Proskauer

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Editor's Overview

In this issue, our lead article focuses on the Obama administration's landmark healthcare legislation, which is currently under Supreme Court review, and considers the potential outcomes of pending constitutional challenges. However, these challenges have not stifled regulatory efforts by the Department of Labor; accordingly, our authors turn to a discussion of current enforcement initiatives as the Department moves forward to evaluate plan compliance with the new legislative regime. The authors go on to offer perspectives on what regulatory interaction may lie in store, and concludes with practical suggestions for addressing regulatory inquiries and for anticipating compliance questions in this uncertain environment.

Our second article examines the impact of a recent Supreme Court decision, *Wal-Mart v. Dukes*, on class litigation of ERISA claims. Although the *Dukes* decision involved Title VII claims, it established new guidance on the so-called commonality requirement in class cases, guidance which may be taking hold in ERISA litigation. The *Dukes* Court also limited the availability of "no opt out" classes in actions purporting to seek injunctive and/or declaratory relief as the principal remedy. The author reviews the application of *Dukes* to ERISA class actions, and considers ways in which *Dukes* could continue to influence outcomes in the ERISA context.

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

Health Care Reform Remains Alive and Well as DOL Enforces ACA through Plan Audits

By James R. Napoli and Kara L. Lincoln

With the Supreme Court's ruling on health care reform pending, the fate of the Affordable Care Act (ACA or Act) remains largely uncertain. In the meantime, however, the law is still in force.

The Department of Labor (DOL) has begun requesting, through recent audit requests on health and welfare plans, that employers prove their plans currently comply with the Act. Is your plan ready?

Challenges to the Act and Possible Rulings

The challenges to the Act primarily focus on the constitutionality of its individual mandate, or minimum coverage provision, which 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.

In addition to the constitutional challenge, the Supreme Court heard arguments regarding the severability of the individual mandate from the remainder of the Act should the individual mandate be held unconstitutional. Three primary arguments were advanced on this issue:

1. the individual mandate is not severable from the remainder of the Act, meaning the remainder of the Act must be struck should the Court rule that the individual mandate is unconstitutional;
2. the individual mandate is completely severable from the remainder of the Act, meaning the remainder of the Act can stand; and
3. the individual mandate is severable from some, but not all, of the remaining provisions of the Act, meaning that certain provisions of the Act, such as the employer mandate, guaranteed issue and community rating provisions must be struck should the Court rule that the individual mandate is unconstitutional but the remaining provisions could stand.[1]

Accordingly, there are several different ways the Supreme Court could rule on the Act—or even hold that the case is not ripe for review. The primary possibilities include:

- ***Constitutional.*** The individual mandate and the entire Act could be upheld as constitutional, i.e., within Congress' power and enforceable.
- ***Unconstitutional and Unable To Be Severed.*** The individual mandate could be struck down as unconstitutional and the entire remainder of the Act could be struck as unseverable from the individual mandate (i.e., the remainder of the Act does not function as Congress intended absent the individual mandate, and must as a matter of judicial doctrine be struck).
- ***Unconstitutional and Completely Severable.*** The individual mandate could be struck down as unconstitutional, but completely severable from the Act—leaving

the rest of the Act intact.

- ***Unconstitutional but Partially Severable.*** The individual mandate could be struck down as unconstitutional, but severable from some, but not all, of the Act—leaving certain provisions of the Act intact.

Recent DOL Audit Requests: Plans Must Prove They Comply

While the recent Supreme Court oral arguments caused speculation as to the future of the ACA, the Act is law unless and until the Court holds otherwise. As such, the Act is enforceable by the federal government, and employer-provided group health plans must continue to comply and otherwise implement the ACA's various coverage and related mandates. The DOL is already taking the first steps toward enforcing the Act.

The DOL's recent written audit requests relating to health and welfare plans have included inquiries related to various mandates under the Act. This is a significant development in the ongoing implementation of the ACA's various coverage and related mandates, in that it marks the first appearance of ACA-related topics in DOL auditing practices. As such, it seems the DOL is enforcing the Act—and will continue to do so unless and until the ACA is ruled unconstitutional. As a result, plan sponsors must be prepared to produce documents to prove that their plans comply with the ACA's various mandates.

Three Types of Requests

The DOL audit requests relating to the ACA can be divided into three types:

1. requests as to plans claiming grandfathered status;
2. requests as to plans not claiming grandfathered status; and
3. requests as to all health plans regardless of grandfathered status.

For each type of request, the DOL has asked to examine documents establishing the plan sponsor's compliance with the Act.

Requests Applicable to Grandfathered Plans

Some of the DOL's attention is focused on whether a plan is properly accorded grandfathered status under Section 1251 of the ACA. DOL inquiries can include:

- ???disclosure statements regarding grandfathered status included in material distributed to participants and beneficiaries describing the benefits provided under the plan; and
- ???records documenting the terms of the plan on March 23, 2010, the ACA's enactment date, along with any ancillary documents required to verify the status of the grandfathered plan.

