Proskauer

The ERISA Litigation Newsletter

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Editor's Overview

This month, we lead with an article addressing the Supreme Court's decision in *CIGNA Corp. v. Amara.* The opinion provides useful guidance with respect to the content of plan documents, but the eventual impact of this decision on the scope of available ERISA equitable remedies remains uncertain. A second article reviews the pending cases before four United States Courts of Appeals addressing the constitutionality of the Patient Protection & Affordable Care Act (PPACA) (now called the Affordable Care Act (ACA)). Finally, we focus on a recent Seventh Circuit decision, *Peabody v. Davis,* that exposes potential risks for the fiduciaries of eligible individual account plans.

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

***CIGNA Corp. v. Amara*: Changing the Landscape of ERISA Litigation**

Contributed by Myron Rumeld and Nicole A. Eichberger[1]

On May 16, 2011, the U.S. Supreme Court issued its long awaited opinion in *CIGNA Corp. v. Amara*, Case No. 09-804. Certiorari was granted to address the question of what showing of harm, if any, a participant must demonstrate to recover on a claim where the Summary Plan Description (SPD) conflicts with the terms of the plan document. Related to this question was the issue of what cause of action the plaintiffs could proceed under in these circumstances.

The Court specifically addressed these issues by rejecting the district court's finding that relief was available on a claim for benefits under Section 502(a)(1)(B) of ERISA and that plaintiffs were entitled to relief on a showing of "likely prejudice." Instead, the Court stated that the relief that the district court ordered may be available under Section 502(a)(3) of ERISA, to the extent the relief ordered coincided with, and plaintiffs satisfied the conditions for, relief that would be available in a traditional court of equity. Although the Supreme Court, in dicta, discussed what remedies might be available in equity, and what showing would be required for such relief, the decision left many questions unanswered. As a result, the decision left both the plaintiffs' and defendants' bar with opportunities to claim "victory" for the moment, while leaving many crucial issues to be decided another day.

Factual Background

Plaintiff Janice C. Amara and the other plaintiffs (Plaintiffs) were, when the lawsuit was filed, current or former employees of defendant CIGNA Corp. (CIGNA). In 1998, CIGNA amended the CIGNA Pension Plan (Plan) from a traditional defined benefit formula to a cash balance formula. Under CIGNA's traditional defined benefit formula, employees earned benefits over time based on their service and salary and, upon retirement, received an annuity with their annual benefit payable for life. Following the amendment to the Plan, each participant was provided with a starting balance in his/her cash balance account, which was calculated by taking the frozen annual benefit earned under the prior defined benefit plan and discounting it into a lump sum amount using prescribed interest rate and mortality assumptions that were less favorable to participants than the assumptions required by statute to calculate a lump sum retirement benefit. Thereafter, participants earned annual service and salary credits plus quarterly interest credits. Because the balance in the cash balance account could be worth less than the present value of the frozen defined benefit calculated under the statutorily prescribed rates, the Plan provided that participants would receive the greater of their frozen defined benefit or their cash balance benefit. For many participants, there was a period of time, known as the "wear-away" period, during which their benefits did not increase because their frozen benefit under the defined benefit plan remained greater than the benefit accrued under the cash balance plan.

Both before and following the Plan's conversion to a cash balance formula, CIGNA issued communications to participants regarding the operation of that formula. The disclosures included those that are required by statute, such as the ERISA Section 204(h) notice of amendments that may reduce benefit accruals, the summary of material modification (SMM), SPDs, annual benefit statements and, upon request, a copy of the Plan itself.

Procedural History

In 2001, Plaintiffs filed a class action lawsuit against CIGNA and the CIGNA Pension Plan (Defendants), alleging that the conversion of the Plan to a cash balance formula discriminated on the basis of age and violated ERISA's non-forfeiture and anti-backloading rules. In addition, Plaintiffs alleged that the SPD was deficient for failing to properly communicate the wear-away effect. According to Plaintiffs, the SPD mistakenly led participants to believe that they would receive the full value of their frozen benefit under the defined benefit plan *plus* whatever new benefits were accrued under the cash balance plan. Plaintiffs sought certification of a class of approximately 27,000 participants, which was later certified, and relief for the putative class under ERISA Section 502(a)(1)(B), which permits a participant to sue to recover benefits due under the terms of the plan, and ERISA Section 502(a)(3), which entitles participants to recover equitable relief for breaches of the Plan or ERISA, including deficient SPDs, fiduciary breaches for material misrepresentations, and/or equitable estoppel.

Following a bench trial, the district court issued two opinions, one as to liability and one as to damages. In the liability opinion, the district court concluded that the Plan's cash balance formula was not age discriminatory and did not violate ERISA's anti-backloading and non-forfeiture rules. However, the district court concluded that the Plan's SPDs were deficient under ERISA because they failed to adequately disclose the "wear-away" phenomenon to participants. For the same reason, the district court also held that CIGNA's 204(h) notice and SMM were deficient as well.

Following the opinion as to liability, the district court issued its opinion as to remedies. The district court determined that it should fashion relief for the deficient SPD claim, rather than the deficient 204(h) notice and SMM claims because: (i) the statutorily-mandated relief for the 204(h) violation would place the participants in a worse position by invalidating entirely the cash balance benefits, without restoring the prior benefits (which were frozen pursuant to a separate amendment); and because the court believed that monetary relief was unavailable under ERISA Section 502(a)(3), the vehicle for relief for a deficient SMM. With respect to the deficient SPD claim, the court determined that, pursuant to ERISA Section 502(a)(1)(B), the cause of action for contractual benefit claims, it could award each participant the benefit that the SPD purported to offer: the frozen traditional defined benefit *plus* his/her cash balance benefits. It awarded such relief via the issuance of an injunction to reform the plan, and another injunction directing payment to the retirees of the amount due them under the plan as reformed.

The court determined that all members of the class were entitled to this relief because they were "likely harmed" by the notice violations. The district court applied a "likely harm" standard because that it found that standard to be akin to the "likely prejudice" applied by the Second Circuit in other instances of statutory or regulatory violations. *See, e.g., Burke v. Kodak Retirement Income Plan*, 336 F.3d 103 (2d Cir. 2003). As a result, the court made no participant-by-participant evaluation of injury.

Both parties appealed the district court's opinions as to liability and relief to the Second Circuit. Following briefing by the parties, the Second Circuit issued an unpublished summary opinion affirming the district court's rulings.

