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BENEFITS LITIGATION UPDATE

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Message from ERIC President and CEO Annette Guarisco Fildes:

Welcome to the Fall edition of *Benefits Litigation Update*, brought to you by The ERISA Industry Committee (ERIC) and the law firm of Epstein Becker Green.

As employers, it is critical that we both monitor and engage with the judiciary, because so much of the law governing the administration and provisioning of employee benefits is dependent upon court decisions. ERIC works with member companies and allies to develop amicus briefs supporting the positions of plan sponsors, and keeps an eye on emerging decisions to stay informed and get a good picture of where the case law going.

This issue of the *BLU* takes a look at critical cases in the health and retirement space, as well as an update on state encroachment upon the ERISA framework that is meant to allow national, uniform administration of multi-state employee benefit plans. The issues could not be more timely – as a new administration prepares to take the reins in Washington, D.C., the role of ERIC in educating policymakers about the importance of national uniformity is more important than ever.

I think you'll agree that some of the cases this issue analyzes are cause for consternation. New routes for plaintiffs' attorneys to pursue class actions, new expectations for plan administrators, and evolving standards for independent third parties, all need to be considered as you go forward designing your company's plans for the coming years.

We greatly appreciate the expertise of Epstein Becker Green for working with us to prepare this report. By all means, if you would like to know more or have questions, please don't hesitate to reach out.

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ERIC will hold a conference call discussing cases addressed in this issue on Thursday, December 1, 2016 from 2:00 to 3:30 pm EST.

ERIC members and trial members can register for the call by clicking here. If you are a prospective member and would like to participate in the call, please contact ERIC at (202) 789-1400 or by email at memberservices@eric.org.

FEATURED ARTICLE

The Goldilocks Paradox for Defined Contribution Plans: How Will Plan Sponsors Determine Whether Investment Alternatives Offered Are "Just Right"?

By John Houston Pope, Member of the Firm in the Employee Benefits, Litigation, and Employment, Labor & Workforce Management practices

Litigation over the selection of investment alternatives for defined contribution retirement plans ("DC plans") has taken an interesting turn. Over time, the litigation trend has moved from allegedly not offering sufficient choice to now offering too many choices. This development evokes echoes of the familiar story of Goldilocks and the three bears, which teaches the virtues of a middle course. Goldilocks finds that the first two of each thing that she tries – porridge or a bed, for example - presents an unacceptable extreme – too hot, too cold; too hard, too soft. The third choice, though, always is "just right". How plan sponsors will determine whether their investment alternative lineup is "just right" presents an emerging challenge.

The initial tranche of lawsuits against DC plans argued that plans offered too few investment choices, leaving participants with high cost, low performing alternatives into which to invest their monies. Courts frequently disagreed, finding ample selection where the investment alternatives offered within a DC plan ranged from 25 to 73 distinct investment options.

A new wave of lawsuits has emerged, however. These actions, presently brought against more than a dozen private university defendants that offer Section 403(b) DC plans, argue that too many investment options have been offered to participants, and too many recordkeepers have been utilized by those plans. These cases, prosecuted by the Schlichter Bogard firm, and rapidly being copied by other plaintiffs' firms, present the Goldilocks Paradox in full: has the need to avoid one extreme resulted in another? These cases deserve attention as a potential harbinger of things to come in the DC plan arena in which ERIC members operate.

By way of background, the universities sued include Columbia, Cornell, Northwestern, Southern Cal, Johns Hopkins, Emory, Vanderbilt, Duke, Penn, NYU, MIT and Yale. Two of the cases (Columbia and Cornell) are pending in the Southern District of New York. The others are spread around the country, in the respective courts that each institution calls home. These cases are still in the early stages of litigation. Decisions about the potential viability of the theories driving these cases may not emerge for many months or years.

The Complaint filed against Duke University provides the most extreme example for this new litigation. Duke offers a typical 403(b) DC plan, with employer matching contributions. Plan participants may select from over 400 investment products offered through the platforms of 4 different recordkeepers – TIAA-CREF, Vanguard, Fidelity, and VALIC. None of the recordkeepers have been sued; only the university and its investment committee were targeted.

