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# BENEFITS LITIGATION UPDATE

*A Quarterly Publication From Epstein Becker Green & The ERISA Industry Committee*

Winter 2014 Issue 5

## - FEATURED ARTICLES -



## - NOTEWORTHY PENDING CASE -

***Fifth Third Bancorp, et al. v. Dudenhoeffer et al.***
**Case No. 12-751 (Supreme Court)**



## A Short Message from ERIC President Scott Macey:

All of us probably groan from time to time about the burdens of regulations and compliance. We know that employee benefits are continually impacted by the actions of all three branches of government. This communication and our January 29 Benefits Litigation Update call focuses on some significant legal and litigation developments regarding ERISA and benefit plans. 2013 was a busy year for the courts in benefit cases or decisions that affected benefits. The Supreme Court's DOMA decision, the continued litigation concerning different aspects of the Affordable Care Act (ACA), ongoing lawsuits regarding 401(k) fees and stock drop disputes, and emerging case law relating to ERISA equitable remedies are all matters that either directly impacted the design or administration of our plans or caused us anxiety about possible future litigation risks. We have addressed some of these issues in other forums over the last year and address some of them in this issue of the Benefits Litigation Update.

As usual, we have partnered with our colleagues at Epstein Becker Green on this issue and we appreciate their terrific contribution (as usual).

Additionally, ERIC has been active in filing amicus briefs in key cases involving significant benefit policy issues. Last fall, we filed a brief with the Second Circuit in the *Foot Locker* case urging the court to uphold a district court ruling in favor of *Foot Locker* that held that there was no liability in situations involving alleged participant misunderstandings of legitimate benefit provisions that were communicated to participants. In December, we filed an amicus brief in the *Quality Stores* case before the Supreme Court. That case involves a claim by the IRS that FICA taxes should apply to severance plans. In early February, we will be filing a brief with the U.S. Supreme Court in the *Fifth Third Bancorp* case involving the application of the prudence presumption (*i.e.* the presumption that a sponsor or fiduciary has acted prudently in maintaining/continuing an employer shares fund in the absence of specific factual allegations to the contrary) in situations involving a decrease in value (oftentimes only temporary) of employer shares.

In this issue of the Benefits Litigation Update, we review the possible interaction of the ACA with the so-called non-discrimination/non-interference provision (Section 510) of ERISA, summarize the background and status of equitable remedies under ERISA after the Supreme Court's *Amara* decision several years ago, review the late 2013 Supreme Court decision in the *Heimeshoff* case regarding statute of limitations provisions set forth in plans, discuss the status of ongoing disputes regarding 401(k) fees, and briefly mention several other key litigation developments.

We hope you will participate in the January 29 *FocusOn* call (2 pm to 3:30 pm EST) where counsel from Epstein Becker Green will join Debra Davis and I from ERIC to discuss the issues and cases addressed in this Update.

**Register Now for the Benefits Litigation Update Conference Call:**

If you would like to register for the Benefits Litigation Update *FocusOn* Conference Call, please send an email to: **ERICConfCall@eric.org**.

## FEATURED ARTICLES

### Will Section 510 of ERISA Restrict Workforce Structuring under the Affordable Care Act?

*By: Jeffrey A. Lieberman and Kenneth J. Kelly*

The "employer mandate" at the center of the Affordable Care Act (the "ACA") generally requires employers with 50 or more full-time employees (and full-time equivalents or FTEs) to provide "affordable" health insurance to 95% of their full-time employees or face paying a penalty.[1] A fundamental issue for an employer is determining whether it in fact has 50 or more full time employees or FTEs and which employees must be covered by a plan, or whether it can avoid the "employer mandate" altogether by managing its workforce. The latter strategy presents risks.

Under the ACA, a full-time employee is a person who works on average 30 hours or more each week. This definition came as some surprise to many employers because of the generally-held view that for most purposes, "full-time" work is viewed as 40 hours per week. Assuming an employer is subject to the mandate (because it employs 50 or more full-time employees or FTEs), there still remains the question exactly which employees are full-time and must be offered coverage. Particularly in certain industries where employers tend to use large numbers of part-time employees, a 30-hour-per-week standard could significantly increase the number of employees that must be offered a plan, thus increasing either an employer's costs if it does, or increasing the potential penalty if it does not.