Both parties filed writs of certiorari with the Supreme Court. Defendants petitioned for certiorari from the U.S. Supreme Court on the issue of what showing of harm, if any, a participant must demonstrate to recover on a claim when the SPD conflicts with the terms of the plan document. Plaintiffs petitioned for certiorari on two questions: (1) whether CIGNA's challenge to the "likely harmed" standard is proper for appeal; and (2) whether after a finding of misleading statements in the SMM and SPD, a district court is precluded from finding a violation of ERISA's disclosure requirements unless the district court conducts individual hearings into how each individual participant detrimentally relied on the misleading statements.

On June 28, 2010, the U.S. Supreme Court granted Defendants' petition for certiorari as to the following issue: When a corporation's summary plan description and actual retirement benefit plan are inconsistent, is the proper standard for measuring harm a standard of "likely harm" rebuttable by the defendant after a showing of "harmless error," or must a plaintiff show "detrimental reliance" on the inconsistency. The Supreme Court held Plaintiffs' petition in abeyance, pending decision as to Defendants' certiorari petition. On May 23, 2011, following its ruling on Defendants' petition, the Supreme Court granted plaintiffs' writ of certiorari with respect to the relief for the 204(h) and SMM claims, and vacated and remanded that part of the district court's decision, so as to permit further consideration of those issues consistent with the Supreme Court's ruling.

The Supreme Court's Opinion

On November 30, 2010, the Supreme Court heard oral argument from the respective parties and the Department of Labor, which filed an amicus curiae brief supporting the plaintiffs' position. On May 16, 2011, the Supreme Court handed down a unanimous decision (8-0, with Justice Sotomayor not participating), which (i) rejected the district court's holding that reformation of the plan was appropriate relief under ERISA Section 502(a)(1)(B), and remanded the decision for consideration of whether the relief the district court ordered was available under Section 502(a)(3). The opinion of the Court was written by Justice Breyer. Justice Scalia filed a concurring opinion, joined by Justice Thomas, which joined Justice Breyer's opinion insofar as it rejected the Plaintiffs' claim under Section 502(a)(1)(B) but disagreed with the opinion insofar as it proceeded to discuss the standards for relief under Section 502(a)(3) of ERISA.

The Supreme Court rejected the argument that an SPD could be a binding contract that trumps the underlying plan document. Rather, the Court stated, an SPD is meant to be a summary of the underlying plan document, written by a different entity (the plan administrator) than the entity responsible for the plan document (the corporate plan sponsor), with the entity responsible for the SPD being subject to ERISA's fiduciary provisions while the entity responsible for the plan document not subject to ERISA's fiduciary provisions. Because an SPD is not the plan document, the Supreme Court held that the district court erred in ordering relief under ERISA Section 502(a)(1)(B), which only authorizes relief for enforcement of a plan's terms.

The Supreme Court then stated, however, that the relief the district court entered might be available as "other equitable relief" under Section 502(a)(3), pursuant to one of the following theories: "estoppel," "reformation," or "surcharge." Rather than impose a specific, uniform burden of proof for sustaining a claim for such relief, the Supreme Court stated that the required burden of proof would depend on the specific equitable remedy being sought.

According to the Court, equitable reformation, the remedy that appeared to the Court to most closely resemble the lower court's direction that the plan be reformed to provide a benefit pursuant to an "A plus B" formula, was appropriate where "'fraudulent suppression, omission, or insertions…materially…affect[ed]' the 'substance' of the contact."

The Court further observed that, insofar as the lower court also issued an injunction directing that retired participants receive additional payments to comport with the plan as revised, such relief might be available under the equitable theory of "surcharge." To sustain a claim for surcharge, the Court stated, a plaintiff must prove actual harm by a preponderance of the evidence. The Court clarified that "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, however, that actual harm might not take the form of detrimental reliance on the terms of the SPD."

In ruling that monetary relief may be available under a surcharge theory, the Supreme Court distinguished its prior rulings in *Mertens v. Hewitt Assocs.*, 508 U.S. 248 (1993) and *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002), stating that while these decisions precluded monetary relief for claims against non-fiduciaries, monetary relief was available in trust law where there is a breach of trust.

Justice Scalia in his concurring opinion observed that the surcharge remedy must be calibrated to the harm alleged, and thus would not necessarily take the form of the remedy ordered by the district court.

Proskauer's Perspective

It is important to separate out the holdings contained in the Supreme Court's decision, which will likely have a broad impact, and the dicta, the impact of which is far less clear.

The Court clearly held that the SPD is not a contract and cannot supersede the plan document, and, thus, there is no relief available under Section 502(a)(1)(B) for a faulty communication. This holding presumably extinguishes any efforts by plaintiffs' attorneys to obtain automatic relief, absent any showing of harm, for a miscommunication, whether it is contained in an SPD or elsewhere. The ruling also should serve to encourage plan sponsors to issue SPDs that, consistent with the statutory intent, summarize the terms of the plan, rather than re-state all the intricacies contained in the formal plan document for fear that any omission, re-characterization or simplification will effectively lead to a claim that alters the plan's terms.

With respect to the relief available under Section 502(a)(3) for a miscommunication, the Court's dicta leaves many questions unanswered. On the one hand, it is clear that there is no presumption of harm; rather, the plaintiff will bear the burden of proving whatever harm is required to sustain the elements of an equitable claim for relief. However, the Court said little on what evidence would constitute "fraud," sufficient to sustain a reformation claim. With respect to the "surcharge" theory, the vehicle identified for awarding monetary relief to the retirees, the Court stated that "actual harm" was required, but it is far from clear what evidence would sustain a showing of actual harm in a cash balance conversion case, let alone in other contexts. As Justice Scalia pointed out, relief under a "surcharge" theory should be calibrated to the actual harm shown, which should call into question whether the district court should award payment of the "A plus B" benefit, as it originally ordered. Finally, the Supreme Court's opinion makes no mention of the suitability of these equitable claims for relief to class certification, even though the issue was mentioned in passing during the oral argument.

In short, *CIGNA Corp. v. Amara* laid the groundwork for future litigation. It outlined the battlefield, but not the victor.

The Constitutionality of the Affordable Care Act's Individual Mandate Set to be Scrutinized by Four United States Courts of Appeals [2]

Contributed by Peter J. Marathas, Jr. & Anthony S. Cacace

The stated purpose of the Patient Protection & Affordable Care Act (PPACA) (now called the Affordable Care Act (ACA)), according to the United States Department of Health and Human Services, is to put in place "comprehensive health insurance reforms that will hold insurance companies more accountable, lower health care costs, guarantee more health care choices, and enhance the quality of health care for all Americans."[3]

ACA contains many provisions aimed at achieving these purposes, one of which is the individual mandate, or minimum coverage provision. There are an estimated 30 to 35 million Americans who are uninsured at any given moment. The individual mandate provision requires every United States citizen, with limited exceptions, either to obtain "minimum essential coverage" for health care starting in 2014, or to pay a penalty to the federal government for failing to do so. The legislative intent of the individual mandate is at least twofold: (i) to increase the pool of insured individuals with an eye towards decreasing insurance costs (by increasing the risk pool); and (ii) to decrease the costs of health care, and health insurance nationwide, by reducing the number of individuals who use "free" or "uncompensated medical services," including costly emergency room services, and thereby reduce the costs today absorbed by state governments, premium increases passed on to employers that sponsor group health plans, and individuals who act responsibly and purchase insurance.