The DOL audit questions listed above appear to be aimed at substantiating that the plan in question complies with two requirements under the final interim regulations on grandfathered health plans under the ACA issued by the departments of Labor, Health and Human Services, and Treasury on June 14, 2010.

Under those regulations, plans must: (1) provide a specific notice, in any materials that describe the plan’s benefits to participants or beneficiaries, that the plan believes it is a grandfathered health plan; and (2) maintain, and make available upon a government agency's request, records documenting the terms of the plan or health insurance coverage in effect on March 23, 2010, as necessary to verify, explain, or clarify the plan's grandfathered status.

Requests Applicable to Nongrandfathered Plans

- ???the plan's choice provider disclosure notice, along with a list of participants who received that notice;
- ???documents relating to the plan's emergencies services benefits;
- ???documents relating to the preventative services for each plan year on or after Sept. 23, 2010;
- ???the plan's internal claims and appeals procedures;
- ???notices relating to adverse benefit determinations, the plan's final internal adverse determination notice, and the plan's final external review determination notice; and
- ???contracts or agreements with independent review organizations or third-party administrators providing external review.

The DOL audit requests listed above appear to be aimed at substantiating that the plan in question complies with certain coverage mandates that apply only to nongrandfathered health plans, including to cover certain preventive care services without cost-sharing, as well as that any emergency hospital services must be provided without requiring prior authorization or higher cost-sharing amounts, even for out-of-network services. In addition to these mandates, nongrandfathered health plans must adopt new internal and external claims procedures pursuant to guidance issued under the ACA. This guidance provides a safe harbor for compliance with the Act's requirement to offer a binding external review process under the plan, pursuant to which nongrandfathered health plans can contract with three independent review organizations to handle external claims appeals.

Requests Applicable to All Plans

- ???for plans with dependent care coverage, a sample of the notice describing enrollment opportunities relating to coverage of children up to age 26;
- ???a list of any participants who had coverage rescinded and the reason for such rescission;
- ???if the plan imposes or has imposed a lifetime limit since Sept. 23, 2010, documents relating to that limit for each plan year; and
- ???if the plan has imposed an annual limit since Sept. 23, 2010, documents relating to that limit.

These requests appear to be aimed at eliciting information necessary for the DOL to determine a group health plan's compliance with several primary mandates applicable to all group health plans, regardless of the plan's grandfathered status.

First, the Act requires that group health plans and insurance issuers that provide dependent child coverage make that coverage available for children until they attain age 26.

Second, the Act does not permit the rescission of coverage absent fraud or material misrepresentation on behalf of the individual claiming coverage under the group health plan. For this purpose, a rescission is simply the retroactive termination of coverage for any reason other than nonpayment of premiums.

Finally, the ACA does not permit group health plans to impose lifetime dollar limits on benefits deemed to be "essential," a term that needs further definition by the oversight agencies, nor does the Act permit annual dollar limits to be placed on these benefits.

Proskauer's Perspective

As explained above, the ACA remains the law of the land unless and until the Supreme Court rules otherwise. The fact that the DOL has begun auditing health and welfare plans for ACA compliance underscores this reality.

With this in mind, we identify various steps plan sponsors should be taking in preparation for a ruling by the Supreme Court regarding the viability of the Act, as well as in preparation for a DOL audit.

Plan Sponsors Should Prepare for Any Ruling on the ACA

In light of the uncertainty as to the Supreme Court's ruling, employers should consider their alternatives and keep their options open. While it is premature to act based on a perceived notion of how the court may rule, sponsors should nonetheless be considering contingency plans so as to position themselves to respond accordingly.

Here are a few examples of issues that may arise if the court strikes the Act in its entirety (or at least the provisions of the Act that relate directly to the individual mandate, employer mandate, coverage mandates, and the establishment of the state-sponsored health insurance exchanges).

- *Coverage Mandates.* Some plans are drafted such that the ACA's coverage mandates are automatically eliminated from the plan if the ACA is struck down by the Supreme Court. For example, the ban on lifetime and annual dollar limits with respect to essential health benefits would automatically be eliminated from the plan, and the pre-ACA annual and lifetime limits reinstated. Sponsors of such plans need to consider the possible negative consequences of such an action, including, for example, the employee morale issues that inevitably arise whenever there is a real or perceived benefit cutback, as well as the claims and litigation that often follow. Likewise, the sponsor of a plan that does not include an "automatic repeal" provision, but that nevertheless is considering amending its plan to effectuate such a repeal, needs to consider now the implementation of such a strategy.
- *Retiree Medical Exit Strategy.* An employer that is looking to exit sponsorship of its retiree medical plan, and to use the ACA-mandated state-sponsored health

insurance exchanges as a "soft landing" for retirees whose plan coverage is thereby terminated, needs to consider a world absent those exchanges. If the entire Act is ruled unconstitutional, the health insurance exchanges would no longer be required. Under such a scenario, it is anticipated that many states would likely not offer an exchange. Thus, a strategy for eliminating retiree medical coverage based on the assumption that exchanges will be available would have to be reconsidered.