Some employers have considered the strategy of limiting the hours worked by certain employees to less than 30, thus potentially reducing the number of employees who must be eligible for coverage. While this approach raises a number of potential issues, how a court would view it in light of Section 510 of the Employee Retirement Income Security Act of 1974 ("ERISA") raises concerns.

Section 510 of ERISA provides that, "It shall be unlawful for any person to discharge, fine, suspend, expel, discipline, or discriminate against a participant or beneficiary for exercising any right to which he is entitled under the provisions of an employee benefit plan or *for the purpose of interfering with the attainment of any right* to which such participant may become entitled under the plan." The classic example of such interference is an employer terminating an employee days before the employee's pension vests in order to prevent the employee from receiving the pension.

Historically, in actions arising under Section 510, courts have considered whether the employee has shown that the employee had the opportunity to attain rights under the plan, and was subjected to adverse action interfering with such rights. If the employee establishes those facts, an employer would have to state a legitimate, nondiscriminatory reason for the action taken. If the employer can do so, then the employee would need to show that the employer's specific intent was to avoid providing the benefit at issue.

Employers may argue against liability by asserting that an employee who does not fit the definition of "full-time" would never (now or in the future) have any right to health coverage because an employee who is not "full-time" is simply not entitled, and will never become entitled, to the benefits of a health plan covering full time employees. Because the "employer mandate" does not require a plan to cover other than full-time employees, there is no right of the employee with which the employer could interfere.

While this argument might prevail as to employees who were always part time, it does not address the tactic of reducing a full-time employee's hours to less than 30, or (if possible within the 50-employee limit), hiring part-time employees to do some of the work of a full-time employee, and reducing the latter's hours.[2]

Employees affected by this tactic would likely assert that reducing or limiting a current employee's hours of work was precisely "for the purpose of interfering with the attainment of a right to which the participant may become entitled." This standard implies (as courts have applied this provision) a specific intent by an employer, rather than just a consequence. Thus, the decisive question is whether managing the makeup of the workforce is simply a legitimate management of costs (*i.e.*, business planning to minimize costs) or is it intentional interference with an employee's benefits rights. In this regard, the Supreme Court's holding that the penalties under the ACA for not satisfying the employer mandate are "taxes," would support an employer's argument that such workforce adjustments are in fact the result of business tax planning strategies, and not the interference of employee rights. The answer to these questions will in many cases be fact sensitive.

Another unresolved question under Section 510 is whether the courts would distinguish between hiring new employees at fewer hours and reduction in the hours of an existing workforce to reduce the number of covered employees, or whether capping a workforce at 49 by replacing departing full-time employees with less-than-30 hours part-time employees would be considered a subterfuge to avoid the mandate altogether. It would seem particularly difficult for a plaintiff to argue that an employee specifically hired on a part-time basis (which position is not otherwise eligible for coverage) ever had any right to health plan coverage in the first instance.

Employers would certainly argue that they must have the ability to hire workers for any amount of hours they deem appropriate, taking into account its business needs. Such needs presumably would include management of taxes and other costs, which may include health and welfare costs, even those not mandated by the ACA. While not necessarily ideal from all political and macroeconomic perspectives, many employers would consider any limitation on their ability to shape their workforce as undue interference with their ability to manage their business.

Whether the any of these positions on either side of the argument would prevail remains to be seen. Since the employer mandate is so new, and not yet even subject to enforcement, none of these arguments has been tested in court, so there are not yet any answers. Risks exist, however, and employers considering this type of workforce management will need to take into account the possibility of employee-driven litigation, and possible governmental action. If in fact courts conclude that limiting hours could be interpreted as intentional interference with benefit plan rights, it seems likely that the court would look for evidence of that intent. Consequently, specific communications that the reason for a reduction or limitation of hours is to avoid the employer mandate could be fatal (or at least not helpful) to an employer's case. It is likely that employers taking any such actions will need to consider carefully how they characterize workforce management decisions internally and publicly, so as to avoid any misinterpretation that could fuel a Section 510 claim.

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[1] Under the ACA, coverage is affordable if its cost does not exceed 9.5% of a full-time employee's household income (W-2 wages can be used) and provides minimum value to the employee (*i.e.*, provides at least 60% actuarial value).

