

**RECENT LEGAL DECISIONS IN EMPLOYEE BENEFITS,
LABOR AND EMPLOYMENT LAW**

**GREATER BOSTON CHAPTER OF THE
INTERNATIONAL SOCIETY OF CERTIFIED EMPLOYEE
BENEFITS SPECIALISTS**

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**RECENT LEGAL DECISIONS IN EMPLOYEE BENEFITS,
LABOR AND EMPLOYMENT LAW**

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I. FIDUCIARY DUTY

**C. PARTICIPANT IN SELF DIRECTED ACCOUNT MAY
RECOVER FOR BREACH OF FIDUCIARY DUTY FOR
FAILURE TO FOLLOW INSTRUCTIONS.**

LaRue v. DeWolff, Boberg & Associates, Inc., 128 S.Ct. 1020 (February 20, 2008). *Although ERISA does not provide a remedy for individual injuries distinct from plan injuries, it does allow recovery for fiduciary breaches that impair the value of plan assets, including those in an individual's account.*

James LaRue participated in his former employer's ERISA-regulated 401(k) plan. The plan allowed the participants to manage their own accounts by choosing their investment options. In 2001 and 2002, LaRue instructed his former employer (DeWolff, Boberg & Associates, Inc.) to make changes to the investment of his 401(k) account money, but DeWolff never made the changes. LaRue then filed an action against DeWolff and the ERISA-regulated 401(k) retirement plan administered by DeWolff alleging that his personal account lost \$150,000 because of DeWolff's

¹ The presenter wishes to thank Robyn Hegerich, Andrew Brown and Jillian Harrison who compiled these materials.

failure to follow his instructions. He sought “make whole” or “other equitable” relief.

The district court held that the kind of relief LaRue was seeking was not authorized under ERISA, so it dismissed the case and LaRue appealed to the Fourth Circuit. The Fourth Circuit held that James had no claim for breach of fiduciary duty since he sought only to recover the loss to his own account. An individual may not bring a breach of fiduciary duty claim to recover money lost from his own account. Recovery must benefit the plan as a whole, not simply the individual. The group plan itself could file a breach of fiduciary duty claim to recover money lost, and an individual may raise a claim on behalf of the group plan, but one person may not bring an ERISA claim for money lost from his own retirement plan account.

ERISA also allows a beneficiary to sue for “other equitable relief.” Equitable remedies generally require that an action be taken or that an action stop, while legal remedies generally require one party to pay money to another. James sought a monetary recovery, alleging that it was a claim for an equitable remedy (restitution) because the action he sought was to have DeWolff restore his \$150,000. Relying upon previous United States Supreme Court cases, the Fourth Circuit held that James could not recover a legal remedy by trying to disguise it as an equitable one, and the remedy he

sought was not equitable because he was not seeking recovery of lost money being held by someone else. The Supreme Court granted *certiorari* to hear the case.

The Supreme Court stated that section 502(a) of ERISA identifies six types of civil actions that can be brought. The one at issue in this case authorizes a party to bring an action on behalf of a plan to recover for violations of an obligation. The Court then distinguished between defined benefit plans and defined contribution plans. It stated that when ERISA was enacted, the defined benefit plan was the norm; it paid a fixed benefit based on the employee's salary. Today, defined contribution plans are the norm and for these types of plans, "fiduciary misconduct need not threaten the solvency of the entire plan to reduce benefits below the amount that participants would otherwise receive." In addition, other sections of ERISA confirm that the "entire plan" language does not apply to defined contribution plans. The Supreme Court therefore held that although section 502(a)(2) did not provide a remedy for individual injuries distinct from plan injuries, it did allow recovery for fiduciary breaches that impair the value of plan assets in an individual's account. The Supreme Court vacated the judgment of the Fourth Circuit and remanded the case.

D. INDIVIDUAL 401(K) PARTICIPANTS MAY BRING FIDUCIARY BREACH SUIT.

Tullis v. UMB Bank, N.A., 515 F.3d 673 (6th Cir. January 28, 2008).
Individual participants in a Section 401(k) plan have the standing to sue the plan's trustee for fiduciary breaches even if any eventual relief will flow to the participants individually instead of to the plan as a whole because the intent of ERISA is to protect individual participants from fiduciary breaches.

David H. Tullis and Michael S. Mack were two physicians who participated in the Toledo Clinic Employees' 401(k) Profit Sharing Plan. Their investment advisor in the early 1990s was William Davis of Continental Capital Corporation. In 1999, the Securities and Exchange Commission entered a temporary restraining order against Continental Capital because two of its brokers had engaged in fraudulent activities. It was alleged by Tullis and Mack that UMB Bank N.A., the plan's trustee, knew of this fraud yet failed to inform them of it.

UMB Bank filed suit against Davis and a subsidiary of Continental Capital on behalf of the plan in 2001, and alleged that several investments made by Davis and Continental Capital were improper or simply never took place. It was asserted by Tullis and Mack that even after filing the lawsuit, UMB never informed them of the fraudulent activities.

Continental Capital filed for bankruptcy under a court order in the spring of 2003. Not long after the filing, it was discovered that many of Davis's investments were nonexistent. This was how Tullis and Mack

learned of the magnitude of the losses to the value of their plan accounts.

Tullis alleged that as of February 2003, UMB told him that his plan account was worth \$724,561, when in fact it was only worth \$142,269. Mack alleged that UMB said his account was valued at \$1.6 million when in reality, it was only worth \$420,794.

Tullis' and Mack's first attempt at filing suit against Davis and Continental Capital was stayed pending the outcome of Continental Capital's bankruptcy. They then requested that the plan bring suit against UMB for fiduciary breach. However, the plan refused to do so, citing an indemnification clause in the master trust agreement between the plan and UMB.

Tullis and Mack then filed suit in their individual capacities to recover benefits they lost because of UMB's alleged fiduciary breach in not disclosing to them the information about the fraudulent activities of Continental Capital and Davis. The District Court dismissed the suit, finding that Tullis and Mack lacked standing under ERISA Section 502(a)(2) because they did not seek relief on behalf of the plan as a whole.

The Sixth Circuit reversed the district court's decision and held that that the court erred in construing Section 502(a)(2) as allowing for relief only if the plan as a whole will benefit. It rejected the district court's reliance

on the Fourth Circuit's ruling in *LaRue*. In *LaRue*, the Fourth Circuit held that an individual participant in a 401(k) plan lacked standing to pursue a fiduciary breach claim under ERISA Section 502(a)(2) because he sought relief in an individual capacity as opposed to on behalf of the plan as a whole. The Sixth Circuit reasoned that Congress's intent in passing ERISA was to prevent the misuse and mismanagement of plan assets and to ensure relief is available in cases of fiduciary breaches. It further held that the lower court's holding "precludes any relief for plaintiffs whose recovery could be characterized as benefiting only an individual and not the plan as a whole."

In addition, the court also held that the language of ERISA Sections 502(a)(2) and 409 compelled the conclusion that individual participants in a defined contribution plan, such as a 401(k) plan, should have the standing to seek recovery for losses to their pension plan. The court also held that the district court erred by concluding that a "loss to the plan," found Section 502(a)(2) of ERISA, meant that Tullis and Mack had to seek relief in a representative capacity for the entire plan. It reasoned that the number of participants allegedly affected by the breach is irrelevant because the loss still occurs to the plan.

C. WHERE PLAN ADMINISTRATOR DECIDES WHO GETS BENEFITS AND MAKES BENEFIT PAYMENTS, IT HAS A CONFLICT OF INTEREST TO BE TAKEN INTO ACCOUNT AS ONE FACTOR BY THE REVIEWING COURT.

Metropolitan Life Insurance Co. v. Glenn, __S.Ct.__, 2008 WL 2444796 (6/19/08). *An ERISA plan administrator, whether it is an insurance company or a self-insured employer, has a conflict of interest if it both decides who receives benefits and makes benefits payments. That conflict of interest is one factor that should be taken into account in determining whether the administrator has abused its discretion in a case.*

Wanda Glenn worked for Sears, Roebuck from 1986 to 2000. Her final position there was sales manager in the women's department, where she worked 40 to 50 hours per week. Her duties included supervising other employees, making sure the merchandise was properly stocked, helping customers, and solving problems as they arose. Her job description indicated that she was required to sit up to 20 percent of the work day and stand for 20 to 60 percent of the day. She was also required to do some climbing, reaching, and lifting.

On April 29, 2000, Glenn took a medical leave of absence. She submitted a disability claim under Sear's long-term disability plan on June 20, 2000. The claim was accompanied by a letter from her doctor, Rajendra Patel, indicating that Glenn had been diagnosed with severe dilated cardiomyopathy. A disease that causes the heart to become enlarged and pump inadequately, cardiomyopathy caused Glenn to be fatigued and have

shortness of breath on exertion. In the letter, Patel stated that he did not believe Glenn could return to any kind of job that would require significant physical or psychological stress.

Glenn's disability plan was administered by Metropolitan Life Insurance Company and included two distinct phases of total disability. The first required the applicant to show that she could no longer perform the material duties of her regular job. The second category, which only became relevant after 24 months of benefits, required that the applicant be unable to perform the duties of any gainful work or service for which she was qualified. Glenn's claim under the first phase of the plan was approved and she began receiving benefits in June 2000. In August, at the direction of plan administrators, Glenn applied for and received Social Security disability benefits. As a result of receiving the benefits, MetLife demanded reimbursement from Glenn for benefits they paid her and the company received \$13,502.50 from her.

On May 20, 2002, MetLife informed Glenn that if she wished to continue receiving long-term disability benefits she would have to prove that she was unable to perform the duties required by any gainful employment. In making the claim determination MetLife reviewed her vocational information, medical information, and specific medical restrictions and

limitations. The company relied primarily on documents submitted by Dr. Patel to examine her medical history. There were several reports from Patel from the two years in which Glenn had been on medical leave. In some of the reports he indicated that she made progress but his overall evaluation of her was that she was disabled and could not handle psychological stress at work.

On September 16, 2002, MetLife terminated Glenn's long-term disability benefits. It explained that medical records did not support her claim of cardiovascular impairment that would prevent her from returning to work. Glenn appealed the decision and Patel again submitted a letter stating he did not feel she was fit to return to work. MetLife referred the case to a doctor who reviewed Glenn's medical files. Although his report was equivocal, he concluded that Glenn might be able to try a job with a low stress level. On May 20, 2003, MetLife issued a final notice of termination of benefits to Glenn.

Glenn filed a lawsuit against MetLife in federal district court under the Employee Retirement Income Security Act. The district court found for MetLife and Glenn appealed to the United States Court of Appeals for the Sixth Circuit. The Court of Appeals reversed the district court and found for Glenn. It found that the administrator's decision was not the result of a

“deliberate, principled reasoning process” that was “supported by substantial evidence.” It based its decision on several different factors.

The United States Supreme Court, which heard the case on appeal from the Sixth Circuit, also found for Glenn. The court decided to hear the case in order to settle the issue of how a court reviewing an ERISA plan administrator’s decision should weigh an administrator’s conflict of interest. The court found in this case that MetLife had a conflict of interest because under the Sears plan it both determined who would receive benefits and paid those benefits. In any scenario where an employer both determines the merits of claims and pays those claims, there is a conflict of interest. The court stated:

“The employer’s fiduciary interest may counsel in favor of granting a borderline claim while its immediate financial interest counsels to the contrary.”

The court noted that the conflict of interest is not as severe when an insurance company is acting as the administrator. Insurance companies have a much greater incentive than a self-insuring employer to provide accurate claims processing because they charge a fee to cover the cost of claims payouts. As a result, in comparison to a regular employer who must pay claims itself, insurance companies do not have to pay from their “own pockets”. Insurance companies will also lose business in the market when

their products “fall below par.” When they make biased decisions while processing claims their product suffers. Despite these differences, the court found that there was still a conflict of interest when insurance companies are plan administrators. An employer’s conflict of interest may influence the choice of insurance company to administer the plan because the employer may elect to save money rather than provide better service for its employees. Additionally, it is not enough to say that insurance companies are regulated by the market because ERISA holds plan fiduciaries to a higher standard than the market.

Although the court held that such conflicts of interest must be taken into account during judicial review, it provided little guidance as to how much weight such conflicts should be given. According to the court, conflicts of interest are one factor among many that must be evaluated in determining whether a plan administrator abused its discretion in ruling on a benefit claim. In this case the court found that MetLife’s conflict of interest was one of many factors that added up to an abuse its discretion in terminating Glenn’s benefits. Other factors included MetLife’s contradictory actions in encouraging Glenn to seek Social Security benefits while at the same time finding she was not disabled, and its reliance on aberrant medical reports that did not accurately reflect the opinion of

Glenn's doctor. The court refused to adopt a rigid rule concerning such conflicts. "Benefits decisions arise in too many contexts, concern too many circumstances, and can relate in too many different ways to conflicts...for us to come up with a one-size-fits-all procedural system that is likely to promote fair and accurate review," the court said.

D. DELEGATION OF DISCRETION DID NOT TRIGGER DE NOVO STANDARD OF REVIEW.

Geddes v. United Staffing, 469 F.3d 919 (10th Cir. 2006): *When an ERISA plan administrator delegates his discretionary authority to render plan benefit decisions to a third party, even one that is not a fiduciary, de novo review is not triggered when litigation arises. Rather, the standard for review is the "arbitrary and capricious" standard as set by the U.S.*

Supreme Court's 1989 decision in Firestone Tire and Rubber Co. v. Bruch.

Andrew Geddes ("Andrew"), a teenager from Utah, severely injured his spinal cord by when he dove into the shallow water of a lake while on a church-sponsored summer trip in 2002. He was air transported to St. Mary's Hospital ("St. Mary's"), where he was placed in intensive care and had surgery to repair his spine. He remained in intensive care in a halo device, until he was transferred to Primary Children's Hospital ("Primary Children's") about two weeks later, where he was admitted to the neuroscience ward. His doctor at Primary Children's recommended two months of rehabilitation, bowel and bladder treatment, medication for infectious disease, and pain control—medically-necessary and typical for patients with Andrew's injuries.

Andrew's healthcare coverage was provided through his father's employer, United Staffing Alliance ("United"). The United Staffing Plan ("Plan") is an employee welfare benefit plan covered by the Employee Retirement Income Security Act of 1974 ("ERISA"). United acted as fiduciary and Plan administrator, but delegated its discretion over benefits decisions to a third party, Everest Administrators ("Everest"). The Plan explicitly reserved to United the right to make all final decisions about plan benefits in its discretion, which United delegated to Everest.

Everest reviewed Andrew's benefits claims and decided to cover only \$40,921 of the \$185,892 in medical bills incurred by the Geddes family. It based its decision on the rehabilitative nature of the treatment at Primary Children's and the fact that the rates at St. Mary's exceeded what the Plan considers "usual and customary" for Plan coverage. Even though the Geddes family appealed and Everest acknowledged that the rehabilitation treatment was medically necessary, Everest remained firm in its denial. Andrew's parents sued, arguing that the denial was improper under ERISA, alleging a breach of fiduciary duty and also a claim relating to a failure to provide plan documents. The district court ruled in the Geddeses' favor for the ERISA claim, but in favor of United and Everest on the other two claims.

United and Everest appealed to the Tenth Circuit, arguing that the district court should not have applied the *de novo* standard of review, but rather should have reviewed the benefits decision based on the “arbitrary and capricious” standard set by the U.S. Supreme Court in Firestone Tire and Rubber Co. v. Bruch. The Tenth Circuit agreed with United and reversed, remanding the case to the district court for a new trial with the appropriate standard of review, although only for the benefits from Andrew’s care at Primary Children’s, for reasons discussed below.

ERISA permits plaintiffs to seek remedies in federal court to recover benefits due under an ERISA plan. The Supreme Court decision in Firestone mandates the *de novo* standard, unless a plan explicitly gives its plan administrator discretionary authority to determine who is eligible for benefits and construe the terms of the plan. In that case, the standard is the far more deferential “arbitrary and capricious” standard of review. The Plan contained such language and, although the Geddeses argued that it did not apply when the delegation of discretion was to a non-fiduciary, like Everest, the Court found that “arbitrary and capricious” was still the appropriate standard.

The Court found that in Firestone, the Supreme Court relied on principles of trust law in rendering its Firestone decision and, accordingly,

consulted trust law to determine whether a delegation to a non-fiduciary changed the standard of review. The Court found that it did not because ERISA specifically provides for the designation of “persons other than named fiduciaries” and trust law “regards as inherent” a fiduciary-trustee’s ability to delegate and does not constrict a fiduciary to delegations to only other fiduciaries. Just as a trustee may delegate his administrative tasks, so too may a health plan administrator delegate plan determinations and “this is especially true when such delegation is explicitly authorized by the plan document.” Importantly, the plan administrator remains liable for the decisions made by his delegated agents. The decisions of the agent are entitled to so-called Firestone deference because they are essentially the decisions of the administrator—he remains legally responsible for them.