Plaintiffs in the *Duke* action assert that the multiple recordkeepers and enormous diversity of investment options renders the plan unnecessarily complex. Their argument is that participants become confused and unable to make wise investment decisions, as the multitude of choices overwhelms them. Meanwhile, the use of multiple recordkeepers diminishes the leverage of the plan's fiduciaries in bargaining over fees, and introduces inefficiency into the management of the investment infrastructure.

Plaintiffs contend that a reasonably prudent fiduciary would use a single recordkeeper to avoid repetitive or redundant costs on the administrative side and to leverage the bargaining power of the entire plan's assets for bargaining over fees. Moreover, a reasonably prudent fiduciary would, in plaintiffs' view, engage in detailed due diligence to narrow the choices to investments that demonstrate value based on risk, return and expense while allowing participants to diversify their portfolios.

The complaints in these lawsuits quote liberally from an eclectic mix of studies and reports by academics, the insurance industry, and professional plan consultants that recommend various improvements in the practices of DC plans. For example, the *Duke* complaint looks to an AonHewitt study published in January 2016 that concluded $10 billion in wasted costs exist in the DC plan retirement system. Plaintiffs claim that study proves that these costs could be remedied with reduced investment options, use of an open architecture investment menu, and packaging of the investment options for participants within a tiered structure.

The Duke DC plan, with its 400-plus investment options and four recordkeepers, lies at one extreme. Johns Hopkins also occupies a similar outlying position (440 investment options and five recordkeepers). If these "excesses" defined the threshold for suit, few private for-profit companies would have much concern over this development. Other targets, however, come much closer to the for-profit sector's customary practices. In the Yale suit, for example, approximately 90 different investment options are offered through two recordkeepers. (Cornell also uses only two recordkeepers, but they collectively manage 300 investment options.) Plans with a smaller diversity of options are not so different from plans sponsored by private for-profit employers, who may offer upwards of 70 or more investment options through their plans. *See Renfro v. Unisys Corp.*, 671 F.3d 314 (3d Cir. 2011) (approving of diversity of options in plan that offered 73 distinct investment options).

Prior to this new wave of suits, the "too much choice" argument seemed stillborn. In *Tibble v. Edison Int'l*, 729 F.3d 1110 (9th Cir. 2013), *vacated on other grounds*, 135 S. Ct. 1823 (2015), for example, the Ninth Circuit explained that "[b]ecause participant choice is the centerpiece of what ERISA envisions for defined-contribution plans, these sorts of paternalistic arguments have had little traction in the courts." Plaintiffs in the new suits disagree, arguing that social science data supports the proposition that too much choice can become paralyzing for the participants. Perhaps by framing the argument around a group of English professors or university janitors, plaintiffs hope to lend sympathy and credence to this proposition.

The private, for-profit sector must maintain vigilance about this new tactic for DC plan litigation. The current set of cases, while significant in their own right, should be viewed as a series of trial balloons for testing the viability of a potential new attack against DC plans that have responded to the earlier wave of litigation by expanding choice for participants. Like Goldilocks, plans must avoid reacting to litigation by swinging to extremes and instead find the "just right" space for participant choice – enough to be empowering, without becoming overwhelming.

NOTEWORTHY PENDING CASE

Standing to Sue: An Update

By John Houston Pope, Member of the Firm in the Employee Benefits, Litigation, and Employment, Labor & Workforce Management practices

In Issue 11, we reported on *Spokeo, Inc. v. Robins, 135 S. Ct. 1892 (2015)*, and its potential impact on ERISA plaintiffs through a remand directed in *Pundt v. Verizon Communications, Inc.*, 135 S. Ct. __ (2015). The Fifth Circuit has now weighed in with the revised opinion directed by the Supreme Court. In *Lee v. Verizon Communications, Inc.*, __ F.3d __, Dkt. No. 14-10553, 2016 U.S. App. LEXIS 16929 (5th Cir. September 15, 2016), the Fifth Circuit stood by its earlier disposition and provided guidance on the important question of who can sue when.