[2] See, *e.g.* Investors.com of 11/5/13, listing 363 employers nationwide which have purportedly reduced employees hours to fewer than 30. http://news.investors.com/politics-obamacare/110513

## A New Threat to Sponsors and Fiduciaries: Equitable Remedies After *Amara*

*By: Scott J. Macey, The ERISA Industry Committee*

Perhaps the most significant emerging legal risk to plan sponsors arises from the evolving law regarding equitable remedies in litigation. The term "equitable remedies" refers to types of relief that typically were available in courts of equity, such as reformation, surcharge and disgorgement of unjust gains. Nearly forty years of case law has left the subject of equitable remedies under the Employee Retirement Income Security Act of 1974 (ERISA) confusing and poorly understood. This article explores the recent trends from court cases, including the Supreme Court's 2011 decision in *CIGNA Corp. v. Amara*, and examines where we might be headed.

### Background

ERISA allows for both legal and equitable remedies, each in its defined place. Generally, legal remedies include some form of monetary damages or relief (such as contractual, compensatory or punitive damages, although ERISA does not authorize compensatory or punitive damages). On the other hand, equitable remedies traditionally include such matters as restitution or disgorgement of unjust gains, specific performance of an agreement or trust, and constructive trust (being required to hold something and turn it over to another). Money damages are generally not classified as a form of equitable relief. The relevant ERISA remedial provision refers to "appropriate equitable relief" to address violations of ERISA or enforce ERISA or the terms of a plan, but does not refer to legal relief. Thus, ERISA does not directly refer to the availability of legal (money) damages.

What does this mean in the context of benefit litigation? Well, let's look at the ERISA statute and a little bit of ERISA history as a starting point. ERISA serves as a remedial and protective statute for participants, providing participants with protections and means to seek redress for certain improper actions by sponsors and fiduciaries. The Section 502(a) enforcement provisions set forth the persons who may bring a lawsuit and the general circumstances under which a suit may be brought. In three subsections, this provision allows for (i) claims by participants for denied benefits, (ii) redress for a plan to recover losses in the event of a breach of fiduciary responsibility (*e.g.*, a bad investment decision constituting a breach of fiduciary responsibility or outright theft by a fiduciary), and (iii) appropriate equitable relief to redress violations of ERISA or to enforce the provisions of ERISA or the terms of a plan. But two matters remained unclear for many years: (i) whether the "appropriate equitable" relief provision in ERISA Section 502(a)(3) authorized a participant or a fiduciary to seek relief only for the plan as a whole when it had been harmed or relief for an individual or a class of participants who had been injured and (ii) exactly what specific type of relief could be sought.

Accordingly, up until 1996, confusion surrounded whether participants could use the "appropriate equitable relief" prong of the remedies section to recover individualized relief. Then, in *Varity v. Howe* (516 U.S. 489 (1996)), the U.S. Supreme Court determined that this provision could be the basis for individual relief for improper fiduciary acts. *Varity* involved claims by participants who voluntarily transferred from one plan to another when their division was spun-off as a separate company; after a trial the district court concluded that the sponsor had intentionally misrepresented facts to the participants in order to induce those transfers. The Court reinstated the affected participants in their prior plan. Essentially, the Court put its stake in the ground by holding that a defendant sponsor/fiduciary could be liable to individual participants when it was found to have lied to participants. However, the *Varity* case did not address whether participants could recover money damages under Section 502(a)(3).

For the next fifteen years, various Circuit Court rulings, and a smattering of Supreme Court opinions, created a judicial consensus that Section 502(a)(3) did not authorize money damages or their equivalent. The plaintiffs' bar complained loudly about this because in some types of cases that meant there was no relief available at all (*e.g.*, improper denial of health benefit that is no longer relevant or helpful to the claimant.)

## The *Amara* Holding

The Supreme Court's decision in *CIGNA Corp. v. Amara*, 131 S. Ct. 1866 (2011), has effectively changed the landscape of certain types of ERISA litigation that could involve equitable remedies. The Court, in *Amara*, concluded that the equitable remedies provision of ERISA could be relied upon in certain circumstances to either reform the terms of a plan to provide the benefits allegedly communicated, to provide for monetary damages to participants for alleged harm, or to estop the sponsor and fiduciaries from applying the plan as written rather than as communicated.