The Court then applied the appropriate standard to the benefits denied to Andrew. The Court found that the district court erred in applying the *de novo* standard to the denied Primary Children’s benefits, by considering new evidence not in the administrative record. Therefore, the decision to award benefits for Andrew’s treatment at Primary Children’s was reversed and remanded to the district court for a new trial with the appropriate standard of review, based only on the administrative record that was available to those

who made the original benefits determinations in the Plan administrator's discretion.

Regarding the St. Mary's claims, however, the Court found that although the district court did not apply the appropriate standard in name, it did so in action. It found that the way United interpreted what is "usual and customary" to pay for out-of-network services was unreasonable under either standard of review and upheld the district court's decision to grant Andrew's benefits for his treatment at St. Mary's. Specifically, the Tenth Circuit found that United interpreted "usual and customary" costs for out-of-network healthcare to be identical to its negotiated, lower rate for in network services, which misled Plan members and denied them necessary medical coverage. The actual, appropriate interpretation of "usual and customary," was what the Geddeses argued—consultation of rate schedules from a survey of the average healthcare treatment costs in the geographical area.

Lastly, the Court found that the Geddeses had no statutory remedy under ERISA that permitted a money award against Everest. ERISA permits federal suits against a plan as an entity and against plan administrators—Everest is neither the Plan, nor its administrator. The Court reasoned that Everest may still bear liability as an independent, non-fiduciary, third-party administrator of the Plan if the Geddeses had sued Everest individually, but

they did not and therefore the district court erred in finding personal liability for Everest and the money judgment against Everest was reversed.

On October 1, 2007, the Supreme Court invited the U.S. Solicitor General to file a brief “expressing the views of the United States” in this matter in order to help determine if the Supreme Court will grant review in this case. That brief recommended that the Court wait until it had rendered a decision in another, pending case with similar issues (MetLife v. Glenn) or deny review. The Supreme Court has not yet decided whether or not it will hear Geddes on appeal. Therefore, it remains to be seen if the Tenth Circuit’s decision extending Firestone discretion to an independent, non-fiduciary, third party will stand.

II. DEFINED CONTRIBUTION PLAN LITIGATION

A. PARTICIPANT IN SELF DIRECTED ACCOUNT MAY RECOVER FOR BREACH OF FIDUCIARY DUTY FOR FAILURE TO FOLLOW INSTRUCTIONS.

LaRue v. DeWolff, Boberg & Associates, Inc., 128 S.Ct. 1020 (February 20, 2008). See above.

B. JUDGE IN MARKET TIMING LITIGATION FOLLOWS LARUE PERMITTING FORMER PARTICIPANTS TO SUE AND RECOVER FOR BREACH OF FIDUCIARY DUTY.

In re Mutual Funds Investment Litigation, 529 F.3d 207 (4th Cir. June 16, 2008). *A participant in a defined contribution plan regulated by ERISA who cashed out his account has standing to sue under both ERISA and the U.S. Constitution if breaches of fiduciary duty caused him to receive less money than he should have when he received his benefits.*

Craig Wangberg and the other plaintiffs in this case had enrolled in defined contribution plans sponsored by their employers. When they retired, they “cashed out” their interests in the plans. Before withdrawing the money from the accounts, the plans had invested in mutual funds that permitted investors to practice market timing, a form of arbitrage. Market timing involves moving “in and out of the funds to take advantage of the temporary differentials between the mutual funds’ daily-calculated ‘net asset value’ (“NAV”) and the market price of the component stocks during the course of a day. This practice favors market timers at the expense of long-term investors in the funds, increases the costs of the fund, and impairs the value of investments. Essentially, market timers are harmful to mutual fund investors because they cause mutual funds to manager their portfolio in a manner that does not favor long-term investors. In 2003, market timing led to settlements sponsored by the Securities and Exchange Commission in which \$2.3 billion was paid by investment advisors to mutual funds.

The plaintiffs brought lawsuits in federal district court in Maryland against plan fiduciaries alleging violations of the Employee Retirement Income Security Act (ERISA). They argued that plan fiduciaries had violated the fiduciary duties imposed upon them by ERISA § 409 (29 U.S.C. § 1109(a)) by investing in mutual funds that allowed market timing, which

diluted the value of individual accounts. When they cashed out their accounts they did not receive the full amount of benefits to which they were entitled because of the investment in funds allowing market timing. The fiduciaries argued that the plaintiffs had no standing to bring a lawsuit against them because they were no longer plan participants. The district court dismissed the case, finding that the plaintiffs did not have the right to sue under ERISA § 502(a)(2) (29 U.S.C. § 1132(a)(2)) because in their lawsuits they sought damages instead of vested benefits. The plaintiffs appealed to the United States Court of Appeals for the Fourth Circuit, which reversed the district court.

The Fourth Circuit reached its decision by relying on a recent decision by the United States Supreme Court. In LaRue v. DeWolff, Boberg & Associates, Inc., 128 S.Ct. 1020 (2008), the Supreme Court found that a former employee who had cashed out his vested benefits in a defined contribution plan remained a participant under ERISA as long as plan fiduciaries are responsible for profits that would have accrued had they not breached fiduciary duties and the participant's account would have been more profitable had no such breach occurred. Similarly, in this case plaintiffs argued that they were entitled to receive more money on the day they cashed out because their accounts would have been more profitable if

not for the breaches of fiduciary duty. Consequently, the plaintiffs' claims are for additional benefits, not damages. The court likened the plaintiffs' claims to a plan participant who has been the victim of theft. If a plan fiduciary stole all of the money in a participant's account that participant would not cease to be a participant simply because his account balance was at zero. Under the same rationale, a participant is still a participant if he has cashed out his account but failed to receive the full amount of benefits due to him because of a breach of fiduciary duty. Therefore, the plaintiffs had standing to sue under ERISA.

The court also found that the plaintiffs had standing to sue under the United States Constitution. Under Article III of the Constitution, to maintain a lawsuit in federal court the plaintiff must be able to show injury-in-fact, causation, and redressability. There would be no problems with the plaintiffs' ability to show injury-in-fact and causation if they were able to prove that the fiduciaries had breached their duties and caused the value of their accounts to suffer. However, the fiduciaries argued that they lacked the ability to show the third requirement, redressability. Specifically, the defendants argued that whether or not the plaintiffs could actually recover anything depended on the actions of third parties who were not controlled by the courts and that the court would lack the authority to order fiduciaries to

compensate plaintiffs for losses to individual accounts. The court disagreed with both arguments. It found that because the plaintiffs had sued plan fiduciaries, plan administrators, and other people associated with the plan the party who would be responsible for compensating the plaintiffs was before the court and hence subject to its rulings. As for the second argument, the court found that only under defined benefit plans are plan fiduciaries not authorized to reimburse losses to specific accounts. Under defined contribution plans, fiduciaries may reimburse plaintiffs for losses to individual accounts, according to LaRue.

C. DISTRICT COURT DECIDES FOR DEFENDANTS IN CLOSELY WATCHED 401(K) FEE LITIGATION MATTER.

Hecker v. Deere & Co., 496 F.Supp.2d 967 (W.D. Wisc. 2007). *ERISA does not require 401(k) service providers or plan fiduciaries to disclose information regarding revenue sharing between sibling corporations. Such information does not have any impact on investment decisions made by plan participants. When 401(k) fiduciaries have properly disclosed financial information about pension plans and offered a wide variety of mutual funds to invest in, ERISA's safe harbor provision will protect them from allegations that they breached their fiduciary duties by offering funds with excessive fee ratios. Note: This decision is on appeal to the Seventh Circuit. The Department of Labor has submitted an amicus brief in support of the plaintiffs.*

John Deere & Co. sponsors personal savings plans (401(k)) for its employees. Employees contribute a portion of their earnings to the plan and Deere matches those contributions up to a certain percentage. The plans offer employees several different investment options and each employee

chooses which investment fund he wishes to place his money in. Employees may choose a fund from the 26 options offered specifically by Deere or choose a plan through BrokerageLink, an alternative system that allows participants to invest in over 2,500 publicly available mutual funds.

Deere is the administrator of the plans and chooses which funds will be available to participants for investment. Fidelity Trust acts as trustee of the plans. Its duties are to perform record keeping and other administrative tasks for the plans. Fidelity Research, which along with Fidelity Trust is a subsidiary of Fidelity Investments, is the investment advisor for 23 of the 26 funds offered to plan participants. Deere pays a fee to Fidelity Trust for maintaining the funds, but the plans themselves pay no fee to Fidelity Trust.

However, each of the funds for which Fidelity Research is investment advisor charge fund investors a fee. The total fee is detailed in each fund prospectus, and is itemized to specify a management fee, service fee, and others. The fees, which are expressed as a percentage of the total assets invested, vary from fund to fund. Among the funds offered to plan participants, the fees range from .07% on the low end to 1.01% at the other end. The fees increase as the total amount of money in the fund increases. Fidelity Research shares a portion of the fee revenue it receives with Fidelity Trust, but this amount is not disclosed to Deere or the plan participants. The

funds offered to investors through the Deere 401(k) plans are the same funds, and charge the same fees, as those that are offered on the retail market to investors.

Three employees apparently felt overcharged and deceived by the fee structure. They filed a class action lawsuit in the United States District Court for the Western District of Wisconsin against Deere, Fidelity Trust, and Fidelity Research. They alleged violations of fiduciary duties under the Employee Retirement and Income Security Act (ERISA) for providing investment options with “excessive and unreasonable fees and costs,” and failure to adequately disclose information about the fees to plan participants. Specifically, the suit alleged that plan participants were never informed that Fidelity Research shared some of the fees it collected with Fidelity Trust. This lawsuit was one of more than a dozen filed starting in the fall of 2006 against 401(k) plan fiduciaries and service providers alleging violations of ERISA in connection with fund fees.

Deere defended these allegations on the ground that it fully complied with all of ERISA’s disclosure requirements. ERISA requires plan administrators to provide participants with a summary plan description and an annual report that includes a financial statement detailing plan expenses, assets and liabilities, and changes in assets. 29 USC §§ 1021(a), 1023(b),

1024(b). The district court agreed with Deere, finding that it complied with current law regarding disclosure of 401(k) fees. It relied in part on an ERISA Advisory Council report that discussed proposals for amending the laws to require more detailed disclosure about revenue sharing. This was evidence, according to the district court, that current law does not require the type of disclosure plaintiffs sought. Because they were in compliance with ERISA disclosure requirements, Deere and the other defendants could not have violated their fiduciary duties.

The district court also rejected the plaintiffs' argument that disclosure not required by ERISA itself is required as a general fiduciary obligation under the law. The court noted that the ERISA disclosure rules are detailed and were carefully planned. It would be inappropriate to augment them "using the general power to define fiduciary obligations." Consequently, the plaintiff's disclosure argument failed.

The district court disagreed with plaintiffs on the excessive fee allegation as well. ERISA includes a "safe harbor" provision, which states that a plan fiduciary is not responsible for any losses suffered by an individual who invests in a pension plan if that individual exercises control over the assets in his account. 29 U.S.C. § 1104(c). To qualify for this provision, a fiduciary must comply with federal regulations, including

regulations that require disclosure of cost and fee information relating to 401(k) plans. 29 C.F.R. § 2550.404c-1. Once again, the court found that Deere and the other defendants complied with all of the disclosure requirements under then-current law. It further noted that information regarding fees being shared between Fidelity Trust and Fidelity Research would not enhance participants' investment decisions. "In assessing the likely return on an investment the fees netted against the return are certainly relevant, but knowing the subsequent distribution of those fees has no impact on the investment's value," the court noted.

Plaintiffs further argued that the safe harbor provision did not apply because any exercise of control by individuals was illusory due to the fact that every fund offered through the plans had an excessive fee ratio. The court found this position untenable. It is nearly impossible that the more than 2,500 investment funds offered through BrokerageLink all had excessive fee ratios. If employees incurred losses it is because they failed to assess the fee ratios and choose a fund accordingly, the court said. This means the safe harbor provision applies squarely to the case. The court went on to find that even if the defendants failed to qualify for the safe harbor provision they are insulated from liability by the wide variety of funds made available to participants through the plans.

Finally, the court found that had any liability been found to exist against any of the defendants it could not have been against Fidelity Trust or Fidelity Research. Neither company had fiduciary responsibility for making plan disclosures or selecting plan investments. Deere was the only fiduciary under ERISA because it had the power to select the investment options for its employees.

The case has been appealed to the 7th Circuit Court of Appeals. The Department of Labor has submitted an *amicus* brief in support of the plaintiffs.

D. PLAINTIFF MAY PROCEED WITH SUIT ALLEGING EXCESSIVE FEES.

Charters v. John Hancock Life Insurance Co., 534 F.Supp.2d 168 (D.Mass. 2007) *Hancock may be a fiduciary under ERISA because the company has the power to substitute stocks in individual sub-accounts of a defined contribution plan. A plaintiff has no power to bring a suit on behalf of plan sponsors under ERISA, but may represent trustees of unaffiliated plans if the plaintiff meets the federal requirements for filing a class action lawsuit.*

John Charters is the trustee of the Charters, Heck, O'Donnell & Petrusis, P.C. 401(k) plan ("the Plan"). The Plan is a defined contribution plan which provides individual accounts for participants. In April 2005, Charters purchased an Accumulated Retirement Account Group Annuity Contract from Hancock. Under the contract, Hancock manages and holds assets of the Plan in an account, and invests those assets. Pursuant to the

contract, Hancock maintains a variety of investment options, including a Guaranteed Interest Account and several mutual fund options. Hancock has the right to substitute mutual funds for the ones it offers under the contract. It offers these mutual funds through sub-accounts, which are maintained by Hancock as bookkeeping records to track investment in the mutual funds. It has a sub-account for each mutual fund and keeps track of individual investments in each fund. Hancock buys the shares of the mutual funds in its own name, and the participants' accounts do not actually own any shares.

Hancock charges a variety of fees for maintaining the accounts. It charges a fixed participant fee and an asset charge based on the amount of assets in the account. These compensate Hancock for the record-keeping services it performs. It also charges an annual investment charge for investments in each sub-account. This charge is comprised of the investment fee from the underlying mutual fund and an "administrative maintenance charge," which can be as high as .5% to .75% of each dollar invested in each sub-account. The administrative maintenance charge is reduced by any revenue sharing payments Hancock receives from the underlying mutual funds. It does not charge an administrative maintenance fee for investments in the Guaranteed Interest Account.

On July 26, 2007, Charters filed a lawsuit against Hancock in the United States District Court for the District of Massachusetts. He accused Hancock of breaching its fiduciary duty by charging excessive fees for the maintenance of the account and for failing to reduce administrative maintenance charges by the full amount it received in revenue sharing payments. He also alleged that Hancock engaged in transactions prohibited by the Employee Retirement and Income Security Act (ERISA). Hancock moved to dismiss the suit, arguing that it is not a fiduciary under ERISA. The company also argued that Charters lacked standing to bring a claim against Hancock on behalf of any employee benefit plan for which he was not the trustee.

A fiduciary is defined by ERISA as a person who “exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets.” 29 U.S.C. § 1002(21)(A). Hancock argued Charters made all of the important decisions, and that consequently it did not possess the requisite amount of discretion to make it a fiduciary under this definition. Charters chose Hancock and the investment choices it offered, and Charters selected the specific options that would be available to investors in his plan. The court disagreed. It pointed out that Hancock had

the right to substitute shares from different mutual funds in each sub-account. The court pointed to two conflicting Department of Labor advisory letters that indicate that when a party possesses such substitution power it may have the requisite “authority or control over the disposition of plan assets” to be considered a fiduciary under ERISA. This would be a determination a jury would have to make. Consequently, the district court denied the motion to dismiss on those grounds.

That left the court with the question of what other parties Charters can represent in his suit. Hancock argued that Charters had no power to sue on behalf of sponsors, trustees, and administrator of plans with which Charters has no affiliation. In response, Charters cited cases indicating that plaintiffs can bring class actions under ERISA on behalf of plans they are not associated with so long as they meet the federal requirements for filing a class action suit. The court agreed that this allows Charters to sue on behalf of trustees of other benefit plans that have purchased annuity contracts from Hancock, provided he meets the federal requirements for class actions. However, because plan sponsors have no right of action under ERISA, the court found that Charters could not bring suit on behalf of plan sponsors. Finally, the court found that even though Charters is not a plan administrator he may still have sustained injury which allows him to bring a cause of

action. Trustees often have the same duties as administrators and therefore suffer the same injuries, the court found.