In *Lee/Pundt* (the name change at the Supreme Court is not consequential), the Fifth Circuit initially dismissed the claims of a group of participants in a defined benefit pension plan that was sued over the use of plan assets to pay certain fees involving an annuitization transaction. The Fifth Circuit held that the future risk of underfunding did not confer standing to sue, because the company stood by its commitment to ensure that the plan would have the

resources to pay benefits. Additionally, the mere fact of an alleged statutory violation (an alleged breach of fiduciary duty) did not provide the injury-in-fact to plan participants necessary to confer standing to sue. The Supreme Court vacated that initial decision and directed the Fifth Circuit to reexamine the issues anew, in light of its *Spokeo* decision. *Spokeo* had emphasized the requirement of "*de facto injury*" in creating a right to bring suit.

On remand, the Fifth Circuit stood by its original holding. It said: "a de facto injury is not alleged by reference to fiduciary misconduct under ERISA alone." In other words, it is not enough for participants in a defined benefit pension plan to contend that the fiduciaries failed to perform one or more of their duties. Participants have a right only to the defined level of benefits promised. Their ability to bring suit depends upon their ability to plausibly allege "a real risk" that the alleged breach of fiduciary duty will affect their payments under the plan.

TAKEAWAYS: Participant plaintiffs must allege an injury-in-fact in their rights to benefits, as the Fifth Circuit reaffirms that an ERISA fiduciary violation alone will not support a lawsuit. However, the issue may be on track to return to the Supreme Court.

NOTEWORTHY DEVELOPMENTS

Wit v. United Behavioral Health: ERISA Class Action Certified Challenging Behavioral Health TPA's Administration of Mental Health Benefits

By Gretchen Harders, Member in the Employee Benefits practice

In *Wit v. United Behavioral Health*, 2016 U.S. Dist. LEXIS 127435 (N.D. Cal., Sept. 19, 2016), the District Court certified a class of plan participants under at least 10 different health insurance plans who allege that their common third party administrator, United Behavioral Health ("UBH"), improperly denied coverage for mental health and substance use disorder benefits.

The plaintiffs' claims centered on UBH's use of certain coverage and level of care guidelines it developed and applied consistently on a national basis for adjudicating claims for their client group health plans. The District Court found commonality between the various different plaintiffs because the terms of all of their respective group health plans required that coverage for mental health and substance use disorder benefits be consistent with "generally accepted standards of care." The plaintiffs argued that UBH failed to follow generally accepted standards of care by applying guidelines it alone had developed, the guidelines were narrower than generally accepted standards of care, and that UBH breached its fiduciary duties by applying the guidelines. There is much discussion in the decision on what constitutes generally accepted standards of care, with UBH arguing that the guidelines were essentially developed nationally to implement the mental health parity requirements and followed appropriate standards of care and with the plaintiffs citing to certain studies and state law mandates on mental health coverage as constituting the generally accepted standard of care.

The District Court rejected UBH's arguments that each plan document separately governs the rights of the claimants and that claimants are essentially making individual claims for reimbursement of coverage. Rather, the District Court determined that plaintiffs are requesting a preliminary injunction to prohibit the use of the UBH guidelines under all of the group health plans and to require a reprocessing of claims, which it argues is an appropriate class action.

This decision is interesting because it is not based on a claim of violation of mental health parity, but rather a claim of a breach of ERISA fiduciary duty based on the use of adjudication guidelines by a behavioral health administrator that speaks to the substance of what constitutes "generally accepted standards of care."

The decision also highlights the risk of an employer in the deference provided to third party administrators and the prevalence of standard contracts. Given that many of UBH's clients have agreed to the same terms applicable to their respective group health plans, instead of participants contesting the denial of benefits on a plan-by-plan basis under the ERISA claims procedures, participants may bring class action litigation outside of the standard ERISA claims procedure process based on common plan terms of unrelated employers' group health plans.

