaches of fiduciary duties related to the fees and expenses charged by investment funds in defined contribution plans. In fact, since the fall of 2006, more than 30 class action complaints claiming breaches of fiduciary duties under ERISA related to fees and expenses have been filed.[2] The rulings rendered, both at the district court and circuit level, have diverged, and it is often difficult to determine the extent to which the divergent results are driven by different facts or different views on the applicable legal standards. With the Seventh Circuit's recent decision in *Loomis v. Exelon*, Nos. 09-4081 and 10-1755, 2011 WL 3890453 (7th Cir. Sept. 6, 2011), we have the opportunity to evaluate more closely that Circuit's treatment of the issues and to reach some tentative conclusions as to the overriding principles impacting that Circuit's rulings. Only time will tell whether in light of the dominant role that this Circuit has played – having rendered the majority of Circuit Court decisions on this subject – the law in the Seventh Circuit will become the state of the law elsewhere.

Circuit Court Rulings Prior to Loomis

The *Loomis* decision follows the prior Seventh Circuit ruling in *Hecker v. Deere*, the first of the leading rulings on the subject.[3] In *Hecker*, the Seventh Circuit dismissed claims that defendants breached their fiduciary duties by offering funds that required excessive fees. In so ruling, the Court held that the claim was implausible because the funds at issue totaled 25 out of a total of 2500 funds offered by the plan with fees varying between .07 and 1 percent, the funds at issue were offered to the general public, and nothing in ERISA required the fiduciaries to offer only the cheapest fund options.

Since *Hecker*, other Circuit Courts have addressed excessive fee claims. In *Braden v. Wal-Mart Stores, Inc*., 588 F.3d 585 (8th Cir. 2009), the Eighth Circuit held plaintiffs' allegations of expensive fees were sufficient to state a claim that the process for selecting the funds was flawed and that overpriced funds were selected despite the availability of better options. More recently, the Third Circuit in *Renfro v. Unisys,* No. 10–2447, --- F.3d ----, 2011 WL 3630121 (3d Cir. August 11, 2011), affirmed the district court's dismissal of plaintiffs' class action complaint alleging that Unisys and the 401(k) plan's directed trustee breached their fiduciary duties under ERISA by failing to adequately investigate the investment options offered under the plan and, more specifically, by offering as investment options retail mutual funds whose fees allegedly were excessive in comparison to the fees of other mutual funds. The Third Circuit reasoned that the range of investment options offered by the plan, which included 73 investment choices, was reasonable because the options included a multitude of risk profiles, investment strategies, and associated fees.

The Decision in Loomis

The issues in *Loomis* were similar to those presented in *Hecker*. Exelon sponsored a defined-contribution pension plan (the "Exelon Plan") that allowed participants to choose how their retirement funds would be invested. Out of the 32 options, the Exelon Plan offered 24 "retail" funds -- mutual funds that were also open to the public. The "retail" funds were "no-load" funds. They did not charge investors a fee to buy or sell shares, but covered their expenses by deducting them from the assets under management and had expense ratios ranging from .03% to 96%. The "retail" funds on the low expense side were passively managed and had certain features that discouraged turnover, such as not allowing new investments for a certain period of time after withdrawal. The "retail" funds on the higher expense side were actively managed where the fund's investment advisors buy underpriced securities and sell overvalued securities, and placed no restrictions on turnover. The Plan also had at least 8 options other than the "retail" mutual funds. *Loomis*, at *1.

Plaintiffs' claims were directed exclusively at the 24 "retail" funds. Plaintiffs argued that the Exelon Plan Administrator breached its fiduciary duties by making these funds available because plan participants were offered the same terms and bore the same expenses as the general public, and by requiring the participants to bear the cost of those expenses rather than having the Plan cover the fees. Plaintiffs contended that the Plan should have instead arranged access to "wholesale" or "institutional" investment vehicles and that the Plan should have participated in trusts and investment pools that were not available to the general public. Essentially, plaintiffs argued the participants should not have had any opportunity to invest in "retail" funds.

The Seventh Circuit upheld the district court's dismissal of plaintiffs' claims. In so doing, it explicitly approved giving multiple choices to participants in defined contribution plans, even if the choices include high-priced, actively managed, retail mutual funds. It described as "paternalistic" the plaintiffs' theory that participants should not have a choice of retail funds.

Lessons Learned from Loomis

The decision in *Loomis*, coupled with the Court's prior ruling in *Hecker*, contain several components that should help guide the adjudication of future claims in the Seventh Circuit, and possibly elsewhere.

Institutional Funds Are Not Always Superior

The Court rejected plaintiffs' paternalistic notion that institutional funds are always better. In so ruling, the Court reinforced the ruling in *Hecker,* which had rejected the same argument on the grounds that the costs of publicly available "retail" funds are kept reasonable by the competition of the open market. Expanding on *Hecker,* the *Loomis* Court rejected the argument for institutional funds for the following additional reasons: First, privately held and commingled trusts' assets are hard to value when a participant wants to withdraw the funds and any type of valuation error could hurt other participant investors. Second, privately held trusts and commingled pools lack the benchmarks available for retail mutual funds; therefore, it can be hard to tell whether these types of investments are doing well or whether the fees are excessive in relation to the benefits they provide. Third, the information provided to the Court, including an amicus brief from the Investment Company Institute, demonstrated that it was not the case that retail fund fees were necessarily higher than the fees for institutional funds. Finally, the Court noted that the lack of liquidity was a big drawback to the institutional funds, one that might outweigh the benefit of lower fees. *Loomis*, at *2-4.

