Proskauer

The ERISA Litigation Newsletter

November 2011

Editor's Overview

This month, we review the Department of Labor's decision to re-propose a controversial regulation expanding the definition of an ERISA fiduciary. In response to public criticism and Congressional intervention, the DOL announced it will re-propose the regulation originally published one year ago, citing the need for further public comment and economic analysis.

We also present the insights of several of Proskauer's ERISA practice attorneys regarding the following hot topics: high deductible health plan/health savings account re-design and planning for open enrollment; the constitutionality of the individual mandate under the Affordable Care Act, an issue now ripe for Supreme Court review; the Supreme Court's Decision in *CIGNA Corp. v. Amara*, 131 S. Ct. 1866 (2011); and reconciling obligations relating to the production of documents under ERISA § 104(b)(4) versus the claims regulation, 29 C.F.R. § 2560.503-1.

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

"Never Mind" – DOL Withdraws Proposed Regulation on the Definition of an ERISA "Fiduciary" [1]

Contributed by Charles F. Seemann III

In October 2010, the Department of Labor (DOL) issued a proposed regulation setting forth a new, broader interpretation of the statutory definition of a "fiduciary" under the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1001, *et seq*. After nearly a year of public criticism and intervention by numerous members of Congress, DOL announced last month that it will withdraw its initial proposal and re-propose a revised regulation in early 2012. In doing so, DOL has pledged to address concerns that its original proposal was overbroad, would raise administrative costs of ERISA plans, and might force many smaller service providers out of business.

Background

Under Section 3(21)(A) of ERISA,[2]

… a person is a fiduciary with respect to a plan to the extent

(i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets,

(ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or

(iii) he has any discretionary authority or discretionary responsibility in the administration of such plan. Such term includes any person designated under section 1105(c)(1)(B) of this title.

In 1975, DOL issued an interpretive regulation elaborating on fiduciary status attained by those who provide "investment advice for a fee."[3] This regulation specifies that a person provides fiduciary investment advice *only* if the person wields direct or indirect discretionary authority over the plan's purchases or sales of securities or other investment property, or, alternatively, if the person satisfies a multi-part test set forth in the regulation. This test provides that an investment adviser is a fiduciary *only* if the adviser provides investment advice (1) on a regular basis, (2) pursuant to a mutual understanding that (3) the advice will serve as the primary basis for investment decisions, and (4) the advice itself is based on the particular needs of the plan.[4]

In the thirty-five years since DOL first issued that regulation, the landscape of retirement plans has changed substantially. In 1975, private defined-benefit plans covered over 27 million participants, with assets totaling nearly $186 billion. Defined-contribution plans covered 11 million participants, with assets of $74 billion. By 2008, however, defined-contribution plans covered 67 million participants, while the number of participants in defined-benefit plans had slipped to just 19 million. In addition, the proportion of participant-directed accounts rose dramatically: for example, as of 2008, there were approximately 60 million participants in 401(k) plans, of whom ninety-five percent bore some responsibility for directing the investment of their accounts.[5]

DOL's Proposal to Expand the Definition of the Term "Fiduciary"

Accompanying the evolution in retirement plan vehicles have been equally dramatic changes in the plan investment services. The types of products and services available to investors have become considerably more numerous and more complex.[6] These changes, coupled with the trend towards more defined-contribution plans offering greater participant control, created concerns at DOL over the potential for conflicts-of-interest and self-dealing.[7] As one example, DOL posited that financial services firms advising plans on mutual-fund options frequently recommend mutual funds that made revenue-sharing payments to recommending firms.[8] Consequently, in October 2010, DOL proposed an amended version of the regulation governing fiduciary investment advice.

The supplementary information accompanying the proposed regulation makes it clear that DOL seeks to depart from its earlier interpretation of ERISA's "investment advice for a fee" provision, and to broaden the circumstances in which fiduciary status is attained. DOL took pains to justify the proposed departure from thirty-five years of practice, characterizing the earlier regulation as narrowing ERISA's application in ways not warranted by the statutory text.[9] In addition, DOL decried the original regulation's effects, insofar as it permitted advisers to avoid attribution of ERISA fiduciary status (and therefore ERISA liability) in cases where advice was not provided on a regular basis,[10] or was not given pursuant to a mutual understanding that such advice would serve as the primary basis for investment decisions, yet still played a significant role in plan investment decisions.[11]

The regulation proposed in October 2010 identifies three categories of activity that constitute "advice" for purposes of evaluating fiduciary status: (1) appraisals and fairness opinions; (2) recommendations regarding the advisability of purchasing, holding, or selling investment assets; and (3) recommendations regarding the management of securities or other investment property. Under the proposed regulation, persons who receive a fee for these types of advice are ERISA fiduciaries if they give advice to plans, plan fiduciaries, participants, or beneficiaries *and* (1) represent themselves as acting as an ERISA fiduciary; (2) already exercise authority as an ERISA fiduciary; (3) are an investment adviser under the Investment Adviser Act of 1940 (1940 Act); or (4) provide advice that, pursuant to an agreement or understanding, "may be considered in connection with" an investment decision.[12] The proposed regulation thus purports to modify past practice in several significant ways, including:

Appraisals and Fairness Opinions – The text of the proposed regulation expressly includes "appraisals and fairness opinions." This revision represents an intentional departure from past practice, and expressly seeks to supersede a prior DOL advisory opinion[13] indicating that valuation services provided to an employee stock ownership plan (ESOP) in connection with the purchase of closely held employer securities do not qualify as fiduciary investment advice. In contrast to prior practice, the proposed regulation would treat such services as fiduciary advice. Additionally, appraisals and fairness opinions would be treated as fiduciary advice in contexts beyond employer securities, such as the provision of real estate valuation.[14]