TAKEAWAYS: In addition to reviewing group health plans for compliance with the mental health parity standards, employers may wish to review the guidelines used by the employer and its behavioral health administrator in adjudicating mental health and substance use disorder benefits.

Defining the Scope of ERISA Preemption: Understanding *SIIA v. Snyder* in a Post-*Gobeille* World

By Allison Wils, The ERISA Industry Committee

The Sixth Circuit recently ruled (for the second time) in *SIIA v. Snyder* that the Michigan's Health Insurance Claims Assessment Act (HICA) tax[1] – an assessment on carriers and third party administrators (TPAs), including self-insured group health plans, to help fund Michigan's Medicaid program – is not preempted by ERISA. The ERISA-based challenge to the law was first dismissed by the Sixth Circuit, affirming the lower court's dismissal, on the basis that HICA did not violate ERISA's express preemption since it did not "relate to" an ERISA-governed group health plan.

Following that decision, the Supreme Court granted certiorari, vacated the judgment of the Sixth Circuit, and then remanded the case in light of *Gobeille v. Liberty Mut. Ins. Co.*[2] In *Gobeille*, the primary purpose of the law was the reporting function; whereas, in *SIIA*, the primary purpose of the law is to generate funds through the 1 percent assessment, and the reporting, although a factor, is for the purposes of administering the tax. Although both laws include reporting of some claims data, the Sixth Circuit found that HICA does not directly regulate "integral aspects of ERISA plan administration" (which include reporting, disclosure, and record-keeping), and instead only touches on these aspects peripherally. Thus, on review, the Sixth Circuit once again found that HICA "escapes the preemptive reach of federal law," because *Gobeille* "held that only direct regulations of fundamental functions are preempted."

Although the distinction between the Sixth Circuit's *SIIA v. Snyder* decision and the Supreme Court's *Gobeille* decision is narrow, the ramifications are significant. By upholding the HICA tax, the Sixth Circuit has blessed state-imposed taxes on self-insured group health plans to help fund various state programs, as long as revenue-raising, not reporting, is the primary function of the law. For other states around the country, these taxes could be an appealing source of funds for state-supported programs.

Aside from the tax itself, which at 1 percent may not be overly burdensome, if similar policies are enacted in other states, the tax could quickly become a significant cost concern. Further, the administration, compliance, and reporting required to implement the tax are additional complicating factors for large employers. For the HICA tax alone, all carriers and TPAs are required to submit quarterly reports to the Michigan Department of the Treasury,

[1] HICA includes "a one-percent tax on all "paid claims" by "carriers" or "third party administrators" for services rendered in Michigan for Michigan residents." Under this law "carriers" include self-insured group health plans.

[2] In *Gobeille*, the Supreme Court found that a Vermont law that required ERISA-covered entities to report claims data for the state's all-payers claims database was preempted by ERISA.

keep complete records and related information as required by the department, and develop a methodology by which to collect the tax. From a plan administration perspective, coordinating and tracking all of this information is another layer on top of already complex and growing reporting requirements that employers are subject to at both state and federal levels. Furthermore, where the Sixth Circuit took a dismissive tone and determined that the "only other potential effects on employee benefits plans are to cut the plans' profits… and to create work independent of the core functions of ERISA," we recognize that the additional workload and cost ramifications could be significant for employers if more states begin taking similar actions across the country.

It is also possible that *SIIA v. Snyder* will be used by states in an effort to adopt and defend other state mandates (including but not limited to taxes) that have "peripheral" reporting requirements, as long as these requirements are tied to a program or tax that does not address "integral aspects of ERISA plan administration." In other words, this case may inspire other states to not only raise revenue through taxes on self-funded plans, but also to gather additional information and require additional reporting, record-keeping and disclosures from self-funded plans.

TAKEAWAYS: Employers must remain vigilant when monitoring state mandates, both those enacted and those coming down the pike, because ERISA preemption of state mandates on self-funded plans is no guarantee. As more states move down this path, the patchwork of state requirements becomes increasingly complex, burdensome and expensive for plan sponsors.