The court sided with Hancock only on the issue of whether Charters can represent plan sponsors. Any claims he brought on behalf of such sponsors were dismissed. It allowed the rest of the case to go forward to the next stage.

E. FIDUCIARY NOT REQUIRED TO DISCLOSE SALE OF COMPANY STOCK WHERE SUCH INFORMATION IS NOT MATERIAL.

Nelson v. Hodowal, 512 F.3d 347 (7th Cir. 2008). *A pension plan fiduciary is not required under ERISA to disclose information that is not material to an investment decision. This could include the sale of the fiduciary's own personal stock if the decision to sell has no effect on the performance of the stock.*

Indianapolis Power & Light Company offers its employees a defined-benefit pension plan and a defined-contribution supplemental plan (the “Thrift Plan”). The defined-benefit plan holds a diversified portfolio of investments. The defined-contribution plan initially limited employees to holding stock of IPALCO Enterprises, Inc., the parent corporation of Indianapolis Power & Light, or United States bonds. In 1995 it was amended to allow employees to diversify their investments. Employees may contribute to the Thrift Plan in accordance with the provisions of §401(k) of

the Internal Revenue Code and the employer matches these contributions up to 4% of the employee's salary.

By 2000 the Thrift Plan offered nine investment options, ranging from conservative money market funds to riskier choices with little or no diversification. The Plan hired Merrill Lynch, Pierce, Fenner & Smith, Inc., to advise participants about appropriate investments. Participants could alter their investment choices daily, but as of 2000 all of the matching contributions were made in IPALCO stock. This was mandated by the Plan's terms.

On March 27, 2001, IPALCO merged with AES Corporation, a large firm that operates energy businesses throughout the world. When the merger closed, about 64% of investments in the Thrift Plan were held as IPALCO stock. At this time AES was trading for \$49.60 per share. Three months later the price fell to \$42.28. On September 25, 2001, it was trading for \$24.25 and the next day it fell to \$12.25. It finally bottomed out on February 21, 2002, at \$4.11 per share.

Two of the Thrift Plan's participants filed a class-action lawsuit in federal district court under the Employment Retirement and Income Security Act (ERISA) against the Plan's fiduciaries. Their primary argument was that the fiduciaries (all executives at Indianapolis Power and Light), should

have anticipated the decline in value of AES's stock or at least should have recognized that AES was too volatile to be a suitable investment for pension holdings. The lawsuit alleged that the fiduciaries should have compelled all of the participants to exchange their IPALCO stock for other investment options before the merger was completed. The district court found that the fiduciaries had no reason to foresee any decline in the value of AES's stock, and ruled in favor of the defendants. The judge concluded that the Plan's fiduciaries had acted as reasonable fiduciaries by determining AES to be a suitable stock for a pension plan. Furthermore, the employees had been warned, both by the company and Merrill Lynch, about the dangers of an undiversified portfolio. The fiduciaries had no duty to prevent employees from making their own decisions about their stock and were not at liberty to ignore the provision in the Plan requiring matching contributions to be made in IPALCO stock.

On appeal to the United States Court of Appeals for the Seventh Circuit, the plaintiffs made only one argument. They argued that the fiduciaries were required to disclose to the employees that the defendants (the fiduciaries) were selling most of their IPALCO stock around the time of the merger. By not telling the employees of their sales, the plaintiffs argued, the fiduciaries were promoting AES as a good stock when they did not

actually believe that to be true. ERISA requires fiduciaries to act in the same manner that a “prudent man” would act in the circumstances. The plaintiffs’ argument was that selling IPALCO stock just before the merger is what a prudent man would have done. By failing to warn employees of this, the fiduciaries violated their duties under ERISA.

The Seventh Circuit found this argument to be inconsistent with many of the findings by the lower court. The district court judge had found that the fiduciaries actually believed what they told the employees and only sold their own stock because they were told they were being replaced with new management at Indianapolis Light and Power. Consequently, they no longer had any reason to own AES stock any more than any other utility stock. The employees, on the other hand, were remaining as employees of AES and hence had less reason to sell their stock in the company. Furthermore, the fiduciaries had disclosed their stock sales through filings in accordance with the Securities Exchange Act of 1934. These disclosures did not affect the price of AES stock and were therefore not considered to be material to investors’ decisions.

Relying on the inconsistencies between the plaintiffs’ argument and the findings of the district court, the Seventh Circuit found for the defendants. The defendants sold their stock for reasons that did not apply to

the employees. Their stock sales were not material and therefore did not need to be disclosed. The court noted that had they been disclosed, employees may have misunderstood the reason for the sales and sold their own stock. This kind of “idiosyncratic reaction” could be caused by any piece of information, which is why fiduciaries are not required to disclose information that is not material to investors’ decisions. ERISA does not require fiduciaries to reveal information that would lead to such reactions, the court found. Furthermore, the fiduciaries did disclose their sale of the stock and relied on Merrill Lynch to inform employees. The court found that such reliance on a professional third party is acceptable.

F. EMPLOYER DID NOT BREACH FIDUCIARY DUTY FOR FAILURE TO DIVEST 401(K) PLAN OF EMPLOYER STOCK.

Kirschbaum v. Reliant Energy Inc., 2008 WL 1838324 (5th Cir 4/25/08).
An employer does not breach its fiduciary duties by failing to divest its 401(k) plan of the company’s common stock after it becomes aware of circumstances that may impair the value of company stock. The plaintiff has a “heavy burden” of rebutting the presumption that the employer and the plan fiduciaries satisfied their duties by sticking to the plan terms. Any plan amendments that would be made by the employer would be done in its capacity as plan settlor, not as a plan fiduciary.

Reliant Energy Inc. had a 401(k) plan with an investment option under the plan called the Reliant Common Stock Fund. With the exception of a small cash component for liquidity purposes, the Common Stock Fund was invested entirely in Reliant common stock. The participants were permitted

to invest up to 16 percent of their compensation in the plan and the company agreed to match up to the first 6 percent of a participant's contributions to the plan with shares of Reliant common stock. The contributions by Reliant were to remain in the Common Stock Fund until the employee reached the age of 55 years and had 10 years of service with the company. After reaching that benchmark, participants could then divest a portion of their holdings in the Fund.

In May of 2002, the value of the Common Stock Fund fell which was precipitated by the public disclosure that some employees had engaged in "round trip" energy trades between 1999 and 2001. Round trip energy trades involve sham transactions where energy traders would "sell" identical quantities of power or natural gas to each other simultaneously, for the same price. Although nothing was really traded, they were booked as transactions to inflate Reliant's trading volume.

Kirschbaum, an employee of Reliant and a participant in the plan brought a class action against Reliant, and Reliant's Benefits Committee. He alleged that Reliant and the plan fiduciaries were responsible under ERISA to make good the losses the Plan sustained on Reliant common stock. There were three counts to the complaint. First, Kirschbaum alleged that the defendants "should have known, based on information available to them,

that Reliant stock was not a prudent investment” because the stock price was inflated by the round trip energy trades. In the second count, he asserted that the “defendants had a fiduciary duty to halt all plan purchases of Reliant common stock, sell the plan's holdings in Reliant common stock, and terminate the Common Stock Fund.” In the third count, Kirschbaum contended that the defendants breached their ERISA fiduciary duties by “negligently misrepresenting Reliant's financial condition to plan participants in documents that incorporated the company's Securities and Exchange Commission filings.”

The district court granted summary judgment to the defendants on all counts. It reasoned that since the defendant’s did not have the authority to terminate the fund or halt investments in it, there was no fiduciary duty to do so.

The Fifth Circuit first rejected Kirschbaum's argument that the defendants should have concluded, based on publicly available information, that Reliant common stock was an imprudent investment. He argued that the plan became too heavily weighted in high risk Reliant stock when the company transformed from a traditional power utility company into a "speculative energy trading operation." Kirschbaum's imprudent investment claim was really a claim that the fiduciaries failed to diversify the plan. The

court rejected his argument, finding that “ERISA exempts an EIAP from the duty to diversify with regard to the purchase or holding of company stock.” The court further stated that “Despite the risks inherent in concentrating plan assets in any one security, the express statutory exemption of the diversification duty in relation to an employer's stock holding precludes the recovery Kirschbaum seeks.”

In Count II, Kirschbaum alleged that it was imprudent for the 401(k) plan to hold even one share of Reliant stock during the period when round-trip energy trading had artificially inflated the stock's price. The court rejected his argument and found that the plan mandated that the Common Stock Fund be an available investment option for participants, and that matching contributions be made in Reliant common stock. The court reasoned that “These mandatory provisions are embedded in the Plan and could not be terminated or modified absent a Plan amendment.” The court added, “Because the Plan's requirements to invest in Reliant stock are mandatory and were treated as such by Reliant and the Benefits Committee, we agree with the district court that no fiduciary duties are inherent in the Plan other than to follow its terms.”

While the appeals court found that in some situations, plan fiduciaries should disobey the clear requirements of an eligible individual account plan

(EIAP) and divest the plan of employer stock, fiduciaries' failure to do so should be tested by "how the fiduciary acted," not by "whether his investments succeeded or failed." Here, Kirschbaum had not overcome the presumption of prudence that attaches to ESOPs and EIAPs that invest in employer stock. The court held that "there was no indication that Reliant's viability as a going concern was ever threatened, nor that Reliant's stock was in danger of becoming essentially worthless." The court then added that a plan fiduciary "cannot be placed in the untenable position of having to predict the future of the company's stock performance." The court noted that if a fiduciary can be sued for not deviating from the plan terms that require investment in the employer, the fiduciary would also be exposed to liability if he or she deviated from the plan's requirements and sold the stock, only to have the stock price rebound. The court also noted that if a plan fiduciary were to override the plan terms and sell the plan stock based on insider knowledge, the fiduciary would violate securities laws.

The court also ruled in favor of the defendants as to Count III. It found that Reliant did not breach its fiduciary duties by allegedly making misrepresentations about the company's financial position in documents filed with the SEC. Kirschbaum did admit that the SEC filings were made in Reliant's corporate capacity and did not constitute fiduciary

communications, but he argued that the filings became fiduciary communications when Reliant incorporated them into other documents that were distributed to plan participants. The documents distributed to participants included a Form S-8 Registration Statement for Reliant common stock filed May 28, 1999, and a 10a Prospectus for Reliant common stock dated Oct. 25, 2000. The court stated that the obligation that Reliant had to “file a Form S-8 incorporating its SEC filings is a corporate obligation arising under the securities laws. 15 U.S.C. § 77e; 17 C.F.R. § 239.16b. The same is true of its obligation to incorporate its SEC filings into a 10a Prospectus, and to distribute the Prospectus to Plan participants. 17 C.F.R. § 230.428(a)(1), (b)(1). When it incorporated its SEC filings into Forms S-8 and 10a Prospectus, it was discharging its corporate duties under the securities laws, and was not acting as an ERISA fiduciary.”

III. WELFARE PLANS

A. MARYLAND’S HEALTH CARE REFORM LAW PREEMPTED BY ERISA.

Retail Industry Leaders Association v. Fielder, 475 F.3d 180 (4th Cir. 2007): *The Maryland Fair Share Health Care Fund Act which requires employers with more than 10,000 employees to spend at least 8% of their total payroll on employee health insurance or pay the difference to the State is preempted by ERISA because it conflicts directly with ERISA’s purpose of providing for uniform nationwide plan administration. An act like Maryland’s denies employers uniform nationwide administration, one of ERISA’s primary goals, by requiring them to keep an eye on conflicting state and local minimum spending requirements in order to adjust their healthcare spending and restructure their plans accordingly.*

Maryland passed the Fair Share Health Care Fund Act (the Act) on January 12, 2006. The Act, aimed at covering Wal-Mart, required for-profit employers with more than 10,000 employees to spend at least 8% of their total payroll on employee health insurance or pay the difference to the State of Maryland. There are only four employers of more than 10,000 employees in Maryland. Of those, Johns Hopkins University was subject to and satisfied a lower, 6 % requirement because it is a non-profit employer. Giant Food already spent over the 8% threshold on its employees' health care costs and Northrop Grumman, a defense contractor, was "effectively excluded" by an amendment concerning high-salaried workers. Wal-Mart was spending between 7% and 8% on health care insurance and has been targeted by a number of states who have accused it of providing poor health benefits. A Georgia survey claimed that more than 10,000 children of Wal-Mart employees were in the state's children's health insurance program at a cost to the state of almost \$10 million a year. A North Carolina hospital found 31% of 1,900 patients who said they worked for Wal-Mart were enrolled in Medicaid, and 16% more said they were uninsured. While Wal-Mart provides health coverage to about 45% of its workforce, Costco provides it to 96% of its employees.

Wal-Mart is a member of the Retail Industry Leaders Association (RILA). RILA filed suit in federal district court against James D. Fielder, Jr., in his capacity as Maryland's Secretary of Labor, Licensing, and Regulation, for a declaration that ERISA preempted the Act and to prohibit Maryland from

enforcing it. The district court held that ERISA preempted the Act, and the Fourth Circuit Court of Appeals affirmed. The Act is preempted because it conflicted with ERISA's goals of permitting uniform nationwide administration by requiring employers in Maryland to restructure their employee health insurance plans.

ERISA's purpose authorizes Wal-Mart and other large, nationwide employers to provide uniform benefits to all its employees, wherever they live in the country. If Maryland can change what Wal-Mart must provide in benefits in Maryland, other states would likely follow suit. The advantage of uniform administration nationwide is a foundational policy of ERISA. The Act clashes with that policy because it leaves employers no reasonable choice except to change how they structure their employee benefit plans.

B. CITY OF SAN FRANCISCO SUCCESSFULLY DEFENDS LOCAL HEALTH CARE ORDINANCE AGAINST REQUEST FOR INJUNCTIVE RELIEF ON ERISA PREEMPTION GROUNDS.

Golden Gate Restaurant Association v. City and County of San Francisco, 512 F.3d 1112 (9th Cir. 2008). *A state or local ordinance is not preempted by ERISA if it does not bind plan administrators to structure plans in a certain way or mandate that they provide specific benefits to employees. A local law could be preempted if it contains specific provisions relating to ERISA or the operation of the law itself depends upon ERISA.*

In July 2006 the City of San Francisco passed the San Francisco Health Care Security Ordinance (the "Ordinance"). The Ordinance mandates that all businesses with 20 or more employees and all non-profit corporations with 50 or more employees make health care expenditures to or

on behalf of their employees each quarter. Employers must make expenditures for any employee who works in the city, works at least 10 hours per week, and has worked for the employer for at least 90 days. The amount of money an employer is required to spend on health care depends on the type of business an employer is engaged in and number of employees an employer has. For-profit employers with between 20 and 29 employees and non-profit employers with 50 or more employees must spend \$1.17 per hour for each employee. For-profit employers with 100 or more employees are required to spend \$1.76 per hour.

A health care expenditure is defined under the Ordinance as any amount paid by an employer to its employees or to a third party on behalf of its employees for the purposes of providing health care services or reimbursing the cost of such services. The employer may choose what type of expenditure it wishes to make on behalf of its employees. If the employer already provides its employees with a plan under ERISA, it may leave that plan in place and simply provide the city with records that show the employer is making expenditures. If the employer offers no ERISA plan, the employer must make payments directly to the city. The Ordinance does not require employers to establish ERISA plans or offer any minimum level

of health care benefits to employees. It only requires them to spend a certain amount of money each quarter on health care.

On November 8, 2006, the Golden Gate Restaurant Association filed a lawsuit in federal district court against the City to prevent it from implementing the Ordinance. The Association argued that the law is preempted by the Employee Retirement and Income Security Act (ERISA). On April 2, 2007, the City amended the Ordinance to defer implementation until January 1, 2008 for employers with 50 or more employees, and April 1, 2008 for employers with 20 or more employees. On December 26, 2007, the District Court ruled in favor of the Association, finding the law preempted by ERISA. After unsuccessfully petitioning the district court for a stay of its judgment, the City appealed to the United States Court of Appeals for the Ninth Circuit.

To successfully prevent the district court from immediately enforcing its ruling striking down the Ordinance, the City had to show some likelihood of winning its appeal and some evidence that enforcing the injunction against the law would create a hardship for the City. The Ninth Circuit found that the City successfully proved both of these elements.

