Proskauer

The ERISA Litigation Newsletter

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Editor's Overview

This month, we examine the requirements of the equitable surcharge remedy, recently recognized by the Supreme Court in *CIGNA v. Amara* as an appropriate vehicle for the recovery of monetary relief for breach of fiduciary duty. We also review the decision in *Bacon v. Stiefel Laboratories*, denying class certification because recovery depended on an individualized showing of reliance. The Florida district court's decision in *Stiefel* provides a roadmap for defending against class claims.

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

"Surcharge" as Monetary Relief after *Amara*[1]

Contributed by Myron Rumeld and Kara L. Lincoln

In *CIGNA Corporation v. Amara*, 131 S. Ct. 1866 (U.S. 2011), the Supreme Court held that ERISA plaintiffs who seek anything other than benefits pursuant to the governing plan document cannot assert their claims under ERISA Section 502(a)(1)(B). The Court held that claims seeking individual relief for breach of fiduciary duty or other ERISA violations must be brought under ERISA Section 502(a)(3). The Court reaffirmed that the only relief available under Section 502(a)(3) is "appropriate equitable relief" that was "typically available in equity," but indicated that such relief could include monetary relief if the elements of a claim for such relief were satisfied. One vehicle for recovering monetary relief identified by the Court was a claim for equitable "surcharge" to remedy a fiduciary's breach of duty.[2]

The Supreme Court's approval of monetary relief for breaches of fiduciary duties and other statutory violations has been viewed as a victory by the ERISA plaintiffs' bar because, until now, there was considerable doubt as to whether such relief was available. The practical extent of that "victory" remains to be seen, however, given the stringent requirements for recovery under a theory of equitable surcharge.

In *Amara,* the Supreme Court stated that, to recover under a theory of equitable surcharge, plaintiffs must establish actual harm and causation as required under trust law. Additionally, plaintiffs seeking surcharge would presumably have to satisfy the requirement previously imposed by the Court for Section 502(a)(3) recovery – that such relief is not available under the plan terms or under one of the other available causes of action under ERISA.

Although the Court did not provide much guidance as to the circumstances in which the conditions for surcharge would be satisfied in the ERISA context, it directed us to traditional theories of equity for guidance. Accordingly, we examine below what traditional trust law may teach us about the scope of surcharge relief under ERISA. Although we will know little for certain until the courts interpret and apply *Amara*, a review of applicable trust law principles suggests that the door to monetary relief that was cracked opened in *Amara* may not be as wide as plaintiffs think.

Limitations on Surcharge in Traditional Courts of Equity

According to the authorities cited by the Supreme Court in *Amara*, it appears that surcharge was "typically available in equity" *only* from a trustee. In fact, liability was imposed personally on the breaching trustee; recovery was never obtained from the trust.[3] Furthermore, surcharge was available *only* to compensate for the loss of trust benefits (or to disgorge profits) that resulted from a trustee's breach of duty. For example, the forthcoming Restatement (Third) of Trusts provides that the trustee whose "breach of trust causes a loss" may be "surcharged" for "the amount of any profit made" or the lost trust benefits, *i.e.*, "the amount required to restore the values of the trust estate and trust distributions to what they would have been if the portion of the trust affected by the breach had been properly administered."[4]

ERISA Surcharge Potentially Limited to Recovery from Breaching Fiduciaries

In light of the first condition cited above, it would appear that, in ERISA lawsuits, surcharge would not be available in circumstances where relief is sought from the plan, rather than the plan's fiduciaries. The SupremeCourt in *Amara* appears to have explicitly embraced this limitation. First, the Court limited recovery from the plan under Section 502(a)(1)(B) to claims based on the terms of the plan document, thus precluding any recovery against the plan for compensatory relief such as surcharge. Second, the Court distinguished *Mertens v. Hewitt Associates*, 508 U.S. 248 (1993), which held that monetary relief is not available from non-fiduciaries, and noted that the fiduciary status of the *Amara* defendant "makes a critical difference." The Court's distinction was consistent with the position of the Department of Labor, which has long maintained that monetary relief should be available from ERISA fiduciaries, even if not available from non-fiduciaries, because it was available from trustees under equitable trust law.[5]

ERISA Surcharge Potentially Limited to "Actual Harm" Resulting from an ERISA Violation

In light of the second condition identified above, it appears that surcharge would not be available to compensate for any harm other than a loss of benefits that would have been available if the breach had not occurred. The Supreme Court in *Amara* appears to have specifically embraced this limitation in that the Court stated that ERISA plaintiffs seeking surcharge must show "actual harm" and causation. A trust law treatise cited by the Supreme Court in *Amara* provides that surcharge is not available for a trustee's breach "that results in no loss to the trust estate," and, where the loss would have occurred even absent the breach, the trustee is not generally liable.[6] For example, in *Day v. Avery*, 548 F.2d 1018 (D.C. Cir. 1976), the court concluded that surcharge was not available to remedy a fiduciary's failure to inform of a merger, since the court found the merger would have occurred anyway and the failure to inform caused no loss.