White v. Chevron: Plan Fiduciaries Continue to be Scrutinized

By Michelle Capezza, Member of the Firm in the
Employee Benefits and Health Care and Life Sciences practices

In a preliminary win for plan fiduciaries, the United States District Court for the Northern District of California granted a motion to dismiss in *White v. Chevron Corp.*, 2016 BL 281396, N.D. Cal. (August 29, 2016), a proposed class action case brought by six participants in the Chevron Employee Savings Investment Plan (the "Plan") against the Chevron Corporation, the Plan Investment Committee and twenty additional defendants. The plaintiffs raised claims concerning breach of the fiduciary duties of loyalty and prudence in selecting the investment options for a $19 billion Plan. The plaintiffs asserted wrongdoing with regard to the Plan's offer of (i) a money market option instead of a stable value fund, (ii) retail investment options that charged higher management fees rather than lower cost institutional versions, and (iii) mutual funds that charged higher investment fees than other lower cost options such as collective trusts and separate accounts. In addition, the plaintiff's asserted that there was a failure to solicit regular bids for services, payment of excessive recordkeeping fees and revenue sharing, and that an underperforming small cap value fund was retained as an investment option for too long. In addition, plaintiff's alleged that Chevron failed to monitor its appointee's performance, fiduciary processes, and, failed to remove appointees whose performance was inadequate.

The Court found that there were insufficient facts to raise a plausible inference that defendants breached their fiduciary duties. The Court opined that plan fiduciaries have the ability to evaluate investment options on factors other than lowest price, there are no specific "right" Plan investment options, there is no per se rule against revenue sharing to cover recordkeeping costs, and there is no specific rule regarding frequency for solicitation of competitive bids for plan services. Further, the Court did not agree with the argument that later actions to

change share classes and replace an underperforming fund equated to earlier improper decision-making, but rather showed that monitoring was performed. Since the case was dismissed without prejudice, the plaintiffs have an opportunity to file an amended complaint.

TAKEAWAYS: Plan fiduciaries continue to be under scrutiny and therefore should be vigilant in establishing and following a prudent process with regard to delegation of duties and the selection and monitoring of plan investments, fees, and services.

Employers Offering Their Own Proprietary Funds Under Their 401(k) Plans at Heightened Risk for Litigation

By Gretchen Harders, Member of the Firm in the Employee Benefits practice

During 2016, a handful of plaintiff law firms filed or amended federal class action lawsuits against a number of financial institutions, claiming the firms breached their ERISA fiduciary duties when they offered their own proprietary investment products to plan participants under the firms' respective 401(k) plans. These lawsuits were filed as ERISA class action complaints against Allianz Asset Management, American Century, BB&T Corporation, Deutsche Bank, Franklin Templeton, M&T Bank, Morgan Stanley, Neuberger Berman, New York Life, and Putnam Investments. These lawsuits have a common theme, that is, the employer or its affiliates' proprietary investment funds or products ("proprietary funds") offered under the employer's own 401(k) plan are too expensive or poor performers, costing plan participants millions of dollars in excess fees every year on their retirement accounts.

Proprietary fund litigation is not a new area of litigation. This recent spate of lawsuits against financial institutions seems to be bolstered by an increase in fee litigation and perhaps a reliance on generalized data demonstrating the long-term impact of fees on a participant's retirement account. When an employer offers its own proprietary funds (including proprietary funds of its affiliates) or uses its own recordkeeping services for its 401(k) plan, the employer is essentially engaging in a prohibited transaction under ERISA Section 406(a)(1) for which an exemption will be needed. An employer also may be engaging in prohibited self-dealing under ERISA Section 406(b) if it receives a financial benefit from the transaction. Furthermore, the exclusive benefit rule and prudence standards under ERISA apply to the selection of the proprietary funds, so procedural process needs to be followed in the review and monitoring of those proprietary funds.

There are several prohibited transaction exemptions upon which employers rely, including, by way of example, Prohibited Transaction Class Exemption 77-3 for investments in affiliated mutual funds, ERISA Section 408(b)(8) for investments in bank collective investment trusts, and ERISA Section 408(b)(4) for use of affiliated bank deposits. Generally the exemptions make clear that plan participants should not be charged any fees or compensation other than what is reasonable and prudent.