The Ninth Circuit found that the ordinance is not preempted by ERISA. To begin with, there is a presumption that ERISA does not preempt

state or local laws that govern traditional state powers. This includes general health care regulation. Furthermore, the Court found, the law was not preempted under Section 514(a) of ERISA, which preempts any state or local laws that “relate to” employee benefit plans governed by ERISA. A law is considered to “relate to” an ERISA benefit plan if it has a “connection with or reference to such a plan.”

According to the Ninth Circuit, the ordinance does not have a connection with ERISA because it does not require health care plan administrators in the City to structure their benefit plans in any way. In other cases, laws were found to be preempted when they bound ERISA plan administrators to provide certain types of benefits or structure their plans in a specific way. Those laws interfered with the purpose of ERISA, which is to ensure that plans would be subject to a uniform body of law. In contrast, the Ordinance does not require employers to adopt ERISA plans or provide a certain level of health care benefits. An employer may choose to adopt an ERISA plan or simply make payments directly to the City. The flexibility afforded employers by the Ordinance means it does not interfere with the uniform regulatory regime of ERISA. Although the Ordinance may influence employers to adopt an ERISA plan because they wish to avoid making payments to the City, such influence is entirely permissible. The

Ordinance also does not bind administrators to a particular set of rules or impose an administrative burden of complying with conflicting directives about benefits law.

The Ordinance does not contain any “reference” to ERISA plans either, the Ninth Circuit found. A law may be preempted for a reference to ERISA if it acts immediately upon an ERISA plan or needs such a plan to function properly. For example, a local or state ordinance that specifically exempts ERISA benefits from the operation of the statute is considered to “refer to” ERISA, and is therefore preempted by it. The San Francisco Ordinance does not include any specific provisions dealing with ERISA and thus does not act on ERISA plans at all. Nor is the existence of an ERISA plan essential to the operation of the statute. If no employer in the City provided an ERISA plan the statute would still function properly. The Ordinance does not require employers to provide any specific level of benefits to employees. Rather, compliance with the statute is measured by how much an employer spends on health care costs. The level of benefits an employee receives is completely unrelated to whether the employer is in compliance with the statute.

The Ninth Circuit also found that postponing the operation of the Ordinance would work a more significant hardship on the City than on the

Association. The delay in implementing the Ordinance while the parties wait for the appeal decision would mean 20,000 uninsured San Francisco residents would have to wait even longer to receive health care. This could pose health risks for those people by preventing them from seeking medical attention for serious or chronic illnesses. The City could also face financial costs as some of those uninsured people receive emergency medical care. The Association would have to make a quarterly health care payment and incur administrative burdens in maintaining health care records. After comparing these two costs, the Court decided that postponing implementation of the Ordinance would be a significant hardship on the City.

Finally, the Court found that it is in the public interest to apply the Ordinance immediately. The City has a general interest in maintaining the health of its workforce, especially those people who work in the food service industry. The Ordinance would also benefit the health care industry. On the other side, businesses may be hurt as they are forced to raise prices to cover the cost of the health care. However, the Court found that the extent to which this would damage area businesses is speculative.

**D. SUIT FOR MONEY DAMAGES FOUND NOT TO BE
EQUITABLE RELIEF IN PRE-LARUE CASE
INTERPRETING ACTIVE WORK RULE IN GROUP
INSURANCE PLAN.**

Amschwand v. Spherion Corp, 505 F.3d 342 (5th Cir. 2007). *A suit for money damages cannot be brought under ERISA §502(a)(3) because such damages do not constitute equitable relief.*

In 2000, Spherion switched insurance companies from Prudential to Aetna Life Insurance Company (Aetna). Aetna's group insurance policy included a "special provision" entitled the "Active Work Rule." The rule required employees who were away from work with an illness or injury when the insurance coverage switched to Aetna to return to work for one full day before receiving coverage under the policy. Spherion and Aetna agreed to exempt employees from the rule who were suffering from a medical condition which antedated the switch in coverage. When the switch occurred, Spherion employee Thomas Amschwand was on medical leave fighting cancer. He was informed of the new Aetna policy and began paying the premiums for the plan. However, Amschwand never received a waiver and remained subject to the Active Work Rule. After Amschwand died from cancer his widow filed a claim and was told he was never eligible for benefits under the Aetna policy.

Mrs. Amschwand filed a lawsuit in federal district court alleging a breach of fiduciary duty. She sought relief under the Employee Retirement

Income Security Act (ERISA) for the life insurance benefits she would have received if her husband had complied with the Active Work Rule. The district court found that money damages did not constitute “appropriate equitable relief” under ERISA §502(a)(3). On appeal, the United States Court of Appeals for the Fifth Circuit agreed.

The Fifth Circuit relied on a line of cases that found that money damages did not qualify as equitable relief under ERISA §502(a)(3) because they were not historically considered equitable relief. Consequently, they were not available in a suit against a nonfiduciary that participated in a plan fiduciary’s breach of duty. The cases also specified that not only must the remedy sought be equitable but the type of suit must be equitable as well. Amschwand argued that her case was different because she was suing a plan fiduciary, and make-whole relief was routinely available as a remedy for breach of fiduciary duty against fiduciaries. The court disagreed with Amschwand, finding nothing significant in the distinction between defendants. It found that Amschwand’s desired relief was not typically equitable. Damages are only equitable when they are designed not to make a plaintiff whole for a loss but instead to eliminate a defendant’s gain. Therefore, Amschwand was only entitled in restitution to the premium payments made on the policy and not damages equal to the denied benefits.

If Spherion kept the premium payments it would be gaining from its breach of a fiduciary duty but by failing to make benefits payments it was not gaining anything.

D. NO EMOTIONAL DISTRESS DAMAGES AVAILABLE UNDER LMRA FOR BREACH OF BARGAINING AGREEMENT'S PROMISE TO PAY RETIREE HEALTH BENEFITS.

Yolton v. El Paso Tennessee Pipeline Co., 2008 WL 275685 (E.D. Mich. 1/31/08). *Plaintiffs are not entitled to emotional distress damages under the LMRA when an employer breaches a collective bargaining agreement by failing to provide retiree health benefits. Plaintiffs may recover damages for the cost of replacement insurance incurred as a result of such a breach.*

Case Corporation paid the health benefits of its retired employees for over 30 years. Beginning in 1971, Case signed a series of collective bargaining agreements with the United Automobile, Aerospace, Agricultural Workers of America (UAW). Although the agreements modified the form of the benefits in certain ways over the years, Case had always agreed to provide health benefits to retired employees. After a reorganization in 1994 and a merger in 1996 in which Case's parent corporation Tenneco merged with El Paso Tennessee Pipeline Co., the retiree health benefits operation was transferred to El Paso. In 1997, El Paso informed retirees that they would need to contribute \$56 per month to maintain their health benefits. After a series of agreements in which Case agreed to pay those premiums for a period of time, El Paso again sought premium payments from retirees. By

2002, El Paso sought \$501 per month from retirees to maintain their health care coverage.

In 2003, the plaintiffs brought a claim against El Paso for mental distress and anguish damages under the Employee Retirement and Income Security Act (ERISA) for breach of the collective bargaining agreement. The court struck those claims, but issued a preliminary injunction that required employers to continue to make payments while the dispute over the breach of the collective bargaining agreement was being settled. Four years later, the plaintiffs brought a lawsuit in United States District Court for the Eastern District of Michigan seeking emotional distress damages and damages for replacement insurance coverage under Section 301 of the Labor Management Relations Act.

The district court, relying on previous cases, found that emotional distress damages are not always appropriate in a breach of contract case but are applicable when the contract so clearly involves the emotions of the plaintiff that “liability for mental distress was or could have been within the contemplation of the breaching party when the contract was executed.” The court drew a distinction between commercial contracts where “pecuniary interests are most important” and other contracts, such as agreements to perform medical procedures. While emotional distress damages are

commonplace in medical contracts, they are not applicable to commercial contracts. The court concluded that a contract to provide retiree health benefits was a commercial contract and emotional distress damages were thus not applicable. Although the court noted that with contracts to pay retiree benefits the party who is to receive the benefit will suffer some adverse emotional consequence if that benefit is not paid, it found that simply because it may cause some hardship does not mean such nonpayment gives rise to liability for emotional distress damages. It consequently granted El Paso's motion to strike the claim for emotional distress damages.

El Paso was not as successful with its motion to strike the action for damages for replacement insurance coverage. The plaintiffs sought damages for medical coverage incurred before the preliminary injunction was issued. El Paso argued that such damages are not recoverable under ERISA and therefore to award them would be to "circumvent ERISA's damages scheme." The court disagreed, finding no indication that ERISA was designed to limit a plaintiff's recovery under the LMRA. The purpose of an award under the LMRA is to "make employees whole for the losses suffered." Therefore, for an action brought under the LMRA the court should attempt to place the plaintiff in the position he would have been in had the contract violation never occurred. In this case that means awarding

damages for substitute insurance coverage and out-of-pocket medical expenses that resulted from the breach of the collective bargaining agreement. If these damages could not be awarded, the court noted, employers could terminate retiree benefits and not have to pay them for years while the parties are litigating the violation of the collective bargaining agreement.

The court also decided that a class action suit was appropriate in this case. Despite the fact that the plaintiffs in the class all have different situations concerning their medical care and insurance costs, this type of variety is not an impediment to bringing a class action suit. Finally, the court found that plaintiffs were not entitled to a jury trial because the relief they sought was equitable in nature.

E. SHORTER PERIOD OF LTD BENEFITS FOUND PERMISSABLE FOR DISABILITY CAUSED BY MENTAL DISORDER.

Schwob v. Standard Insurance Company, 248 Fed. Appx. 22; 2007 U.S. App. Lexis 21541 (10th Cir. 2007). *Where the evidence supported a finding that an employee's disability was the result of a mental disorder and not a physical disease, the plan was not precluded from applying the mental-disorder limitation. Therefore, there was no improper denial of benefits under an employee benefit plan pursuant to ERISA even though the limitation had a shorter time period where the employee would receive benefits under the plan.*

In 1995, Valerie Schwob was eligible for long-term disability benefits through her employer, Urocor, Inc. The Plan was issued by Standard

Insurance Company. In 1997, Schwob claimed she suffered from a physical disability as a result from a recurrence of Lyme Disease and applied for benefits from Standard. She alleged that she could not perform her job safely anymore. She also alleged that from 1995-1997 the disease was controlled, but now became active and debilitating. Schwob had her three physicians submit statements identifying Lyme disease as the cause of her disability.

Standard had an independent examination done, and when it was concluded that there was no evidence of active Lyme disease, they had a psychiatric evaluation done. After that doctor concluded she suffered from depression and hypochondriasis with poor insight, Standard asked a Lyme disease specialist to review her file. He concluded that her disability was psychological and found little evidence of active Lyme disease. Standard then told Schwob they would apply the mental-disorder limitation to her claim which limits payment of the benefits to twenty-four months. Schwob no longer qualified for benefits after January of 2000.

Schwob continued to submit evidence to Standard from her physicians and they agreed to reopen the case. They arranged for another examination of Schwob and asked both a psychiatrist and a neurologist to look at the file. After it was again concluded that she suffered from a mental disorder, in

March of 2003, Standard notified Schwob it was upholding its decision. Schwob then filed suit against Standard for improper denial of benefits pursuant to ERISA. The district court ruled in favor of Standard and Schwob appealed.

The Tenth Circuit affirmed the lower court's decision and held that the district court had applied the correct standard which required Standard to have the burden of proving the reasonableness of its decision. The court also held that the majority of evidence did not support the diagnosis of Lyme disease as the cause of her disability. Independent tests and examinations conducted by Standard showed no signs of active Lyme disease. In addition, the court reasoned that even Schwob's own evidence was inconclusive of active Lyme disease being the cause of her disability. Her own treating physicians recognized the lack of objective evidence. The court said that at best, this evidence showed that she had symptoms compatible with Lyme disease. Therefore, the court held that the records contained substantial evidence supporting Standard's original decision that Lyme disease had not caused her disability.

The court said that there was sufficient evidence however that a mental disorder caused her disability. It reasoned that Schwob had a documented history of depression, and there were reports from doctors that

it was ongoing. In addition, Standard had conducted its own independent evaluation which was conclusive that she suffered from depression and hypochondriasis with poor insight which contributed to her cognitive impairment. The court also said that Schwob's own evidence did not detract from the weight of this evidence. The court reasoned that a reasonable person could accept this evidence as adequate support for Standard's decision. It further added that even if they accepted the mental disorder is secondary to Lyme disease, it didn't preclude Standard from applying the mental-disorder limitation to her claim. The cause was irrelevant, as long as the mental-disorder contributed to her disability.

F. WOMEN'S HEALTH AND CANCER RIGHTS ACT DOES NOT PRECLUDE APPLYING CONSISTENT PLAN LIMITATIONS.

Krauss v. Oxford Health Plans, Inc., 517 F.3d 614 (2nd Cir. 2008).
Health care plans' payment of all but one-fourth of the cost of cancer-related breast reconstruction surgery and denial of private duty nurse care was not an abuse of discretion under ERISA, because the plan excluded private nurse care, and the surgery limitation comported with plan terms and was based on Medicare's policy.

Geri and Daniel Krauss were a married couple who were participants in an ERISA governed health care plan whose claims were administered by Oxford Health Plans, Inc. After Geri Krauss was diagnosed with breast cancer, she underwent a double mastectomy and a bilateral breast reconstruction performed by two doctors outside of her plan. Oxford pre-

certified the breast reconstruction surgery stating that payment would be consistent with the Certificate of Coverage. She received private nursing care after the surgery, and after paying out of pocket for the surgeries and care, sought reimbursement from Oxford. Oxford reimbursed all but ¼ of the cost of the surgery and refused payment for the private nursing care. The Explanation of Benefits that was included in the partial reimbursement did not explain why there was not a full reimbursement for the surgery or why they denied her private nursing care claim.

The Supplemental Certificate concerns out-of-network services and states that a Plan member will pay a higher percentage of costs with out-of-network providers as opposed to those in the network. Oxford limits this plan by restricting the services covered, imposing deductibles and coinsurance payments and paying expenses with a schedule of “usual, customary, and reasonable” (“UCR”) fees. In addition, the Plan expressly excluded private nursing care.

If a Plan member wanted to challenge a denial of benefits they could seek review through a grievance procedure. The first step would be to submit a written grievance to Oxford’s “Issues Resolution Department.” If the benefits were again denied, a member may appeal that decision to a

“Grievance Review Board,” and then to a committee appointed by Oxford’s Board of Directors.

After the denial of benefits, the Krausses filed a grievance for both the remainder of the cost of the surgery and all of the private nursing care.

Oxford denied the grievance for the surgery explaining it was paid at the “usual and customary rate.” It also notified the Krausses that it had referred the nursing care claim to its claims department. It later denied that claim too because it was not a service covered by the Plan.

The Krausses then sent Oxford two letters requesting information from Oxford to help them with filing the second appeal. Oxford responded in three separated letters informing the Krausses that in-network providers could have performed the surgery, and were available to do so, that there was no medical reason to grant an exception, and that no additional payment would be sent because it was determined that the payment was accurate at the “UCR.” The Krausses then filed a second appeal asserting that Oxford had not complied with ERISA disclosure requirements. Oxford responded and included additional documents, including the Bilateral Surgery Policy. In it, it explains that the multiple procedures would be reimbursed at the rate of one and a half times the rate of a single procedure. The Krausses then responded that the policy was not disclosed in their Plan’s terms, had not

been disclosed to them, violated state and federal laws and had not applied in other previous surgeries that Geri Krauss underwent.

Oxford then denied the second appeal and explained for the first time to the Krausses that “UCR” is the level of 90% of the doctors, not 100% of the doctors in the area would accept as full payment. It further asserted that what the Krausses received was 150% of the UCR for a single reconstruction, and that the Policy was consistent with industry standards, was disclosed to them and such disclosure exceeded what was required under ERISA. It also added that an “in-network exception” is only available if no in-network provider was available, and that was not the case here.

The Krausses then filed suit in federal court for recovery of unpaid benefits under ERISA s 502(a)(1)(B) on the grounds it violate the Women’s Health and Cancer Rights Act and the terms of the Plan. They also claimed that Oxford breached its fiduciary duty in violation of ERISA s 502(a)(3) on the grounds Oxford failed to provide benefits owed to the Krausses and improperly handled their claims for reimbursement and appeals. They further sought statutory damages, a declaratory judgment barring the application of Oxford’s Bilateral Surgery Policy to post-mastectomy breast reconstruction surgeries, and for attorney’s costs and fees. The district court ruled in favor of Oxford on all claims and the Krausses appealed.