As we recently noted in Bloomberg Law Reports, *CIGNA Corp. v. Amara: Changing the Landscape of ERISA Litigation* (published June 6, 2011), the Supreme Court provided mixed messages as to the circumstances in which surcharge would be an appropriate remedy in the context of statutory claims arising from improper plan communications. The Court in fact acknowledged that "it is far from clear what evidence would sustain a showing of actual harm." The Court noted "[t]hat actual harm may sometimes consist of detrimental reliance, but it might also come from the loss of a right protected by ERISA or its trust-law antecedents." The Court opined that the *Amara* plaintiffs could have been harmed by the faulty plan-wide communications even if they did not read them or act in reliance on them because they might have expected to learn about the plan conversion from other employees or through other informal means. The Court did not specifically state that plaintiffs must show a loss of plan benefits to justify surcharge to represent those benefits, only that the violation caused injury. But, in light of traditional trust law, it is unclear how harm other than a loss of benefits due to the breach could entitle plaintiffs to surcharge. This concern appears to be reflected in Justice Scalia's concurrence in *Amara*, in which he noted that a remedy for the harm shown, "stemming from reliance on the SPD or the lost opportunity to contest or react to the switch," would be "far different" from the remedy of additional benefits that was awarded by the district court.

Thus, plaintiffs seeking to recover additional plan benefits via a surcharge claim may be required to show they lost those plan benefits due to the ERISA violation. In other words, for surcharge to replace plan benefits otherwise unavailable, the participant may be required to show that the benefits would have been available under the plan if the ERISA violation had not occurred. In some situations, plan benefits would obviously have been available absent the violation. For example, where, in violation of ERISA, participants are wrongfully removed or never enrolled in a plan, and they otherwise qualify for plan benefits, it is clear they would have received the benefits but for the wrongful removal or lack of enrollment.[7]

In other situations, however, it is not apparent that the fiduciary's breach caused a loss of plan benefits. For example, in *Amara,* the plaintiffs claimed that they were inadequately informed of the plan conversion and lost the opportunity to contest it. The plan conversion occurred anyway, and the participants received the benefits to which they were entitled under the written plan terms. Did they "lose" plan benefits due to the inadequate information? It seems they did not; rather, they became entitled to additional benefits only because the district court awarded to them the benefits to which the participants believed they were entitled.[8] Similar situations arise when ERISA plan participants are inadequately informed of eligibility requirements, but could not meet those requirements even if properly informed.[9] The participants may have been harmed, but it is not evident that the harm caused a loss of plan benefits, as opposed to some other form of incidental harm. In such cases, plaintiffs could conceivably seek to recover monetary relief via one of the other equitable remedies identified by the Supreme Court – estoppel or reformation – but one could logically challenge their entitlement to relief under a claim of equitable surcharge.

On a related note, it is unlikely that surcharge under ERISA could encompass damages that are punitive or extracontractual, *i.e.*, not representative of benefits potentially available from the plan, since surcharge is limited under trust law to the value of lost trust benefits (or the trustee's profits). The Court in *Amara* did not purport to abrogate its prior statement in *Massachusetts Mutual Life Insurance Company v. Russell*, 473 U.S. 134 (1985), that neither extracontractual nor punitive damages are available under ERISA.

ERISA Surcharge Potentially Deemed Not "Appropriate" Where Benefits Are Otherwise Recoverable

Additionally, it seems that surcharge, like any equitable remedy, would not be considered "appropriate" relief under ERISA Section 502(a)(3) if a plaintiff is seeking benefits available under the original plan terms pursuant to Section 502(a)(1)(B). In *Amara*, the Court endorsed *Varity*'s pronouncement that "where Congress elsewhere provided adequate relief for a beneficiary's injury [as under Section 502(a)(1)(B)], . . . further equitable relief [under Section 502(a)(3)] . . . would not be 'appropriate.'" The *Amara* plaintiffs could seek relief under Section 502(a)(3) only because they had no cognizable claim under the more specific Section 502(a)(1)(B).

Since the Court's decision in *Amara*, one district court held that surcharge was not "appropriate equitable relief" under Section 502(a)(3) where the plaintiff alternatively sought plan benefits under ERISA Section 502(a)(1)(B). In *Biglands v. Raytheon Employee Savings & Investment Plan*, No. 10-351, 2011 WL 2709893 (N.D. Ind. July 12, 2011),[10] the executor of a deceased plan participant's estate sought retirement benefits she claimed should be paid to the estate, alleging the failure to pay them while searching for the participant's beneficiary was a breach of fiduciary duty. The court distinguished *Varity* and *Amara*, where benefits were not available under the plan terms, and dismissed the plaintiff's Section 502(a)(3) claim because her loss of plan benefits could be remedied under Section 502(a)(1)(B).