The Court indicated that **reformation** could be used to remedy cases of fraud or mutual mistake.

Although *Amara* did not discuss the type of mistake required to be entitled to reformation, traditional equity law requires a mistake in the actual plan or trust document so that it does not reflect the sponsor or settlor's intent (but, in the typical case, the plan document does reflect the intended terms), not a mistake in the way the plan is communicated. (It should be noted that the Court did not say that a mere inadvertent mistake in plan communications gave rise to equitable remedies, although that is what plaintiffs and the Department of Labor (DOL) are now arguing post *Amara*.)

The Court also concluded that money-type damages were available under traditional equity law and indicated that **surcharge**-type money damages would be available under ERISA if affected individuals can show an improper action, harm and causation. The Court indicated plaintiffs need not show actual detrimental reliance and it alluded to the mere loss of an ERISA right, such as being given an improper summary plan description (SPD), being sufficient harm. The DOL has since referenced this allusion in a number of amicus briefs arguing that an incorrect or ambiguous SPD is sufficient alone to give rise to liability.

The third relevant type of equitable relief, **estoppel**, requires actual reliance upon the faulty disclosure by those claiming to be harmed.

As a result of the Supreme Court's discussion of equitable remedies in *Amara* the devil truly will be in the details: what must be shown in order to evince a right to reform the plan or receive monetary compensation. In any case, reformation must generally be based on fraud, surcharge upon actual harm and causation, and estoppel upon detrimental reliance.

Courts become understandably offended when a sponsor or fiduciary has intentionally misled participants concerning a material matter and thus look to find a means to provide relief to the affected individuals. Some commentators have concluded that this desire to do justice drove the Supreme Court to set forth a roadmap for plaintiffs and lower courts to follow in *Amara* after it ruled against plaintiffs on their statutory claim under the benefit claim subdivision of the ERISA remedial section. What remains unclear is how judges will react to less culpable misrepresentation or ambiguity (*e.g.*, an honest, inadvertent mistake), but no fraud or deceit.

## Post-*Amara* Landscape and Issues

While courts will generally not allow a fiduciary or sponsor to outright lie or intentionally mislead participants (see, *Varity v. Howe*), many disputes do not involve such alleged intentionally improper actions by sponsors and fiduciaries. Before *Amara*, the forms of equitable relief deemed available by the courts under ERISA were strictly circumscribed.

In a Fifth Circuit case, *Amschwand v. Spherion Corp.*, 505 F.3d 342 (5th Cir. 2007), the appellate court held that there was no available remedy where a plan administrator mistakenly informed an individual that he was eligible for life insurance coverage and collected insurance premiums for a substantial period of time from the individual who subsequently died and whose family tried to collect the policy proceeds. The insurer offered to return the premiums. The Fifth Circuit, consistent with rulings in a number of other appellate courts pre-*Amara*, held that the

ERISA equitable remedy provisions did not provide any further remedy because traditional equity principles had no further remedy. The Supreme Court denied certiorari on this case prior to its *Amara* ruling, but this type of holding would seem to no longer apply post-*Amara*.

The types of issues and the disputes that involve claims for equitable relief under Section 502(a)(3) oftentimes emerge from situations involving conflicts between plan terms and various plan disclosures or administrative actions (*e.g.*, medical plan pre-certification decisions). Prior to *Amara*, many of these types of cases were dismissed by the courts based on the absence of any effective remedy. *Amara* seems to change the landscape by endorsing reformation of the plan to conform with the communications, surcharge or essentially money damages to compensate for claimed losses, and estoppel for detrimental reliance. This comports with the DOL's long-standing position that traditional equity law recognizes financial compensation beyond just restitution of unjust gains or estoppel for injured individuals.

As courts expound upon *Amara*'s endorsement of this view, defendants argue the conflicts or mistaken actions must be material, the affected individuals must have relied upon the disclosures or actions, and that such must have caused actual harm to specific individuals. For example, should a sponsor be liable for an ambiguous or mistaken SPD if it wasn't read or relied upon by participants? Or, even if participants read the SPD and relied on it, the SPD caused no harm because the plan is what it is and there is nothing that the participants could do to change that? (For example, the participants either did not adversely act upon the alleged misinformation or they could not have taken any other demonstrative action to change the result.) This typifies the legal debate that the courts are now considering post-*Amara*.