The Second Circuit upheld the lower court's decision. First, it agreed that the court applied the correct standard of review of "arbitrary and capricious", despite Krauss' arguments that it should be de novo. It reasoned that the terms of the Plan gave Oxford the right to determine what constitutes a reasonable charge. It added that it would look at the WHCRA claim de novo. The court declined to decide on the proper standard for the private nursing claim, stating only that even under a de novo review, the claim would fail.

As to the WHCRA claim, the court agreed with Oxford that it requires only that insurers cover the surgeries consistent with policies for other benefits under the plan. It discounted the Krausses' arguments that the Newborns' and Mothers' Health protection Act, and the Mental Health Parity Act illustrate Congress' intention to preclude insurers from including cost-sharing mechanisms other than co-pays and deductibles. The court stated that despite the fact that the WHCRA was silent as to other cost-sharing possibilities, it did not preclude an insurer from using the mechanisms.

As to the private nursing claim, the court stated that the same reasoning could be applied. It said that there was nothing in the WHCRA that would require an insurer to pay for private-duty nurses where these

services are not covered under the plan. Even though the WHCRA requires coverage for all stages of breast reconstruction surgery, the court did not think it would override a plan's explicit terms to not cover private-duty nursing.

The Krausses also argued that both the Bilateral Surgery Policy and denial of benefits for private nursing violated the terms of the Plan.

However, the court disagreed as to both arguments. The "UCR" accords Oxford the discretion to determine what is a reasonable amount and it could base it on not only HIAA data but other recognized sources. The court found the policy to be similar to that of Medicare and stated that since it can not conclude that Medicare's policy is arbitrary and capricious, likewise it could not conclude the Policy here was either. As to the private nursing claim, Oxford's denial did not violate the Plan because there was an explicit and unambiguous exclusion for such services in the Plan itself. The court further explained that just because Oxford pre-certified Krauss' surgery knowing it would require post-operative care, that did not oblige Oxford to pay for such care by any and all means.

The court also dismissed the Krausses' claim that Oxford breached its fiduciary duty in violation of ERISA s 502(a)(3) because Oxford failed to provide benefits owed to the Krausses and improperly handled their claims for reimbursement and appeals. First, it stated that were not entitled to such

relief because money damages were not cognizable under that section.

Secondly, it added Oxford's denial was a substantive matter and was an appropriate implementation of the Policy. Therefore, it was irrelevant if the denial was improperly explained.

The court also denied the Krausses' claims for statutory damages and declaratory judgment, because Oxford was not the administrator as required under ERISA. It further denied them attorney's fees and disagreed with the Krausses that it was improper for the district court to allow evidence outside of the administrative record.

IV. DEFINED BENEFIT PLANS

A. DISABILITY BENEFIT FOUND NOT SUBJECT TO ANTI-CUTBACK RULE.

Robinson v. Sheet Metal Workers' National Pension Fund Plan A, 515 F.3d 93 (2nd Cir. 2008). *An amendment to an ERISA plan that reduced industry-related disability benefits did not violate ERISA's anti-cutback rule. The amendment also did not violate the terms of the Plan itself.*

The Sheet Metal Workers' National Pension Fund (the "Plan") is a multi-employer plan that provides retirement pensions, early retirement pensions, and disability pensions. In 1994, the Plan was amended to include industry-related disability (IRD) benefits for participants who are permanently unable to return to work in the sheet metal industry but are capable of working in a different field. IRD benefits are available for people

who have not attained the retirement age (65) but have earned sufficient pension and service credits. Under the IRD a person receives 10 percent more than he would under the early retirement benefit program. The Plan grants the trustees discretion to determine eligibility for IRD and to make eligibility subject to periodic medical examinations. The Plan also gives the Trustees the power to interpret and apply the Plan, as well as amend it “consistent with the provisions of the Trust Agreement.” Under the agreement, an amendment would not be effective if it was “deemed to decrease the accrued benefit of any Participant.”

In 2004, the trustees amended the plan to impose an earnings limitation on IRD benefits. Under the amendment, any IRD recipient who earned \$35,000 or more in a calendar year was deemed to no longer be disabled and eligible for IRD benefits. In September 2005 two IRD recipients brought a class-action lawsuit against the Plan in federal district court. They alleged that the amendment limiting earnings for IRD recipients violated ERISA and constituted a breach of contract. The District Court ruled in favor of the Plan. The IRD recipients appealed to the United States Court of Appeals for the Second Circuit. The Court of Appeals once again found in favor of the Plan.

The Second Circuit ruled that the amendment to the Plan did not violate ERISA's anti-cutback rule. 29 U.S.C. § 1054(g) (2006). Under the anti-cutback rule, a plan may not be amended to reduce the accrued benefit of a participant. It defines a reduction in an accrued benefit as an amendment "eliminating or reducing an early retirement benefit or a retirement-type subsidy...with respect to benefits attributable to service before the amendment...." 29 U.S.C. § 1054(g) (2006). The Second Circuit found that the IRD was a welfare benefit plan, not a pension plan. Additionally, it found that the IRD was an ancillary benefit instead of an accrued benefit. For both of those reasons, the ERISA anti-cutback provision was found not to apply to the IRD.

The Court also rejected the IRD recipients' breach of contract claims. The Court noted that it had previously held that absent "explicit language to the contrary, a plan document provides for disability benefits promises that these benefits vest with respect to an employee no later than the time that the employee becomes disabled." Feifer v. Prudential Ins. C. of Am 306 F. 3d 1202, 1212 (2d Cir. 2002). Thus the court stated that the burden was on the Fund to identify "explicit language reserving [its] right to terminate or alter a disabled employee's benefits." Gibbs ex. real Estate of Gibbs v. CIGNA Corp., 440 F. 3d 571, 577 (2d Cir.2002). Upon review, the Court found that

the Trustees of the Plan reserved their right to alter or terminate disabled workers' benefits by including clear language in both the Plan and the summary plan description indicating that they reserved the right to amend the Plan at any time. The only exception to the amending power was that amendments could not reduce accrued benefits. However, the Court, by examining several definitions in the Plan, determined that the IRD benefit was not an accrued benefit. The IRD was not a "retirement-type subsidiary" nor an optional form of pension benefit. The Plan specified that the IRD could not exceed the benefit that would be paid to the participant if he retired at a normal age. The Court interpreted this to mean that the IRD was a qualified disability benefit and not a retirement-type subsidy. Therefore, it could be reduced by an amendment to the Plan. The Court also rejected an argument that the Plan awarded recipients IRD benefits for life. This argument failed, according to the Court, because the Plan contained language that said the IRD would terminate if the employee ceased to be disabled. Since the Plan allowed the Trustees to amend it at any time and there was no contractual right to lifetime IRD benefits, the amendment to the Plan did not violate the contract. See Abbruscato v. Empire Blue Cross Blue Shield, 274 F. 3d 90, 99 (2d Cir. 2002).

B. POST-RETIREMENT INCREASE FOUND NOT TO BE AN ACCRUED BENEFIT FOR PURPOSE OF THE ANTI-CUTBACK RULE.

Thornton v. Graphic Communications Conference of the International Brotherhood of Teamsters Supplement Retirement and Disability Fund, 2008 U.S. Dist. Lexis 12051 (W.D. of Kentucky, 2008). *For the purposes of the ERISA anti-cutback rule, a benefit increase in an ERISA governed plan to a plan participant who retires before the increase is added is not an “accrued benefit” within the meaning of ERISA. Therefore, a plan may rescind the increase without liability under the rule.*

Charles Thornton was a participant in a multi-employer defined benefit pension plan under ERISA which provides benefits to employees in the graphic communications industry. Thornton retired in 1995 and began receiving monthly pension benefits. In 1999, the Board of Trustees of the Plan amended the Plan to increase benefits by 9.4 percent. Then in 2002, it adopted a reduction proposal which was effective in April of 2003 to rescind the 1999 benefit increase for those who retired before 1999. Thornton filed a class action against the Board for violating the cut-back rule under ERISA and breaching their fiduciary duty by failing to administer the Plan under section 404(a)(1)(D), 29 U.S.C. S 1104(a)(1)(D).

As to the alleged anti-cutback rule violation, the court held that the 9.4 increase was not an “accrued benefit” and therefore, the Board could rescind the increase without violating the anti-cutback rule. The court said that while it is true that under ERISA an accrued benefit may not be rescinded by

an amendment of a plan, the benefit is defined at the person's normal retirement age. Thornton retired in 1995, the 9.4 percent increase went into effect in 1999, four years after he retired. The court reasoned that the purpose of the rule is to prevent employers from "eliminating or reducing that which an employee has been promised and earned over time." The plan in effect at the time of Thornton's retirement had no promise of a 9.4 percent increase and did not accumulate during his employment. Therefore, there was no legitimate expectation of such benefit on Thornton's part and the Board was entitled to rescind the increase without liability under ERISA. Thornton argued that a Treasury Regulation adopted in 2005 compels the conclusion that the increase was an accrued benefit because it says it applies at the amendment date. However, the court did not find this argument persuasive because it applied to amendments after 2005, unlike the case at hand. The court also discounted Thornton's argument that discovery was necessary to obtain documents related to the 2002 amendment. The relevant evidence was proffered by the Board when it submitted evidence as to what the plan was at the time of Thornton's retirement and not in 2002. The court also added that since there was no violation of the anti-cutback rule, the Board can not be said to have breached their fiduciary duty and dismissed both counts.

V. COMMUNICATION

A. INACCURATE BENEFIT ESTIMATE STATEMENTS WHICH CONTRADICTED PLAN TERMS WERE NOT A FIDUCIARY BREACH UNDER THE CIRCUMSTANCES.

Livick v. The Gillette Company, --- F.3d ----, 2008 WL 1747225, (1st Cir. 2008). *An employer did not breach its ERISA fiduciary duties by providing an employee with inaccurate pension benefit statements where the terms of the plan are clear and unambiguous. Providing estimates of benefits is not a fiduciary function.*

John Livick worked for Parker Pen for 17 years before it was bought by Gillette Stationary products Group. Two years later, the pension plans of both companies merged. Livick received letters in 1997 and 1998 explaining how his Parker Pen pensions would be treated under Gillette's plan. He was told he would receive his Parker Pen pension which was \$1047 per month and any benefit accrued under the Gillette plan for his service after January 1, 1996. After Gillette was sold to Rubbermaid, Livick's position was eliminated. Gillette held a meeting in which Livick and other employees in the same situation were told what benefits they would receive.

Following the meeting, Livick met with Wayne Brundige, a human resources representative. Brundige calculated an estimate of Livick's Gillette pension based on his hire date at Parker Pen instead of his hire date for Gillette which was in 1996. His estimate was \$2832 per month. Gillette

had an online estimator where an employee could calculate his/her benefits. There is a disclaimer which states that it is only an estimate and that if there is a discrepancy between the estimate and the benefits to which one is entitled, the terms of the Gillette plan apply. The web-site miscalculated Livick's benefits as had Brundige by using his Parker Pen start date.

Livick was formally terminated on January 12, 2001. After visiting the web-site estimator again and receiving an even higher amount, he called human resources who advised him that the online estimate was more likely accurate but they would send a new estimate of his benefit. The benefit letter sent to Livick included his \$1047 per month plan from Parker Pen but only an additional \$789 per month from Gillette.

Livick sued Gillette alleging that it had breached its fiduciary duty to Livick under ERISA by making these misrepresentations. He requested relief under section 502(a)(3) and asserted he was entitled to a Gillette pension that accounted for his time at Gillette and Parker Pen. The district court ruled against Livick and he appealed.

On appeal, he argued that the part of an affidavit from a human resources manager was that was struck, was done so erroneously and the court abused its discretion by ruling it was inadmissible due to its lack of relevance. The First Circuit disagreed and upheld the court's ruling.

The First Circuit also held that Gillette was not in breach of its fiduciary duty under ERISA and therefore did not decide whether the relief Livick sought is the type of equitable relief available under 502(a)(3). The court stated that Brundige was not a named fiduciary under the Plan nor was he a functional fiduciary because providing Livick with an estimate of his benefits is not a fiduciary task. Livick also argued that Gillette breached its fiduciary duty when it "hired, retained, and failed to properly train Brundige to perform such non-fiduciary tasks." Despite the Department of Labor's interpretation of ERISA that a fiduciary can be liable for the acts of a person designated to carry out fiduciary responsibilities, Brundige was not exercising fiduciary functions. The court also acknowledged that other courts have held fiduciaries liable for non-fiduciaries providing misleading information, but only when there is a lack of clear and accurate information in the first place. This was not the case here. Gillette did provide Livick with clear information when they sent him two letters in 1997 and 1998, on the estimator's web-site, and the Plan itself.

The court also rejected Livick's theory that Gillette should be estopped from denying him the benefits in the mistaken statements. The court held that even if it allowed estoppel claims in ERISA cases, Livick's claim would fail because it was "unreasonable for him to rely on informal

communications which contradicted clear plan terms.” The court also rejected his argument that the repeated mistaken estimates led him to believe that the plan had changes under the company’s retention of the right to amend the plan. The terms of the plan were clear that such amendments are made by the Compensation Committee of Gillette’s Board of Directors. The court therefore affirmed the district court’s decision.

B. TIME LIMITS FOR FILING APPEAL OF CLAIM DENIAL SHOULD HAVE BEEN DISCLOSED AT TIME OF CLAIM DENIAL.

Solien v. Raytheon Long Term Disability Plan #590, 2008 WL 2323915 (D.Ariz. 2008). *An ERISA plan provider may place a time limit on filing a legal claim under the plan that is shorter than the state statute of limitations. The plan must explain the time limit and appeal procedure in a manner that will be understood by the claimant.*

Raytheon terminated plaintiff Claudia Solien’s long term disability benefits on August 3, 2005. The company’s Summary Plan Description (SPD) included a provision that prohibited employees from filing lawsuits under the Employee Retirement Income Security Act (ERISA) more than one year after a final denial of benefits. This policy was detailed in the Raytheon Benefits Handbook, which was available on the company website but was not distributed in hard copy form since 2004. When it denied Solien’s benefits it notified her that she had a right to bring a lawsuit under

ERISA and informed her of how to access information on appealing the benefits denial.

Solien filed a lawsuit in federal district court in Arizona on September 17, 2007. She initially alleged that the termination constituted a breach of the company's benefits plan. Raytheon motioned to dismiss the case on the grounds that Solien missed the one year deadline for filing ERISA suits by over a year. Solien then amended her complaint and alleged that Raytheon violated its fiduciary duties by failing to notify her of the one year time limit. The District Court found for Solien and allowed her to proceed with her case.

Solien made two main arguments as to why the one year limit in the SPD should not be enforced. First, she argued that the time limit was unreasonable because it conflicts with Arizona's six-year statute of limitations on lawsuits related to contracts. The Court did not find this argument persuasive. It found that time limits in policies that provide less time than the state statute of limitations are enforceable under general principles of contract law. Additionally, the court cited several cases where time limits shorter than limits provided in statutes of limitations were found to be reasonable. These included cases where the contract provided for a

one year limit and even cases where the limit was shorter. Drawing on these sources, the Court found the one year limit to be reasonable.

Although the time limit in the SPD was reasonable, Raytheon's efforts to inform Solien of the limit were not found to be adequate. Noting that judicial review of a benefits decision is an "appeal procedure for an adverse benefits determination," the court found that procedures for informing plan participants of the review process are mandated by federal regulations. 29 C.F.R. § 2560.503-1 (2007). Such regulations require fiduciaries to disclose the reasons for the adverse decision, reference to the plan provisions on which the decision is based, a description of "any additional material or information necessary...to perfect the claim," and a description of the plan's review procedures and any time limits associated with such procedures. 29 C.F.R. § 2560.503-1(g) (2007). Any notice of such procedures must be "set forth in a manner calculated to be understood by the claimant." 29 C.F.R. § 2560.503-1(g) (2007).

After reviewing Raytheon's SPD, the Court decided that it failed to satisfy the criteria established by the regulations. The "Disability" section of the SPD said the procedure for appealing a denied claim would be explained in the "Administrative" section. However, later in the "Disability" section it disclosed the one year limitation, which was never mentioned in the

“Administrative” section. “The Court finds that the required notice to the claimant of her right to sue under ERISA, was not set forth in a manner calculated to be understood by her when it failed to provide notice of the time limitation.” Ultimately, the Court found that Raytheon failed to fulfill its duties toward Solien under federal law. These duties must be discharged “with respect to a plan solely in the interest of the participants and beneficiaries.” 29 U.S.C. § 1104(a). By not informing her of the time limit for filing her claim, Raytheon failed to act solely in Solien’s interests. Consequently, it allowed Solien to file a late appeal.