- *Workforce Realignment.* Beginning in 2014, the Act imposes an employer mandate, which is a penalty on employers who fail to provide affordable health care coverage to full-time employees. For this purpose, the ACA defines a full-time employee as an individual who works more than 30 hours per week. Some employers may be planning to realign their work forces to employ more employees who work less than 30 hours per week (or to otherwise reduce the hours of its current part-time workforce to no more than 30 hours per week) to avoid penalty. Any such workforce realignment inherently carries with it risks of litigation under the Employee Retirement Income Security Act and the various federal antidiscrimination statutes (e.g., the Age Discrimination in Employment Act and Title VII of the Civil Rights Act). Therefore, if the employer mandate is invalidated, employers will wish to reconsider this strategy.

Best Practices To Prepare for DOL ACA-Related Audits

Generally, plan sponsors and administrators should be prepared to demonstrate that their plans comply with every aspect of the ACA, which generally requires documentary evidence from plans, recordkeepers, and/or service providers.

Based on the substance of the recent DOL audit requests, plans will likely be expected to prove they comply with multiple ACA-related requirements, such as:

- grandfathered status;
- notice to participants of grandfathered status;
- coverage for dependents to age 26 since Sept. 23, 2010, and notice of special enrollment periods for the same;
- elimination of lifetime and annual limits on essential health benefits;
- participation and rescission of coverage;
- internal and external claims procedures; and
- other coverage mandates, such as those concerning preventive care services and emergency hospital services.

Inadequate responses to these requests could lead to additional inquiries from the DOL, such as requests for additional documents, interviews, information, site visits, investigations, and even DOL enforcement actions, and lawsuits by individual participants and beneficiaries. Various penalties could be imposed by the DOL and/or the IRS for failure to implement certain ACA-related coverage mandates. For example, the Act levies a penalty of up to $100 a day per affected individual for the failure to provide coverage to adult children who are under the age of 26.

Further, the DOL and individual participants could file lawsuits, at least under ERISA, to ensure proper implementation of the ACA. For example, they could contend that the Act's coverage mandates were not implemented or were not implemented correctly, or could complain that they were not properly notified. Possible future litigation related to compliance with the ACA includes, but is not limited to, the following:

- ???claims to mandated coverages that were or are not being provided;
- ???breach of fiduciary duty for failure to provide proper notice of the availability of a mandated coverage;
- ???claims for interference with rights to benefits growing from the implementation of a workforce realignment and/or a retiree medical exit strategy; and
- ???whistle-blower actions brought pursuant to the Act.

Given these risks, plan sponsors should prepare now to be able to prove their plans' compliance with the ACA. In particular, there are several specific steps that plan sponsors, administrators, fiduciaries, and service providers can take to ensure that compliance can be proven and that such audits go as smoothly as possible:

- ???document steps taken to comply with the ACA's requirements;
- ???retain all records of plan design, administration, and maintenance, including contracts with third-party service providers such as IMOs;
- ???have agreements with entities such as service providers or record keepers to obtain records that are needed to prove compliance;
- ???have any plan amendments or written policies that were adopted to implement the ACA mandates ready to produce; and
- ???upon receiving such an audit request, contact counsel immediately, as the issues are complex, and swift action is often necessary to protect the various rights and interests of the numerous entities involved in administering health and welfare

plans.

In short, while employers must wait to learn the future of health care reform, they should not wait to prepare for the potential consequences of the Supreme Court's ruling, or to respond to DOL audits in the interim.

Class Warfare—ERISA Class Litigation in Light of *Wal-Mart v. Dukes*

By Charles F. Seemann III

As millions of American workers approach retirement age and health care costs rise, the prospects for class action litigation of Employee Retirement Income Security Act claims remain robust.

Class litigation can present a quagmire of potentially far-reaching management decisions, as well as litigation costs, document-retention headaches and often, serious financial exposures. The high-stakes nature of class litigation has, in turn, engendered a great deal of court scrutiny of class certification determinations.

Last year, the Supreme Court once again revisited the subject of class actions in *Wal-Mart Stores, Inc. v. Dukes*.[2] There, the Court reversed the lower courts' decisions to sustain a nationwide class encompassing nearly 1.5 million female Wal-Mart employees who claimed harm from an allegedly discriminatory (although facially neutral) corporate policy governing promotion and advancement.

The *Dukes* Court's guidance on significant aspects of the class certification process has, in turn, driven a number of recent class-related decisions in ERISA cases.