Proskauer's Perspective

There is no denying that the Supreme Court intended to make a significant pronouncement when stating that monetary relief may be available under Section 502(a)(3). A close review of the trust law principles on which the Court's ruling is founded, however, provides a substantial basis for questioning how widespread the practical impact of the ruling will be. The availability of monetary relief may be substantially curtailed if, based on a faithful reading of trust law principles and the language of Section 502(a)(3), such relief is available only: against breaching plan fiduciaries, rather than the plan itself; upon a showing of actual harm and causation, particularly if harm is limited to the loss of benefits rather than some form of collateral harm; and where benefits are not available under the terms of the plan. In short, while *Amara* will certainly be viewed as a watershed decision for ERISA practitioners, its impact on the availability of monetary relief against breaching plan fiduciaries remains uncertain.

Bacon v. Stiefel Laboratories: **Court Denies Class Certification of ERISA Claims Based on Finding that Individual Reliance Must be Proved[11]**

Contributed by Anthony S. Cacace

In *Bacon v. Stiefel Laboratories*, No. 09-cv-21871, 2011 WL 2973677 (S.D. Fla. July 21, 2011),[12] a federal district court denied plaintiffs' motion for class certification in a lawsuit alleging that plan fiduciaries and the corporate plan sponsor breached their fiduciary duties under ERISA and federal securities laws by, among other things, allegedly engaging in a fraudulent scheme to convince plaintiffs to sell their shares in the company to defendants in advance of a merger that would yield large profits for shareholders. In a thoroughly reasoned opinion, the court analyzed why certification of the putative class was not warranted, holding that "for a case largely predicated on alleged fraud, class treatment is inappropriate in the context of investment decisions [made] in reliance upon that fraud."

This case is a useful tool for ERISA defense practitioners because it provides a roadmap for defending against class certification motions in cases where the participant claims are deemed to require a showing of individual reliance. The case also illustrates the essential relationship between the adjudication of class certification motions in ERISA cases and the underlying determination of the substantive elements of the claims for which certification is sought.

The Court's Decision

Factual Background

Defendant Stiefel Laboratories (Stiefel Labs), the largest privately-held dermatological products manufacturer in the world, was a closely held corporation owned by the Stiefel family. In 1975, Stiefel Labs established an Employee Stock Ownership Plan (ESOP), under which Stiefel Labs made annual contributions of common stock. Effective January 1, 2009, in an effort to become "current with industry practices," the ESOP was combined with the company's 401(k) plan. Under the newly-created plan (the "Plan"), an "optional diversification program" was created pursuant to which employees of Stiefel Labs were able to diversify their holdings and vested participants of the plan were permitted to obtain distributions of their shares of Stiefel Labs' stock. At the time of the Plan restructuring, the value of each share of Stiefel Labs' stock was determined to be $16,469, based on a valuation performed on March 31, 2008, by an external consulting firm.

After recapturing many of the Stiefel Labs' shares that were previously held in the Plan, Stiefel Labs notified its shareholders of a merger with GlaxoSmithKline in April of 2009. GlaxoSmithKline purchased Stiefel Labs at a price of $65,515.29 for each share of common or preferred stock, significantly more than the price that participants received for the shares of stock that they had earlier liquidated.

The Alleged Breach of Fiduciary Duty

Plaintiffs, a putative class of former Plan participants, claimed that defendants Stiefel Labs, Plan fiduciaries, and others breached their fiduciary duties under ERISA and violated federal securities laws by making several misstatements and omissions as part of "a pervasive and fraudulent pattern of behavior by Defendants, which was allegedly designed to prevent Plan participants from realizing the value of their shares in the privately-held company." Specifically, plaintiffs contended that the Plan fiduciaries failed to provide an accurate appraisal of Stiefel Labs' value and stock price because they did not retain an independent appraiser as required by ERISA. Plaintiffs alleged that the appraisal procured by the Plan fiduciaries "grossly undervalued" the participants' accounts. In support of this allegation, plaintiffs cited other valuations of Stiefel Labs performed by reputable investment firms in connection with a potential sale of the company, in which the company was valued at a significantly higher amount. The Plan Trustees, including Charles Stiefel (a Stiefel family member and officer of the company), allegedly never notified the Plan participants of these valuations.

Plaintiffs also alleged that the defendants attempted to recapture shares from the Plan at a discounted price by: (i) offering participants the "optional diversification" program, thus enabling participants to sell their shares in Stiefel Labs back to the company; (ii) enacting a reduction in force, which resulted in many terminated employees putting their shares to Stiefel Labs; and (iii) compensating the participants who diversified or took distributions of company stock at the per-share-value calculated by Stiefel Labs' so-called "independent appraiser," rather than at fair market value. Plaintiffs alleged that, once defendants controlled an increased number of shares of the company, they merged Stiefel Labs into GlaxoSmithKline in exchange for a stock price that was significantly higher than the price defendants paid for the shares that were sold back to the company by Plan participants. According to plaintiffs' complaint, these actions by defendants constituted a "fraudulent cover-up by Defendants that was created to mask the individual motives of the Board and certain individuals in maximizing the value of their own holdings in the company."

Class Certification Denied

The proposed class representatives were all employed by Stiefel Labs at one time and were participants in the Plan. Each of the proposed class representatives put their shares back to Stiefel Labs as a result of the Plan's restructuring prior to the merger. They purported to bring their suit on behalf of "[a]ll *vested participants* in the Stiefel Laboratories, Inc. Employee Stock Ownership Plan who sold their shares or directed that the shares in their account in the Employee Plan be sold to Stiefel Laboratories, Inc." during the applicable time period.