C. FAILURE TO PROVIDE INFORMATION ABOUT HOW TO FILE CLAIMS APPEALS MAY EXTEND TIME FOR FILING.

Hahnemann University Hospital v. All Shore, Inc., 514 F.3d 300 (3rd Cir. 2008). *The state statute of limitations on contract claims applies to suits under 29 U.S.C. § 1132(a)(1)(B) of ERISA. A plan participant does not violate a time limit for filing an administrative appeal if they are given no information about how to file the appeal. A company that administers a plan can be sued under ERISA if they are individually liable for the plaintiff’s injury.*

In March 1999, a patient covered under the Allshore Plan was treated at Hahnemann University Hospital. The patient assigned her claims for benefits under the plan to Hahnemann, which submitted a medical bill to the Allshore Plan for approximately \$250,000 in April 1999. Allshore had hired Benefit Concepts, Inc. (BCI), to act as claims administrator for the Allshore Plan. BCI entered into contracts with PPOs, which allowed the benefit plans

BCI worked with to receive the PPOs' price discounts. These discounts applied despite the fact that there was no agreement between the plans and the PPOs themselves. BCI was not a fiduciary under the plan and exercised no discretionary authority. When BCI received Hahnemann's claim it determined that a 10 percent discount might apply to the claim based upon BCI's contract with a Multi Plan Preferred Provider Organization (PPO).

When Hahnemann received payment from Allshore in September 1999, it only received 60 percent of its claim, or about \$150,000. The managing general underwriter concluded that instead of a 10 percent discount applying to the claim, a 40 percent discount applied to the claim through a different PPO, the National Preferred Provider Network. When it received payment, Hahnemann sought to question the applicability of the 40 percent discount because it did not have a contract with NPPN. However, the documentation with the payment did not indicate how to seek administrative review. In April 2000, Hahnemann requested review from BCI. In March 2003, NPPN informed BCI that the 40% discount did not apply to Hahnemann's claim. After waiting several months without receiving the balance it was owed, Hahnemann filed a lawsuit against Allshore, Inc., and the Allshore Plan in federal district court in July 2003.

Hahnemann sought to recover the benefits it was owed under Section 502 of the Employee Retirement Income Security Act (29 U.S.C. § 1132(a)(1)(B)), which allows a plan participant or beneficiary to “recover benefits due to him under the terms of the plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.” The District Court found for Hahnemann, and awarded it not only the money it was owed under the claim but also more than \$140,000 in attorney’s fees and costs. Allshore appealed to the United States Court of Appeals for the Third Circuit, which affirmed the decision but sent the case back to the District Court to alter the award of attorney’s fees and costs.

The Third Circuit first decided that Hahnemann filed its claim before the statute of limitations expired. Section 502 of ERISA (29 U.S.C. § 1132(a)(1)(B)) does not contain a statute of limitations, which means that the federal courts are required to apply a local statute. Allshore argued that the plan included a one year limitation period because it stated that “all claims must be filed with the Plan within the twelve (12) month period from the date of the expense.” However, the court found that this provision only set a time limit on filing a claim for benefits, not a limit on filing a lawsuit under ERISA. Hahnemann complied with the limit by filing its claim one

month after the expenses were incurred. The court also rejected Allshore's argument that a three year statute of limitations found in ERISA § 413 (29 U.S.C. § 1113) applied because the case was brought under Section 502 of ERISA. Accordingly, the court applied a Pennsylvania state four year statute of limitations for contract claims because it was the local limitation most analogous to the claim.

Allshore also argued that Hahnemann failed to file a claim for administrative review on time. The plan specified a 60-day time limit for filing for administrative review. Hahnemann did not file a request for review until seven months after it received its payment. However, the Court found that Hahnemann did not violate the 60-day limit because Allshore failed to notify Hahnemann of the review procedure. Under both ERISA § 503 (29 U.S.C. § 1133) and federal regulations, a plan administrator must provide adequate notice to a participant or beneficiary of a claim denial and furnish them with appropriate information regarding how to file an administrative appeal. 29 C.F.R. § 2560.503-1(f)(1999). Since Allshore failed to provide any information to Hahnemann regarding the appeal procedure, the 60-day limitation never began running, and Hahnemann filed its appeal on time.

The Court also found that the 10 percent discount on Hahnemann's claim was not applicable. Hahnemann never had a contract with the PPOs and was not subject to the discount.

The Court also found that the judgment against Allshore, Inc. was valid. Under Section 502 of ERISA, a plaintiff may only sue a plan itself or plan administrators in their individual capacities. However, under Section 502, any person can be sued as long as "liability against such person is established in his individual capacity under this subchapter." The Court found two different theories under which Allshore, Inc. could be found individually liable: 1) it agreed to be financially liable for the medical expenses incurred by Hahnemann; or 2) as plan administrator it breached a fiduciary duty by refusing to pay Hahnemann's claim without justification. Therefore, despite the fact that Allshore, Inc. was not the plan itself it could be sued by Hahnemann.

Finally, the Court examined the award of attorneys' fees and costs. Allshore argued that attorneys' fees should not be awarded for pre-litigation expenses, but only for fees related to official judicial proceedings. The Court noted that the United States Supreme Court has not ruled on the issue. It decided to join the Second, Fourth, Sixth, Eighth, and Ninth Circuits in ruling that pre-litigation fees are not recoverable under ERISA. It based its

decision on the fact that ERISA § 502 authorizes recovery of fees “in any action,” which indicates only formal proceedings. 29 U.S.C. § 1132(g)(1). The law makes no mention of recovery for fees associated with informal proceedings. The Court also found that some of the costs and fees incurred by Hahnemann’s counsel could have been avoided by using local counsel instead of paying for out-of-state counsel to travel. Accordingly, it remanded the case to the District Court to adjust the fee award.

VI. PLAN ADMINISTRATION

A. ON THE SUPREME COURT DOCKET: QDROs AS THE SOLE MECHANISM FOR ELIMINATING SPOUSAL INTEREST IN PENSION BENEFITS.

Kennedy v. Plan Administrator for DuPont Savings and Investment Plan, 497 F.3d 426 (5th Cir. 2007). *A Qualified Domestic Relations Order is the only mechanism for eliminating a spouse’s interest in pension plan benefits under ERISA. A waiver in the form of a divorce decree is prevented from eliminating the interest by an anti-alienation clause in the plan.*

William Patrick Kennedy was a DuPont employee who participated in its savings and investment plan (SIP), an employee pension benefit plan under the Employee Retirement Income Security Act (ERISA). The SIP included an anti-alienation provision that stated “no assignment of the rights or interests of account holders under this plan will be permitted or recognized.” In 1971, Kennedy married Liv Kennedy. In 1974, he signed a

beneficiary-designation form, designating Liv Kennedy as the SIP's sole beneficiary.

In 1994, the Kennedys divorced, and Liv Kennedy agreed to be divested of "all right, title, interest, and claim in and to...the proceeds therefrom, and any other rights related to any...retirement plan, pension plan, or like benefit program existing by reason of [decedent's] employment." In 1997, an ERISA Qualified Domestic Relations Order (QDRO) was approved. Although it contained benefit-disbursement instructions for some of William Kennedy's non-SIP employee-benefit plans, no QDRO for the SIP was ever submitted.

Kennedy retired from DuPont in 1998 and died in 2001. He never replaced or removed Liv Kennedy as the SIP beneficiary. Kari Kennedy, William and Liv Kennedy's daughter, was appointed executrix of his estate. She demanded from DuPont that the SIP funds be distributed to the estate, arguing Liv Kennedy's beneficiary designation was invalid pursuant to Texas law. DuPont refused to comply with the demand, citing the SIP beneficiary-designation. Liv Kennedy also refused to relinquish her SIP interest, and collected the SIP balance of \$400,000.

The estate filed a lawsuit in federal district court to recover the SIP benefits. It argued that by not turning over the SIP benefits to the estate,

DuPont was in violation of both ERISA and state contract law. Specifically, the estate argued that Liv Kennedy waived her rights to the SIP benefits through the divorce decree, which invalidated the beneficiary-designation. The district court found for the estate after determining that federal common law applied to determine if the divorce decree waived Liv Kennedy's rights to the SIP benefits. Under federal common law, the divorce decree constituted a valid waiver.

On appeal, the United States Court of Appeals for the Fifth Circuit reversed the district court. The Fifth Circuit found that the district court incorrectly relied on a series of cases which found that the anti-alienation provision in the plan did not apply. However, the Fifth Circuit pointed out, those cases dealt with life insurance and other welfare policies under ERISA, while this case deals with a pension plan. Consequently, the anti-alienation provision applies instead of the common law waiver approach.

An assignment or alienation is defined in the regulations as any "direct or indirect arrangement" where a party acquires rights from a participant or beneficiary enforceable against the plan. The Fifth Circuit found that Liv Kennedy's divorce decree constituted an "indirect arrangement" whereby the estate gained an interest against the plan. The anti-alienation provision in the plan thus bars the decree's operation on the

SIP benefits. Furthermore, the only exception to the anti-alienation provision is a QDRO. Congress specifically provided the QDRO as the only mechanism for addressing the elimination of a spouse's interest in plan benefits. When that mechanism is not invoked, courts cannot resort to a common law rule. In order for the divorce decree to be considered a QDRO, it would have to "clearly specify the identity of any beneficiary, the particular plans affected, and the exact manner of calculating benefits." The Fifth Circuit found that it did not meet these criteria.

The Fifth Circuit also decided to uphold the district court's decision not to award attorney's fees to either party in the case. The court employed a five-factor test to determine whether to award attorney's fees. After determining that DuPont showed little culpability or bad faith the court decided that an award may not have any deterrent value. Therefore, it declined to award any attorney's fees.

The United States Supreme Court has taken this case on appeal but has not yet scheduled a date for oral arguments. The issues include: 1.) whether federal common law governs the judicial determination of whether the divorce decree or the beneficiary-designation card controls the case, 2.) whether a QDRO is the only way a spouse can waive her rights to pension

benefits, and 3.) what legal standards govern the award of fees to prevailing parties under ERISA.

B. PLAN CORRECTLY FILED FOR INTERPLEADER IN CASE OF DUELING EX-SPOUSES.

Taliaferro v. Goodyear Tire & Rubber Company v. Parsons, 265 Fed. Appx. 240; 2008 U.S. Appx. LEXIS 2747 (5th Cir. February 7, 2008). *ERISA preempts any state law that relates to ERISA covered pension plans. Therefore, a person is not entitled to benefits in an ERISA-covered plan unless he/she complies with ERISA's requirements.*

Robert Taliaferro married Mabel Parsons and then they divorced in 1968. In 2001, Parsons brought an action in Smith County, Texas against Taliaferro to collect child support. In 2002, Parson's attorney supplied Goodyear with notice of the action in which she alleged that she had an interest in Taliaferro's pension benefits. Goodyear responded to Parsons that ERISA did not allow payment of child support obligations from a pension benefit without a Qualifying Domestic Relations Order ("QDRO"). Goodyear subsequently received orders on two occasions from Smith County to withhold Taliaferro's pension benefits to pay his child support obligations. Goodyear responded to both orders that it needed a QDRO to transfer benefits under ERISA. Goodyear also offered assistance to Parson's counsel who apparently ignored the other.

In July of 2004 Taliaferro and his second wife obtained a divorce decree in Rusk County, Texas state court. The court awarded Ms. Taliaferro

70% of Mr. Taliaferro's pension benefits, and her counsel provided the necessary QDRO to Goodyear that same month. In September, 2004, Goodyear advised both parties that a QDRO from a Texas court specifying the proper distribution of the funds was necessary before it would distribute any money.

After the parties were unable to resolve the conflict, Ms. Taliaferro filed suit in the Rusk County, Texas court seeking payment from Goodyear. Goodyear then had the case removed to federal court and filed a cross-claim and counterclaim seeking a determination of its obligations under ERISA. In August of 2005, the Texas court issued an order that concluded that the Taliaferro's community property was subject to Ms. Parson's child support lien, and directed them to turn over property sufficient to satisfy the obligation. The federal court held that Mr. Taliaferro's pension benefits were subject to the child support lien but did not address Goodyear's obligations under ERISA and declined to retain jurisdiction over the state claims. Instead of remanding the claims back to the Rusk County court, it transferred them to Smith County. Both Goodyear and Mr. Taliaferro appealed.

The Fifth Circuit held that the district court erred by deciding the case based on Texas law instead of under ERISA which preempts any state law

that relates to ERISA covered pension plans. A QDRO was required under ERISA and Parsons had not provided one, therefore she was not entitled to the pension benefit. The court also held that Goodyear's questions as to who was entitled to the pension benefit was properly presented and should have been addressed by the Smith County court and remanded it to the federal district court to be addressed. The court also held that it was improper for the federal district court to transfer the claims to Smith County when they were filed in Risk County. If after the review by the federal district court the claims are subject to remand, it should be remanded to Rusk County.

C. EMPLOYER FOUND RESPONSIBLE TO MAKE PENSION FUND CONTRIBUTIONS FOR NON-UNION EMPLOYEES UNDER PROJECT WORK AGREEMENT.

Trustees of the Southern California IBEW-NECA Pension Fund v. Flores, 2008 WL 795347 (9th Cir. 2008). *An agreement between an employer and a union where an employer is responsible for making pension fund contributions for all employees engaged in project work can make the employer responsible for contributions for all employees regardless of his/her union membership.*

In August 2003, Herman Flores was hired as an electrical subcontractor on a construction project for the Los Angeles School District. In October, Flores signed a subscription agreement with Local Union 11 whereby he agreed to make contributions to his employees' pension trust funds. His obligation was also regulated by a project stabilization agreement (PSA) and the Union's Inside Wiremen's Agreement (IWA). Sections 4.6

and 4.8 of the PSA required Flores to hire all project workers, excluding his core employees, from the union's referral system, unless there was no referral within 48 hours. In October and November, Flores made requests for workers, but none were referred until December. In the meantime, he used his own non-union employees and made no contributions to the employees' pension trust funds prior to December. After discovering the unpaid contributions for project work before December, the Trustees filed an action in federal court under section 301(a) of the Labor Management Relations Act and section 503(e)(1) of ERISA. The district court ruled in favor of Flores holding that the PSA is ambiguous because "it never defines the term 'covered workers' and never expressly requires contributions for nonunion workers." The court also considered extrinsic evidence of the parties' oral representations.

The court held that the collective bargaining agreement covered both union and non-union employees because a section of the PSA provided a detailed list of excluded classifications. When an agreement defines covered employees by classification, it covers all employees in that classification regardless of union membership. The court also held that the clause in the PSA and IWA show that the agreements covered all electrical workers for the project, regardless of their membership in a union.

In addition, the court held that because the IWA stated that the union was the sole and exclusive representative of the employees engaged in work within the jurisdiction of the Union and the PSA also stated that the employees participating in the project were the bargaining unit, therefore the bargaining agreements covered all of the electrical workers engaged in project work.

The court rejected Flores' argument that the PSA's benefits contribution requirement was not effective until the actual referral of union workers. It held that none of the agreements contained that condition. The court also held that the PSA was clear and unambiguous that Flores' obligations arose prior to the employees starting work on the project. In addition, he agreed to be bound by all contract provisions when he accepted the construction contract, and also when he signed the subscription agreement for work in October of 2003.

**D. PLAN ADMINISTRATOR MAY BRING 502(a)(3)
SUBROGATION REIMBURSEMENT SUIT TO RECOVER
FUNDS BELONGING TO A THIRD PARTY.**

Administrative Committee for the Wal-Mart Stores, Inc. Associates' Health and Welfare Plan v. Horton, 513 F.3d 1223 (11th Cir. 2008).
Under ERISA § 502(a)(3), the administrator of a health plan can sue a third party in possession of specific, identifiable funds pursuant to a reimbursement provision in the plan.

Joshua Horton was hit by a car when he was 14 years old, suffering permanent injuries. His mother, Denica Jayne Werber, worked for Wal-Mart at the time of the accident and participated in the Wal-Mart Stores, Inc. Associates' Health and Welfare Plan (the "Plan"). Horton was covered under the Plan, which paid \$51,446 in medical benefits on Horton's behalf following the accident. Eventually, Horton, through Werber because Horton was a minor, filed a tort claim in a Georgia court against the driver of the car. They received a \$99,000 settlement, which was split three ways: \$1,000 went to Werber, \$33,000 went to pay attorney's fees, and \$65,000 was deposited in a probate court account for Horton's benefit. The probate court appointed Werber as Horton's conservator, and she took possession of the funds and deposited them in a bank account.