Advice to Participants and Beneficiaries – The proposed regulation also codifies the long-standing DOL view that fiduciary status may flow from providing advice or recommendations to plan participants and beneficiaries. In proposing the new regulation, however, DOL specifically requested comment on whether to exclude advice given to plan participants regarding otherwise-permitted plan distributions from the category of fiduciary investment advice.[15]

Expansion of Existing "Investment Advice" Status – Under the current regulation, a person giving advice is an ERISA fiduciary only if each part of the multi-step test is satisfied. Under the proposed regulation, however, fiduciary status can be established without examining all of the relationship's characteristics, such as when the adviser purports to be an ERISA fiduciary, or when the adviser already serves as an adviser under the 1940 Act. Thus, the proposed regulation relaxes the existing test for fiduciary adviser status in several ways. First, the advice need not be given on a "regular basis," as previously required; rather, a single instance of advice can support a finding of fiduciary conduct. Second, under the proposed regulation, fiduciary status no longer depends on a mutual understanding that the advice serve as the "primary basis" for an investment decision. Rather, the proposed regulation will treat advice as fiduciary advice where the adviser is aware that the advice may be "considered" in connection with an investment decision.[16]

Limitations on the Term "Advice" – The proposed regulation sets forth several limitations on fiduciary "advice" as well. For instance, it states that providing "investment education information and materials" does not constitute fiduciary investment advice. The act of providing a plan fiduciary with "general financial information and data" to assist in the selection of plan investment options is also excluded from the definition of "advice," so long as the information is accompanied by a disclosure that the information is not intended to be impartial investment advice.[17]

Public Resistance

The proposed regulation not only expands the reach of ERISA's fiduciary provisions to previously unaffected arrangements, but also represents a marked departure from thirty-five years of industry practice established in reliance on DOL's existing interpretation. It is not surprising, then, that the proposed regulation has met with stiff resistance. The public comments covered a host of issues, but many of them focused on concerns over increased compliance costs borne by service providers, which, in turn, would raise plans' administrative costs. Many commentators warned of other unintended consequences, such as depriving participants of useful resources or the possibility that compliance burdens would force smaller plan-service providers (*e.g.*, appraisers) out of business. Numerous members of Congress also criticized the proposed regulation, both in substance and on the grounds that DOL had not followed proper regulatory procedures. In some cases, these Congressional critics also called for DOL to withdraw and re-propose the regulation after further consideration and economic analysis.[18]

In addition, many written comments took issue with the proposed application of fiduciary status to individual retirement account (IRA) advisers, and an apparent failure by DOL to coordinate ERISA's fiduciary standards with standards imposed by other regulatory agencies, such as the Securities & Exchange Commission (SEC) and the Commodity Futures Trading Commission (CFTC). As a result, commentators feared that the proposed regulation would subject a wide array of financial professionals to inconsistent or conflicting standards of conduct.

On September 19, 2011, DOL relented, and announced it was withdrawing the proposed regulation. Citing a need for further public comment and economic analysis, the DOL announcement suggests several areas where revision of the regulatory proposal is likely:

[T]he agency anticipates revising provisions of the rule including, but not restricted to, clarifying that fiduciary advice is limited to individualized advice directed to specific parties, responding to concerns about the application of the regulation to routine appraisals and clarifying the limits of the rule's application to arm's length commercial transactions, such as swap transactions.

Also anticipated are exemptions addressing concerns about the impact of the new regulation on the current fee practices of brokers and advisers, and clarifying the continued applicability of exemptions that have long been in existence that allow brokers to receive commissions in connection with mutual funds, stocks and insurance products. The agency will carefully craft new or amended exemptions that can best preserve beneficial fee practices, while at the same time protecting plan participants and individual retirement account owners from abusive practices and conflicted advice.[19]

Prior to the announcement, DOL had also indicated that it was reevaluating the impact of its proposals in several other areas. These included a review of the regulation's impact on appraisal and valuation services, including those offered to plans in connection with employer securities, so as not to "cause unnecessary harm or cost to small businesses." DOL has also indicated its intention to make a clearer distinction between fiduciary investment advice and non-fiduciary investment education.[20]

DOL's Next Steps

DOL's announcement predicted that DOL would re-propose a revised version of the regulation in early 2012. Although the precise nature of the expected revisions remains unclear, it is possible to discern some likely areas where a modified proposal is likely. For example, much attention was given to compensation arrangements in advisory relationships. In this regard, DOL is coordinating its efforts with the SEC and CFTC to ensure that advisory professionals are not subjected to conflicting pronouncements regarding adviser compensation and the corresponding standards of conduct. In announcing its plans, DOL also hinted that it would address fee-related concerns through a combination of regulatory revisions and prohibited-transaction exemptions.

With regard to such compensation arrangements, one area of special interest in the ERISA services industry involves those service providers giving advice on selection of an investment "menu" for use with participant-directed retirement plan accounts in plans for which those providers provide other services. The now-withdrawn regulation suggested that advice on "menu" selections must be accompanied by an awkward, and arguably self-defeating, disclosure that the provider's interests are adverse to the plan's interests. This provision was the subject of specific industry criticism. It is unclear whether, and to what extent, there might be revisions to DOL's initial proposal.

DOL has pledged to develop a better understanding of industry compensation practices and to determine how those practices should be addressed in the revised regulation, or alternatively, by a prohibited transaction exemption. DOL has, however, communicated its determination to ferret out what it calls abusive advisory practices, so the revised proposal will undoubtedly expand the types of advisory activities that are subject to ERISA's fiduciary duties.