The Decision in *Wal-Mart v. Dukes*

The *Dukes* decision arose in the Title VII context. The named plaintiffs claimed that Wal-Mart’s decentralized procedures for making pay and promotion decisions had a disparate impact on female employees, and effectively denied them equal access to advancement and associated increases in compensation.

Plaintiffs also asserted that, because Wal-Mart was aware its pay and promotion process had a disparate adverse impact on women, Wal-Mart's refusal to exercise more centralized control over the process amounted to disparate treatment of women. Based on these allegations, plaintiffs sought injunctive and declaratory relief, as well as punitive damages and a backpay award.

The district court certified a nationwide class that included every current and former female employee of Wal-Mart, dating back to 1998. The district court based its decision on Rule 23(b)(2), which authorizes class treatment in situations in which "the party opposing the class has acted or refused to act on grounds that are generally applicable to the class, so that injunctive relief or corresponding declaratory relief is appropriate respecting the class as a whole."[3] The Ninth Circuit, in a divided en banc decision, substantially affirmed.[4]

The Supreme Court reversed, holding that class certification was improper. In doing so, the Court found that the class, as certified, failed to satisfy two provisions of Rule 23. First, the Court focused on Rule 23(a)(2) and its requirement that class litigation address common issues of law or fact. The Court suggested that this so-called "commonality" requirement is "easy to misread, since any competently crafted class complaint literally raises common questions."[5] Instead, the majority cautioned, lower courts must look for a common contention, which in the Court's view, must be "capable of classwide resolution—which means that determination of its truth or falsity will resolve an issue that is central to the validity of each one of the claims in one stroke."[6]

Noting that Wal-Mart had a companywide policy against gender discrimination, the Court turned to statistical analyses that, plaintiffs contended, suggested Wal-Mart's gender hiring practices were inconsistent with national norms. The Court held that this evidence did not satisfy Rule 23(a)(2), because Wal-Mart could demonstrate that nondiscriminatory reasons—for example, regional or local variations in the workforce and the promotion process—accounted for any inconsistencies between Wal-Mart's hiring statistics at any given location and the national norms cited in statistical studies.[7]

The Court then turned to the decision certifying a class of backpay claimants under Rule 23(b)(2).[8] The Court noted that Rule 23(b)(2) class actions did not incorporate the same procedural protections afforded by Rule 23(b)(3)—namely, mandatory notice to absent class members, and the right to opt out of the action altogether. This structural feature of Rule 23(b) led the Court to observe that individualized claims for monetary relief were more properly asserted in the Rule 23(b)(3) context, where those protections were in place.

The Court also rejected the rationale underlying the Ninth Circuit's ruling: that is, that the "predominance" of common issues (as advanced by plaintiffs) would nevertheless justify a class. In doing so, the Court emphasized that the plaintiffs' decision to omit claims for compensatory relief, which was apparently calculated to satisfy a "predominance" inquiry, still exposed claimants to having potentially valid claims for compensatory relief precluded by a classwide adverse judgment that claimants could not avoid through an opt-out procedure.[9]

Next, the Court addressed plaintiffs' contention that backpay claims are still properly certified under Rule 23(b)(2) because backpay remedies are equitable in nature. Relying on the express terms of Rule 23(b)(2), the Court noted that the rule did not contemplate "equitable" remedies in general, but specified injunctive and declaratory remedies. Since the rule does not speak to general equitable remedies, the Court rejected plaintiffs' argument.

In rejecting the arguments for a Rule 23(b)(2) certification, the Court endorsed Wal-Mart's argument that it was entitled to individualized determinations on each employee's backpay claim. The circuit court had proposed adjudicating those claims through sampling of class members, and used that approach to help justify the conclusion that the backpay remedies were "incidental" to the injunctive and declaratory relief sought by the class. Noting that there were various, highly individualized defenses applicable to backpay claims, the *Dukes* Court concluded that this approach was improper: "[A] class cannot be certified on the premise that Wal-Mart will not be entitled to litigate its statutory defenses to individual claims. And because the necessity of that litigation will prevent backpay from being ‘incidental’ to the classwide injunction, respondents’ class could not be certified even assuming, *arguendo*, that 'incidental' monetary relief can be awarded to a 23(b)(2) class."[10]

Decisions Since *Wal-Mart v. Dukes*

In the ensuing months, the *Dukes* decision has received attention from a number of courts considering the class action device in the ERISA context, but the full extent of its import to class litigation of ERISA claims remains undefined.