In adjudicating plaintiffs' motion for class certification, the Court thoroughly examined whether the putative class satisfied the four criteria of Fed. R. Civ. P. 23(a), namely: numerosity, commonality, typicality, and adequacy of representation. With respect to those criteria, the court ruled as follows:

- ???The Court determined that the class satisfied the numerosity prerequisite of Rule 23(a)(1), requiring that "the class is so numerous that joinder of all members is impracticable," because plaintiffs' proposed number of class members "easily exceed[ed] the minimum threshold recognized by the Eleventh Circuit. . . . [and] joinder of the proposed class members would be impractical, given the number of class members and their geographic distribution."

- The Court held that the commonality prerequisite, requiring that there be at least one issue common to all members of the class and that any class certification be predicated on "questions of law or fact common to the class," was also met because plaintiffs satisfied the "minimal threshold" of having at least a "single common question" upon which class certification could be granted, *i.e.*, whether defendants breached their fiduciary duty to Plan participants by failing to hire an independent appraiser to properly value the company's stock price and failing to disclose to participants that other valuations performed had estimated the company's value as much greater than what was communicated to participants.
- The third factor under Rule 23(a)(3), mandating that "the claims or defenses of the representative parties [be] typical of the claims or defenses of the class," was also deemed satisfied. The Court accepted plaintiffs' broad statement that class representatives suffered from the same harms as did the proposed class members because "Defendants' scheme to undervalue the shares of Plaintiffs … makes the representatives' claims identical to those of the proposed class members … [and] claims do not vary across classes because, regardless of when the shares were sold, a fractional value of their worth was obtained."
- The fourth factor under Rule 23(a)(4), requiring that the "the representative parties will fairly and adequately protect the interests of the class," was not ruled on by the Court. The Court decided that defendants' argument that class counsel was conflicted because his firm represented others in individual suits against similar defendants on substantially the same grounds was not yet fully developed. Accordingly, the Court declined to rule on the issue in light of the Court's holding with respect to Rule 23(b) (discussed below).

In addition to satisfying the requirements of Rule 23(a), plaintiffs needed to prove that there are one or more grounds for maintaining the lawsuit as a class action under Rule 23(b). Plaintiffs in this case sought class certification under Rule 23(b)(3), under which there must be a showing made by plaintiffs of: (i) predominance of the questions of law or fact common to the members of the class over any questions affecting only individual members; and (ii) superiority of the class action device for the fair and efficient adjudication of the controversy. The rule also delineates four specific areas of inquiry relevant to both predominance and superiority: i) class members' interest in individually controlling the prosecution or defense of separate actions; ii) the extent and nature of any litigation concerning the controversy already begun by or against class members; iii) the desirability or undesirability of concentrating the litigation of the claims in a particular forum; and iv) the likely difficulties in managing a class action.

As the Court acknowledged, the inquiry into predominance "tests whether proposed classes are sufficiently cohesive to warrant adjudication by representation … and [w]hen common questions present a significant aspect of the case and they can be resolved for all members of the class in a single adjudication, there is clear justification for handling the dispute on a representative rather than on an individual basis." Defendants dedicated much of their opposition brief to the predominance issue, claiming that the plaintiffs sought "to lump together incongruous claims and issues in the same classes." Plaintiffs argued that there were several common questions of law and fact that predominated over any individual questions of law or fact, including, among others, whether defendants "caused, or took advantage of, the merger or amendment of the Employee Plan for the purpose of obtaining for their benefit the value of the Company Stock held by the Employee Plan participants upon the sale of the Company."

The Court ultimately determined that "one of the greatest barriers to satisfying the predominance standard, and thus for class certification, is the issue of reliance. Reliance is a required element of Plaintiffs' claims …. Therefore, a central question for this Court to address is whether class certification is appropriate where, as here, proof of individual reliance may be necessary."

Plaintiffs argued that the determination of reliance need not require individual inquiry. Based on theories advanced in securities law claims, plaintiffs contended that the court could presume reliance in the instances of omission and the existence of a "common scheme or plan." The Court explored the merits of plaintiffs' arguments and ultimately found them unconvincing.[13] The Court ruled that Rule 23(b)(3) "is unequivocal: any class action certified thereunder must be capable of resolution on a class-wide basis…[and] [n]otwithstanding Plaintiffs' allegations of a 'common scheme' here, the Court finds that individual issues predominate over those of the class." The Court opined:

> Plaintiffs argue that Defendants' misrepresentations and omissions have been uniform. However, Plaintiffs' subsequent actions in reliance upon those misrepresentations cannot be similarly uniform across the proposed classes. At the heart of their claims, Plaintiffs seek recovery for damages suffered after individual decisions to put shares to Stiefel Laboratories, even though individual determinations made in reliance upon Defendants' omissions and misrepresentations likely varied with each individual's needs. Plaintiffs ignore this hurdle, asking the Court to presume reliance on Defendants' omissions and misrepresentations as the basis for each of the Plaintiffs' individual determinations to retain or to put shares to Stiefel Laboratories. "This, in effect, places on the defendants the burden of proving plaintiff's nonreliance, that is, proving that the plaintiffs' decision would not have been affected even if defendants had disclosed the omitted facts" (citations omitted).