Since President Obama signed ACA into law in March 2010, there have been reportedly approximately 20 lawsuits filed nationwide challenging ACA generally and the constitutionality of the individual mandate. As of May 2011, five of these lawsuits brought in two federal district courts in Virginia and one each in Florida, Michigan and Washington, D.C., have been decided. Of the five district courts, three (VA, MI and DC) held that the individual mandate was within Congress' prescribed authority under the U.S. Constitution. The other two district courts (VA and FL) held that ACA's individual mandate is unconstitutional and that Congress exceeded its constitutional authority in enacting the individual mandate. As noted below, the court in the Florida case declared all of ACA unconstitutional because of the Act's failure to include a "severability clause." All five district court decisions are final and appeals have been filed with the respective appellate courts in the Fourth, Sixth, Eleventh, and Federal Circuits. Oral arguments in those appeals have occurred or are scheduled to occur in the coming months.

The Obama Administration has defended the constitutionality of the individual mandate under the Commerce Clause and Necessary and Proper Clause of the U.S. Constitution. In the five decided cases to date, the major arguments have focused on whether the Commerce Clause provides sufficient authority under the U.S. Constitution for Congress to mandate that individuals buy health insurance in 2014. The government's position is that Congress' authority is well-established under a line of cases interpreting the Commerce Clause, beginning with the famous "Wheat Case" of 1942, which introduced the idea that a private citizen not engaged in interstate commerce nonetheless falls under the purview of the federal government when his "activity" could have an impact on federal commerce. *See Wickard v. Filburn*, 317 U.S. 111 (1942). The plaintiffs in all five cases argue that the "activity" established as a key element in the Wheat Case (and the subsequent Commerce Clause cases decided by the U.S. Supreme Court) is missing here, since what the government seeks to regulate is "inactivity" (*i.e.*, the non-purchase of health insurance). All five of the decided cases have focused their analysis on this "activity equals inactivity" question.

District Court Decisions

ACA's individual mandate was held to be constitutional in these following cases in the Eastern District of Michigan, the Western District of Virginia, and the District of Columbia:

Thomas More Law Center v. Obama, 720 F. Supp.2d 882 (E.D. Mich. 2010): Two uninsured individuals, along with a national public interest law firm, brought suit against President Barack Obama, among others, seeking a declaration that Congress acted outside of its authority under the Commerce Clause and its power to tax and spend in passing the individual mandate. They asserted that requiring citizens to purchase health insurance constitutes a regulation of "economic inactivity" and the penalty associated with the regulation is an improper use of Congress' power to tax and spend. Plaintiffs argued that expanding Congress' Commerce Clause power to such a degree would give Congress the authority to "regulate every aspect of our lives, including our choice to refrain from acting." The court denied plaintiffs' motion for a preliminary injunction and dismissed plaintiffs' claims, reasoning that there was a "rational basis to conclude that, in the aggregate, decisions to forego insurance coverage" by individuals would "drive up the cost of insurance" and have "clear and direct impacts on healthcare providers, taxpayers and the insured population who ultimately pay for the care provided to those who go without insurance." Accordingly, the court concluded that the individual mandate addresses "economic decisions regarding health care service that everyone eventually, and inevitably, will need" and is a "reasonable means of effectuating Congress's goal." Having ruled that Congress has the power to pass the individual mandate under the Commerce Clause, the court declined to rule on the issue of whether the penalty associated with the mandate exceeded Congress' power to tax and spend.

Liberty University, Inc. v. Geithner, 753 F.Supp.2d 611 (W.D. Va. 2010):[4] An employer, state and local officials, and uninsured individuals brought suit against the Secretary of the Treasury, among others, seeking a declaration that ACA is unconstitutional because its individual mandate exceeds Congress' power under the Commerce Clause. Consistent with the *Thomas More Law Center* decision, the court dismissed plaintiffs' complaint, concluding that "the conduct regulated by the individual coverage provision . . . is economic in nature" and "how and when to pay for health care are activities that in the aggregate substantially affect the interstate health care market."

Mead v. Holder, -- F.Supp.2d --, 2011 WL 611139 (D.D.C. Feb. 22, 2011):[5] A group of federal taxpayers brought suit against the United States Attorney General and various government agencies alleging that the individual insurance mandate set forth in ACA is unconstitutional on its face. The government moved to dismiss the complaint. The court determined that Congress had a rational basis for its conclusion that an individual's decision to purchase health insurance was economic in nature and that the aggregate of these individual decisions "substantially affects the national health insurance market." Accordingly, the court determined that Congress acted within the bounds of its Commerce Clause authority when it enacted the individual mandate. In granting the government's motion to dismiss, the court rejected plaintiffs' arguments that Congress was regulating "inactivity," reasoning that citizens are "inevitable participants in the health care market,'" and, thus, choosing not to purchase health insurance does not equate to "inactivity" but is essentially "activity" enough to satisfy the Wheat Case rationale.

ACA's individual mandate was held to be unconstitutional in these following cases in the Eastern District of Virginia and the Northern District of Florida, two cases brought on behalf of the majority of the states.

Virginia v. Sebelius, 702 F. Supp.2d. 598 (E.D. Va. 2010): In this case, brought by Attorney General Ken Cuccinelli on behalf of the Commonwealth of Virginia against the Secretary of the Department of Health and Human Services, the plaintiff sought declaratory relief challenging the constitutionality of ACA's individual mandate. The Secretary moved to dismiss the complaint. The court denied the motion to dismiss, concluding that "the Secretary has [not] demonstrated that the Complaint fails to state a cause of action" with respect to plaintiffs' contention that Congress exceeded its authority under the Commerce Clause in passing the "Minimum Essential Coverage Provision." The court noted plaintiffs' argument that the mandate seeks to regulate "a virtual state of repose – or idleness – the converse of activity." The court also held that if the individual mandate was determined to be unconstitutional, then the penalty associated with failing to purchase healthcare insurance under the mandate would also be unconstitutional.