The Plan's Asset Base Does Not Necessarily Translate Into Lower Fees

Plaintiffs argued that because the Plan had total assets worth over $1 billion dollars, it could exercise buying power by negotiating lower fees in exchange for a promise to place more money with a given investment manager and also could demand the same retail services for which mutual funds charge their normal expenses. Plaintiffs also contended that Exelon could use its buying power to negotiate an annual flat fee per investor versus the current fees that are a percentage of the assets being managed. *Loomis*, at *4-5.

The Court rejected both of these theories. First, the Court noted that the fact that the Plan had $1 billion to spend did not mean the Plan would obtain lower fees because Exelon could not commit any portion of that sum to any one fund without undermining its guarantee that participants could freely make their investment choices and violating the Plan terms.

The Court also questioned whether a participant would view a flat-fee as an advantage. A flat-fee structure might benefit participants with large balances, but individuals with small investment accounts would end up paying more, per dollar under management, than a fee between .03% and .96%.

Paternalistic Concerns Should Not Prohibit Plan Sponsors From Offering A Choice Of Funds That Includes Higher Cost "Retail" Funds

The Court rejected plaintiffs' arguments that the Plan fiduciaries should have removed the more expensive actively-managed retail mutual funds from the Plan because they were overpriced and because the lower-cost passively managed funds were preferable, and that participants tended to be influenced by advertising that caused them to like the retail funds for "the wrong reasons." The Court found that these paternalistic arguments did not amount to a basis for finding a breach of fiduciary duties. *Loomis*, at *5-7.

In rejecting these arguments, the Court was influenced by the fact that ERISA encourages plan sponsors to give participants choice and control with respect to their investments. In fact, as the Court observed, the safe harbor from fiduciary exposure that ERISA § 404(c) offers to 401(k) plan administrators is expressly conditioned on the availability of multiple investment vehicles for participants to choose from. In light of these strong federal policies, the *Loomis* Court held that ERISA plan fiduciaries do not breach their fiduciary duties by giving participants the ability and responsibility to choose from among a diverse selection of investment options, even if those options include relatively high-priced, actively-managed retail mutual funds. The *Loomis* Court upheld the participant's right to choose under ERISA and refused to rule that the participants' choice should be taken away. *Id.*

Proskauer's Perspective

The ruling in *Loomis*, like the ruling in *Hecker*, appears to be motivated, not merely by a finding that the facts alleged in these cases were insufficient to sustain a claim, but by the Seventh Circuit's disdain for the legal theories that are at the heart of the excessive fee cases. In writing for the three-judge panel of the Seventh Circuit in *Loomis*, Judge Easterbrook summed up the "damned if you do, damned if you don't" philosophy of these types of cases: "Many defined-contribution pension plans offer participants an opportunity to select investments from a portfolio, which often includes mutual funds. In recent years participants in pension plans have contended that the sponsor offers too few funds (not enough choice), too many funds (producing confusion), or too expensive funds (meaning that the funds' ratios of expenses to assets are needlessly high). *See, e.g., Hecker v. Deere & Co.,* 556 F.3d 575, rehearing denied, 569 F.3d 708 (7th Cir. 2009); *Howell v. Motorola, Inc.,* 633 F.3d 552 (7th Cir. 2011); *Spano v. Boeing Co.,* 633 F.3d 574 (7th Cir. 2011); *George v. Kraft Foods Global, Inc.,* 641 F.3d 786 (7th Cir. 2011)."

In summarily rejecting these claims, the Seventh Circuit appears to be recognizing — and preserving — the fundamental distinction that ERISA draws between the operation of defined benefit plans and defined contribution plans. In the former, the fiduciaries or the employer plan sponsor assume responsibility for all decisions about the investments (how much to invest, what asset classes to invest in, whether to use active or passive management, and what manager to hire, etc.), while in the latter, these decisions are left up to the participants, who are empowered to decide whether to invest at all, how much to invest, what asset classes to invest in, and which funds to use. The excessive fee claims threaten to undermine this distinction by shifting responsibility for investment choices back to the plan fiduciaries. The Seventh Circuit's decisions have responded to this threat by affirmatively establishing that in a defined contribution plan that offers a reasonable choice of investments, it is the participants – "the people who have the most interest in the outcome" – who are responsible for the choice of investments.

Tenth Circuit Issues Significant Post-*Amara* Ruling on Disclosure Requirements in Connection with Cash Balance Conversions[4]

Contributed by Bridgit M. DePietto

Just three months after the Supreme Court's decision in *CIGNA Corporation v. Amara*, 131 S. Ct. 1866 (2011), the Tenth Circuit issued an opinion in *Tomlinson v. El Paso Corp.*, No. 10-CV-1385, 2011 U.S. App. LEXIS 16525 (10th Cir. Aug. 11, 2011), which addresses the disclosure issues under ERISA §§ 102 and 204(h), 29 U.S.C. §§ 1022 and 1054(h), that arise when employers convert traditional defined benefit plans to cash balance plans. Importantly, the Tenth Circuit held that ERISA does not require notification of wear-away periods so long as employees are informed and forewarned of plan changes. The Court also held, consistent with *Amara*, that a plaintiff seeking injunctive relief under ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), with respect to a SPD disclosure violation need not prove that he detrimentally relied upon the defective SPD, but instead must show actual harm caused by an ERISA violation.