Allegations made under these ERISA class actions claim that the proprietary funds provide for excessive fees or indirect compensation that make the employer ineligible to rely on a prohibited transaction exemption and constitute a breach of the employer's fiduciary duties under ERISA. One factor cited is whether the 401(k) plan offers all or primarily all of its investment alternatives as proprietary funds or whether investment alternatives of other unrelated providers are also made available. Similar to claims made in fee litigation, plaintiffs have

questioned whether the lowest cost share class is offered, whether any revenue sharing or float income is derived from the investment, and whether other lower cost fund alternatives are available. One area of particular concern are claims of self-dealing under ERISA where a new investment product is offered under the employer's 401(k) plan and (plaintiffs allege) the plan's investment is intended to be "seed" money for the new fund. Plaintiffs also have questioned decisions made to continue offering poorly performing proprietary funds. The argument is that the employer is not prudently monitoring the investment choices in favor of the direct or indirect benefit the employer may receive from having plan participants investing in the proprietary funds.

TAKEAWAYS: Employers that offer proprietary funds under their 401(k) plans are at an increased risk of ERISA litigation. These employers should carefully monitor the direct and indirect compensation they receive from proprietary funds and scrutinize the investment performance of those funds, as well as the overall plan investment offerings.

EEOC Loses Another Wellness Plan Voluntariness Challenge But Prevails on its ADA Safe Harbor Argument

By Frank C. Morris, Jr., Member of the Firm in the Litigation and Employee Benefits practices

Another court has rejected an EEOC challenge to a wellness program. In *EEOC v. Orion Energy Systems* (E.D. Wis. Sept. 19, 2016), the EEOC challenged a wellness program that included a biometric screen and an HRA. The personally identifiable information from the HRAs went to third-party vendors. The HRAs supplied only anonymous, aggregated data to Orion to facilitate review of the percentage of plan participants with particular health risks, assess common health problems and provide educational health improvement ideas. For employees who participated in the wellness program, Orion paid 100 percent of the health premium, although employees still had deductibles and co-pays.

One employee chose to opt out of the program and therefore had to pay 100 percent of the premium. This employee criticized the program and company management. Soon thereafter, the employee was terminated.

The EEOC sued Orion alleging its wellness program was not voluntary because employees who did not complete the biometric screening and HRA had to pay 100 percent of the premium. The EEOC also alleged Orion retaliated against the employee by terminating her shortly after her criticisms of the program.

Both Orion and the EEOC moved for summary judgment. Orion first relied on the ADA safe harbor for bona fide benefit plans based on underwriting, classifying or administering risks consistent with state law. In a win for the EEOC, the Court refused to follow *Seff v. Broward* and *EEOC v. Flambeau*, and instead agreed with the EEOC's final ADA rule rejecting this interpretation of the safe harbor. The Court found EEOC's final ADA rule was a permissible interpretation of the ADA, entitled to deference, and could be retroactively applied.

Nonetheless, the Court rejected EEOC's challenge, despite noting that under the EEOC final rule, an employer's wellness program is voluntary only if the incentive is 30 percent or less of the single coverage premium. Despite the shift of the entire premium to employees who opted out, the Court found that "even a strong incentive is still no more than an incentive; it is not compulsion." The court further found that "Orion's wellness initiative is voluntary in the sense that it is optional" and therefore granted summary judgment to Orion as to the program (though finding disputed issues of fact regarding the reasons for the employee's termination).

TAKEAWAYS: Clearly, employers should continue to focus on the voluntariness of their wellness programs. Despite the *Orion* decision, incentives exceeding those sanctioned by the EEOC final rule, or the more generous ACA wellness rule, should be carefully considered by employers in light of the risks of EEOC or private litigation.