The trend in post-*Dukes* ERISA cases seems to be toward closer scrutiny of commonality issues, although the results have not yet coalesced into clear guiding principles. In one recent decision, a court refused certification of claims based primarily on alleged fiduciary misrepresentations, noting that reliance questions were too individualized to be resolved "in one stroke," as *Dukes* would appear to require.[11] In contrast, another court found that alleged misrepresentations and omissions about the value of closely held employer stock were sufficient to satisfy the "relatively low standard" for commonality, although the court ultimately declined to certify the class on different grounds.[12]

The closer scrutiny of Rule 23(a)(2)'s commonality requirement in the wake of *Dukes* has also led some courts to reconsider the validity of classes previously certified. In one long-running case, a court recently decertified a class of participants seeking to recover unvested benefits forfeited after a corporate reorganization resulting in an alleged partial plan termination. Citing *Dukes*, the court held that plaintiff could only represent a class that shared a common injury—specifically, that they were terminated on account of the reorganization, as opposed to an independent reason. The court subsequently certified a redefined class consisting of participants who were involuntarily terminated, without cause, and forfeited benefits due to the reorganization.[13]

Another area receiving more attention in the wake of *Dukes* involves the nature of monetary remedies sought by the class. For example, in *Nationwide Life Insurance Co. v. Haddock*,[14] the district court certified a class of approximately 24,000 ERISA plans challenging revenue-sharing payments made to Nationwide in connection with annuity contracts held as plan investments. On appeal, the Second Circuit found certification under Rule 23(b)(2) improper, citing each plan's individualized monetary remedy. It remanded to the district court for consideration whether the class warranted certification under Rule 23(b)(3).

Proskauer's Perspective

Based on *Dukes* and its recent application in ERISA cases, we can identify several areas in which we anticipate that *Dukes* will likely have an impact on the future conduct of class certification motions in ERISA cases:

- ***Higher Commonality Threshold***—Although commonality has often been treated as a low standard, some courts have been giving closer attention to the commonality standard enunciated in *Dukes*, and we would expect that trend to

continue. The *Dukes* Court's emphasis on one-stroke resolution of common questions, as well as its obvious concern for preserving defendants' ability to raise individualized defenses, may provide opportunities for parties to resist certification on the grounds of lack of commonality

Commonality may also now serve an effective deterrent in ERISA cases in which there are individualized defenses, such as when participants have executed releases. It is not uncommon for participants to sign a release of ERISA claims when they receive a distribution of benefits upon retirement; when they receive a pay-out under an ERISA severance plan; or when receiving benefits under so-called “window plans,” which offer enhanced benefits to participants as part of a reduction-in-force. The presence of releases within a class should serve to undermine commonality, but in at least one case, a court has held otherwise.[15]

- ***Potential Significance of Section 404(c) Defenses***—*Dukes* may also give rise to additional obstacles to certification in cases featuring participant-directed accounts governed by ERISA Section 404(c).[16] In such cases, individualized inquiries into the participants’ exercise of control clearly implicates the *Dukes* court’s concerns over preserving defendants’ right to litigate each claim on its own merits, including applicable statutory defenses.[17]
- ***Renewed Resort to Claims for Plan-Wide Relief***—Individual ERISA claimants challenging alleged breaches of fiduciary duty under ERISA Section 502(a)(2) are authorized to recover "losses to the plan" associated with the breach.[18] Class counsel seeking to avoid the cost and logistical hassles of maintaining a traditional class action—including mandatory notice, opt-out rights, and the like—may turn to statutory claims for planwide relief, in lieu of the potentially more cumbersome class vehicle. However, resort to this device will be limited when the rights of individual participants are potentially impacted, such as in claims involving 401(k) plans and similar individual-account plans, since courts have held in these contexts that plaintiffs cannot avoid the procedural protections that Rule 23 provides to absent class members.[19]
- ***Fewer Class Claims for Equitable Relief under ERISA Section 502(a)(3)*** —ERISA Section 502(a)(3), which authorizes injunctions and "other appropriate equitable relief," serves as ERISA’s catch-all remedial provision. Although the Supreme Court has recently expanded the availability of "equitable relief" to ser-ve as a vehicle for recovering monetary relief, *Dukes* makes clear that the characterization of monetary relief as "equitable" will not, without more, render Rule 23(b)(2) certification appropriate. Thus, class resolution of ERISA claims seeking "equitable relief"—for example, claims for nonfiduciary statutory

violations—may become more difficult to maintain as a credible class action threat.

- ***Potential Complication of Settlements***—Settlement classes under Rule 23(b)(2) are often desirable, given their no-notice and no-opt-out features. Yet these features, and their implications for absent class members, are among the main reasons that the *Dukes* Court took issue with the lower courts' lax standards for Rule 23(b)(2) certification. Litigants and counsel contemplating settlement of pending ERISA class cases should therefore consider whether a no-opt-out class settlement is better pursued under Rule 23(b)(1), which the *Dukes* decision did not specifically address.

These represent some of the anticipated implications of *Dukes* in the ERISA context, but by no means all of them. Complex litigation, by its nature, involves manifold permutations of fact and law, and as ERISA class action law continues to develop in the wake of *Dukes*, new applications of the *Dukes* decision will become known. In the interim, litigants and litigators alike would do well to understand the *Dukes* decision and to review their class-action dockets in its light.