Florida v. United States Department of Health and Human Services, 716 F. Supp.2d 1120 (N.D. Fla. 2010); *Florida ex rel. Bondi v. United States Department of Health and Human Services*, -- F.Supp.2d --, 2011 WL 285683 (N.D. Fla. Jan. 31, 2011):[6] This case, brought by 22 states' attorneys general and four governors, along with a number of private citizens, and a business federation, was filed against the Department of Health and Human Services and other government agencies and sought declaratory relief on the basis that the individual mandate was unconstitutional. In denying the government's motion to dismiss the complaint, the court examined the previous Commerce Clause cases and placed ACA in the context of laws previously passed by Congress that were held to be constitutional under the Commerce Clause. The court noted that all prior Congresses before the 111th Congress (the Congress that passed ACA) recognized that the limitations placed on the federal government precluded their (the prior Congresses') ability to require U.S. citizens to act in a certain manner. The court eschewed the government's argument that "inactivity" equals "activity" and thus the individual mandate is constitutional under the Commerce Clause cases that started with the Wheat Case. Reciting a "parade of horribles" that would ensue if this line of reasoning were adopted, the court in Florida held, among other things, that the individual mandate is unconstitutional. In addition, the Florida court noted that ACA does not include a so-called "severability clause," which provides that a finding that any part of the act is unconstitutional will not cause the entire act to be unconstitutional. As such, on January 31, 2011, the Florida court ruled on a motion for summary judgment that all of ACA is unconstitutional. Finally, Judge Roger Vinson, who presided over Florida, denied plaintiff's claim for injunctive relief, observing that injunctive relief is unnecessary because of a "long-standing presumption 'that officials of the Executive Branch will adhere to the law as declared by the court...[and as such] the declaratory judgment is the functional equivalent of an injunction." Citing Committee On Judiciary of U.S. House of Representatives v. Miers, 542 F.3d 909, 911 (D.C. Cir. 2008); accord Sanchez-Espinoza v. Reagan, 770 F.2d 202, 208 n.8 (D.C. Cir. 1985).

It is interesting to note that in all five cases, the U.S. government questioned the standing of each of the plaintiffs to bring their suits, including the standing of the various states' attorneys general and governors. Each of the district courts had previously ruled that the plaintiffs had standing to contest the constitutionality of the individual mandate and that the issue was ripe for adjudication.[7]

The Appeals

Appeals are currently pending and in different stages in all five cases. On February 8, 2011, the Attorney General of Virginia filed a petition with the U.S. Supreme Court in *Virginia v. Sebelius* requesting that the Court grant an expedited review of the district court's decision, bypassing intermediate appellate review by the Court of Appeals for the Fourth Circuit. On April 24, 2011, the U.S. Supreme Court denied Virginia's petition without providing an explanation for its denial. The parties in that case, as well as in *Liberty University,* completed briefing of the appeals before the Fourth Circuit and oral argument was conducted on May 10, 2011.[8]

Briefing is also complete in the *Thomas More Law Center* appeal before the Sixth Circuit Court of Appeals and in the *Florida v. United States Department of Health and Human Services* appeal before the Eleventh Circuit Court of Appeals. Oral arguments in those appeals will take place on June 1, 2011, and June 8, 2011, respectively.[9] Of note in the *Florida* case was the government's request that Judge Vinson clarify whether he had issued an injunction. The judge offered very little by way of additional clarity, but ordered the government to act fast if it was going to appeal his decision. *Florida v. United States Department of Health and Human Services,* No. 10-CV-91 (N.D. Fla. Feb. 18, 2011) (Docket Entry No. 157).

Lastly, briefs are scheduled to be fully submitted by July 25, 2011, in the *Mead v. Holder* appeal before the United States Court of Appeals for the District of Columbia. As of the date of this article, oral argument has not yet been scheduled.

The issues before the various Courts of Appeals are, as expected, largely consistent. All of the appeals primarily address whether "inactivity" equals "activity" under the Wheat Case and its progeny, which is essentially the underlying question of whether Congress exceeded its authority under the Commerce Clause in enacting the individual mandate. Of course, all five of these cases included a number of different claims asserted by the plaintiffs and defenses urged by the federal government. In general, all of the courts considering the issue agreed that ACA is constitutionally sound with regard to its mandates on state governments and employers (with the notable exception of the *Florida* case, of course). Also, various arguments were developed on both sides of the "v" regarding the penalty assessed against individuals starting in 2014 who do not obtain adequate insurance. In the *Florida* case, for example, the government argued that the action was not justiciable because of the Tax Anti-Injunction Act, currently codified at 26 U.S.C. § 7421(a), which, with limited exceptions, provides that "no suit for the purpose of restraining the assessment or collection of any tax shall be maintained in any court by any person, whether or not such person is the person against whom such tax was assessed." In *Florida,* the government argued that the only relief available to individual taxpayers is suit after the payment of the tax, because of the Tax Anti-Injunction Act. Judge Vinson noted that ACA uses the term "penalty" and chastised Attorney General Holder when the latter attempted to argue that "penalty" and "tax" are interchangeable. All of these issues will be ripe for appeal.

Proskauer's Perspective

Because ACA is, as Judge Vinson wrote in the *Florida* case, a "controversial and polarizing law," and because it is concurrently being scrutinized by four different United States Courts of Appeals, it seems likely that the constitutionality of the individual mandate will ultimately be decided by the U.S. Supreme Court in its 2012 term. Supreme Court review would be avoided, it seems, only if all the circuit court rulings are consistent.

Rather than await the outcome of the judicial process, employers, individuals, and multiemployer welfare funds, among others, should make preparations to ensure compliance with all of the law's provisions in advance of the various effective dates of the different provisions of ACA. It would not be prudent to wait and see if portions of the law are deemed unconstitutional (or are repealed). In addition, the 2010 mid-term elections saw the return of the conservatives to power, at least in the House of Representatives. While most informed observers agree that "total repeal and replace" is pure fantasy, there has already been bi-partisan agreement to revoke some of the more burdensome aspects of ACA (including the requirement that employers issue a Form 1099 to all vendors providing more than $600 worth of services in a tax year, and the "Employee Vouchers" that were set to begin in 2014, both of which have been repealed). We will continue to monitor the course of the appeals and expect that the Supreme Court may ultimately issue a ruling as to the individual mandate's constitutionality.

***Peabody v. Davis:* What Is A Fiduciary To Do?[10]**

Contributed by Yolanda D. Montgomery

In *Peabody v. Davis*, Nos. 09-3428, 09-3452, 09-3497, 10-1851, 10-2079, 10-2091, 2011 WL 1364427 (7th Cir. April 12, 2011),[11] the Seventh Circuit ruled that the fiduciaries of an Eligible Individual Account Plan (EIAP) plan breached their duty of prudence under ERISA by allowing the plan to remain heavily invested in stock of a closely held corporation when they knew the value of the company's profit margin had substantially decreased due to regulatory changes. The Court acknowledged that EIAP's are exempt from the duty to diversify, but nevertheless concluded that the fiduciaries had a duty to reduce exposure to company stock in an orderly way, as company profitability abruptly and openly dropped. Although the facts of the case are unique, the ruling may expose potential risks for the fiduciaries of EIAPs.