Another area where DOL has indicated it might revisit its proposed regulation involves the inclusion of appraisal and valuation specialists in the category of fiduciary advisers. In many cases, such advisers are retained for isolated or non-routine transactions, and, as such, do not provide advice on a "regular basis," as required under the existing regulation. Based on DOL's reaction to related criticisms, it seems likely that the law will expand to encompass some of these actors within ERISA's definition of a "fiduciary." There is reason to believe, however, that providers furnishing "routine" appraisal or valuation services (*i.e.*, for purposes other than investment transactions) may receive some relief in the new proposal.

A third area where DOL is considering modifications to its initial proposal involves service providers that furnish education materials to plan fiduciaries, participants and/or beneficiaries. Many commentators expressed fear that the broader regulation would confuse the distinction between educational materials and fiduciary advice, which is recognized under existing law. This confusion gives rise to a concern, shared by DOL, that providers will withhold helpful educational information for fear of fiduciary exposure. DOL has indicated it did not intend to restrict existing exemptions for educational materials, but it remains uncertain how the re-proposed regulation will address the potential for confusion noted in the public comments to DOL.

Proskauer's Perspective

DOL defended its sweeping proposals as necessary to protect plan participants and beneficiaries from conflicts-of-interest and self-dealing by unscrupulous advisers. In crafting its originally proposed regulation, however, DOL broadened ERISA's definition of "fiduciary" substantially, which in turn, challenged thirty-five years of established investment industry practice related to retirement assets. The volume and breadth of the public criticism of the proposed regulation underscores the significance of the proposed changes to the current application of ERISA's "investment advice for a fee" language.

The industry's reaction reveals the practical problems inherent in a slow regulatory reaction to marketplace changes. Industry adjustments to regulation are more readily made, and more warmly received, when change comes at a gradual and timely pace. In the case of the investment adviser regulation, a more modest set of changes, coupled with more regular review of industry practice in the future, would seem better suited to serve the public interest and the salutary goals DOL hopes to achieve.

DOL seems to have taken cognizance of the public's concerns, and is taking steps to address them. However, the aggressive nature of DOL's initial proposal suggests that aspects of current industry practice may not survive in their present form. And while DOL has evinced some willingness to consider a more measured approach, the precise contours of that approach remain a mystery. The public has DOL's assurance that it does not want to disadvantage plans or plan participants, but the new proposal's impact on advisers and other service providers will not be fully appreciated until the revised regulation is re-proposed.

Views from Proskauer: Perspectives on Hot Topics In Employee Benefits[21]

Edited by Heather G. Magier

This articlepresents the insights, expectations, and advice of several ERISA practice attorneys regarding noteworthy issues or developments that are attracting media attention and triggering client inquiries. Here, we present the thoughts of Paul Hamburger, Peter Marathas, Robert Rachal, and Stacey Cerrone on issues relating to ERISA plan administration and related litigation. From time to time we will address other current issues in a similar format.

Implementing a High Deductible Health Plan/Health Savings Account Re-design and Planning for Open Enrollment **- Paul Hamburger**

In light of health care reform and health plan re-design issues, a lot of employers are looking at high deductible health plans and health savings accounts to give people additional options. The idea is that if you add a high deductible plan (HDHP), then employees can set money aside to offset deductibles and co-pays in separate health savings accounts (HSAs). It's a fundamental re-design of the plan, and the issues employers are facing are complex technical and design and compliance issues.

For example, one question that arises immediately is whether the employer should migrate only to a HDHP design (with HSA), or also continue to provide a low deductible health plan (LDHP) as an alternative without a HSA. For employees, there's a trade off between a higher premium for the LDHP, as opposed to a lower premium for the HDHP with more out of pocket costs -- which can be offset with the HSA.

Problems come in when you want to migrate people from one environment to another. For example, if we have an existing LDHP with a traditional Flexible Spending Account (FSA), that structure might make people ineligible for HSAs in certain circumstances. How do you adjust for that if the employee would like to choose coverage under the HDHP/HSA option? Another issue that makes implementation difficult is dealing with the uncertain implications for employees who want to make changes during the year due to changes in life status. Will employees be allowed to change from the LDHP to HDHP (or vice versa) and, if so, what are the HSA implications?

For employers and their advisers, the primary difficulty is that the legal environment is one in which there are lots of questions but very few specific answers. Although there are many IRS notices and other rulings on HDHP/HSA matters dating back to 2004, and they answer a number of important questions, there is not one comprehensive place to go for practical answers to the many different fact patterns employers encounter.

On the practical level, an important question relates to how much education employers will provide for HSA-eligible employees. For example, should the employer tailor payroll systems to automatically contribute the appropriate amount (up to the family limit, single limit, or catch up limit for HSA contributions) or leave it up to the employee to figure out how much he or she can contribute? Some companies have a paternalistic philosophy and want to educate their employees, walk them through the options, and prevent them from doing the wrong thing. However, in doing this, a number of technical problems and difficulties arise – for example, when deductions need to be re-calculated when an employee switches from family coverage to single coverage during the year. If the employer tries to "do the best thing" for the employees, it is not entirely clear how the adjustment should be made. So, the "best" thing to do might be to let employees make the adjustments that they feel are best for them.

This is going to be an increasing trend over time because health care costs are going up and employers need to do something to moderate their health care costs. In 2018, health care reform implements a 40% excise tax on so-called "Cadillac coverage." Unless an employer does something to moderate such "overly generous" plans, there could be a significant cost down the road. To mitigate the exposure to that tax, a HDHP/HSA strategy might be an appropriate strategy.

The bottom line is that before employers go down this road, they need to make sure they have adequately vetted these technical and compliance issues.