El Paso's Cash Balance Plan Conversion

Prior to 1996, the El Paso Corporation offered its employees a traditional defined benefit plan. Under that plan, employees received retirement benefits equal to a percentage of their final average monthly earnings multiplied by their years of service. In 1996, El Paso converted the plan into a cash balance plan. Under the new plan, each participating employee received a hypothetical account and earned quarterly pay credits based upon a percentage of the participant's salary, which increased with an employee's age and years of service, and interest credits based upon the yield of a five-year U.S. Treasury Bond.

The new plan provided for a transition period from January 1, 1997, through December 31, 2001. At the beginning of this transition period, El Paso credited employees' cash balance accounts with an amount that was purportedly equivalent to the lump sum value of their accrued benefit payable upon retirement under the old plan. The cash balance account thereafter increased with pay and interest credits. During the transition period, participants also accrued benefits under the terms of the old plan. At the conclusion of the transition period, participants ceased accruing benefits under the old plan formula. However, their cash balance accounts continued to grow.

Upon retirement, participants in the new plan were entitled to choose the greater of the "minimum benefit," defined as the participant's accrued benefit under the old plan at the end of the transition period, or the cash balance account benefit. As it turned out, the minimum benefit was higher than the value of the cash balance account for many participants at the conclusion of the transition period. For some participants, the value of their cash balance account did not exceed the value of their minimum benefit for several years. This period, during which the participant's cash balance account caught up to the minimum benefit under the old plan, is referred to as a "wear-away period." Older employees were more likely to experience wear-away, and their wear-away periods tended to be longer than younger employees' wear-away periods.

Plan Communications

In January 1996, El Paso informed its employees of its decision to convert the traditional defined benefit plan into a cash balance plan, noting that employees would earn future benefits at a lower rate than under the old plan. In another communication issued in the beginning of October 1996, El Paso warned its employees that the new plan was "no longer at the top of the range," that "the hard truth is that those who are not prepared may have to postpone retirement," and that after the transition period "the current pension plan formula will be frozen for [some] participants and they will not earn any additional benefits under the current plan." El Paso issued another communication at the end of October 1996, which summarized the terms of the new plan and described the conversion as "no risk" and advised employees that they "can't lose" under the new plan and their "account can only go up."

In 2002, the plan administrator furnished participants with a Summary Plan Description (SPD), which explained in detail certain provisions of the new plan, including the calculation of benefits, the transition period, and the greater-of formula. Neither the 2002 SPD nor the 1996 communications contained any explicit reference or warning regarding "wear-away periods" described as such. Two of the three plaintiffs failed to read the SPD, and the third consulted the SPD to find certain information.

Procedural History

In December 2004, plaintiffs filed a purported class action complaint asserting four claims: (1) the relatively longer wear-away period for older El Paso employees violated Section 4 of the ADEA, 29 U.S.C. § 623, which, among other things, prohibits employee pension benefit plans from reducing the rate of an employee's benefit accrual because of age; (2) the wear-away periods violated Section 204(b) of ERISA, 29 U.S.C. § 1054(b), which prohibits employers from "backloading" pension benefits by structuring a pension plan in such a way that participants accrue the bulk of their benefits when they approach retirement; (3) El Paso's notice of plan changes violated ERISA § 204(h), which requires the plan administrator to provide written notice of a plan amendment that significantly reduces the rate of future benefit accruals; and (4) the 2002 SPD failed to comply with ERISA § 102, which requires the SPD to be written in a manner "calculated to be understood by the average plan participant," and "sufficiently accurate and comprehensive to reasonably apprise" participants of plan rights and obligations.

On March 19, 2008, the district court granted defendants' motion to dismiss plaintiffs' anti-backloading and notice claims under ERISA §§ 204(b) and 204(h), respectively, for failure to state a claim. On January 21, 2009, the district court granted defendants' motion for summary judgment dismissing plaintiffs' SPD claim on the merits and the ADEA as untimely. Plaintiffs moved to alter or amend the district court's judgment reviving the ADEA claim based on the Lilly Ledbetter Fair Pay Act of 2009, Pub. L. 111-2, which the district court granted. However, on July 26, 2010, the district court dismissed plaintiffs' ADEA claim on the merits. Plaintiffs appealed the dismissal of their claims.

Tenth Circuit Affirms Dismissal of Claims

ADEA Claim. Plaintiffs appealed the dismissal of their ADEA claim, arguing that, even though younger employees received the same pay and interest credits as older employees, older employees were more likely to experience wear-away periods that tended to be longer in duration. El Paso argued that the ADEA is satisfied as long as El Paso treats older and younger employees equally with respect to credits to their cash balance accounts, even if such treatment results in longer wear-away periods for older employees. The Tenth Circuit agreed. Joining every circuit court that has considered the issue, the Court held that a meritorious claim under ADEA § 4(i)[5] or its ERISA counterpart must be based on discriminatory inputs rather than outputs. Here, the Court found that the pay and interest credits were the relevant inputs, which were distributed in a nondiscriminatory manner. Further, the pay credit, which was the only input that varied with age, actually increased as the employee got older. Thus, the Court held that "[a]s long as younger and older employees receive credits to their accounts in a non-discriminatory manner, the plan complies with § 4(i)."