Background[12]

Peabody was employed at The Rock Island Company of Chicago (RIC) from 1998 until 2004. Peabody's claims arose from his participation in the Rock Island Securities (RIS) Salary Savings Plan (Plan). RIS, a subsidiary of RIC, was the Plan sponsor. Defendants Davis and Kole were co-founders of RIC, corporate officers, trustees and fiduciaries of the Plan. According to Peabody, he resisted pressure by Davis to buy RIC stock until December 1999 when RIC was no longer contractually bound to give him a bonus. At that time, Davis informed Peabody that RIC was going to give him a bonus in cash and stock. Peabody, not wanting to use the bonus to buy RIC stock, suggested that in exchange for receiving his bonus entirely in cash, he would agree to roll over his external IRA into the Plan and then use those proceeds to buy stock in the Plan. Davis agreed. Peabody eventually rolled over $167,819, of which $166,000 was used to purchase RIC stock. This left Peabody 98% invested in RIC stock. The three other Plan participants each had fewer than 5% of their Plan assets invested in the stock.

Since RIC was a closely-held corporation, the value of RIC could not be determined by the market. Instead the valuation of RIC stock required an analysis of the company's financial data. In 1999 when Peabody purchased his stock in the Plan, the stock was valued at $2,000 per share. In April 2001, after Kole told Peabody that Davis wanted all employees to purchase more RIC stock, Peabody purchased five additional shares which were valued at $500 per share. In 2004, the stock was valued at $550 per share.

The Restricted Stock Agreement provided that upon an employee's termination RIC was granted the option to repurchase an employee's stock at book value; however, employees had no corresponding right to sell the stock back to RIC. When Peabody's employment ended in January 2004, RIC offered to purchase his shares under one of three terms: (1) immediately redeem the 835 RIC shares that he held in the Plan for $215 per share; (2) redeem the shares in 2005 for $300 per share; or (3) redeem the shares in 2007 for $400 per share. Peabody rejected those options and agreed instead to enter into a loan agreement with RIC, pursuant to which RIC agreed to purchase all of Peabody's stock for $350 per share within one year. This transaction transformed Peabody's equity interest in RIC into a creditor's interest. According to the terms of the loan, it was to be repaid in a single payment due on February 1, 2005.

The payment due under the terms of the loan was not made on time, and on or about March 18, 2005, along with other RIC creditors, Peabody was informed that RIC was not creditworthy. That same day, Peabody formally demanded the distribution and was told that the loan could not be repaid. RIC went out of business sometime in 2005.

RIC was a securities firm and its income was derived from commissions. In 2000 the SEC implemented a rule that required all U.S. public exchanges to allow stocks to be traded at values measured in terms of pennies instead of fractional dollars. This change, termed "decimalization," diminished the profit margins yielded by commissions on trades. According to Davis, this decimalization rule "crushed" RIC's profit margins such that by 2003 or 2004 profit margins had declined by 70–80%.

In his complaint, Peabody alleged multiple theories of fiduciary breach against the Plan defendants pursuant to ERISA § 502, and asserted a claim to recover damages against two insurance companies that provided commercial crime policies that insured the Plan against employee dishonesty.

The Ruling By The District Court

After conducting a bench trial, the district court issued a memorandum that found defendants Davis, Kole, and RIS liable for breach of fiduciary duty. The court acknowledged that those defendants did not violate their duty to diversify because Peabody "knowingly and voluntarily" waived this claim at the time of the rollover transaction. However, the district court held that defendants breached their fiduciary duty of prudence when they maintained the investment in RIC stock throughout RIC's decline and when they failed to distribute Peabody's Plan benefit. The district court also determined that the loan-for-stock exchange was a prohibited transaction and that defendant Davis breached his fiduciary duty by offering only a loan in payment for RIC stock.

Although Peabody's expert testimony was struck for failure to comply with discovery rules and Peabody did not offer evidence of damages as to each theory of liability, the district court awarded him damages on his breach of duty of prudence claim based on the rapid decline in profitability of RIC between 2001 and 2003. The district court awarded Peabody $506,601.82 in damages.

The court did not permit recovery, however, via a claim for distribution of benefits. Even though it acknowledged that this form of relief, as opposed to damages relief, might be more favorable to Peabody from a tax standpoint, the court concluded that it would be a duplication of the recovery to which Peabody was entitled under ERISA § 502(a)(3).

The district court dismissed the claims against the insurance companies, finding that the insurance companies were not proper defendants to claims under ERISA §§ 502(a)(1)(B) or 502(a)(2), and that damages were not recoverable against them under ERISA § 502(a)(3).

The Seventh Circuit's Opinion[13]

Duty of Prudence. The Seventh Circuit first recognized that the Plan was an EIAP and, as such, exempt from ERISA's duty to diversify. Specifically, the Court found that ERISA "unambiguously exempts *all* EIAPs from the duty to diversify, including savings plans like that one at issue." Nevertheless, the Court found that, while the duty to diversify was inapplicable to the fiduciaries of this Plan, the duty of prudence under ERISA still applied to them. The Court noted that the Third Circuit in *Moench v. Robertson*, 62 F. 3d 553 (3d Cir. 1995) and the Ninth Circuit in *Quan v. Computer Sciences Corp*., 623 F.3d 870, 881 (9th Cir. 2010), in reconciling the duty of prudence with the absence of an express duty to diversify, determined that for an EIAP or Employee Stock Ownership Plan (ESOP) that required investment in company stock, there was a presumption that an investment in employer stock was prudent. The Court observed that the Plan here, unlike in the cases applying the presumption, did not affirmatively require or encourage investment in employer securities, and thus divestment from company stock would not have required any deviation from the Plan terms. In any event, the Court decided not to "grapple" with the extent to which the *Moench* presumption of prudence applied to EIAPs, and stated that even if the *Moench* presumption applied, the district court correctly concluded that defendants breached their duty of prudence.

In making this determination, the Court agreed with the district court that “a prudent investor would not have remained so heavily invested in RIC’s stock as the company’s fortunes declined precipitously over a five-year period for reasons that foretold further and continuing declines.” The Court noted that defendants Davis and Kole knew that RIC’s profit margins decreased by 70 to 80% because of “a widely-known and permanent change in the regulatory environment that undermined RIC’s core business model.” The Court noted that even though those developments were public, “no one was better positioned to know of RIC’s prospects and the future of its stock values than Davis and Kole, who co-founded the company and set the share value.” The Court stated that those facts were consistent with the circumstances under which its sister courts would have found it imprudent to continue an investment in company stock. The Court concluded that when the SEC changed the regulatory environment, RIC’s business model was impacted and as a result, RIC’s stock became an imprudent investment.