Rulings, Filings, and Settlements of Interest

Fiduciary Duties:

- In *Secretary, Dept. of Labor v. Seibert*, No. 11-10745-cv, 2012 WL 898823 (11th Cir. Mar. 19, 2012), the Eleventh Circuit affirmed a district court ruling that a pension plan's sole trustee and administrator breached his ERISA fiduciary duties when he transferred assets from the plan to companies he owned for his own benefit. The Eleventh Circuit held the lower court properly relied on the trustee's statements from a related criminal plea agreement to find a breach of fiduciary duty. The court also agreed that the trustee was liable to the plan for lost opportunity costs and that the plan (through a court-appointed successor trustee) could use assets from the trustee's individual plan account to satisfy its claim. The court rejected the trustee's argument that ERISA's anti-alienation provision prohibited this result, noting a clear exception to the anti-alienation rule where account assets are used to satisfy a judgment for ERISA violations related to the same plan, as in the case at bar.

- In *Killian v. Concert Health Plan*, — F.3d — 2012 WL 1357703 (7th Cir. Apr. 19, 2012), the court ruled that there was no abuse of discretion in denying coverage for out-of-network services, and that the fiduciary obligation "to convey complete and accurate information" regarding the lack of coverage was not implicated. In so ruling, the court considered the similarities and dissimilarities between this case and *Kenseth v. Dean Health Plan*, 610 F.3d 452 (7th Cir. 2010), in which the court

held that . . . As in *Kenseth*, plaintiff Killian called the number on the back of his insurance card to obtain pre-approval for needed care (Killian's wife urgently required brain surgery). The majority found nevertheless that there was no triable issue arising from Killian's two hurried phone conversations with the plan's call center representatives, because Killian failed to put the call center representatives on notice of the circumstances necessitating the surgery, and contrary to the terms of the plan, he failed to inquire about coverage for services obtained at the facility selected for treatment. In dissent, Judge Ripple argued that the case was analogous to *Kenseth* and that a genuine issue of material fact remained as to whether Killian's conversations with the call center representatives triggered the plan's disclosure duties.

Existence of ERISA Plan:

- In *Stoffels v. SBC Commc'n, Inc.*, — F.3d —, No. 11-50148, 2012 WL 1259014 (5th Cir. Apr. 16, 2012), the Fifth Circuit unanimously affirmed the district court's ruling that SBC's practice of offering reimbursements and discounted telephone services to employees and retirees did not constitute a defined benefit plan under ERISA. The retirees of SBC argued that the company established a defined benefit plan by informing employees they would receive reimbursements if they lived in a region outside of SBC's coverage, and discounted telephone services if they lived in a region serviced by SBC, when they retired with a service or disability pension and by providing these services to retirees. The Fifth Circuit held that that the reimbursements and discounted telephone services were not income, as required for a plan to be a pension plan under ERISA, observing that the SBC plan provided services on a "no additional cost" basis. Addressing the retirees' claim that the reimbursement and discounted telephone service benefits constituted multiple plans under ERISA, the Fifth Circuit looked to employer intent to determine whether a benefit plan is a single or a multiple plan. Acknowledging employer intent as a fact-specific inquiry, the Fifth Circuit held that the reimbursement and discounted telephone service plans constituted a single plan. The court noted that any difference in concessions offered to the various geographical regions were for the ease of administration and that SBC originally designed the reimbursement and discounted telephone benefits to be roughly equal. Finding the "no additional cost" services did not constitute a plan under ERISA, the Fifth Circuit declined to address whether the reduction in reimbursements and discounted telephone services violated ERISA's anti-cutback provisions.

Plan Assets:

- In *Secretary of Labor v. Doyle*, — F.3d —, 2012 WL 1003547 (3d Cir. Mar. 27, 2012), the Third Circuit held the district court erred in failing to determine whether

payments collected from various employers were plan assets subject to ERISA. In this matter, various individuals, owners, employers, and marketing companies were alleged to have violated ERISA by collecting millions of dollars in contributions from various employers for a multi-employer welfare arrangement (MEWA), but forwarding only a small fraction of the amounts collected to pay benefit claims. The court remanded the case for further consideration of defendants' fiduciary status, concluding that the definition of "plan assets" was key to determining the reach of ERISA's fiduciary duties. The court observed that if all of the money collected from the employers was plan assets from the moment of collection, then defendants may be fiduciaries by virtue of exercising control over those assets, and, if defendants are fiduciaries, then they may be liable for breaching their fiduciary duties with respect to those assets. Noting that the term "plan assets" is not comprehensively defined in ERISA and the two definitions provided in DOL's regulations were either irrelevant or inapplicable, the Third Circuit stated that "the assets of a plan generally are to be identified on the basis of ordinary notions of property rights under non-ERISA law. In general, the assets of a welfare plan would include any property, tangible or intangible, in which the plan has a beneficial ownership interest." To make this determination, the Third Circuit instructed the district court on remand to first consult the documents establishing and governing the plan and then, in light of these documents, consult contracts to which the plan is a party or other documents establishing the rights of the plan. The court also noted that any representations made to the businesses which purchased health benefits from the plan may also be relevant to the extent that they affect the property rights of the plan under ordinary property law principles.