The Plan required any covered person who obtains a tort judgment or settlement to reimburse the Plan for 100 percent of any benefits paid. Pursuant to that reimbursement provision, the Administrative Committee for the plan sought reimbursement of the \$51,446 paid to Horton. Horton and Werber refused to comply with the Committee's request for reimbursement. Consequently, the Committee filed a lawsuit against Horton and Werber in federal district court in Georgia. The Committee sought "equitable relief" under Section 502(a)(3)(B) of the Employee Retirement Income Security

Act (ERISA). 29 U.S.C. 1132(a)(3). It sought restitution of the benefits paid, and the establishment of a constructive trust and equitable lien for enforcement of ERISA and the Plan's terms. The District Court found in favor of Horton. The Committee appealed to the United States Court of Appeals for the Eleventh Circuit, which reversed.

ERISA § 502(a)(3) authorizes lawsuits to be brought by “a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;....”

Initially, courts were split over whether the language “other appropriate equitable relief” authorized plan providers and fiduciaries to sue participants under § 502(a)(3) to recover under reimbursement provisions. In Sereboff v. Mid Atl. Med. Servs., Inc., the United States Supreme Court settled the matter by deciding that when plan administrators seek restitution from a beneficiary who possesses specific, identifiable funds, such a suit is equitable in nature. Therefore, plan administrators are authorized under § 502(a)(3) to sue beneficiaries for restitution. For such a suit to be deemed equitable in nature, the reimbursement must be sought from specific funds and not from the general assets of the defendant, according to Sereboff.

Although Sereboff settled the issue of whether a plan administrator could sue a beneficiary for reimbursement, it left open the question of whether a plan administrator could use § 502(a)(3) to recover from a particular fund belonging to a third party, such as a trustee or a conservator, by suing the third party. The Court of Appeals in this case cited several cases that indicated that a claim for equitable relief against a third party is valid. The Court found that “the most important consideration is not the identity of the defendant, but rather that the settlement proceeds are still intact, and thus constitute an identifiable res that can be restored to its rightful recipient.” Since the Committee is stating a claim that it is the rightful recipient of funds that are in the \$65,000 bank account controlled by Werber, then the action under Section 502(a)(3) can be maintained against Werber. Accordingly, the Circuit Court reversed the decision of the District Court and remanded the case for it to be decided under correct legal principles.

VII. AGE DISCRIMINATION

A. “ME TOO” EVIDENCE MAY SOMETIMES BE ADMISSABLE IN AGE BIAS CASES.

Sprint/United Management. Co., v. Mendelsohn 128 S.Ct. 1140 (2008).
Testimony by other RIF'd employees reporting to different supervisors that they also were discriminated against because of their age is neither always admissible nor always inadmissible in cases brought under the Age

Discrimination in Employment Act and instead requires a fact-intensive, context-specific inquiry.

Mendelsohn worked for Sprint, when she was terminated as part of the company-wide reduction in force (RIF) in November 2002. She was the oldest manager in her unit. She then brought suit against Sprint for age discrimination. Before the trial began, Mendelsohn indicated that she planned to offer the testimony of five other RIF'd employees who also alleged age discrimination. None of the five employees worked in Mendelsohn's group or worked under the same chain of command and their potential testimony did not involve Mendelsohn's superiors. Three of the witnesses intended to testify that they had heard Sprint supervisors or managers making denigrating remarks about older workers. One witness alleged that the company's internship program was a mechanism for age discrimination and that she had seen a spreadsheet suggesting that a supervisor considered employees' ages in making layoff decisions. Another witness alleged that he received a poor evaluation and was banned from the company because of his age and that he had witnessed another employee being harassed because of her age. Another witness alleged that Sprint had instructed him not to hire anyone over age 40, that he was replaced following his RIF by a younger employee, and that the company rejected his later employment applications. Sprint attempted to exclude the "me, too"

testimony, arguing that it was irrelevant and that it should be excluded because the probative value of the evidence would be substantially outweighed by the danger of unfair prejudice, confusion of the issues, misleading the jury, and undue delay.

The district court agreed to exclude the evidence of "discrimination against employees not similarly situated to" Mendelsohn. The court defined "similarly situated employees" as those who were selected for the RIF by the same manager who selected Mendelsohn and were chosen during the same time period. During the trial, the judge said Mendelsohn could introduce testimony that the RIF was a pretext for age discrimination. The jury ruled in favor of Sprint and Mendelsohn appealed.

The Tenth Circuit found that the district court had applied a per se rule that other-supervisor evidence is irrelevant to proving discrimination and that it had erroneously relied on Aramburu v. Boeing Co., which held in a discriminatory discipline case that only employees who had the same supervisor as the plaintiff could testify that they were treated more favorably for violating the same work rule. The appeals court found that Aramburu was inapplicable because it did not involve an alleged company-wide policy of discrimination. The Tenth Circuit then found that the testimony by the

five other RIF'd employees was admissible because it was relevant and not unduly prejudicial. The appeals court remanded the case for a new trial.

When the case went to the Supreme Court, the Court concluded that the Tenth Circuit had erroneously found that the district court had applied a per se rule of inadmissibility. The court acknowledged that Sprint cited Aramburu in arguing that other employees are similarly situated to Mendelsohn only if they had the same supervisor and that the district court's order "mirrors that blanket language." However, it found that the district court's discussion of the evidence neither cited Aramburu nor gave any other indication that its decision relied on that case. The Court also noted that the order included no analysis suggesting that the district court applied a per se rule excluding this type of evidence.

The Court found that neither party's submissions to the district court suggested that Aramburu was controlling. The Court would not assume that the district court adopted the Aramburu analysis when it addressed a very different kind of evidence and when the district court's order was equally susceptible of a correct reading. The Court also found that Sprint's motion did not suggest that such evidence would never be admissible; it simply argued that such evidence lacked sufficient probative value in this case to be relevant or outweigh prejudice and delay. Rather than assess the relevance

of the evidence itself and conduct its own balancing of its probative value and potential prejudicial effect, the court of appeals should have allowed the district court to make these determinations.

B. EMPLOYER HAD THE BURDEN OF PERSUASION ON WHETHER DECISION WAS BASED ON A REASONABLE FACTOR OTHER THAN AGE.

Meacham v. Knolls Atomic Power Laboratory, 128 S.Ct. 2395 (2008).

In an ADEA suit for discrimination, an employer may raise the defense that although its employment policies led to seemingly discriminatory results, he relied on reasonable factors other than age to reach such results. The employer has the burden of persuading a court that the factors it relied on were truly reasonable.

KAPL, Inc., is a private contractor hired by the United States Government to operate the Knolls Atomic Power Laboratory. At Knolls, KAPL maintains the United States' fleet of nuclear-powered warships. In 1996, Knolls was ordered to reduce its workforce due to decreased demand for naval nuclear reactors. After about 100 employees accepted a buy-out, Knolls was still left with 31 jobs to cut. To determine who to layoff, Knolls told its managers to score employees on three scales: "performance," "flexibility," and "critical skills." The "performance" score was based on the worker's two most recent evaluations. The "flexibility" category called for the manager to assess the range of an employee's skills and their potential to be used on future projects. "Critical skills" measured how valuable an employee was to the laboratory, and whether his skills could be

replaced on the external market. The scores from each category were added together, and each employee was given points for years of service. The total scores determined who would be let go.

Thirty of the thirty-one workers who were laid off were at least forty years old. Twenty-eight of them sued Knolls in federal district court. They accused Knolls of violating both the Age Discrimination in Employment Act (ADEA) and state law by designing a workforce reduction process with the intent of discriminating against older employees. They also alleged that the process had the result of discriminating against older employees. To show that the lay-off process had a discriminatory result the workers relied on statistical evidence that suggested that it was rare that results so skewed by age occurred by chance. The statistics showed that the scores for “flexibility” and “criticality,” which managers had the most discretion over, were most directly linked with the results. The jury found for the workers, finding that the process had a discriminatory result but not a discriminatory motive. The United States Court of Appeals for the Second Circuit initially affirmed the decision, but later changed their decision to find that there was no discriminatory result. The workers appealed to the United States Supreme Court, which reversed the decision of the Second Circuit and remanded the case.

The major issue before the Supreme Court was which party had to carry the burden of persuasion. Did the workers have to prove that Knolls based its lay-off decisions on factors it knew would lead to discrimination? Or did Knolls have to prove that its lay-offs, although they may have resulted in discrimination, were based on reasonable criteria other than age? The Court found that while the workers had to show that a specific practice resulted in discrimination, Knolls would ultimately have to convince the jury that its lay-off decisions were based on reasonable factors.

The ADEA generally prohibits an employer from discriminating against employees on the basis of age. 29 U.S.C. §§ 623(a)-(c), (e). However, the law also contains exemptions from the discrimination prohibitions. These exemptions make it lawful for an employer to “take any action otherwise prohibited under subsections (a), (b), (c), or (e)...where age is a bona fide occupational qualification reasonably necessary to the normal operation of the particular business, or where the differentiation is based on reasonable factors other than age....” 29 U.S.C. § 623(f)(1). In a previous case the Supreme Court ruled that the “bona fide occupational qualification” (BFOQ) provision was an affirmative defense. That means the employer could raise it as a defense to a claim of discrimination, but it was the employer’s responsibility to prove that age was a BFOQ. The Court found

no reason to consider the “reasonable factors other than age” (RFOA) provision as any different from the BFOQ. The two provisions are grouped together and apply to the same provisions of the ADEA. Accordingly, the Court found that the RFOA defense was an affirmative defense and Knolls had the burden of proving that it used reasonable factors other than age in determining which of its workers would be laid off.

This does not mean that the plaintiff does not have to prove anything. The Court found that the plaintiff has to identify the specific employment practices that are responsible for creating a discriminatory result. If the plaintiff did not have to make any showing regarding wrongdoing, the Court found, the employer could potentially be held liable for innocent practices that incidentally led to circumstances suggesting discrimination. The Court noted the fear that forcing the employer to prove his innocence could lead to a flood of frivolous discrimination suits. The potential for such lawsuits is significantly diminished if the worker has to point to a specific practice that led to a discriminatory result. The Court also noted that if the employer relied on reasonable factors it will not be hard to prove that it has done nothing wrong.

C. DISABILITY PENSION ELIGIBILITY CONDITIONED PARTIALLY ON AGE NOT DISCRIMINATORY UNDER ADEA.

Kentucky Retirement Systems v. Equal Employment Opportunity Commission, 128 S.Ct. 2361 (2008). *A state retirement system that conditions pension eligibility at least partly on age does not violate the ADEA unless disparate treatment of workers is actually motivated by age.*

The Commonwealth of Kentucky has a retirement plan (the “Plan”) for state and county workers who have “hazardous positions.” These include active duty law enforcement officers, firefighters, paramedics, and correctional systems workers. The plan allows workers to become eligible to receive retirement benefits after 20 years of service, or after five years of service if they have reached age 55. Under either route, the pension amount for the employee is calculated by multiplying his years of service times 2.5 percent times his final pay prior to retirement.

The Plan also provides benefits for workers who become permanently disabled but are not yet eligible for retirement. If such an employee has worked for five years or become disabled in the line of duty he can retire immediately. The amount of benefits he receives is calculated using the same method for employees who retire at the standard time, except he is given credit for years of service he never worked. The number of extra (imputed) years the employee receives is equal to the number of years he would have had to work to gain 20 years of service or the number of years

he would have had to work to reach age 55, whichever amount is smaller. For example, if a 48-year-old employee with 17 years of service becomes disabled, he is given three imputed years to calculate his benefits. If a 54-year-old employee with 18 years of service becomes disabled, he is given one imputed year of service. The Plan also places a ceiling on imputed years equal to the number of years already worked and mandates a certain minimum payment.

Charles Lickteig became disabled and retired at age 61. At that time he had 18 years of service. The Plan added no imputed years to his total because he became disabled after age 55. Lickteig complained to the Equal Employment Opportunity Commission (EEOC), who brought a lawsuit against the Commonwealth of Kentucky, the Plan administrator, and other state entities in federal district court. The EEOC alleged that the Plan violated the Age Discrimination in Employment Act (ADEA) by paying workers who became disabled after age 55 less than some workers who became disabled before age 55. The District Court found for the Plan. The United States Court of Appeals for the Sixth Circuit found that the Plan did violate the ADEA, and reversed. Kentucky appealed to the United States Supreme Court, who found no violation and reversed the Sixth Circuit.

The ADEA prohibits employers from discriminating “against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual’s age.” 29 U.S.C. § 623(a)(1). To prove that an employer intentionally discriminated against an employee because of his age the employee must prove that age “actually motivated” the employer’s decision, the Supreme Court found in Hazen Paper Co. v. Biggins. 507 U.S. 604, 610 (1993). It is not a violation of the ADEA for an employer to discriminate against an employee on the basis of pension status. In other words, an employer does not violate the ADEA when he fires an employee to prevent him from receiving his pension.² However, this could constitute a violation of the ADEA if pension is used as a proxy for age. Kentucky’s Plan conditions pension eligibility party on age, which is authorized by the ADEA. 29 U.S.C. 623(l)(1)(A)(i). Since Kentucky’s Plan makes age a condition of pension eligibility and treats workers differently based on that eligibility, the question before the Court was whether that means the Plan “automatically discriminates because of age.” The Court found that the Plan does not discriminate based on age.

The Court cited several reasons why the differences in treatment of older and younger workers in the Plan were not actually motivated by age.

² Of course it could be a violation of ERISA § 510. 29 U.S.C. § 1140.

To begin with, the Court found that the Plan did not use pension status as a proxy for age. The disability benefit at issue is offered to all workers on a nondiscriminatory basis. Every employee, regardless of his or her age, is guaranteed the disability benefits should they become disabled.

Additionally, the Court noted that Congress specifically authorized a similar system for determining benefits for Social Security Disability Insurance. 42 U.S.C. § 415(b)(2)(B)(iii).

Next the court found that the only reason age factors into benefits calculations for disabled workers is because it factors into benefits decisions for standard workers. The Court found that similar disparities between disabled workers and non-disabled workers could be found in an age-neutral system. The Court offered the example of a plan that allowed day-shift workers to become eligible for benefits after 20 years of service and night-shift workers to become eligible after 15 years. If the workers were paid \$1,000 per year for each year of service they had and disabled workers were given imputed years of service for each year they needed to become eligible for benefits similar disparities could be created. A day-shift worker who becomes disabled would receive \$20,000 per year while a night-shift worker who becomes disabled after 16 years would only receive \$16,000. In this sense, the Kentucky Plan and the plan in the example are both systems that

treat some workers more favorably because of the timing of their eligibility for normal retirement benefits. This shows that age only plays a factor in the disability benefits of the Kentucky Plan because it plays a factor in the timing of pension eligibility.

The Court went on to note that Kentucky's Plan can actually be favorable to older workers. For example, a 45-year-old disabled worker with 10 years of service would receive more than a 40-year-old disabled worker with 15 years of service. The older worker would actually receive more imputed years of service under the Plan. Additionally, the Plan does not rely on any of the standard stereotypes about older employees that the ADEA is designed to combat. Finally, the Court noted the difficulty in fashioning a better system than Kentucky has for compensating individuals with disabilities. If the Plan were to increase the amount of benefits it gave to disabled workers who were pension-eligible, like Lickteig, there is no easy way to determine how much of an increase those individuals should receive. For all of these reasons, the Court found that disparities in the Plan were not actually motivated by age.

D. COURT UPHOLDS EEOC RULE PERMITTING REDUCTION IN RETIREE HEALTH BENEFITS WHEN RETIREE BECOMES ELIGIBLE FOR MEDICARE.

American Association of Retired Persons v. Equal Employment Opportunity Commission, 489 F.3d 558 (3rd Cir. 2007). *A rule was*

upheld that would allow employers to decrease retiree health care benefit levels or terminate such benefits for retirees eligible to receive Medicare. With many employers terminating all retiree health benefits, the rule would benefit all workers by allowing employers to provide retiree health care to a wider range of workers.

On July 14, 2003, the Equal Employment Opportunity Commission (EEOC) proposed a rule exempting from federal prohibitions under ADEA the practice of “altering, reducing or eliminating employer-sponsored retiree health benefits when retirees become eligible for Medicare or a State-sponsored retiree health benefits program.” Age Discrimination in Employment Act; Retiree Health Benefits, 68 Fed. Reg. 41,542, 41,542 (EEOC July 14, 2003) (notice of proposed rulemaking). The rule would allow employers to reduce or terminate retiree health care benefits when retired employees become eligible for federal or state-sponsored health care programs. In February 2005, the American Association of Retired Persons (AARP) brought a lawsuit in federal district court in Pennsylvania challenging the proposed rule. AARP argued that the rule violated both the Age Discrimination in Employment Act (ADEA) and the Administrative Procedure Act (APA).