The Court emphasized the narrowness of its ruling, in that most business failures were not foreseeable and that a severe decline in the value of company stock did not, without considerably more, create a duty to divest from company stock.

In finding that defendants breached their fiduciary duty, the Court rejected the argument that Peabody’s fiduciary breach claim was waived when he agreed to the stock investment and never requested that the fiduciaries reduce his investment. The Court found that although Peabody consented to the non-diversified investment of RIC stock at the time of the rollover transaction, defendants were not relieved of their fiduciary duties with regard to carrying out the rollover transaction and subsequently allowing Peabody to remain invested exclusively in company stock during the company’s decline.

In so ruling, the Court found that the defense of waiver was the same as a defense available under ERISA § 404(c), which "frees fiduciaries from responsibility for plan losses attributable to the participant's investment decision" for certain types of accounts. The Court noted that when a plan does not comply with ERISA § 404(c), fiduciaries are not entitled to the safe harbor protection it provides. Here, defendants never argued that the Plan complied with ERISA § 404(c). Applying this standard, the Court affirmed that defendants could be liable for allowing Peabody to select company stock as an investment if it was "manifestly imprudent to allow [him] to do so." Concluding that defendants did not justify their failure to divest the Plan of company stock, the Court affirmed the district court's finding that defendants breached their duty of prudence under ERISA.

Prohibited Transaction Claim. The Court found that Peabody was "technically correct" that the loan-for-stock transaction constituted a prohibited transaction under ERISA § 406(a)(1)(B) because the fiduciaries loaned Plan money to RIC, a party-in-interest. However, the Court also found that the transaction consisted of the exchange of worthless stock for a worthless loan. Accordingly, even though a prohibited transaction occurred, there were no losses directly attributable to that transaction. And, because there was no injury to the Plan, there were no damages to Peabody as a result of the substitution of debt for equity.

Damages. The remedy in an action for breach of fiduciary duty under § 502(a)(2) is for the fiduciary to make good the loss to the Plan. Here, the Seventh Circuit found the district court's method of calculating damages erroneous because the figures used were not solidly tied to the breach of fiduciary duty. In determining damages, the Court stated that "[t]he key questions are when did the fiduciary breach occur, and what was the resultant loss." The Court advised the district court to proceed, on remand, on the theory that defendants were required to divest from RIC as the profitability of the company sharply declined. For purposes of calculating damages, the Court stated that "because of the uncertainties involved, prudence did not require that the account be totally drained of the arguably imprudent stock investment immediately, even though it eventually became worthless." Rather, it would be reasonable for at least a quarter to a third of the original RIC stock to be left in the account when it was converted to a loan, without an imprudence violation. The Court pointed out that it did not mean to suggest there was a general duty to "diversify" Peabody's stock holding, but rather that defendants had "a prudential duty to reduce exposure to company stock in an orderly way, as the company's profitably abruptly and openly dropped."

The Seventh Circuit did not disturb the district court's ruling denying Peabody's claim for distribution of benefits under ERISA § 502(a)(1)(B) as duplicative of the court's award under ERISA § 502(a)(2), even though this would have enabled Peabody to maintain the benefits of a tax rollover. The Seventh Circuit observed that after the Supreme Court's decision in *LaRue v. DeWolff, Boberg & Assocs., Inc.,* 552 U.S. 248 (2008), the relationship between ERISA § 502(a)(2) and the traditional mechanism of individual relief under ERISA § 502(a)(1)(B) has been muddied. The Court stated that Peabody's tax-related concerns could be addressed when defendants complied with the district court's order.

Liability of Insurance Defendants. With respect to the liability of the insurance defendants under their dishonesty bonds issued to the Plan, the Court held that Peabody's argument under ERISA § 502(a)(3) failed because the relief he sought was money damages under the plan's insurance policy, not equitable relief.

Proskauer's Perspective

The Seventh Circuit's opinion in *Peabody*, while recognizing that ERISA unambiguously exempts all EIAPs invested in employer securities from the duty to diversify, nevertheless defines a fiduciary's "prudential duty" to include reducing an EIAP's exposure to company stock when the company's fortunes precipitously decline. In creating this duty, the Court failed to give any instruction to fiduciaries as to how to implement this duty when there is a steady decline in the company's stock and there is no market for the shares because the company is a closely-held corporation. Should the company be forced to buy back the shares or should they be required to find a private investor who is willing to buy the shares? Unfortunately, there is no concrete answer. At a minimum, though, before a fiduciary decides to divest the company stock from the plan in these circumstances, he/she should read the plan document, investigate alternative actions, and consider obtaining advice from an outside consultant.

Rulings, Filings, and Settlements of Interest

Remedies:

- ???On the same day that the United States Supreme Court in *CIGNA Corp. v. Amara* (see above) suggested that the remedy of surcharge was one of equity and may be available under ERISA, the Fourth Circuit in *McCravy v. Metro. Life Ins. Co.*, 2011 WL 1833873 (4th Cir. May 16, 2011), concluded the opposite, finding that an employee of Bank of America could not recover the full value of her daughter's life insurance policy via the remedy of surcharge under Section 502(a)(3) of ERISA. The Fourth Circuit affirmed the district court's ruling that plaintiff was entitled to recover the premiums that were improperly withheld by the plan, but could not recover the full value of the life insurance policy. The court reasoned that plaintiff "s[ought] a monetary award in the amount of the life insurance benefits lost[,]...but [wa]s not the true owner of any funds in MetLife's possession," and thus, was not seeking equitable relief. Plaintiff's counsel intends to file a motion for reconsideration in light of the Supreme Court's ruling in *Amara*.

Plan Language Controls:

- ???In *Farhner v. United Trans. Union Discipline Income Protection Program*, No. 09-4431-cv, 2011 WL 1641551 (6th Cir. May 3, 2011), the Sixth Circuit affirmed the district court's ruling that the denial of a participant's application for income replacement benefits was not arbitrary and capricious because it was based on the express terms of the plan, which required the denial of benefits to participants who were discharged for insubordination. Plaintiff argued that the administrator should

have looked beyond the plan language to determine if his discharge was lawful, contending that he was improperly terminated because his employer improperly failed to grant him leave under the Family and Medical Leave Act. The Sixth Circuit rejected these arguments, concluding that "the Plan Administrator was not required to look beyond the language of the Plan" to determine if the plaintiff was properly terminated for insubordination, "where the language of the Plan was unambiguous and the Plan did not require it to do so."