Anti-Cutback Claims:

- In *Cinotto v. Delta Air Lines Inc*., No 10-14704, 2012 U.S. App. LEXIS 6075 (11th Cir. Mar. 23, 2012), the Eleventh Circuit concluded that, where the right to future benefit accruals under a defined benefit pension plan is dependent upon additional service, those future increases are not yet accrued benefits. Thus, changes to a Social Security offset for participants under the age of 52, which resulted in a reduction in benefits, did not constitute illegal cutbacks under ERISA Section 204(g). The court found that, under the terms of the plan, participants would not have been entitled to the offset until they were age 52. As a result, the court reasoned that the amendment was not a part of the plaintiff's accrued benefit, because she had not yet attained age 52 and depended on future employment to become eligible for the retirement benefit that would have been calculated with the Social Security offset formula at issue.

Procedure:

- In *Santomenno v. John Hancock Life Ins. Co.*, 11-2520-cv, — F.3d —, 2012 WL 1255096 (3d Cir. Apr. 16, 2012), the Third Circuit held that a pre-suit demand is not a prerequisite for claims under ERISA Sections 502(a)(2) and (a)(3), and further, that the joinder of the trustees themselves was not required. In vacating the district court's ruling, the Third Circuit observed that ERISA is silent on the issues of joinder and pre-suit demand, and thus, imposes "no precondition on a participant or beneficiary's right to bring a civil action to remedy a fiduciary breach." The court distinguished decisions to the contrary from the Second Circuit, since the claims in those cases arose under ERISA Section 502(g)(2). Since Section 502(g)(2) applies to suits where participants assert the right of fiduciaries, the court found it "sensible" to require a pre-suit demand in those cases. Noting that ERISA Sections 502(a)(2) and (a)(3) provide an express right of action for participants, without preconditions to suit, the court concluded that "the protective purposes of ERISA would be subverted if the section covering fiduciary breach required beneficiaries to ask trustees to sue themselves."

Statute of Limitations:

- In *Cataldo v. U. S. Steel Corp.*, No. 10-3583, 2012 U.S. App. LEXIS 7460 (6th Cir. Apr. 13, 2012), the Sixth Circuit applied ERISA's three-year statute of limitations in a putative class action, and on that basis upheld the dismissal of a claim for breach of fiduciary duty. The complaint alleged reliance by plan participants on misleading statements from defendants that promised participants that they would receive the same benefits as other employees if they elected to participate in an early retirement program. After making such elections, plaintiffs alleged they began to receive significantly less than they were promised. Since plaintiffs affirmatively alleged that they learned they would not receive the promised benefits in 2003, the district court applied the three-year limitations period and dismissed their claim. On appeal, plaintiffs argued that the the employer’s allegedly misleading statements brought their claims within an exception to ERISA's limitations period, which allows claimants to bring suit within six years from the date of discovery in cases of fraud or concealment. The Sixth Circuit rejected this contention, noting that plaintiffs had failed to plead fraud with particularity under Rule 9(b).

Settlements:

- The DOL's Employee Benefits Security Administration concluded its investigation of Morgan Keegan, a broker-dealer recently acquired by Raymond James, and found that the company violated ERISA standards for plan fiduciaries who provide investment advice for a fee. Between April 2001 and November 2008, Morgan Keegan failed to disclose third-party payments it received when it recommended certain hedge funds as investments to ERISA-covered employee benefit plans.

Under ERISA, a person or entity that gives investment advice for a fee is a fiduciary and is bound to act solely in the best interests of the plan participants. As a result of the DOL's findings, Morgan Keegan entered into a settlement agreement whereby it will pay $633,715.46 to the 10 pension funds it advised that are covered by ERISA. Under the terms of the settlement, Morgan Keegan also agreed to specify the services it provides the plans as a fiduciary and will provide its ERISA plan clients with a description of all compensation and fees received in any form and from any source involving any transaction related to the plans.

??? In *Downes v. Wisconsin Energy Corp. Ret. Account Plan*, No. 09-C-0637, 2012 WL 1410023 (E.D.Wis. Apr. 20, 2012), the district court granted final approval of a $45 million settlement in an action alleging that a cash balance plan failed to calculate pre-retirement-age plan participants' lump-sum benefits under ERISA's minimum distribution requirements because it did not use a "whipsaw" calculation prior to computing the lump-sum distributions of participants who terminated before reaching normal retirement age. Whipsaw refers to the adjustment which plans were required to make, prior to the passage of the Pension Protection Act of 2006, when the interest rate used to project a participant's current account balance to normal retirement date is higher than the interest rate used to discount the annuity to present-day value. Wisconsin Energy admitted it miscalculated the participants' benefits under the whipsaw calculation. In finding the $45 million settlement fair and reasonable, the court noted the class faced the substantial risk of non-recovery due to statute of limitations risks and distinctions in relative exposure between class members.