NOTEWORTHY RECENT DECISIONS

Equitable Estoppel Theory Scores Rare Win For Participant: *Deschamps v. Bridgestone Americans, Inc. Salaried Employees Retirement Plan*

By John Houston Pope, Member of the Firm in the Employee Benefits, Litigation, and Employment, Labor & Workforce Management practices

"Equitable estoppel" – the term frequently pops up in benefit litigation, but the theory infrequently brings success to participants. A rare participant win was affirmed on appeal recently, in *Deschamps v. Bridgestone Americans, Inc. Salaried Employees Retirement Plan*, Dkt. No. 15-6112, 2016 U.S. App. LEXIS 16839 (6th Cir. Sept. 12, 2016). The opinion sheds light on the circumstances that may lead to the successful use of the equitable estoppel doctrine against a benefit plan.

A claim for equitable estoppel under ERISA asserts that a participant should be awarded a benefit because an authorized representative of the plan engaged in conduct or used language that amounted to a statement regarding a material fact that would entitle the participant to the benefit and the participant relied, to his or her detriment, on the assertion.

In *Deschamps*, the participant was employed in the Canadian operations of his employer. He was offered a job in an American facility. As part of the interview process, he made inquiries of several executives on the American side to ensure that he would maintain his pension service date. While he received no written guarantees, the executives testified that the participant had raised his concerns about his service date and had been reassured by them that he would have the same service date. Over the remaining course of his employment, the participant turned down a job offer from a competitor, which had a greater salary, in large part because his pension would suffer.

In 2010, more than sixteen years after the participant had transferred, the plan investigated and corrected service date errors for certain employees. As part of this investigation, the participant's service was adjusted, and he lost ten years of service credit. The reason for this loss was a plan provision defining "covered employee." Notably, it would not be apparent from reading this provision that the participant would not receive credit for his Canadian employment, but the plan apparently had consistently interpreted the provision to reach that result.

The participant won on a theory of equitable estoppel because the plan was ambiguous about the participant's alleged ineligibility for pension service credit after the transfer and he relied on the representations about receiving the credit in deciding to transfer and in turning down the job offer from a competitor.

Notably, the court concluded that a breach of fiduciary duty occurred as well, because the company, which acted as a fiduciary when it conveyed information about the plan's terms and likely benefits, acted through its agents with apparent authority (the executives who interviewed the participant when he transferred), and these agents conveyed misleading information.

TAKEAWAYS: Employers should work to reduce ambiguity in provisions that establish eligibility for service credit and other important benefit calculation criteria. In the hiring process, the employer should channel and control the dissemination of information about benefit plan eligibility to interviewees, and should not leave this task to business executives who may be unfamiliar with nuances of particular plans. Employers should urge employees involved in the hiring process to refer interviewees back to benefits professionals who can verify an individual's eligibility under the terms of the plan.

Mergers, Acquisitions, And Benefit Plans: *Hunter v. Berkshire Hathaway, Inc.*

By John Houston Pope, Member of the Firm in the Employee Benefits, Litigation, and Employment, Labor & Workforce Management practices

Changes in corporate ownership often may alter the landscape of an acquired company's benefit programs. Consequently, many sellers exact promises regarding future changes to the benefit programs by the buyer. It is well established that provisions ceding the right to make future changes or modifications will be enforced. Construing these provisions raises a different question entirely, as the Fifth Circuit Court of Appeals recently addressed in *Hunter v. Berkshire Hathaway, Inc.*, __ F.3d __, Dkt. No. 15-10854, 2016 U.S. App. LEXIS 12744 (5th Cir. July 11, 2016).

In *Hunter*, Berkshire had acquired Justin Industries, Inc. in 2000, and along with it, Justin's subsidiary, Acme Brands, Inc. Acme had a 401(k) plan that matched 50% of an employee's contribution on an annual basis, up to 5 percent of the employee's compensation. In the merger agreement, Berkshire agreed that it would not "cause" Acme (which maintained its own management team) to reduce benefits, including the matching contribution for the 401(k) plan. The relevant provision did not contain any time limitation on this restriction.