Fiduciary Exception to Attorney-Client Privilege:

- In *Solis v. Food Employers Labor Relations Association & United Food & Commercial Workers* Pension *Fund*, No. 10-1687, 2011 WL 1663597 (4th Cir. May 4, 2011), the DOL sought communications between the defendant funds' fiduciaries and their attorneys in connection with an investigation into the funds' indirect investments in Bernard L. Madoff's Ponzi scheme, which resulted in a $10.1 million loss in plan assets. The Fourth Circuit held that the fiduciary exception to attorney-client privilege extends to communications between an ERISA trustee and a plan attorney regarding plan administration, as well as when the DOL initiates an investigation or audit under ERISA Section 504. In so holding, the Fourth Circuit concluded that applying the fiduciary exception in the context of a DOL subpoena under ERISA did not require "a showing of good cause; instead, its application turns on the context and content of the individual communications at issue." The court found that the documentation requested related to the funds' administration and was therefore information that ERISA trustees had a fiduciary obligation to disclose, provided that it did not relate to the fiduciary's own legal defense. The court did not reach the issue of whether the work product doctrine is subject to the fiduciary exception because the funds failed to carry their burden to demonstrate applicability of the work product doctrine.

Standing

- In *Santomenno v. John Hancock Life Ins. Co. (U.S.A.)*, No. 10-cv-01655, 2011 WL 2038769 (D.N.J. May 23, 2011), the court held that the participants and beneficiaries of employer-sponsored 401(k) plans cannot maintain claims against plan service providers without joining the plan trustees, who entered into the agreements with the plans' service providers. Plaintiffs alleged that John Hancock charged the plans excessive fees for investment services in violation of ERISA Section 502. Applying traditional trust law principles, the court held that the plaintiffs could not sue third-party service providers without first making a demand on the trustees, or at least alleging the futility of making such demand or some allegations, which if proven, would establish that the trustees improperly refused to

bring suit. Because plaintiffs failed to assert such factual allegations and because the trustees were not joined in the suit, the court dismissed plaintiffs' complaint.

- In *In Re Principal U.S. Property Account ERISA Litig.*, No. 4:10-cv-198, 2011 WL 1898915 (S.D. Iowa May 17, 2011), the district court denied defendants' partial motion to dismiss based on the argument that plaintiffs lacked statutory standing to bring claims related to those plans in the putative class in which they were not participants. The court rejected defendants' argument on the grounds that a plaintiff's ability to represent a putative class depends only on satisfaction of Rule 23's requirements for class certification. Thus, the court reasoned that individual who is not a participant in an ERISA plan may still represent the plan as part of a class action, despite the fact that the individual could not commence an action directly on behalf of the plan.

Breach of Fiduciary Duty:

- In *Tullis v. UMB Bank N.A.*, No. 09-4370, 2011 WL 1885978 (6th Cir. May 18, 2011), the Sixth Circuit affirmed the district court's ruling that the directed trustee of a 401(k) plan did not breach its fiduciary duties under ERISA by allegedly failing to inform participants of nonpublic information that the outside account manager selected by the trustee had previously engaged in illegal activity. The court found that UMB was shielded from liability by ERISA Section 404(c). Plaintiffs conceded that the prerequisites of the safe harbor defense were met, with the exception of one: that UMB concealed from them material non-public facts regarding the account manager's fraud, thereby depriving them of "control" over their accounts. The court, however, found that plaintiffs failed to furnish evidence to create a genuine issue as to whether UMB concealed this information. Consequently, the court concluded that plaintiffs exercised "independent control in fact" over their accounts and UMB's conduct fell within the Section 404(c)'s safe harbor.

- In *Guyan Intl., Inc., v. Professional Benefits Administrators, Inc.*, 10-cv-823 (N.D. Ohio May 10, 2011), the district court granted plaintiff's motion for partial summary judgment, holding that Professional Benefits Administrators, Inc. violated its fiduciary duties under ERISA by using assets of the plans that it was hired to administer to pay its own operational expenses. The court concluded that PBA was a fiduciary to its plan clients because it had "practical control" over their assets, as it was able to issue checks on its clients' behalf and also had the authority to deposit the plans' assets into different accounts of its own choosing while it had control over the funds.

- In *Stark v. Mars, Inc.*, No. 2:10-cv-642, 2011 WL 1792261 (S.D. Ohio May 11, 2011), the district court denied in part and granted in part defendants' motion to dismiss plaintiff's claims. Plaintiff alleged that defendants misrepresented in various

communications that her monthly pension benefits were almost double what they actually were. After months of overpayment, her benefits were reduced to reflect the proper amount and to recoup the prior overpayments. Plaintiff brought four claims relating to this alleged misrepresentation against both her former employer and the plan administrator. The court found that plaintiff alleged sufficient facts to support her breach of fiduciary duty and denial of benefits claims, but only as against the plan administrator. It dismissed the claims against Mars, finding that plaintiff failed to allege facts sufficient to show that Mars was acting in a fiduciary capacity in making the alleged misrepresentations to plaintiff, and the plan administrator is the proper defendant in a claim for benefits. The court also found that plaintiff could pursue her fiduciary breach claim under ERISA Section 502(a)(3) in conjunction with her claim for denial of benefits under Section 502(a)(1)(B), concluding that her fiduciary breach claim was not "a repackaged benefits claim." Finally, the court found that plaintiff alleged sufficient facts to satisfy the elements of estoppel, including extraordinary circumstances based on defendants' repeated and consistent misrepresentations.

Retiree Benefits:

- In *CNH America LLC v. International Union, United Automobile, Aerospace & Agricultural* Implement *Workers of America (UAW)*, — F.3d —, 2011 WL 1833202 (6th Cir. May 16, 2011), the Sixth Circuit, in a split decision, held that the Labor Management Relations Act did not preempt an employer's state-law tort claims based on a union's alleged misrepresentations regarding its authority to bind retirees during collective bargaining over changes to retiree health insurance coverage. The appeals court determined that resolving the claims would not require an interpretation of the collective bargaining agreement, and, further, that UAW's actions giving rise to the claims took place before the CBA's formation. The Sixth Circuit also affirmed the district court's determination that a VEBA unambiguously contained no covenant by the UAW not to sue with respect to retiree benefit contributions, and thus no breach of such covenant could have occurred.