The Court also found that questions of reliance, investment strategy, and damages necessitate individual inquiry and "[s]imply put, for a case largely predicated on alleged fraud, class treatment is inappropriate in the context of investment decisions [made] in reliance upon that fraud." Accordingly, the Court ruled that the putative class claims did not predominate over the areas of individual inquiry.

With respect to superiority, the Court held that plaintiffs would be better served by controlling their own personal litigation, as opposed to participating in a class, because in cases where there are allegations of fraud, individual showings of proof are appropriate. The court stated: "[r]equiring each individual Plaintiff to detail any relevant omissions and misrepresentations pertinent to them alone—as well as the resulting decision as to whether to put the Stiefel Laboratories' shares to the company—will result in more desirable individualized treatment." Additionally, the Court observed that individualized treatment will not prevent plaintiffs from pursuing their claims for substantial monetary damages.

Proskauer's Perspective

One of the most effective ways to minimize the exposure in complex ERISA litigation is by defeating class certification. This Court's decision illustrates one means for mounting an effective attack on the class: demonstrating that recovery depends on an individualized showing of reliance that causes the claim not to satisfy one or more of the Rule 23 requirements. The Court in this case accommodated this strategy by holding that, even though the alleged material omissions or misstatements took place on a plan-wide basis, reliance upon those omissions or misstatements by individuals will not be presumed, and thus that individualized showings of reliance would be required.

The Court's ruling appears to be consistent with the principles recently enunciated by the Supreme Court in *Wal-mart Stores, Inc. v. Dukes*, 131 S. Ct. 2541 (2011), wherein the Supreme Court emphasized the need for class claims to be cohesive, and, therefore, that the need for individualized evaluations of claims can defeat class certification.

Whether rulings like this one will have widespread applicability will depend largely on whether the Court's views on the substantive requirements for misrepresentation claims are endorsed in other jurisdictions and in other contexts. For many claims brought under ERISA, there is still a lack of clarity as to the participant's burden of proof with respect to causation and harm. Under those circumstances where participants are required to make individualized showings of reliance – or at least some showing of individualized harm – as a condition for prevailing, the chances of defeating class certification will be substantially enhanced.

Rulings, Filings, and Settlements of Interest

Affordable Care Act:

In *Florida v. United States Dep't of Health and Human Servs.*, 11-11021-cv, 2011 WL 3519178 (11th Cir. Aug. 12, 2011), the Eleventh Circuit affirmed in part and reversed in part the district court's ruling that the Affordable Care Act was unconstitutional. The district court had found that the Act's minimum coverage provision, which requires that all applicable individuals maintain minimum essential heath insurance coverage or pay a fine, was unconstitutional as it exceeded the parameters of Congress' authority under the Commerce Clause. It also ruled that the entire Act was unconstitutional because it did not contain a severability clause, which would have saved at least the portions of the Act that were not deemed unconstitutional. The Eleventh Circuit upheld the lower court's ruling with respect to the unconstitutionality of the minimum coverage provision, reasoning that for the federal government to require citizens to purchase health insurance coverage from private insurance companies for the entirety of their lives is to grant authority that "lacks cognizable limits" and "imperils our federalist structure." However, the Eleventh Circuit overruled the district court's decision to invalidate the entire Act on the grounds that the Act lacked a severability clause. The Circuit Court reasoned that courts in general should attempt to save acts of Congress by "severing any constitutionally infirm provisions while leaving the remainder intact" in an effort to avoid frustrating the will of the elected representatives of the citizens.

In *Baldwin v. Sebelius*, 10-56374-cv, 2011 WL 3524287 (9th Cir. Aug. 12, 2011), the Ninth Circuit affirmed the district court's decision dismissing a lawsuit challenging the constitutionality of the Affordable Care Act's minimum coverage provisions on the ground that plaintiffs, a former California assemblyman and the Pacific Justice Institute, lacked constitutional standing. Defendants, several federal agencies, argued that plaintiffs lacked standing because they failed to assert an "injury in fact." The Ninth Circuit held that the assemblyman failed to show an injury in fact because he did not allege that he currently was without qualifying health insurance, thus making him "non-compliant" when the Act would take effect. The court also ruled that the Institute did not have standing because the challenged provision does not apply to employers.

In *New Jersey Physicians, Inc. v. President of the U.S.*, 10-4600-cv, 2011 WL 3366340 (3d Cir. Aug. 3, 2011), the Third Circuit affirmed the district court's decision dismissing plaintiffs' challenge to the constitutionality of the minimum coverage provision of the Affordable Care Act on the grounds that plaintiffs lacked constitutional standing because they failed to establish an actual, future, or imminent "concrete and particularized injury." The Third Circuit concluded that plaintiffs – a doctor, his patient, and a nonprofit corporation – lacked standing because their complaint did not allege: (i) "a 'realistic danger' that [they] would be harmed by the individual mandate;" or (ii) that they would be impacted by the employer responsibility provision, which requires large employers to offer full-time employees the opportunity to enroll in employer-sponsored insurance plans.