***The Constitutionality of the Individual Mandate under the Affordable Care Act — An Issue Now Ripe for Supreme Court Review* - Peter Marathas**

Section 1501 of the Affordable Care Act[22] requires all individuals (with limited exception) to buy health insurance or pay a penalty to the federal government, starting in 2014. Challengers of this "individual mandate"—including a majority of States—argue the federal government exceeded its authority under the Constitution with this mandate. The Obama administration contends that passage of the individual mandate is a valid exercise of the federal government's authority under, among other things, the Commerce Clause of the Constitution.[23]

Practitioners have agreed that the debate must ultimately be settled by the United States Supreme Court.[24] The big question has not been *if* the Supreme Court would decide the issue but *when*. And, specifically for some, whether its decision would come prior to the 2012 election. It now looks like all the stars have aligned and the issue is ripe for Supreme Court review, with a decision possible before November 2012.

The Supreme Court is not required to review the issue. Rather, a Constitutional issue like this is reviewed only if there is a request for review (a *writ of certiorari)* by a party to a case, and at least one United States court of appeals "has entered a decision in conflict with the decision of another United States court of appeals on the same important matter."[25]

To date, two[26] of the over two dozen reported cases challenging the individual mandates have progressed through the judicial system and have received substantive review at the appellate level. Those two decisions do not agree on the constitutionality of the individual mandate.

The Sixth Circuit, reviewing *Thomas More Law Ctr. v. Obama*, agreed with the administration and the district court that the individual mandate is a legitimate exercise of federal power under the commerce clause, essentially accepting the argument that an individual's *inactivity*—the decision not to buy insurance—is actually *activity* that impacts interstate commerce. The court opined that the government need only show a *rational basis* for passing the law, a low standard that effectively guarantees the government's actions are constitutional.

The Eleventh Circuit agreed with twenty-two state attorneys general and four governors and the district court in the *Florida ex rel. Atty. Gen. v. U.S. Dep't of Health & Human Services* case that the individual mandate is unconstitutional, exceeding the limited scope of federal power. The Eleventh Circuit agreed with the district court's determination that *inactivity* does not equal *activity* and that a person's decision to not buy a product cannot be federally regulated under the Commerce Clause. However, the district court also ruled the *entire Act* unconstitutional because it lacked a *severability clause*. A severability clause is a routine provision in federal legislation that states that a finding that one provision of the law is unconstitutional will not render the whole law unconstitutional. The Eleventh Circuit, however, did not agree with the district court's finding insofar as it invalidated the entire law.

In September the administration chose not to have the Eleventh Circuit's decision re-reviewed by all of the Circuit's judges. Days later the administration submitted its *writ of certiorari* asking the Supreme Court for review. *Florida v. Dep't of Health & Human Services*, No. 11-400 (2011).

The decisions in the Sixth and Eleventh Circuits, accompanied by the administration's request, complete the requirements for the Supreme Court to review the constitutionality of the individual mandate. Most practitioners believe that they will review these cases in the October 2011 session. This means that a decision about the constitutionality of the individual mandate could be delivered by mid- or late-2012, just weeks before the 2012 election.

***The Supreme Court's Decision in CIGNA Corp. v. Amara, 131 S. Ct. 1866 (2011)* - Robert Rachal**

Amara was a very significant decision in several respects. First, it cut off the availability of ERISA Section 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B) as a means to circumvent the equitable relief requirements of Section 502(a)(3), 29 U.S.C. § 1132(a)(3). Prior to *Amara*, plaintiffs would argue that Section 502(a)(1)(B) remedies encompassed reforming the plan to be consistent with the law. This strategy was applied to statutory claims, breach of fiduciary duty, and disclosure claims. *Amara* was a classic example. Plaintiffs alleged the plan's disclosures were defective because they did not disclose adverse information, so the appropriate remedy was to reform the plan to conform to the benefit suggested by the disclosures. But Justice Breyer explained that the remedy under Section 502(a)(1)(B) is to enforce the plan *as written*. So if plaintiffs claim the plan must be reformed, Justice Breyer suggested that they must satisfy the Section 502(a)(3) requirements to justify this equitable remedy. These can be significant requirements; for example, plaintiffs may have to prove harm, causation, and reliance to justify reformation, which often may make it an individualized (not class) remedy.

Another significant aspect of the decision is the notion that the summary plan description (SPD) is not the plan. The rationale for the Supreme Court's reading was straightforward: the SPD is usually not drafted to be the plan, it is typically not amended pursuant to the requirements for amending the plan, and under *Curtiss-Wright,* **[27]** one can't use the SPD to informally amend the plan document. This seems rather obvious, but prior to *Amara*, many courts had treated the SPD as if it were the plan. *Amara* doesn't mean the SPD is not important. But if plaintiffs have a claim based on the SPD, they will likely need to comply with Section 502(a)(3) by showing harm, causation, and reliance to entitle themselves to any relief based on a defective SPD.

Those first two rulings were very pro-defendant. The *Amara* decision also includes a significant ruling that is less defendant friendly; basically, that there may be monetary relief available under Section 502(a)(3). The Court did so by distinguishing *Mertens*' **[28]** limitation on monetary relief under Section 502(a)(3) as applying only to claims against non-fiduciaries, and specifically noted that surcharge may be available against fiduciaries.

Stepping back, however, *Amara* appears to fit comfortably within equitable remedies jurisprudence and the Court's prior rulings, such as *Mass Mutual*, *Mertens*, *Harris Trust*, *Great West*, and *Sereboff*.[29] If we place all these cases in the big picture, they make some sense. If the Court finds a trust law or equitable relief analog for the remedy being sought, the Court finds such relief constitutes appropriate equitable relief under Section 502(a)(3). Likewise, *Amara* did not set aside *Mertens* or prior case law regarding restrictions on equitable relief. Rather, I believe *Amara* is meant to fit within, not overturn, these prior decisions, including that relief awarded under Section 502(a)(3) must be "typical" and "appropriate" equitable relief based on trust law and equitable remedies antecedents. Viewed in this light, *Amara* simply clarified and corrected the lower courts' over-broad application to fiduciaries of *Mertens*' bar on monetary remedies.