Cert. Denied:

- On May 23, 2011, the Supreme Court denied without comment cross-petitions for certiorari in *Young v. Verizon's Bell Atlantic Cash Balance Plan*, 615 F.3d 808 (7th Cir. 2010), cert. denied, 2011 WL 1936084 (May 23, 2011) and 2011 WL 1936085 (May 23, 2011). In this case, plaintiffs sued for additional retirement benefits, alleging that the Plan failed to follow the written terms of the benefit formula. A victory for plaintiffs would have resulted in at least $1 billion in liability. Because the benefit formula incorrectly multiplied benefits by the same factor two times, the

district court rejected plaintiffs' claim and granted the Plan's counterclaim for reformation due to the scrivener's error. The Seventh Circuit affirmed the reformation of the Plan under ERISA Section 502(a)(3). Plaintiffs filed for certiorari, arguing that the lower courts erred by reforming an unambiguous plan provision because such action undermined ERISA's plan document rule. Defendants cross-filed for certiorari on the issue of whether a benefit committee with broad discretionary powers acted within the scope of its authority by correcting a scrivener's error in response to a benefit inquiry.

Filings:

- A large group of former General Motors executives filed an ERISA complaint alleging that their retirement benefits were improperly reduced in violation of the terms of GM's Executive Retirement Plan ("ERP"). *Tate v. Gen. Motors LLC*, No. 2:11-cv-12028-GCS-MAR (E.D. Mich. May 9, 2011). The ERP provides that participants who have a retirement benefit in excess of $100,000 per year shall have any benefit above $100,000 reduced by 2/3. Plaintiffs argue that GM incorrectly interpreted this provision to count benefits received under the separate General Motors Retirement Program for Salaried Employees, in which the plaintiffs are also participants, towards the $100,000 figure. Two of the plaintiffs also brought a claim under ERISA Section 502(c)(1) for failure to furnish requested plan documents in a timely fashion.
- In *Palmason v. Weyerhauser Co.*, No. 11 Civ. 00695 (W.D. Wash. Apr. 25, 2011), a participant in the Weyerhaeuser Company's defined benefit plan filed a class action complaint against Weyerhauser and the Plan's fiduciaries alleging that they breached their duties under ERISA by investing in "risky alternative investments," including various private equity and hedge funds. The complaint states that the Plan lost several millions of dollars since 2006, when it began investing pursuant to the "portable alpha strategy," which allegedly resulted in the investment of 81% of the Plan's assets in alternative "risky" investments. The lawsuit contends that the Plan fiduciaries' motivation for taking an aggressive investment approach was to improve Weyerhauser's financial position, which constituted a breach of their fiduciary duties under ERISA, and ultimately caused severe losses for the Plan. Notably, the defendant in this case is a defined benefit plan, not a defined contribution plan.

Settlements:

- In *In re PFF Bancorp, Inc. ERISA Litigation*, No. 08-01093 (C.D. Cal. Apr. 27, 2011), the district court approved a $3.4 million settlement in an employer stock drop case based on the employer's alleged failure to accurately disclose its financial condition

prior to its ultimate bankruptcy, and certified a class of approximately 1,000 ESOP participants who invested in the stock between 2003 and 2010.

- In *George v. Duke Energy Retirement Cash Balance Plan*, No. 06-00373(D.S.C. May 16, 2011), the district court approved a $30 million settlement to resolve a class action wherein cash balance retirement plan participants alleged that their lump sum distributions and interest credits were calculated incorrectly.
- In *Paulsen v. CNF, Inc.*, No. 03-03960 (N.D. Cal. May 6, 2011), Towers Perrin agreed to pay $9.2 million to settle class action claims that it breached its fiduciary duty by using unreasonable actuarial assumptions in providing services to the Consolidated Freightways Corporation Pension Plan, which was terminated, while underfunded, following the company's bankruptcy.
- In *Mack Trucks, Inc. v. Int'l Union, United Automobile, Aerospace & Agricultural Implement Workers of America – UAW*, No. 07-3737, 2011 WL 1833108 (E.D. Pa. May 12, 2011), the district court preliminarily approved a settlement to resolve class claims relating to the employer's proposed reductions to retiree healthcare benefits. Under the proposed settlement, Mack Trucks would contribute $525 million to a Voluntary Employees' Beneficiary Association (VEBA) trust to fund approximately 85% of the cost of a restructured retiree medical program.

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[2] Originally published by Bloomberg Finance L.P. Reprinted with permission.

[3] *See* Healthcare.gov at <http://www.healthcare.gov> last visited on May 11, 2011 (containing a summary of the major provisions of ACA and a timeline of when each provision becomes effective).

[4] 2010 BL 282364.

[5] 2011 BL 46193.

[6] 2011 BL 24580.

[7] In each case there were several ancillary issues that were discussed in the court's opinion, including, but not limited to, the applicability of the Anti-Injunction Act, the Establishment Clause, the Free Exercise Clause, the Free Speech Clause, and the Religious Freedom Restoration Act. An analysis of these issues is not included in this article.

[8] Interestingly enough, two district courts within the same circuit reached opposite conclusions on the issue of whether plaintiffs stated plausible claims as to the constitutionality of the individual mandate. These two district court cases have been consolidated into a single appeal before the Fourth Circuit.

[9] On May 12, 2011, the Sixth Circuit Court of Appeals asked the parties to brief two additional issues: (i) if the Commerce Clause challenge was a facial challenge and, if so, must the plaintiffs prove that no set of circumstances exists under which ACA would be valid, citing *United States v. Salerno*, 481 U.S. 739, 745 (1987); and (ii) if the plaintiffs alleged an injury in fact or an imminent injury; if the latter, plaintiffs would be creating a case of actual controversy under Article III and the Declaratory Judgment Act, even though they filed their complaint more than three years in advance of the provision's effective date.

Separately, on May 27, 2011, the government filed a motion to dismiss the appeal, arguing that because one of the individual plaintiff purchased health insurance through her employer, she no longer had standing to sue because she could no longer plausibly allege that the provision would cause her imminent injury. In their response, the plaintiffs contended that the circumstances surrounding the standing of the plaintiffs had not changed and the district court already ruled that plaintiffs in this case did have standing.

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[11] 2011 BL 98231.

[12] Because not all the facts are included in the opinion, some additional facts have been culled from the district court's opinion and the briefing of the parties. *See Peabody v. Davis*, No. 05-CV-5026, 2009 WL 2916824, at *2-3 (N.D. Ill. Sept. 2, 2009); *Peabody v. Davis*, No. 05-CV-5026, Memorandum In Support Of Peabody's Motion For Summary Judgment As To Non-Insurer Defendants, at *2 (filed Nov. 1, 2006).

[13] The Court addresses additional claims which we have chosen not to address. The additional claims include: removal of defendants Davis and Kole as trustees, compelling defendants to make certain disclosures, and the court's ability to retain jurisdiction until Peabody's claims are paid.