Fees Litigation:

In *Renfro v. Unisys Corp.*, 10-2447-cv, 2011 WL 3630121 (3d Cir. Aug. 19, 2011), the Third Circuit affirmed the district court's decision granting defendants' motion to dismiss 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. Additionally, the court ruled that the plan's directed trustee was not a fiduciary with respect to the selection of investment options under the plan pursuant to the applicable trust agreement.

Cash Balance Plan Conversions:

In *Tomlinson v. El Paso Corp.*, --- F.3d ----, 2011 WL 3506091 (10th Cir. Aug. 11, 2011), the Tenth Circuit affirmed the dismissal of a putative class action challenging El Paso's 1997 conversion of its traditional defined benefit plan to a cash balance plan under ERISA and the ADEA. First, the court affirmed the lower court's finding that the new plan complied with the ADEA because the inputs were the same for all participants regardless of age, even though the result, or output, was that older workers were more likely to experience wear-away periods that tended to be longer in duration than that of younger workers. Second, the court affirmed the ruling that the new plan complied with ERISA's anti-backloading provision by satisfying the "133 1/3 percent test." In so ruling, the court determined that the test is properly applied by looking at the cash balance plan as if it had been in effect for all years, rather than comparing the accrued benefit under both the old and new plans. Third, the court found that El Paso's participant communications regarding the plan's conversion provided adequate notice, for purposes of satisfying ERISA § 204(h) 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. Fourth, the court affirmed the lower court's finding that the SPD did not violate ERISA § 102 for failing to disclose wear-away, even though it and the other notices were "somewhat confusing," because there was no evidence the SPD was "deceitful" or failed to explain the "manner of conversion to cash balance accounts." In so ruling, the court held that "ERISA does not require notification of wear-away periods so long as employees are informed and forewarned of plan changes." This case will be the topic of a feature article to appear in the October issue of the *Newsletter*.

Breach of Fiduciary Duty:

In *Faber v. Metropolitan Life Insurance Co.*, --- F.3d ---, No. 09-4901-cv, 2011 WL 3375530 (2d Cir. Aug. 5, 2011), the Second Circuit affirmed a district court's dismissal of a putative class action alleging that MetLife, as a welfare plan claims administrator, did not breach its fiduciary duties under ERISA by profiting from life insurance benefits held in retained asset accounts, or "checkbook" accounts. The court concluded that when MetLife established the retained asset accounts for life insurance proceeds in accordance with plan terms, it discharged its fiduciary obligations as a claims administrator and ceased being an ERISA fiduciary. Thus, MetLife was not acting as a fiduciary, and could not have breached its fiduciary duties, when holding, investing, and profiting from the funds backing the retained asset accounts.

Statute of Limitations:

In *Withrow v. Bache Halsey Stuart Shield, Inc., Salary Protection Plan (Ltd)*, --- F.3d ---, No. 09-55024, 2011 WL 3672778 (9th Cir. Aug. 23, 2011), the Ninth Circuit held that a plan participant's claim that her benefits had been miscalculated in 1990 did not accrue until the claim was actually denied in 2004, even though she first inquired about the alleged miscalculation 14 years earlier. The court reasoned that, although the plan's insurer had communicated its position that the calculation was correct in 1990 when the plaintiff first inquired about it, the insurer's communications over a lengthy period never provided a "clear and convincing repudiation" of her claim. As a result, the Ninth Circuit reversed the district court's ruling that the plaintiff's claim was time barred.

Out-of-Network Rate Litigation:

In *In re WellPoint, Inc. Out-of-Network "UCR" Rates Litigation*, MDL 09-2074 PSG (FFMx), 2011 WL 3555610 (C.D. Cal. Aug. 11, 2011), the district court allowed most of the claims to proceed in a suit by providers, subscribers, and medical associations alleging that the insurer did not properly reimburse them for out-of-network services because it relied on flawed data. The court first determined that WellPoint, as the insurer, was a proper defendant for a claim for benefits under ERISA Section 502(a)(1)(B), following the Ninth Circuit's recent ruling in *Cyr v. Reliance Standard Life Insurance Co.,* 642 F.3d 1202 (9th Cir. 2011). The court also held that the provider plaintiffs, who had valid assignments from patients, had ERISA standing to bring a claim for benefits. Next, the court found that the plaintiffs' failure to exhaust administrative remedies was excusable because administrative appeals would have been futile. The court further determined that the plaintiffs could bring claims for breach of fiduciary duty under ERISA Section 502(a)(2) because the plaintiffs alleged plan-wide injury and harm to more than just the individuals who brought suit. The court dismissed the plaintiffs' claims against WellPoint under ERISA Section 1132(c), finding that those claims could only be brought against a plan administrator. The court also denied the motion to dismiss plaintiffs' Sherman Act and certain state law claims, and granted the motion to dismiss the RICO and certain other state law claims.