Some of the big implications going forward are: How are the lower courts going to construe *Amara*? Will they impose traditional trust law limits on equitable relief? For example, for reformatory remedies, will they require reliance, harm, and causation, as required to justify equitable remedies in the past?

By expanding the potential monetary remedies available against fiduciaries, *Amara* will increase the importance of good fiduciary training, administration, and communication. *Amara* also illustrates the expectations of the federal courts that SPDs should fairly disclose negative or adverse information to participants.

***Reconciling Obligations Relating to the Production of Documents under ERISA § 104(b)(4) versus the Claims Regulation, 29 C.F.R. § 2560.503-1* – Stacey Cerrone**

There are a few issues raised by the need to comply with both the statutory provision and the regulation governing the production of documents in response to participant requests: Who is required to produce what, when, and who is the entity liable for damages? ERISA Section 104(b)(4), 29 U.S.C. § 1024(b)(4) requires that a plan administrator furnish a copy of "the latest updated summary plan description . . . and the latest annual report, any terminal report, . . . trust agreement, contract, or other instruments under which the plan is established or operated." Under 29 C.F.R. Section 2560.503-1, an administrator must provide a claimant all documents, records, and other information relevant to the claimant's claim for benefits. Under Section 104(b)(4), it is clear that if the plan administrator does not produce what he or she is required to produce within 30 days of the written request, then–depending on the jurisdiction–the administrator is subject to ERISA Section 502(c), 29 U.S.C. § 1132(c) penalties. Documents required to be produced under Section 104(b)(4) can be very different from the documents required to be produced under the regulation. While there are some crossovers, it may not be totally clear to participants what they are entitled to under Section 104(b)(4) versus under the regulation, and when. So, for example, under Section 104(b)(4), there is a specific time period within which the administrator must provide the documents: thirty days from receipt of the written request. However, there is no time period under the regulations.

There's also an issue with respect to who is responsible under the regulations for sending the documents to the participant. The regulation does not specify who is considered the "administrator:" the claims administrator or the plan administrator. In addition, while most jurisdictions have determined that a violation of the regulation does not warrant statutory penalties under Section 502(c), one district court found that a violation of the regulation required the imposition of statutory penalties.

Another issue is whether a plan administrator must produce a document under ERISA Section 104(b)(4) that is not in its possession. In many cases, the claims administrator is handling the claims review. So if there is a document in the claims record that the plan is operated under, the plan administrator is responsible for producing that document. However, if the document is in the possession of the claims administrator, or another third party, that creates a potential problem. How does the plan administrator obtain those documents, especially if the claims administrator or third party claims the documents are confidential and proprietary? Some courts have said that the plan administrator still has to obtain those documents from the claims administrator or third-party and produce them to the participant.[30]

At this point, decisions regarding what documents are covered under Section 104(b)(4) and when penalties should be awarded are different based on what jurisdiction you are in. The document production requirements under the regulations add additional issues that each jurisdiction will deal with differently. For example, an administrator may have to turn over a document in one jurisdiction but not in another. Additional decisions on these document production issues will be very helpful. Another potential helpful solution would be a clarification of the regulations.

A plan administrator must be very aware of the law in the different jurisdictions it operates in, because the law on document production under both ERISA Section 104(b)(4) and the regulations may vary. A plan administrator should also be aware of the claims regulations and the law under the claims regulations, especially in terms of making sure the plan's procedures incorporate what the claims regulations specify needs to be done.

Rulings, Filings, and Settlements of Interest

Retiree Benefits:

- ???In *Evans v. Sterling Chemicals, Inc.*, --- F.3d ----, No. 10-20493, 2011 WL 4837847 (5th Cir. Oct. 13, 2011), the Fifth Circuit held that an employer violated ERISA by increasing the cost of certain retirees' health care benefits. In so ruling, the court determined the employer's promise not to increase the cost of benefits in an asset purchase agreement with the retirees' former employer was a plan amendment and an independent obligation to the retirees, even if not so intended, because it (1) was in writing, (2) was directed to a provision of an ERISA plan, and (3) satisfied the plan's formal amendment procedures. The court also held that the employer's

independent obligation survived the asset purchase agreement, which was assumed by the employer as part of a bankruptcy reorganization plan that provided that benefit obligations were assumed unless previously rejected.

Exhaustion of Benefit Claims:

- In *Laird v. Norton Healthcare, Inc.*, No. 10-5205, 2011 WL 4597539 (6th Cir. Oct. 6, 2011), the Sixth Circuit held that claims for short-term disability ("STD") benefits and long-term disability ("LTD") benefits were properly denied for failure to timely exhaust the respective plans' administrative remedies. After the STD administrator denied the STD claim based on its determination that plaintiff was not "totally disabled," plaintiff claimed that she sent a timely appeal letter and submitted an affidavit to that affect. She also claimed to have been advised not to apply for LTD benefits until she was approved for STD benefits. On the basis of these contentions, plaintiff argued that the court should invoke the mailbox rule and, therefore, find that her STD claim had been been appealed and that her failure to timely appeal the LTD claim should be excused either on futility or equitable estoppel grounds. The district court rejected these arguments and dismissed both claims on exhaustion grounds. The Sixth Circuit affirmed, reasoning that: (i) even if the mailbox rule applied to ERISA cases it was not satisfied here because plaintiff's affidavit did not state that "she affixed sufficient postage or, more critically, when she deposited the letter in the mail"; (ii) the futility exception did not apply because plaintiff had not exhausted her STD plan remedies and, in any event, the two plans were administered by different entities; and (iii) estoppel principles did not apply because the Norton employee's alleged representation could not be attributed to the decision-making plan administrator/insurer, a totally separate entity, and, in any event, the representation could not vary unambiguous plan terms.