[1] For more information on the individual mandate and the challenges to the Act, see Bloomberg Law Reports, View from Proskauer: 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).

[2] 131 S. Ct. 2541 (2011).

[3] Fed. R. Civ. P. 23(b)(2).

[4] *Dukes*, 131 S. Ct. at 2557. In affirming, the Ninth Circuit remanded for further consideration the question of whether punitive-damage claims could properly be certified for class resolution under Rule 23(b)(2). Additionally, the court narrowed the class to exclude women who had separated from employment by the time the complaint was filed, on the theory that such claimants had no standing to seek the declaratory or injunctive relief contemplated in Rule 23(b)(2). *Dukes*, 131 S. Ct. at 2550 & n.4.

[5] *Dukes*, 131 S. Ct. at 2551.

[6] Id.

[7] *Id.* at 2555.

[8] Rule 23(b)(2) permits class certification when "the party opposing the class has acted or refused to act on grounds that apply generally to the class, so that final injunctive relief or corresponding declaratory relief is appropriate respecting the class as a whole." In a footnote, the Court observed that other provisions of Rule 23(b) were not before it. *Dukes*, 131 S. Ct. at 2549 n.2.

[9] *Id.* at 2558-59.

[10] *Id.* at 2561.

[11] *Carr v. International Gaming Tech.*, 2012 WL 909437 (D. Nev. Mar. 16, 2012)(53 PBD, 3/20/12; 39 BPR 597, 3/27/12).

[12] *Bacon v. Stiefel Labs., Inc.*, 275 F.R.D. 681, 692, 51 EBC 2809 (S.D. Fla. 2011)(143 PBD, 7/26/11; 38 BPR 1429, 8/2/11). The court found that certification was improper under Rule 23(b)(3), in spite of plaintiffs' allegations of a "common scheme" to mislead participants, because individualized determinations (such as reliance) predominated. *Id.* at 698.

[13] *Matz v. Household Int'l Tax Reduction Inv. Plan*, 2012 WL 832588 (N.D. Ill. Mar 12, 2012)(2012 BL 56527; 50 PBD, 3/15/12; 39 BPR 547, 3/20/12). The court certified a redefined class that, among other things, excluded participants who were terminated for cause. Order, *Matz v. Household Int'l Tax Reduction Inv. Plan*, No. 96-1095 (N.D. Ill. Mar. 29, 2012) (No. 611).

[14] 2012 WL 360633, 52 EBC 1161 (2d Cir. Feb. 5, 2012)(24 PBD, 2/7/12; 39 BPR 306, 2/14/12).

[15] *See, e.g., Bacon*, 275 F.R.D. at 691-92.

[16] In certain circumstances, ERISA Section 404(c), 29 U.S.C. §1104(c), insulates fiduciaries from liability for breaches, when a participant exercises control over the investment of the participant's own account assets.

[17] *See Dukes*, 131 S. Ct. at 2561: "[A] class cannot be certified on the premise that Wal-Mart will not be entitled to litigate its statutory defenses to individual claims." Prior to *Dukes*, at least one circuit court found that ERISA Section 404(c) prevented certification of a class of employer-stock claimants. *Langbecker v. Electronic Data Systems Corp.*, 476 F.3d 299, 309-13, 39 EBC 2352 (5th Cir. 2007)(13 PBD, 1/22/07; 34 BPR 210, 1/23/07).

[18] Under ERISA Section 409, 29 U.S.C. §1109, participants, beneficiaries, and fiduciaries may recover "losses to the plan" resulting from breaches of fiduciary duty. *See* ERISA Section 502(a)(2), 29 U.S.C. §1132(a)(2) (authorizing civil action for relief under ERISA Section 409).

[19] *See, e.g.*, *Coan v. Kaufman*, 457 F.3d 250, 259-61, 38 EBC 1609 (2d Cir. 2006) (141 PBD, 7/25/06; 33 BPR 1805, 8/1/06) (noting that ERISA Section 502(a)(2) may require procedural safeguards for interests of absent parties). Claims under ERISA Section 502(a) may raise other challenges for class counsel. For example, although successful ERISA litigants can often recover attorneys' fees, there is no clear entitlement to a common-fund recovery (as in the Rule 23 context), which in turn could prevent entrepreneurial class counsel from abandoning Rule 23 altogether. Nevertheless, would-be class representatives and their counsel may experiment with claims for plan-wide relief under ERISA Section 502(a)(2).

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