The Court dismissed plaintiffs' argument that it should ignore the pay and interest credits because during the wear-away period participants do not actually earn any inputs under the new plan. The Court stated that a participant will receive the frozen accrued benefit under the old plan only if it is greater than the value of the participant's cash balance account, and it could not hold that an otherwise permissible plan discriminates against older employees merely because the older employees are more likely to qualify for a *greater* benefit. The Court also stated that the transition structure built into the plan did "not render the cash balance credits illusory. Employees in a wear-away period accrue pay and interest credits in their hypothetical accounts; those benefits are simply displaced by a larger benefit available under the old plan."

ERISA Backloading Claim. ERISA § 204(b)(1) prohibits employers from "backloading" pension benefits by structuring plans in such a way that participants accrue the bulk of their benefits when they are close to retirement. A pension plan must satisfy one of three anti-backloading tests in Section 204(b)(1) to comply with ERISA. The Court tested the El Paso plan under the "133 1/3% rule," which mandates that the amount a participant accrues in any given year "is not more than 133 1/3 percent of the annual rate at which he" accrued benefits in the previous year. Plaintiffs argued that the El Paso plan failed to satisfy the 133 1/3% rule because participants in a wear-away period experienced zero accrual during the wear-away but experienced years of positive accrual after the wear-away period ended.

The Tenth Circuit affirmed the lower court's holding that the new plan did not violate Section 204(b) of ERISA, finding that a participant's election of the minimum benefit under the old plan was not relevant to ascertaining whether the new plan satisfied the 133 1/3% rule. Instead, the Court looked only at the new plan formula as if it had been in effect for all years, which it found not to be backloaded. Moreover, the Court observed, to the extent that, during the transition period, participants continued to accrue benefits under the old plan with the higher accrual rate, for purposes of applying the "greater-of" benefit, the benefit accruals were actually frontloaded, not backloaded.

ERISA § 204(h) Claim. Plaintiffs also appealed the district court's finding that El Paso complied with the notice requirements of ERISA § 204(h). In 1997, when the new plan became effective, ERISA provided that a plan "may not be amended so as to provide for a significant reduction in the rate of future benefit accrual, unless, after adoption of the plan amendment and not less than 15 days before the effective date of the plan amendment, the plan administrator provides a written notice, setting forth the plan amendment and its effective date. . . ." As the Court observed, the applicable regulations did not require El Paso to "explain how the individual benefit of each participant . . . will be affected by the amendment," but they did require El Paso to include either the plan amendment or a summary of the plan amendment "written in a manner calculated to be understood by the average plan participant."

Plaintiffs argued that the Court should not consider the communication furnished in early October 1996 because it was circulated before the plan was adopted. The Court disagreed, finding that plaintiffs failed to explain how receiving notice slightly beforehand harmed them, and declined to invalidate the plan "based on such a de minimis technicality" absent a showing of actual harm. The Court also determined that the content of El Paso's October 1996 communications complied with Section 204(h) because: the first communication distributed in October 1996 contained the effective date of the new plan, warned participants that the new plan would be less generous than the old plan, and informed participants that "the current pension plan formula will be frozen for [some] participants and they will not earn any additional benefits under the current plan;" and the second communication issued in October 1996 explained the calculation of benefits and the transition period. The Court found that these two communications together gave employees notice of the wear-away period because they informed participants that: (1) their benefits under the old plan, the minimum benefit, would be frozen, and (2) they would receive the greater of the frozen minimum benefit or the new, more slowly-growing cash balance benefit. The Court also found that the communication issued at the end of October 1996, combined with the January 1996 communication which directly explained the potential downsides of the transition, provided adequate notice under ERISA § 204(h).

ERISA SPD Claim. Finally, plaintiffs argued that because the 2002 SPD failed to include information regarding wear-away periods and benefit reductions, the district court erred in holding that it complied with ERISA Section 102. Defendants contended that: (1) the district court correctly concluded that because plaintiffs never read the SPD, they could not have been injured by any reliance upon allegedly inadequate information contained therein, especially when they received information regarding the plan conversion from other sources, and (2) ERISA § 102 does not require disclosure of wear-away periods and benefit reductions.

Citing *Amara*, the Tenth Circuit held that for the injunctive relief sought, plaintiffs need not "meet the more rigorous standard implicit in the words 'detrimental reliance,'" but instead must show "actual harm" "caused by El Paso's breach of ERISA § 102. . . ." For that reason, the Court did not uphold the district court's first rationale for dismissing the SPD claim. The Court nevertheless concluded that plaintiffs' SPD claim failed for "a more fundamental problem—under our precedent it is clear that wear-aways need not be explicitly disclosed in the SPD." Citing its recent ruling in *Jensen v. Solvay Chemicals, Inc.*, 625 F.3d 641 (10th Cir. 2010), the Court stated that "[a]bsent a finding of deceit on the part of the employer or a failure on the part of the employer to explain how benefits are calculated, we will not invalidate an SPD that neglects to inform employees of a wear-away period." The Court dismissed the plaintiffs' argument that the SPD and surrounding notices were "somewhat confusing," finding that a confusing SPD is not tantamount to a deceitful SPD or one that fails to explain the manner of conversion to cash balance accounts.