Benefit Claim Errors:

- In *Kludka v. Qwest Disability Plan*, No. 10-16035, 2011 WL 5024190 (9th Cir. Oct. 21, 2011), the Ninth Circuit reversed and remanded the district court's dismissal of a claim for long-term disability benefits upon finding that the plan administrator committed two procedural errors when it denied the plaintiff's claim and the district court made an erroneous factual finding. The Ninth Circuit found that the plan administrator failed to comply with the requirement to explain specifically what information would be needed to perfect the plaintiff's claim and why that information was necessary. The appeals court also determined that although the plan administrator was aware that the plaintiff was receiving Social Security benefits, it failed to request the relevant records or explain why its denial of plaintiff's claim conflicted with the Social Security Administration's determination. The Ninth Circuit also concluded that the district court erroneously assumed that

the plaintiff had a standing offer to return to his job with accommodations, when in fact his employer conceded at oral argument that it had not offered to reinstate the plaintiff, and thus plaintiff would have to seek work on the open market and convince a prospective employer to hire him on a part-time basis knowing he had received disability benefits for psychological problems. The Ninth Circuit reasoned that had the district court considered these conditions, it might have determined that the plaintiff was unable to engage in meaningful employment, thus qualifying him for benefits under the plan terms. As a result, the Ninth Circuit remanded the case for reconsideration by the district court as to whether the plan administrator abused its discretion in denying the plaintiff's claim for benefits.

Disability Benefit Offsets:

- In *Riley v. Sun Life & Health Insurance Co.*, --- F.3d ----, No. 10-2850, 2011 WL 4634218 (8th Cir. Oct. 7, 2011), the Eighth Circuit held that a long-term disability plan administrator could not offset from plaintiff's monthly disability benefits the amount of Department of Veterans Affairs benefits the plaintiff also received for the same condition. The relevant plan language allowed the plan to offset from disability benefit payments amounts received under the Social Security Act, the Railroad Retirement Act, or "any other similar act or law." Reversing the district court's decision, the Eighth Circuit reasoned that the plan administrator did not undertake a meaningful analysis when it determined that the Department of Veterans Affairs benefits could be offset because these benefits were derived from the Veterans' Benefits Act, which the administrator concluded was similar to the Social Security Act and the Railroad Retirement Act. Instead, construing the plan language and the relevant statutes, the Eighth Circuit held that benefits resulting from a wartime service-related disability, which are obligatory under the Veterans' Benefits Act, were not derived from an act that was similar to the Social Security Act or the Railroad Retirement Act, which provide disability benefit "insurance" programs based upon employment and depend upon how much has been paid in.

Plan Limitations Period:

- In *Ortega v. Orthobiologics, LLC*, --- F.3d ----, No. 09-2305, 2011 WL 5041744 (1st Cir. Oct. 25, 2011), the First Circuit held that a disability plan's one-year limitations period for filing suit was equitably tolled and did not bar the suit of a former employee who had no notice of it. The company's plan was amended to include the one-year limitations period after the employee requested and received a copy of the plan during the internal appellate process, and the plan administrator failed to inform the employee in the final adverse benefit determination that he could file a lawsuit or that, in light of the new limitations period, he had to do so within one year. Although the court held that Ortega was not entitled to recover benefits on a

claim of equitable estoppel because there was no evidence of unequivocal, intentionally deceptive conduct on the part of the company, the company's failure to provide Ortega with the notice required by ERISA gave rise to equitable tolling of the limitations period. The court also noted that an employee need not be as diligent as possible for equitable tolling to apply and found that Ortega was "reasonably" diligent by requesting a copy of the plan and filing suit within four years of the denial of benefits.

Standing:

- In *Caples v. U.S. Foodservice, Inc.*, No. 11-30120, 2011 WL 4605375 (5th Cir. Oct. 6, 2011), the Fifth Circuit held that a deceased life insurance plan participant's ex-wife lacked standing to sue for benefits because she was neither a surviving spouse nor a designated beneficiary under the most recent life insurance plan. Caples had been a designated beneficiary under a prior plan, but her ex-husband did not designate her – or anyone else – as a beneficiary under a new benefits system. Caples' ex-husband did, however, designate his son as the beneficiary of other benefits. The court thus determined that substantial evidence supported the administrator's determination that the son was the proper life insurance beneficiary.
- In *Cohen v. Independence Blue Cross*, --- F. Supp. 2d ----, No. 10-4910 (FLW), 2011 WL 5040706 (D.N.J. Oct. 24, 2011), the district court held that an out-of-network medical provider who had received an assignment of rights from a patient had no standing to seek reimbursement of costs from a health insurance plan because the plan included an anti-assignment clause. The court held that the clause was not barred under ERISA or Third Circuit precedent. The court also rejected the plaintiffs' argument that the defendants waived their anti-assignment defense, finding that there was no evidence that the defendants had intended to unequivocally relinquish their enforcement rights under the plan's provisions.

Preemption:

- In *Fossen v. Blue Cross and Blue Shield of Montana, Inc.*, ---F.3d---, 2011 WL 4926006 (9th Cir. Oct. 18, 2011), the court held that ERISA and HIPAA preempted plaintiffs' state law claims seeking restitution of health care coverage premiums they allegedly overpaid. The state law claims were filed under Montana's "little HIPAA" statute, which protects insureds from premium increases greater than those imposed on similarly situated individuals. Noting that ERISA completely preempts state law claims falling within the scope of ERISA Section 502(a), the court determined that plaintiffs' claims were properly recast by the district court as ERISA claims. However, the court also held that a claim under the Montana unfair

insurance practices statute was saved from ERISA preemption as a law regulating insurance.