The DOL, in the cases in which it has filed amicus briefs, essentially argues that any harm is sufficient and should be assumed without specific proof. In fact, the DOL argues that a merely inaccurate or ambiguous SPD imposes sufficient harm that should result in a remedy for participants. To sponsors and fiduciaries, this, of course, makes no sense because participants may not have read the SPD or, if they had, there may not be anything they could have done about the mistaken language or ambiguity (*e.g.*, a legally valid plan amendment that was mistakenly communicated in some fashion). But, how should cases involving inadvertent mistakes or ambiguities in communications or administrative actions be determined?

In cases where fraud or intentional misrepresentation is determined, the burden generally shifts to the defendant to disprove the actual improper action, show that there was no injury from the action, or prove that it was not the cause of the injury. In fraud cases, the courts have generally concluded that it is reasonable to assume a likelihood of harm (and permit the defendant to try to rebut such). The more difficult cases, however, don't involve fraud or intentional misrepresentation. Clearly, in these types of cases, several key matters remain undetermined such as, the extent or identity of harm required to be shown (for example, whether an inaccurate or ambiguous SPD alone is sufficient injury as argued by the DOL) and should potential liability apply to all participants or only those who can show individual specific harm. These are critical issues in assessing the current state of the law regarding equitable remedies and the risk to plan sponsors and fiduciaries, and they are the ones with which the courts are starting to grapple. It is hoped that the courts adopt a reasonable approach and clearly differentiate between cases involving fraud and those involving inadvertent mistakes and ambiguities and don't adopt a presumption of harm or a policy that participant expectations are sufficient to impose liability.

The courts will sort out these issues post-*Amara* and one or more of the cases will, no doubt, eventually reach the Supreme Court. Clearly, proven fraud or intentional misrepresentation post-*Amara* will likely to give rise to relief based on reformation of the plan to conform to the communications, surcharge of the sponsor or fiduciary to compensate the affected participants for the difference in value between the plan and its communications, or

estoppel by precluding the application of the plan as written instead of as communicated. A review of some of the post-*Amara* cases may help to put the matter in perspective.

### Post *Amara* Cases

In an interesting case (*Skinner v. Northrup Grumman Retirement Plan B*, 673 F.3d 1162 (9th Cir. 2012)) which has been up and down between the district and appellate courts several times pre- and post-*Amara*, the Ninth Circuit determined (after *Amara*) that plaintiffs were not entitled to either surcharge or reformation even though the SPD was unclear that there was any offset to a calculated pension benefit. The court held that reformation could be obtained as a remedy only when there has been fraud or mistake. The case presented no evidence of fraud. It also failed to present a basis for relief arising out of mistake because the mistake that must be present must exist in the plan itself, such that it doesn't reflect the parties' (including the sponsor's) intent. The court held that a mistake in communication is not the type of mistake that serves as the basis for reformation. The court also refused to impose the surcharge remedy, based on the absence of unjust enrichment or actual harm; the participants failed to show they relied on the SPD. The court rightly observed that liability based on a mere mistake in the SPD without proof of reliance and actual harm would turn communication documents into matters of strict liability. It thus rejected the DOL view that a mistaken or ambiguous SPD alone should result in a presumption of harm and liability. With the Ninth Circit's reputation as a court that usually favors participants, *Skinner* should be particularly useful to sponsors and fiduciaries.

On the other hand, a number of other appellate decisions after *Amara* enhance sponsor liability and expand the circumstances giving rise to equitable remedies. For example, in two different Fourth Circuit cases involving facts similar to the *Amschwand* case (discussed earlier), the Fourth Circuit determined that estoppel or surcharge could be used to provide relief when plans mislead individuals into believing they have insurance coverage for themselves or a family member prior to the purportedly covered person's death (see, *Moon v. BWX Technologies, Inc.*, No. 11-1750 (4th Cir. Dec. 3, 2012) and *McCravy v. Metropolitan Life Ins. Co.*, 690 F.3d 176 (4th Cir. 2012)). The court, in both cases, concluded that *Amara* authorized monetary type relief (essentially money damages) in situations involving breaches of fiduciary duty.