Proskauer's Perspective

The Tenth Circuit's ruling reflects a trend among several courts to avoid findings of onerous liability based on expansive or hyper-technical constructions of ERISA's disclosure rules. The Tenth Circuit appeared to be less concerned than other courts which have addressed the issue that participants might have been confused as to the impact of wear-away. In the Tenth Circuit's view, whether or not the plan communications could have been more forthcoming on this issue, the communications did not amount to statutory disclosure violations that would trigger potential invalidation of the amendments or other expansive forms of relief.

The Court's view on the burdens of proof for recovery of relief in the event of a finding of liability is less clear. In reversing the lower court ruling, insofar as it conditioned relief on a showing of detrimental reliance, the Court parroted the Supreme Court's pronouncement in *Amara.* But because, like *Amara*, the Court did not consider what type of showing of "actual harm" would suffice, we are left not knowing whether plaintiffs would ever have been able to satisfy the conditions for relief. The *El Paso* decision thus helps to frame the relief issue for future cases, without purporting to resolve it.

Rulings, Filings, and Settlements of Interest

Disclosure:

- In *Franco v. Connecticut General Life Ins. Co.*, No. 07-cv-6039, 2011 U.S. Dist. LEXIS 109022 (D.N.J. Sept. 23, 2011), plaintiffs, who were plan subscribers, health care providers, and several associations whose members consisted of out-of-network ("ONET") providers who provided ONET services to patients insured by CIGNA, alleged that CIGNA violated its contractual obligations to pay for ONET services at the "usual, customary and reasonable" ("UCR") rate by relying on the flawed database maintained by Ingenix, which generated artificially low UCRs to underpay ONET benefits to CIGNA plan members. Plaintiffs also alleged that the failure to disclose the Ingenix database and/or CIGNA's ONET processing methodology violated ERISA Sections 102, 404, and 503. In granting in part and denying in part motions to dismiss filed by the various defendants, the court concluded, *inter alia*, that the provider plaintiffs failed to establish that they had standing as assignees of their patients' rights because the provider plaintiffs had not sufficiently alleged that the assignments encompassed the patient's legal claim to benefits under the plan (*i.e.*, the limited assignment of a right to receive reimbursement from an insurer vs. a complete assignment of a subscriber's health insurance benefits). The court found the provider plaintiffs' allegations conclusory and determined that the assignment theory was belied by the fact that ONET providers reserved the right to collect their entire actual charges from patients and that the subscriber plaintiffs were also asserting claims to recover for the same injuries. The court also concluded that: (1) Section 102 does not require that a SPD include information about the methodology for determining UCR or for calculating ONET claims; (2) Section 404 does not require disclosure of the data used to determine the UCR or prevailing fee for a service if knowing that the plan obtained its UCR data from Ingenix would not have impacted the participant's ability to make an informed decision about whether to seek treatment from an ONET provider; and (3) Section 503 does not require a plan to explain the ONET processing methodology underlying the claim decision.

Waiver of Spousal Rights:

- In *Burns v. Orthotek, Inc. Employees' Pension Plan & Trust*, --- F.3d ----, No. 10-1521, 2011 WL 4089798 (7th Cir. Sept. 15, 2011), the Seventh Circuit held that a participant, who was also the plan administrator, named fiduciary, and plan representative of the pension plan he created and sponsored for his orthodontics practice, could witness his spouse's written consent to his designation of his sons as beneficiaries of his pension benefits. ERISA provides that a plan participant may elect to waive his spousal-survivor annuity and designate a beneficiary other than his surviving spouse only if the spouse of the participant consents in writing to the designation, the election designates a beneficiary, and the spouse's consent acknowledges the effect of such election and is witnessed by a plan representative or notary. Consistent with these provisions, prior to his death, the participant signed three related plan documents wherein he waived his right to a joint and

survivor annuity and designated his sons as beneficiaries. The participant's wife signed and consented to both the waiver and designation. However, after her husband's death, she filed a claim for benefits asserting, among other things, that her consent was not "witnessed" by a plan representative because her husband signed the form the day before she did. The Seventh Circuit disagreed, concluding that when a plan participant, who is also the plan representative, signs a beneficiary designation form requiring spousal consent, gives the form to his consenting wife, who in turn signs it in multiple places acknowledging her consent and returns it to her husband, the plan was within its discretion to find that the participant, as a plan representative, verified the authenticity of his wife's signature on the written consent form and this satisfied ERISA's witness requirement even though he did not sign the form a second time as a "witness."