- In *Ehlen Floor Covering, Inc. v. Lamb*, ---F.3d---, 2011 WL 4922017 (11th Cir. Oct. 18, 2011), the court held that ERISA completely preempted state law claims for negligence and misrepresentation filed by participants of a Section 412(I) plan, a defined benefit plan funded with guaranteed life insurance and/or annuity contracts. The claims were filed against the plan's service providers after it was discovered that the plan did not comply with several IRS rules and regulations. The court concluded that the state law claims fell within the scope of ERISA Section 502(a) and were completely preempted because the claims arose from the ERISA relationships and duties between the parties, particularly the fiduciary duty to disclose material information to plan participants. The court also concluded that an arbitration provision in the administrative services agreement between the plan sponsor and the plan administrator did not apply to the participants' claims. Consequently, the district court had subject matter jurisdiction over the dispute and properly rejected the plan administrator's request for arbitration.

- In *Utility Contractors Assoc. of New England, Inc. v. City of Fall River*, No. 10-10994-RWZ, 2011 WL 4710875 (D. Mass. Oct. 4, 2011), the court held that a city ordinance was preempted by ERISA because it required contractors to establish and maintain apprenticeship programs, as well as health and pension benefits for employees. The ordinance in question mandated employee benefits for three years before a contractor could even bid on public work. The court also determined that the law was not saved from preemption by the Fitzgerald Act, a federal statute promoting apprenticeship programs, or the market participant exception of the commerce clause. First, the court held that the Fitzgerald Act does not contain any federal enforcement mechanism, meaning that there was no contradiction with ERISA. Second, the court held that the City failed to advance any factual support for its market participant theory. For the exception to apply, the state entity must directly participate in the market by purchasing goods or services. Requiring contractors to provide employee benefits did not qualify the city as a market participant, as opposed to a regulator.

Attorney's Fees:

- In *Adler v. Raynor*, No.1:09-cv-08877 (DLC) (THK), 2011 WL 5024412 (S.D.N.Y. October 20, 2011), the magistrate judge issued a ruling denying an application for recovery of $1.7 million in attorneys' fees following the settlement of a class action complaint alleging breaches of fiduciary duty arising from the use of certain investment products that were alleged to be imprudent and constitute prohibited transactions because of their affiliation with the Plan sponsor. Applying the standards for recovery of attorney's fees in ERISA lawsuits recently enunciated by

the Supreme Court in *Hardt v. Reliance Standard Life Ins. Co.*, 130 S. Ct. 2149 (2010), the court concluded that the changes achieved by the settlement – including the voluntary resignation of the funds' independent fiduciary and commitments to comply with certain record keeping requirements and to make certain documents available – did not constitute "some degree of success on the merits" since the funds were permitted to continue to engage in the challenged investment activities. The court also determined that, even if the settlement had achieved some success on the merits, recovery of fees would be inappropriate under the "five factor" test set forth in *Chambless v. Masters, Mates & Pilots Pension Plan*, 815 F.2d 869, 871 (2d Cir. 1987), which may still be applied in addition to the *Hardt* test. Finally, the court observed that, even if plaintiffs had satisfied the standards for an award of attorney's fees, it would still have not awarded them based on the application submitted because the amount requested was "excessive in the extreme."

Releases:

- In *Bacon v. Stiefel Laboratories, Inc.*, No. 09-21871-CV, 2011 WL 4944122 (S.D. Fla. Oct. 17, 2011), the district court held that the execution of general releases that specifically referenced ERISA were enforceable and barred the two plaintiffs' ERISA and securities law claims. The court first determined that the releases were knowing and voluntary, after applying the Eleventh Circuit's test requiring consideration of: (1) the plaintiff's education and business experience; (2) the amount of time the plaintiff had to consider the agreement before signing it; (3) the clarity of the agreement; (4) the plaintiff's opportunity to consult with an attorney; (5) the employer's encouragement or discouragement of consultation with an attorney; and (6) the consideration given in exchange for the waiver when compared with the benefits to which the employee was already entitled. The court then rejected the plaintiffs' arguments that the releases violated ERISA's anti-alienation clause and that the releases had to be separately negotiated or supported by separate consideration. As to ERISA's anti-alienation clause, the court determined that the plaintiffs' arguments were precluded by the Supreme Court's decision in *Kennedy v. Plan Administrator for DuPont Savings & Investment Plan*, 555 U.S. 285 (2009), where the Court held that ERISA's anti-alienation provision does not apply to the waiver of rights to vested benefits; instead, it prevents the assignment to a third party of an enforceable right against an ERISA plan for the payment of benefits. Finally, the court noted that the releases and general contract law required that the two plaintiffs return the monies paid to them in exchange for the general releases before attempting to invalidate them and that the two plaintiffs had not done so. As to a third plaintiff, the court found that the general release was not enforceable because it was executed before the conduct challenged in the lawsuit occurred

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[2] 29 U.S.C. § 1002(21)(A).

[3] 29 C.F.R. § 2510.3-21(c).

[4] 29 C.F.R. § 2510.3-21(c)(1)(B).

[5] Testimony of Phyllis C. Borzi, Assistant Secretary of Labor, before the House Committee on Education & the Workforce, Subcommittee on Health, Education, Labor & Pensions (July 26, 2011).

[6] Definition of the Term "Fiduciary," 75 Fed. Reg. 65263, 65271 (Oct. 22, 2010) (withdrawn).