Inaccurate Pension Estimate:

In *Pearson v. Vioth Paper Rolls, Inc.*, --- F.3d ----, 2011 WL 3773343 (7th Cir. Aug. 25, 2011), the Seventh Circuit affirmed the district court's decision that an erroneous estimate of a participant's pension benefits could not support an ERISA estoppel claim against the pension plan. The estimate was furnished to the participant in negotiating his severance package, and erroneously reflected an additional $450 per month if benefits were paid as an annuity due to the omission of an early retirement factor in the calculations. In so ruling, the Seventh Circuit held that, even if an ERISA estoppel claim was cognizable under these circumstances, the participant's claim would fail because he could not show (1) that the plan intentionally misrepresented his estimated benefits – particularly where the estimate correctly reflected his benefits if paid as a lump-sum, (2) detrimental reliance because plaintiff suffered no economic harm, or (3) extraordinary circumstances, which are required to establish an estoppel claim.

Class Certification:

In *Pipefitters Local 636 Ins. Fund v. Blue Cross Blue Shield of Michigan*, --- F.3d --- No. 09-2607, 2011 WL 3524325 (6th Cir. Aug. 12, 2011), the court on interlocutory appeal reversed class certification of a fund's claim challenging fees charged by Blue Cross, finding that the class failed to meet the requirements of Fed. R. Civ. P. 23(b)(1)(A) and 23(b)(3) because separate actions did not present the risk of inconsistent adjudications, and the putative class was not the superior method of adjudication for this matter. The court also concluded that the Fund could not represent a class of Blue Cross clients because individualized determinations regarding the contracts between Blue Cross and each client, as well as a determination of the actual services provided to each client, were required to reach a conclusion as to Blue Cross's fiduciary status when charging the disputed fee.

Retiree Benefits:

In *Dewhurst v. Cent. Alum. Co.*, --- F.3d ---, No. 10-1759, 2011 WL 3659310 (4th Cir. Aug. 22, 2011), the Fourth Circuit held that a preliminary injunction seeking "vested" health benefits was properly denied because the plaintiff retirees failed to prove a likelihood of success on the merits. In so holding, the court rejected the retirees' argument that the Fourth Circuit had previously adopted the Sixth Circuit's decision in *UAW v. Yard-Man, Inc*., 716 F.2d 1476 (6th Cir. 1983), such that an inference in favor of continued welfare benefits applies in retiree rights cases. The court rejected this interpretation of *Yard-Man*, concluding that the case, if adopted by the Fourth Circuit at all, merely requires application of ordinary principles of contract interpretation to retiree rights claims. Because the collective bargaining agreement's language in this case limited the duration of the retirees' health benefits to the term of the agreement, the court concluded that the retirees had failed to make a clear showing that they were entitled to the extraordinary relief of a preliminary injunction.

In *Sullivan v. CUNA Mut. Ins. Soc'y*, --- F.3d ---, No. 10-1558, 2011 WL 3487414 (7th Cir. Aug. 10, 2011), plan retirees argued that defendant could not unilaterally alter a policy of allowing the value of unused sick days to pay for post-retirement health benefits because such action was akin to usurping plan assets. Beginning in 1982, defendant allowed retirees to "pay" their portion of health care costs with unused sick time credits. The court ruled that the retirees misunderstood the nature of their sick-leave accounts, which were mere accounting liabilities and could not meet the definition of "plan assets." The court also noted that the retirees failed to sustain their heavy burden of proving entitlement to vested benefits, and improperly tried to flip the burden to defendant by arguing that the plan's reservation of rights clause did not appear in each and every participant communication, even though it did appear in every version of the plan. Citing *Cigna Corp. v. Amara*, 131 S. Ct. 1866 (2011), the court noted the distinction between governing plan documents and other participant communications, such as benefit election forms, which are not designed to have "pages of caveats and reservations," and therefore rejected the retirees claims insofar as they were based on these collateral documents. In dissent, Judge Hamilton asserted that the retirees' claims should not be dismissed because a viable promissory estoppel claim existed for those retirees who had been allowed to pay their portion of post-retirement health costs via unused sick leave for many years.

In *Tackett v. M & G Polymers USA, LLC*, No. 2:07-cv-126, 2011 WL 3438489 (S.D. Ohio Aug. 5, 2011), the court determined, following a bench trial, that certain sub-classes of retirees were entitled to lifetime contribution-free health benefits. The court noted that welfare benefits only vest if the parties so intend. Citing *UAW v. Yard-Man, Inc.*, 716 F.2d 1476 (6th Cir. 1983), the court applied ordinary principles of contract interpretation to the collective bargaining agreements at issue, concluding that an ambiguity existed regarding the terms "full Company contribution." Relying on trial testimony, the terms of the plan tying health benefits to pension benefits, and the lack of evidence regarding the local union's adoption of the company's health care contribution cap letters, the court determined that the right to contribution-free health benefits vested for those class members retiring prior to August 2005. For post-2005 retirees, the court determined that the company successfully negotiated the right to impose health care contribution requirements on retirees, however harsh the result to the individual members of that sub-class.