Recoupment and Reimbursement:

- In *Bd. of Trustees of Plumbers & Pipefitters Local Union No. 9 Welfare Fund v. Drew*, No. 10-4367, 2011 WL 4152308 (3d Cir. Sept. 16, 2011), the court held that ambiguities in the controlling documents precluded the entry of summary judgment in favor of a plan seeking to enforce its subrogation provision under ERISA Section 502(a)(3). A plan participant was injured in a car accident and the plan paid more than $180,000 in medical expenses on his behalf. Some years later, the participant settled his tort and accident insurance claims for $900,000. The Third Circuit agreed with the plan that it had a right to reimbursement under the plan terms, and that New Jersey's insurance laws limiting subrogation were preempted by ERISA. However, ambiguities in key documents, including the summary plan description and a modified repayment agreement between the fund and the participant, were required to be resolved before a decision could be rendered. Thus, the court remanded for consideration and resolution of these ambiguities.
- In *Int'l Longshore & Warehouse Union-Pacific Maritime Assoc. Welfare Plan Bd. of Trustees v. South Gate Ambulatory Surgery Center, LLC*, No. C 11-01215, 2011 WL 4080054 (N.D. Cal. Sept. 12, 2011), the court held that the fiduciaries of a welfare plan asserted a viable claim for equitable relief under ERISA Section 502(a)(3) to recover monies overpaid or erroneously paid to medical providers as assignees of plan participants. The parties did not dispute plaintiffs' fiduciary status, and the plan contained a provision explicitly authorizing the fiduciaries to collect overpayments due to "error, misrepresentation, or fraud." Citing *Sereboff v. Mid Atl. Med. Servs., Inc.*, 547 U.S. 356 (2006) (holding ERISA Section 502(a)(3) permits only traditional forms of equitable relief, and allowing a plan to enforce its subrogation provision against a participant), the court determined that the complaint asserted a plausible claim for relief because the plan arguably created an equitable lien by agreement over the payments at issue. The court rejected the providers' argument

that the fiduciaries' claims were not equitable, noting that the lack of specifically identifiable funds was not an impediment to recovery because tracing is not required for equitable liens by agreement.

Breach of Fiduciary Duties:

- In *Clark v. Feder, Semo & Bard, P.C.*, --- F. Supp. 2d ----, No. 07-0470, 2011 WL 3912941 (D.D.C. Sept. 7, 2011), the district court held a plan did not violate ERISA's anti-cutback rule by terminating an underfunded cash balance pension plan and paying plaintiff approximately half the present value of the annuity to which she would otherwise have been entitled at normal retirement age. In so ruling, the court noted the plan contained a termination provision providing for the *pro rata* distribution of benefits from available funds, and the plan was not amended to facilitate the termination or reduce distributions. The court also ruled that the plan's distributions to highly compensated individuals, in violation of regulations that could cause the plan to lose its qualified income tax status, could not support a claim for breach of fiduciary duty. On the other hand, the court ruled the plaintiff could pursue breach of fiduciary duty claims based on the plan's actuarial assumptions that allegedly led to the plan's underfunding, and based on the plan's methodology for apportioning the reduced distributions, plus a reporting and disclosure claim based on the SPD's failure to adequately inform participants of the consequences of a plan termination. The court also ruled the plaintiff's claims could proceed under Section 502(a)(1)(B) or 502(a)(3), but not both, and that plaintiff could seek monetary relief as equitable surcharge after the Supreme Court's ruling in *CIGNA Corp. v. Amara*,131 S. Ct. 1866 (2011).
- In *Kujanek v. Houston Poly Bag I, Ltd*., ---F.3d---, No. 10-20664, 2011 WL 4445993 (5th Cir. Sept. 27, 2011), the Fifth Circuit held that a plan administrator breached its fiduciary duty of loyalty when it wrongfully withheld plan documents and instructions needed by a participant to access profit-sharing account benefits. The Court affirmed the district court's award of damages under ERISA Section 502(a)(2) "to restore plan losses," in an amount equal to the loss in value of the account during the time that the administrator had failed to provide the necessary documents and information. The fiduciary breach occurred in connection with a failure to respond to discovery requests in a prior state court suit between the participant and the employer, who was also the plan administrator. Although the state court suit did not involve the employer in its capacity as plan administrator, the court held that the administrator knew or should have known that it needed to distribute plan documents to the participant. ERISA Section 502(c) statutory disclosure penalties were not triggered by the failure to respond to the discovery request, however, because it was not a "written" request under ERISA to the plan administrator. Finally, the Fifth Circuit affirmed the award of attorney's fees to the

participant, concluding that he had obtained a minimum degree of success on the merits, and that the culpability of the employer/plan administrator was substantial.

Benefit Claims:

- In *Frye v. Thompson Steel Co.*, --- F.3d ----, No. 10-1900, 2011 WL 3873769 (7th Cir. Sept. 2, 2011), the Seventh Circuit reaffirmed that trial courts must defer to reasonable plan interpretations by fiduciaries vested with discretionary authority. Frye suffered workplace injuries resulting in workers' compensation settlements of more than $83,000. When Frye retired, he was informed that the settlement payments triggered the plan's pension offset provision, such that pension benefits would be deferred for more than ten years. The trial court held that applying the pension offset was arbitrary and capricious, finding that the plan's terms were ambiguous and that the fiduciaries improperly resolved the ambiguity. Reversing, the Seventh Circuit held that the reconciliation of conflicting plan provisions is precisely the task entrusted to plan administrators vested with discretion, and the decision to offset Frye's pension benefits was reasonably supported by the terms of the plan. Proper application of the abuse of discretion standard thus meant that the fiduciary's interpretation should have been upheld, even if the trial court could have divined a different meaning from its interpretation of the plan.
- In *Daft v. Advest, Inc.*, --- F.3d ----, Nos. 08-3212 & 10-3151, 2011 WL 4430852 (6th Cir. Sept. 23, 2011), the Sixth Circuit held that remand to the plan administrator was required to determine whether a deferred compensation plan was a top-hat plan, and thus exempt from ERISA's vesting requirements, because the administrator failed to apply the proper legal standard, failed to consider certain relevant factors, and the administrative record lacked certain relevant facts. In so ruling, the Sixth Circuit vacated the district court's award of benefits, which hinged on the determination of whether the plan was a top hat plan, and explained that the district court had an "obligation to remand," despite the fact that statutory violations were alleged and the district court found an abuse of discretion. The Sixth Circuit also held that the issue of whether a plan is an employee benefit plan governed by ERISA is a substantive element of an ERISA claim, rather than a jurisdictional issue that could deprive a federal court of subject matter jurisdiction. Thus, by failing to timely raise the issue, defendants had waived it.
- In *Helton v. AT&T, Inc.*, No. 10-0857, 2011 WL 4369054 (E.D. Va. Sept. 16, 2011), the district court awarded retroactive early retirement benefits to a participant based on its determination that the plan administrator abused its discretion in denying the participant's claim for early retirement benefits for failure to timely request them, without meaningfully considering that the participant claimed not to have received notice that early retirement benefits could be available. The court also held that the plan administrator violated ERISA's reporting and disclosure

provisions by failing to distribute the SPD that contained the relevant information about the availability of early retirement benefits to deferred vested participants such as plaintiff. Further, the court held it was a breach of fiduciary duty to inadequately inform the plaintiff, in response to her inquiry, that she could be eligible for early retirement benefits prior to age 65. The court declined to award monetary relief for the breach of fiduciary duty because the participant recovered on her claim for benefits, finding that "double recovery" was not appropriate equitable relief.

Employer Stock Drop:

- In *Kenney v. State Street Corp.*, No. 09-10750, 2011 WL 4344452 (D. Mass. Sept. 15, 2011), the district court held a plaintiff, on behalf of a purported class, could file a second amended complaint to reassert a previously-dismissed breach of fiduciary duty claim alleging it was imprudent to continue to offer company stock as an investment option in the 401(k) plan. The court ruled the amended complaint's claim was plausible because it alleged detailed facts regarding the company's allegedly risky investments, the investments' importance to the company's continued viability, and how and when the fiduciaries should have realized that offering company stock was imprudent. In so ruling, the court refused to apply the *Moench* presumption of prudence at the pleadings stage, noting the First Circuit has not adopted it, and refused to certify the issue for interlocutory appeal. On the other hand, the court held the plaintiff's breach of fiduciary duty claim based on misrepresentations or omissions would fail, and could not be reasserted, because plaintiff did not allege he relied on the misrepresentations, a required element even after the decision *CIGNA Corp. v. Amara*, 131 S. Ct. 1866 (2011).

Affordable Care Act:

- In *Liberty University, Inc. v. Geithner*, 10-2347-cv, 2011 WL 3962915 (4th Cir. Sept. 8, 2011) and *Virginia ex rel. Cuccinelli v Sebelius*, 11-1057-cv, 2011 WL 3925617 (4th Cir. Sept. 8, 2011), the Fourth Circuit avoided deciding the issue of whether the Affordable Care Act's minimum coverage provision, which requires that all applicable individuals maintain minimum essential heath insurance coverage or pay a fine, is constitutional pursuant to Congress's power to regulate interstate commerce. In *Liberty University*, the Court declined to rule on the issue, holding instead that the Act's minimum coverage provision constituted a tax within the meaning of the Anti-Injunction Act, and thus, the Court was barred from adjudicating a pre-enforcement action "seeking to restrain the assessment of a tax." In *Cuccinelli*, the Court ruled that the Commonwealth of Virginia did not have standing to sue because its basis for standing, namely that the minimum coverage provision conflicted with its state law, was without merit and did not give rise to a

cognizable injury. On October 4, 2011, the Attorney General of Virginia filed a petition of certiorari asking the United States Supreme Court to review the Fourth Circuit's ruling with respect to both the standing issue and the merits of the case. So, while the Fourth Circuit may have sidestepped ruling on the constitutionality of the minimum coverage provision for now, the issue may eventually be heard by the United States Supreme Court because in addition to the petition for certiorari filed in this case, other petitions have also been filed in similar cases, including one by the plaintiffs in the case before the Sixth Circuit Court of Appeals and the other by the government in the case before the Eleventh Circuit Court of Appeals. For a more detailed discussion of this case and related cases currently before other Appellate Courts, please see our June, July, and August editions of the *Newsletter.*

New York's Anti-Subrogation Law:

- In *HealthNow New York, Inc. v. New York*, 10-4094-cv, 2011 WL 4014303 (2d Cir. Sept. 15, 2011), the Second Circuit ruled that HealthNow did not have standing to sue the Attorney General of New York in a suit seeking a declaration that the State's Anti-Subrogation law, which prevents benefit providers from recovering medical expenses paid to personal injury plaintiffs who have received settlements or awards, is invalid. The Court held that HealthNow lacked standing because: (i) it could not demonstrate that its injury, *i.e.,* its inability to be reimbursed for medical expenses paid due to the Anti-Subrogation Act, was caused by any action of the Attorney General; and (ii) the Attorney General had not threatened any action against HealthNow to prevent it from pursuing recovery of medical expenses paid.