The Seventh Circuit similarly ruled that "make whole" relief in the form of money damages is available when a health plan participant underwent an elective surgical procedure after the administrator mistakenly informed her that it would be covered, but then refused to pay the costs because it was not. (*Kenseth v. Dean Health Plan, Inc.*, No. 11-1560 (7th Cir. 2013)). And, the Fifth Circuit, in remanding a case to the district court, held that equitable relief in the form of money damages could be available to a participant who was allegedly induced into early retirement with a promise of lifetime medical benefits for which he was actually ineligible because of lack of sufficient service (*Gearlds v. Entergy Services, Inc.*, 709 F.3d 448 (5th Cir. 2013)). These cases did not involve fraud or intentional misrepresentation, but did reflect that participants had relied to their detriment on incorrect information from plan administrators and suffered real injury (*i.e.*, absence of expected and/or paid for insurance coverage).

The *Amara* case itself returned to the Second Circuit after the Supreme Court remanded it and the district court held in favor of the plaintiffs on the equitable remedies claim.

Also at the Second Circuit is *Osberg v. Foot Locker,* 907 F. Supp. 2d 527 (S.D.N.Y. 2012). (ERIC filed an amicus brief supporting the defendants in *Osberg*.). In that case, plaintiffs complain that they were allegedly misled by either mistaken or ambiguous communications regarding a conversion of a traditional pension plan into a cash balance plan. The participants allege that the possible wear-away effect on some participants was not adequately explained. The district court concluded that there was sufficient disclosure of the wear-away effect, there was no fraud or intent to mislead, that participants may not have even reviewed the SPD, and that there was no real harm even if the participants didn't understand the details about the plan conversion because the plan terms and

conversion were legal and that the participants could do nothing to change the plan. On this last point, the district court rejected the plaintiffs' argument (supported by the DOL in an amicus brief before the Second Circuit) that, had they better understood the wear-away effect, participants could have convinced the sponsor to revise the plan, as too speculative to support any possible remedy. The Second Circuit held oral argument on the *Foot Locker* case in December, but has not yet issued an opinion.

In a case previously decided and remanded by the Supreme Court, the Second Circuit also very recently directed the district court to consider equitable remedies in *Frommert v. Conkright*,— F.3d –, 2013 WL 6726965 (2d Cir. Dec. 23, 2013). (ERIC had filed a brief, with other associations, with the Second Circuit in this case.) The case involves a floor-offset plan, that is, a defined benefit plan that coordinates benefits from that plan with those of a defined contribution plan. Certain former employees who received lump-sum distributions of their benefits under the plan and were later re-hired disputed the calculation of their benefits. At issue is the method for taking into account their past distributions when calculating their current benefits.

The Second Circuit held that the plan administrator's interpretation of the plan regarding the offset was unreasonable and that notice had not properly been given. The Second Circuit remanded the case back to the District Court and directed the lower court to find an appropriate equitable remedy, such as reformation or surcharge (*i.e.*, the equivalent of damages). The Second Circuit stated that if the lower court does not find that the pre-conditions for equitable remedies exist, the District Court should again interpret the plan, giving appropriate deference to the plan administrator's interpretation. Unfortunately, the Second Circuit was unclear and ambiguous in this respect.

## Conclusion

Plan sponsors hope that *Amara* has changed the legal landscape only in a limited way, involving either situations where a specific participant has taken some adverse action directly based on incorrect information from a plan administrator or cases involving actual fraud and deceit. Plaintiffs' lawyers and the DOL are arguing that any mistaken communication or administrative action can or should result in liability under the equitable relief provision. In fact, the DOL has filed amicus briefs that argue that a mistaken or ambiguous SPD alone is sufficient to serve as the basis for a surcharge remedy and that liability can be premised on the reasonable expectations of participants.

Sponsors and fiduciaries should be able to argue that, absent clear fraud or injurious detrimental reliance, liability should not apply unless each claimant can show actual individualized harm caused by the mistaken communication or action. There are situations where this may be the case, but generally those types of situations would be fact dependent and in most cases should not be eligible for class action treatment, if properly evaluated by the courts.