Settlements:

On August 8th, 2011, the parties reached a tentative settlement in *In re Nortel Networks Corp. "ERISA" Litigation*, No. 03-MD-1537 (Aug. 8, 2011 M.D. Tenn.), and are seeking preliminary approval of a $21.5 million-dollar settlement for their ERISA claims relating to the Nortel Long-Term Investment Plan. The plaintiffs alleged that the defendants breached their fiduciary duties by engaging in accounting practices that artificially inflated Nortel's stock price, causing participants in Nortel's Long-Term Investment Plan to lose significant amounts of their retirement savings. United States and Canadian bankruptcy courts also must approve the settlement.

In *In re Tribune Co., et al.*, No. 08-13141 (Bankr. D. Del. Aug. 24, 2011), the court preliminarily approved a $32 million settlement involving Tribune's ESOP and the company's Chapter 11 bankruptcy, which allegedly rendered the ESOP's stock worthless just months after the ESOP was created to purchase $250 million of company stock in a leveraged buyout structured to benefit the company's owners. The settlement would compensate the approximately 3,000 ESOP participants with approximately $4.5 million from Tribune, $1 million from the ESOP trustee, and the remaining $26.4 million from the fiduciaries' insurers. The settlement would potentially resolve the DOL's investigation of the Tribune's ESOP, the DOL's objections in the bankruptcy proceedings, on behalf of the ESOP participants, to the Tribune's proposed reorganization plan, and its breach of fiduciary duty and prohibited transaction claims, based on the ESOP's stock purchase, pending against the Tribune, its CEO, and the ESOP's trustee in the Northern District of Illinois, where the settlement also was presented for approval.

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[2] The Court also found that participants could seek recovery under the equitable theories of reformation and estoppel, but only if they can satisfy the requisite burden of proof. With regard to reformation, the Court stated that the power to reform contracts "is a traditional power of an equity court, not a court of law," and was used to prevent fraud or mistake if fraud or mistake was established "even if the 'complaining party' was negligent in not realizing its mistake." On the other hand, with regard to estoppel, the Court stated that estoppel might be available as a remedy to hold a plan fiduciary to what it had promised, but recognized that such relief would be conditioned on proof of detrimental reliance.

[3] *See, e.g.*, G. Bogert & G. Bogert, Trusts & Trustees § 862 (rev. 2d ed. 1995) (explaining surcharge is from "the trustee's own funds"); 4 S. Symons, Pomeroy's Equity Jurisprudence § 1080 (5th ed. 1941) (explaining trustee's liability for surcharge).

[4] Restatement (Third) of Trusts § 100 (Tent. Draft No. 6, 2011); Restatement (Third) of Trusts § 95 cmt. b (Tent. Draft No. 5, 2009).

[5] *See, e.g.,* Brief of the Secretary of Labor, Hilda L. Solis, as Amicus Curiae in Support of Reversal, Kenseth v. Dean Health Plans, Inc., No. 11-1560 (7th Cir. June 13, 2011), http://www.dol.gov/sol/media/briefs/kenseth(A)-6-13-2011.pdf.

[6] 4 A. Scott, W. Fratcher, & M. Ascher, Trusts §§ 24.9 & 24.9.1, pp. 1693-95 (5th ed. 2007).

[7] *See, e.g., LaRocca v. Borden, Inc.*, 276 F.3d 22, 27-29 (1st Cir. 2002) (affirming monetary relief to represent past-due benefits under the plan from which plaintiffs were improperly removed, and that proper future relief was reinstatement in plan and not monetary value of the coverage).

[8] The Court noted this relief resembled estoppel and/or reformation, which require a plaintiff to show detrimental reliance or something akin to fraud. Perhaps notably, district court opinion in *Amara* found intentional misrepresentations that seemingly could support estoppel or reformation (as were also present in *Varity Corp. v. Howe*, 516 U.S. 489 (1996), and *In re Unisys Corp. Retiree Medical Benefits ERISA Litigation*, 579 F.3d 220 (3d Cir. 2009), *cert. denied*, 130 S. Ct. 1546 (U.S. 2010)), and perhaps the availability of such a remedy could make a surcharge remedy available even when the plaintiff could not otherwise show he had "lost" benefits.

[9] *See, e.g.*, *Kenseth v. Dean Health Plan, Inc.*, 610 F.3d 452, 482-83 (7th Cir. 2010) (suggesting monetary relief sought was unavailable for breach of fiduciary duty in erroneously pre-authorizing medical procedure not covered by plan), *on remand*, No. 08-0001, 2011 WL 901388 (W.D. Wis. Feb. 14, 2011) (holding relief unavailable), *appeal filed*, No. 11-1560 (7th Cir. Mar. 9, 2011).

[10] 2011 BL 18166.

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[12] 2011 BL 190100.

[13] A detailed discussion of the Court's analysis of the theories of presumed reliance is found at pages *13-15 of the opinion.

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