The district court found that the proposed rule interfered with the ADEA and permanently enjoined the EEOC from implementing it. The EEOC appealed to the United States Court of Appeals for the Third Circuit.

The Court of Appeals reversed, finding that the EEOC properly exercised its power in proposing the rule.

The Court of Appeals first found that the proposed rule was authorized by the ADEA. The AARP argued that the proposed rule would violate the ADEA because it would allow employers to discriminate against older workers by providing them with less valuable benefits packages than younger workers. According to the AARP, this would violate Section 4 of the ADEA, which makes it unlawful for an employer to “discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual’s age.” 29 U.S.C. § 623(a)(1). Although the proposed rule might allow employers to provide different benefits for older workers and younger workers, the court found that the EEOC was authorized to pass the rule under Section 9 of the ADEA. Section 9 allows the EEOC to “establish such reasonable exemptions to and from any or all provisions of [the Act] as it may find necessary and proper in the public interest.” 29 U.S.C. § 628. The real question then, was whether the proposed rule was “reasonable” and “necessary and proper.”

The Court found that the proposed rule satisfied the criteria established by Section 9. According to the Court, the EEOC was motivated to pass the rule by findings that employer-sponsored retiree health care

levels were declining. In order to avoid discrimination claims many employers were lowering all retiree health benefits instead of maintaining health benefits for retirees eligible for health care. Employers are not required by law to maintain retiree health care plans and in the face of rising health care costs many employers choose to simply terminate such benefits. The EEOC acted in order to benefit all retirees by allowing employers to offer retiree benefits to the greatest extent that they can. Therefore, the proposed rule was considered “reasonable,” “necessary and proper.”

Additionally, the Court found that the rule did not violate the APA. The EEOC’s decision-making process in formulating the rule was clearly reasoned and relied on studies and statistics to support its positions. The Court rejected the AARP’s claim that the EEOC failed to recognize the impact this rule would have on all workers. The rule would benefit all workers by allowing employers to provide coverage for early retirees and possibly to provide supplemental coverage to workers eligible for Medicare.

The EEOC published the final rule in December 2007.

VIII. AMERICANS WITH DISABILITIES ACT

A. TERMINATION OF AN EMPLOYEE FOR CONDUCT ARISING FROM DISABILITY MAY VIOLATE ADA SUBJECT TO EMPLOYER DEFENSES (E.G., UNDUE BURDEN).

Gambini v. Total Renal Care, Inc., 486 F.3d 1087 (9th Cir. 2007). *An employer commits discrimination if it fires an employee for engaging in conduct that results from a disability. Termination does not have to be motivated by the disability itself. Employer is entitled to raise several defenses, including that the termination was a business necessity or accommodating the employee would be an undue burden.*

Stephanie Gambini began working as a contracts clerk at Total Renal Care, Inc. (DaVita) in November 2000. DaVita provides dialysis to patients. Gambini began to experience depression and anxiety after working for a few months at DaVita. In April 2001, she had an emotional breakdown at work and was later diagnosed with bipolar disorder. When she returned to work she informed her supervisors that she had been diagnosed with bipolar disorder and requested some accommodations. She also told her supervisors and co-workers that she experienced mood swings and that they should not be offended if she was short or irritable with them. In April 2002 Gambini's symptoms became more severe and she began to see Bobbie Fletcher, a psychiatric nurse practitioner.

On July 11, 2002, Gambini's supervisors requested that she attend a meeting with them. At the meeting, they gave her a written performance improvement plan, which began, "[Gambini's] attitude and general disposition are no longer acceptable in the SPA department." After reading the first line Gambini began to cry. When she finished reading the performance plan she threw it across the desk and uttered several profanities

while expressing her belief that it was “unfair and unwarranted.” Gambini uttered several more profanities on her way out, and she may have told her supervisors they “will regret this.” At her cubicle after the meeting, Gambini kicked and threw things, and attempted unsuccessfully to call Fletcher to tell her she was having suicidal thoughts.

When she arrived at work the next morning, Gambini received a call from Fletcher, who advised her to go to the hospital. Gambini then informed her supervisors that she was going to the hospital and made accommodations to leave. On July 16, DaVita tentatively approved Gambini’s request for leave under the Family Medical Leave Act, provided that the company received medical certification from Gambini’s health care provider. A human resources official began an investigation into the July 11 incident and several DaVita employees expressed concerns about working with Gambini. The next day the human resources official and one of Gambini’s supervisors called Gambini to inform her that her employment at DaVita had been terminated. Gambini sent a letter to the company three days later requesting a reconsideration, but the company refused to reconsider.

Gambini sued DaVita in 2004, alleging that her termination violated the Washington Law Against Discrimination and the FMLA. DaVita prevailed after a trial in the United States District Court for the Western

District of Washington. Gambini appealed to the United States Court of Appeals for the Ninth Circuit. On appeal she argued that the jury was incorrectly instructed about multiple aspects of the law. The Ninth Circuit reversed the District Court's decision and ordered a new trial.

The Ninth Circuit found that “conduct resulting from a disability is part of the disability and not a separate basis for termination.” Consequently, terminating an employee because of conduct that arises out of a disability is discrimination. The Court found that an employer commits discrimination if its decision to terminate an employee was “motivated even in part” by the employee's disability. The Court found that in Gambini's case there was evidence to suggest that Gambini was fired because of conduct resulting from her bipolar disorder. In the performance improvement plan her supervisors wrote that her “attitude and general disposition” were “no longer acceptable.” This indicates that their decision to terminate her employment was based in part on the moods she was experiencing as a result of her disorder. There was evidence to indicate that Gambini's bipolar disorder caused her irritability and mood swings, as well as led to the violent outburst on July 11. Since there is evidence to suggest that the outburst was caused by the bipolar disorder, it was protected as part of her disability. “In those terms, if the law fails to protect manifestations of

her disability, there is no real protection in the law because it would protect the disabled in name only,” the Court wrote. Consequently, the Court sent the case back to the trial court for a new trial guided by the correct legal standard.

The Court rejected a claim by DaVita that finding every manifestation of a disorder to be protected under anti-discrimination laws gives disabled workers “absolute protection” from termination. The Court disagreed, saying the employer was entitled to argue in its defense that it had to terminate Gambini out of business necessity or because she presented a direct threat to other workers. The company also could have argued that accommodating her disorder would create an undue burden on the company. In other words, DaVita was not required to continue to employ Gambini under any circumstance.

The Ninth Circuit did not find for Gambini on every issue. The Court rejected her argument that DaVita interfered with her FMLA rights by failing to reinstate her after her allotted leave of absence under the law expired. The Court disagreed with this argument because it found that DaVita would have fired her even if she had remained at work after the July 11 incident. The company’s decision to terminate her, according to the

company, had nothing to do with the fact that she took leave under the FMLA.

IX. COMPENSATION

A. CALIFORNIA COURT RULES EMPLOYER MAY DEDUCT COSTS INCLUDING WORKERS COMPENSATION WHEN CALCULATING INCENTIVE BONUS BASED ON PROFITS.

Prachasaisoradej v. Ralphs Grocery Company, Inc., 165 P.3d 133 (Cal. 2007). *When calculating payments to employees under an incentive compensation plan, an employer can offset profits by factoring in the cost of workers' compensation, merchandise loss, cash loss, and tort claims.*

Ralphs Grocery Company owns a chain of grocery stores in California. Ralphs pays its employees a set and guaranteed dollar wage, which does not fluctuate with the store's fortunes. In addition to the set wage, Ralphs has a supplementary incentive compensation plan (ICP) that it offers its employees. Under the ICP, an employee received a compensation payment based on how profitable the store had been compared to set profitability targets for the relevant period. The profit for each store was calculated by first determining the day-to-day operating expenses of the store. These expenses included the cost of the store's merchandise, its payroll, utility bills, rent, etc. Additionally, expenses for workers' compensation, cash shortages, merchandise losses, and third party tort claims not related to gross misconduct by employees, were all included in calculating the store's operating expenses. When all of these expenses were

considered the store's profit was then calculated. After the profit was compared to preset profit targets, Ralphs determined how much of the profit would be shared with the employees.

Plaintiff Eddy Korkiat Prachasaisoradej, a produce manager at Ralphs, brought a lawsuit on behalf of himself and other Ralphs' employees in California state court against the grocery store chain. The plaintiffs alleged that Ralphs' ICP violated California labor law by including in the stores' expenses the cost of workers' compensation, cash shortages, merchandise loss, and tort claims. The trial court found for the employer and dismissed the case. The California appeals court who heard the case reversed. Ralphs appealed to the California Supreme Court, who found for Ralphs.

Section 221 of the California Labor Code makes it illegal for an employer to "collect or receive from an employee any part of wages theretofore paid by said employer to said employee." "Wages" is defined by Section 221 as any compensation for labor performed by employees, whether the "amount is fixed or ascertained by the standard of time, task, piece, commission basis, or other method of calculation." Section 3571 of the Labor Code makes it unlawful for an employer to take or receive any contribution from an employee to cover the cost of workers' compensation. The plaintiffs argued that by factoring workers' compensation and other

impermissible costs into the operating expenses of the store, Ralphs was subjecting the employees' stated and expected wage to an "unanticipated contribution, deduction, withholding, and/or reimbursement to the employer for expenses beyond the employee's control, which the law requires the employer to bear on his own. The California Supreme Court disagreed with the plaintiffs, finding nothing wrong with Ralphs ICP.

The Court began its analysis by comparing the factual circumstances of this case to other cases in which compensation plans were found to have violated labor laws. The Court found that in each case the employees' compensation was essentially set as a sales commission, a share of the revenues attributable to that employee's sales efforts. The commission amount was then reduced by the merchandise and cash losses and the employee was paid what was left. In this way, the employers in those cases passed the cash and merchandise losses onto its employees. This practice of lowering employees' wages to increase employer profits are exactly what the labor laws were designed to prevent, the Court found.

However, the ICP in Ralphs differed from these illegal practices. Under the Ralphs ICP, the amount of a the supplemental compensation was determined based on store profits, a figure which necessarily takes into account operating expenses. From the outset, Ralphs informed the

employees what it was basing its profit margin on, and therefore there were no unauthorized deductions or contributions from wages that were promised to employees. Any uncertainty about how much supplemental income the employees would receive was due to uncertainty about how profitable the store would be. The Court rejected that the fluctuations in the ICP constituted a hardship of unanticipated or undetermined wage variations. The Court noted that employees received a set, hourly wage and the ICP was merely a supplemental program. Moreover, any supplemental compensation plan based on profits is going to fluctuate. If any level of variation constituted an unlawful fluctuation then any compensation plan where the final amount was not predetermined would be illegal. The Court further found that nothing forbids an employer from using a system where final compensation, or at least a portion thereof, is not determined until after the employees have performed their services.

The Court also rejected the argument that it should strike down the ICP because of concerns over employer fraud and deceit. Although the Court noted the potential for such fraud, it also found that employer honesty is a concern in any compensation system. It is not enough, however, to strike down an otherwise legal compensation system. Additionally, the Court found that in a system like Ralphs, where the employer shares some of

the profits with the employees, there is no legal reason why the employer would have to eliminate some of his costs (workers' compensation, merchandise loss, etc.) when determining the profit for the purposes of sharing it with its employees. Those are actual costs that decreased the amount of profits and can be factored into the final profit figures. Finally, the Court rejected the argument that because the final profit number takes into account workers' compensation costs that will motivate some employees not to submit such claims to their employer. However, the Court said, it could equally be argued that including such costs in the profit figure motivates employees to maintain a safe workplace and discourages the filing of faulty claims.

X. FAMILY AND MEDICAL LEAVE

A. FMLA CLAIM GOES TO JURY BUT RETALIATION AND SEX DISCRIMINATION CLAIMS FAIL.

Slanaker v. AccessPoint Employment Alternatives LLC, 2008 U.S. Dist. Lexis 19331 March 2008. *A female former employee of an electronics firm who was terminated during maternity leave may pursue a claim for unlawful interference under the Family and Medical Leave Act.*

Emery Electronics hired Christine Slanaker in January 2003 as a controller. AccessPoint, which handled the firm's administrative functions, was Slanaker's co-employer. Rob Emery was her immediate supervisor who was also the sole shareholder of Emery Electronics. Slanaker's job

duties included managing the company's daily cash activities, accounts receivable and payable, payroll, and human resource functions.

In 2005, Slanaker informed Rob Emery that she was pregnant and requested maternity leave. After Emery asked her to put her plans for leave in writing, Slanaker drafted a "maternity leave request." In it, she stated that she planned to work a minimum of 20 hours per week and wanted to take approximately 10 weeks off. She also stated that she wanted to use her accumulated vacation time to make up the difference between her 20-hour weeks and the normal 40-hour workweek. She then requested additional vacation time instead of a pay raise in order to accumulate more paid leave. She also requested to work from home part of the time once her maternity leave was over and planned to return in September of 2006. Emery accepted the terms of her plan.

While Slanaker was on leave, Emery terminated her along with several other employees. Emery told Slanaker that her position was being eliminated. The company alleged that it was having financial troubles. Amber Patterson was one of the employees that had been terminated; she had just returned from her maternity leave. Five months after Slanaker's termination, Emery hired a new bookkeeper who worked 30 to 35 hours a week. Slanaker then brought suit under the FMLA, alleging interference

with her right to leave and unlawful retaliation for her invoking FMLA rights, and sex discrimination under Michigan's Elliott-Larsen Civil Rights Act.

The court held that Slanaker raised a jury issue of unlawful interference with FMLA rights based on evidence she was fired during an FMLA-covered leave. It further held that the Emery and AccessPoint violated the FMLA by terminating her even though she intended to return to her job as financial controller. The court said that Emery's argument that it was having financial troubles and therefore had to eliminate Slanaker's job regardless of her FMLA status had to be resolved by a jury. It also rejected the defendants' argument that Slanaker's absence was not covered by the FMLA because she had never notified the employer of her intention to take FMLA leave. The court reasoned that a Labor Department regulation, 29 C.F.R. § 825.208(a), compelled the conclusion that it was the employer's duty to designate her leave as FMLA-qualifying. The court said that once Slanaker informed Emery that she wanted to take time off following the birth of her child, it was the defendants' responsibility to inform her that the requested leave was FMLA qualifying and not Slanaker's responsibility to specify it was FMLA leave. Despite AccessPoint's argument that this rule did not apply because Slanaker had "sophisticated knowledge of the

FMLA process," the court said no such exception exists. The court said that there was no dispute that Slanaker indicated her leave was a maternity leave, and therefore, it was FMLA qualifying. It reasoned that it is the employer's obligation to designate whether leave is FMLA qualifying and any employee knowledge of the FMLA procedures is irrelevant. It further added that even though Slanaker was aware of the defendants' FMLA procedures, the defendants still had an obligation, once given sufficient notice, to designate the leave as FMLA qualifying.

The defendants also argued that because they were having serious financial difficulties, Slanaker would have been terminated regardless of her leave status. The court acknowledged that while an employee's right to reinstatement after FMLA leave is not absolute, it was a question for a jury to decide as to whether the company's financial situation was so that Slanaker would have been fired anyway. In addition, the court felt that because the company was opening a new store, and that it hired a new bookkeeper within six months of firing her, the evidence suggested Emery Electronics was not as "financially distressed" as it claimed.

The court held, however, that Slanaker, failed to raise a triable issue that the defendants retaliated against her in violation of the FMLA. The court said that Slanaker had successfully raised an issue of interference with

FMLA rights, but there was no evidence that the defendants knew she was exercising her rights under the FMLA when they decided to terminate her. The court said that the defendants did not provide Slanaker with notice that her leave was FMLA qualifying and she acknowledged that she never told management that she was requesting FMLA leave. The court therefore held that since she did not explicitly request FMLA leave, it was reasonable for the defendants to believe she was not intending to take FMLA leave. It also stated that the payroll records during Slanaker's leave show that she was paid at her regular salary, with the use of vacation and sick pay without reference to FMLA.

Slanaker also alleged that she was discriminated against based on pregnancy, which is a form of sex discrimination under the state's Elliott-Larsen Civil Rights Law. The court however, held that Slanaker failed to raise a jury issue of sex discrimination and there was insufficient evidence to support this claim.