Berkshire asked Acme in 2006 to reduce the matching contribution and was rebuffed based on the merger agreement provision. Berkshire asked again in 2012, at which time Acme discovered it had mistakenly reduced its matching contribution to 25 percent commencing in 2010. Berkshire instructed Acme not to fix this mistake and, over the next two years, further directed Acme to make changes to the 401(k) plan that instituted a "hard freeze" with the prospect of future changes to the matching contributions. Litigation followed.

The Fifth Circuit noted that contractual limitations against future plan amendments will be enforced, but finely parsed the one at issue. Acme's "mistaken" decision to reduce the matching contribution rate to 25 percent did not violate the merger agreement because that agreement imposed its limitation only on changes that Berkshire caused, and Berkshire did not play any role in the change. (Acme also did not violate any fiduciary duty because a change in contribution levels involved a settlor function.) Plaintiffs would be allowed to further litigate their claims based on the plan changes that Berkshire directed Acme to adopt, however, because those changes would fall within the scope of modifications "caused" by Berkshire.

The Fifth Circuit also rejected the proposition that a "reasonable time" condition should be implied as part of the merger agreement to confine the duration of the contractual agreement barring Berkshire-caused changes to the 401(k) plan. The District Court thought that, without such a duration term, the merger agreement effectively vested benefits for life. The Fifth Circuit disagreed, viewing the issue simply as a contractual promise that lacks any time limit on its effect. The court held the provision had indefinite duration, and offhandedly mentioned "forty years" as a period for which it would still be enforced.

TAKEAWAYS: Employers should be mindful that limitations on the power to modify or eliminate benefits contained in a merger agreement likely will be enforced. Accordingly, employers should avoid making promises regarding benefit programs in merger agreements that lack a definite duration and negotiate for the greatest possible flexibility in the future adoption of changes to the benefit plans of acquisition targets.

Ninth Circuit Eyes Outside Medical Reviewers "Skeptically"

By Kenneth J. Kelly, Member of the Firm and Co-Chair of the National Litigation Steering Committee

Insurers of medical and disability benefit plans that adjudicate claims often refer cases to independent (non-employee) physician consultants ("IPCs") for second opinions on benefit denials in order to eliminate the "structural" conflict of interest identified in *MetLife v. Glenn*. Indeed, several Circuits recommend such referrals to accomplish just that result.

A majority opinion of the Ninth Circuit in *Demer v. IBM Corp. LTD Plan and MetLife Ins. Co.*, No. 13-17196 (8/26/16), casts doubt on that practice, at least where the IPC receives "significant" income from a "substantial" number of annual referrals (in the case, $150,000/yr on 250 referrals). The court deemed this volume of work to contribute to a "financial conflict" on the part of the IPC, even though the plaintiff did not offer any proof that the IPC had a financial stake in the outcome of the claim. The majority concluded that the mere fact of repeat business was reason enough to be "skeptical" of the IPC's conclusion, similar to how the structural conflict of the insurer is a "factor" in an arbitrary/capricious analysis. The court suggested that MetLife could have challenged any inference of a conflict by offering statistics showing how often particular IPC's decisions favored claimants.

The dissent characterized the decision as penalizing MetLife for following earlier decisions' suggestions to use IPCs, and criticized the majority for inferring a conflict of interest simply because the IPCs reviewed multiple files and were compensated. It noted that repeatedly seeking the services of a particular IPC indicates quality work that withstands claimant's counsels' and courts' scrutiny, not an anti-claimant bias, and the insurer has an obligation to the plan to seek out specialists' opinions to avoid paying undeserving claims as well as paying meritorious ones.

TAKEAWAYS: It is reasonable and desirable for insurer-adjudicators to seek second opinions on benefit denials as a neutral check on internal decisions and to obtain expert review. However, at least in the Ninth Circuit, *Demer* may result in needlessly increasing the costs of claims review if insurers start to keep track of IPC's decisions, and of litigation as plaintiffs seek discovery regarding referrals to IPCs, contrary to the established rule of limited discovery in ERISA cases. The dissent suggested another possible response: insurers will stop using outside reviewers, thus causing "confusion and change for no reason."

Please send questions, comments, and related requests to James Gelfand, Gretchen Harders or Adam C. Solander.