Section 510 Claim:

- In *Jenkins v. The Union Labor Life Ins. Co. ("ULLICO")*, 10-cv-7361, 2011 WL 3919501 (E.D. Pa. Sept. 7, 2011), the court ruled that participants of ULLICO's defined benefit plan (the "Plan") could proceed with their ERISA claim against their former employer, ULLICO, which was still responsible for paying benefits under the Plan, because plaintiffs were able to demonstrate through the use of circumstantial evidence that plaintiffs' current employer, Amalgamated Life Insurance Company, terminated their employment to avoid paying benefits three months before their benefits were to become vested. The court ruled that because ULLICO and Amalgamated misled participants about vesting requirements and Amalgamated terminated all former ULLICO employees on the same day, the court could "plausibly infer that Amalgamated acted with specific intent to terminate plaintiffs in order to prevent them from vesting in the defined benefit plan in violation" of ERISA. Notably, the court dismissed plaintiffs' claim for benefits under Section 501(a)(1)(B) of ERISA, holding that they were required to exhaust administrative remedies because this was not a claim solely to enforce statutory rights under

ERISA, but instead sought an award of benefits from the plan.

ERISA Plan:

- In *Boos v. AT&T Inc.*, 643 F.3d 127 (5th Cir. 2011), *petition for cert. filed*, 80 U.S.L.W. 3133 (U.S. Sept. 1, 2011) (Nos. 11-288, 11A166), plaintiffs filed a petition for writ of certiorari asking the Supreme Court to review the issue of whether the Fifth Circuit Court of Appeals improperly created its own test of determining whether a plan is covered by ERISA by ruling that because the plan's "primary thrust" was something other than to provide income to retirees, the plan was not covered by ERISA. The plaintiffs argued that ERISA provides that any plan that provides retirement income is an ERISA plan, and thus the plan at issue, which did provide some retirement income to its participants, should be covered by ERISA. For a more detailed description of the Circuit Court's ruling, *see* the July edition of the *Newsletter*.

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[2] *See, e.g George v. Kraft Foods Global, Inc.*, 684 F. Supp. 2d 992 (S.D. Ill. Jan. 27, 2010), *transferred to* N.D. Ill., No. 07-CV-1954, *costs & fees proceeding at* 2010 U.S. Dist. LEXIS 47850 (N.D. Ill. May 14, 2010); *Martin v. Caterpillar,Inc.*, 2010 WL 55691 (C.D. Ill. Jan. 5, 2010); *Tibble v. Edison Int'l*, 639 F. Supp. 2d 1122 (C.D. Cal. 2009); *Loomis v. Exelon Corp.*, 2009 U.S. Dist. LEXIS 114626 (N.D. Ill. Dec. 9, 2009); *Will v. General Dynamics Corp. Hourly Sav. & Stock Inv. Plan*, 2009 U.S. Dist. LEXIS 105987 (S.D. Ill. Nov. 14, 2009); *Abbott v. Lockheed Martin Corp.*, 2009 U.S. Dist. LEXIS 26878 (S.D. Ill. Mar. 31, 2009); *Taylor v. United Techs. Corp.*, 2009 U.S. Dist. LEXIS 19059 (D. Conn. Mar. 3, 2009), *aff'd*, 354 F. App'x. 525 (2d Cir. Dec. 1, 2009); *Kanawi v. Bechtel Corp.*, 590 F. Supp. 2d 1213 (N.D.Cal. 2008); *Beesley v. International Paper Co.*, 2008 U.S. Dist. LEXIS 75788 (S.D. Ill. Sept. 30, 2008); *Spano v. Boeing Co.,* 2007 U.S. Dist. LEXIS 91896 (S.D. Ill. Dec. 14, 2007); *Hecker v. Deere & Co.*, 2007 U.S. Dist. LEXIS 78959 (W.D. Wis. Oct. 19, 2007); *Boeckman v. A.G. Edwards, Inc.*, 2007 U.S. Dist. LEXIS 90251 (S.D. Ill. Aug. 31, 2007); *Kennedy v. ABB, Inc.*, 2007 U.S. Dist. LEXIS 5868 (W.D. Mo. Aug. 10, 2007).

[3] 556 F.3d 575, *reh'g denied*, 569 F.3d 708 (7th Cir. 2009). Other Seventh Circuit rulings include *Spano v. Boeing Co.*, 633 F.3d 574 (7th Cir. 2011) and *Beesley v. International Paper*, 633 F.3d 574 (7th Cir. 2011) (consolidated cases that addressed class certification issues in fee cases).

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[5] The Court held that because plaintiffs' ADEA claim was based on allegedly discriminatory wear-away periods, which plaintiffs defined as "cessation of an employee's benefit accrual," it fit comfortably within the term "benefit accrual," which in common usage refers to the increase in benefits over a given period of time, and therefore should be decided under Section 4(i) of the ADEA rather than Section 4(a). The Court also found that compliance with Section 4(i) of the ADEA with respect to a pension plan shall constitute compliance with Section 4(a) of the ADEA.

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