[7] DOL relied on various studies in support of its concerns over conflicts of interest, but acknowledged that "no single piece of evidence by itself directly demonstrates or provides a basis for quantifying the negative impact" of the conflicts DOL posits. *See* Borzi, *supra*.

[8] *Id.*

[9] *See, e.g.*, Definition of the Term "Fiduciary," 75 Fed. Reg. at 65273-74.

[10] *See, e.g., Schloegel & Hancock Bank Profit Sharing Plan v. Boswell*, 994 F.2d 266, 273 (5th Cir. 1993) (reversing finding of fiduciary adviser status because "regular basis" requirement was not met); *Sullivan, D.D.S. v. Lampf, Lipkind, Prupis, Petigrow & Labue*, Civ. A. Nos. 93-5036, 94-596, 1994 WL 669624, *7 (D.N.J. Nov. 21, 1994) (rejecting finding of fiduciary status where advice was limited to one occasion).

[11] *See, e.g., Cohrs v. Salomon Smith Barney, Inc.*, No. 03-505-KI, 03-506-KI, 2005 WL 2104535 (D. Or. Aug. 31, 2005) (dismissing claims where no mutual understanding that advice would serve as a primary basis for investment decisions), *aff'd*, 319 F. App'x 654 (9th Cir. 2009); *Mid-Atlantic Perfusion Assocs. v. Professional Assoc. Consulting Servs., Inc.*, No. CIV. A. 93-3027, 1994 WL 418990 (E.D. Pa. Aug. 9, 1994) (holding adviser was not a fiduciary where trustee-client made his own investment decisions), *aff'd*, 60 F.3d 816 (3d Cir. 1995).

[12] Definition of the Term "Fiduciary," 75 Fed. Reg. at 65277.

[13] *See* Advisory Opinion 76-65A (June 7, 1976).

[14] Definition of the Term "Fiduciary," *id*. at 65265.

[15] *Id*. at 65266.

[16] *Id*. at 65267.

[17] Bloomberg Law Reports, Employee Benefits, *Investment Consultants Beware: Proposed DOL Regulation Would Expand the Breadth of Fiduciary Breach Claims*, Vol. 3, No. 24 (Nov. 22, 2010).

[18] For example, U.S. Representative Barney Frank, ranking member of the House Committee on Financial Services, wrote to "strongly urge" withdrawal in favor of a revised, re-proposed regulation, suggesting that the current proposal could have "adverse effects on the choices available to consumers, municipalities and pension plans, among others." *See* Letter from Rep. Barney Frank to Labor Secretary Hilda Solis (Sept. 15, 2011), available at http://www.dol.gov/ebsa/pdf/1210-AB32-PH0114.pdf.

[19] "US Labor Department's EBSA to re-propose rule on definition of fiduciary," DOL News Release (Sept. 19, 2011), available at http://www.dol.gov/ebsa/newsroom/2011/11-1382-NAT.html.

[20] *See* Borzi, *supra.*

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[22] The Patient Protection and Affordable Care Act. Pub. L. No. 111-148, 124 Stat.119 (2010), as amended by the *Health Care and Education Reconciliation Act of 2010*, Pub. L. No. 111-152, 124 Stat. 1029 (2010) (the "Act").

[23] Article I, Section 8, Clause 3 of the U.S. Constitution states that Congress shall have the power "To regulate Commerce with foreign Nations, and among the several States, and with the Indian Tribes".

[24] *See* The View From Proskauer in Bloomberg Law Reports, Employee Benefits, The Constitutionality of the Affordable Care Act's Individual Mandate Set to be Scrutinized by Four United States Courts of Appeals, Vol. 4, No. 11 (May 23, 2011).

[25] Part III, Rule 10 of the United States Supreme Court Rules.

[26] *Thomas More Law Ctr. v. Obama*, ___ F.3d ___, No. 10-CV-2388, 2011 WL 2556039, 2011 BL 170453 (6th Cir. June 29, 2011); *Florida ex rel. Atty. Gen. v. U.S. Dep't of Health & Human Servs.,* 648 F.3d 1235 (11th Cir. 2011); *Liberty University, Inc. v. Geithner*, ___ F.3d ___, No. 10-2347, 2011 WL 3962915, 2011 BL 230276 (4th Cir. Sept. 8, 2011) and *Virginia ex rel. Cuccinelli v. Sebelius*, ___ F.3d ___, No. 11-1057, 2011 WL 3925617, 2011 BL 230711 (4th Cir. Sept. 8, 2011). The *Liberty* and *Virginia* cases were not substantive decisions. The Fourth Circuit ruled that neither plaintiff had standing to sue. While the Fourth Circuit avoided rendering an opinion on the merits, this might be reviewed by the Supreme Court.

[27] *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73 (1995).

[28] *Mertens v. Hewitt Assoc.*, 508 U.S. 248 (1993).

[29] *Mass. Mutual Life. Ins. Co. v. Russell*, 473 U.S. 134 (1985); *Mertens v. Hewitt Assoc.,* 508 U.S. 248 (1993); *Harris Trust & Sav. Bank v. Salomon Smith Barney Inc.*, 530 U.S. 238 (2000); *Great-West Life & Ins. Annuity Co. v. Knudson*, 534 U.S. 204 (2002); *Sereboff v. Mid Atlantic Med. Svcs.,* 547 U.S. 356 (2006).

[30] *See Sgro v. Danone Waters of North America, Inc.*, 532 F.3d 940, 945 (9th Cir. 2008); *Eden Surgical Ctr. v. Budco Group, Inc.,* No. 09-CV-3991, 2010 WL 2180360, *10, 2010 BL 127245, *10 (C.D. Cal. May 27, 2010).

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