We don't know yet how broadly the courts will interpret and apply the *Amara* discussion of equitable remedies and whether the Supreme Court will find it necessary to further clarify its views. What we do know is an active and aggressive plaintiffs' bar in the ERISA arena and the *Amara* decision has enhanced the risk of litigation to responsible plan sponsors and fiduciaries who try to act with the care, skill and prudence required by the ERISA fiduciary provisions in administering and communicating benefits.

As the Chief Justice of the Supreme Court said in *Conkright v. Frommert*, 559 U.S. 506 (2010), regarding the appropriate scope of administrative discretion, a plan administrator should not be penalized for a single honest mistake. In the context of equitable remedies, this would mean there should be no presumption of harm or causation without specific individualized proof of such. In any case, reasonable steps can be taken to mitigate many of the enhanced risks after *Amara*. In this regard, plan sponsors, fiduciaries and administrators should closely coordinate their decisions and actions wherever appropriate and should coordinate with their legal counsel to determine the best and most appropriate strategies to follow and the specific actions to take in order to both identify and mitigate the risks generated by the *Amara* case.

## First ERISA Decision From Supreme Court This Term Strongly Endorses Plan-Created Limitations Periods For Benefit Claims

*By: John Houston Pope*

The first ERISA ruling of the Supreme Court's October 2013 Term, *Heimeshoff v. Hartford Life & Accident Insurance Co.*, 134 S. Ct. 604 (2013), brings good news for plan sponsors. The Court unanimously endorsed the use of a plan-created statute of limitations for benefit claims. In fact, the Court emphasized the importance of plan terms.

The plan at issue in *Heimeshoff* imposed a three-year limitations period that commenced at the time that "proof of loss" was due – in other words, from the time of the initial request for benefits. The plaintiff had argued against allowing a limitations period to start running before the plan's internal review process was exhausted. The Supreme Court rejected such a bright line and adopted two rules for measuring the enforceability of a plan-created limitations period.

First, a plan limitations period must allow a reasonable length of time for the claimant to pursue judicial review. Exhaustion of plan internal review procedures is required in most instances, so the key is how much time a claimant has to file suit after that review finishes. The Supreme Court held that one year was sufficient to satisfy this criterion.

Second, a plan term may not conflict with a controlling statutory provision. For benefit claims, however, ERISA does not contain its own statute of limitations. State law is "borrowed" for these suits – usually, the limitations period for breach of contract claims, which runs five or six years. As a result, no controlling statute bars a plan-imposed limitations period.

The *Heimeshoff* opinion strongly reaffirms the right of plan sponsors to include reasonable terms that assist in controlling risk and reducing the unnecessary administrative costs. Indeed, given that borrowing of state law results in the application of varying rules to plans that operate in several states, *Heimeshoff* can be seen as a continuation of the Court's efforts, exemplified in cases like *Conkright v. Frommert*, 559 U.S. 506 (2010), to construe ERISA in a way that facilitates uniform administration of national pension and benefit plans. A logical next step is to apply *Heimeshoff* to venue selection clauses in ERISA plans. The outcome of that application likely will turn on whether a court views such a clause as conflicting with ERISA's express venue provision and whether ERISA's venue provision is deemed "controlling" or merely permissive as well as whether the venue provision is deemed reasonable or overly restrictive.

In light of *Heimeshoff*, plan sponsors who have not already done so should consider adding plan-created limitations periods for benefit claims. The period can commence at an early stage, as in *Heimeshoff*, when the request for benefits first arises, or at the termination of the administrative review process. (If, after the internal review process is completed, there remains only a very short period left within which to sue, a court can apply the equitable tolling doctrine to allow more time.) Either way, if at least one year is available to a claimant in which to go to court, the provision should be enforced. Imposing a uniform period for the filing of claims will assist the administration of plans that operate in locations where claims might arise from more than one state. Choosing a reasonable, but prompt, period in which to file will help control exposure to suit in states with lengthy statutes of limitations.

## Class Action Fee Litigation Continues to Plague Plan Sponsors

*by: Debra Davis, The ERISA Industry Committee*

Class action law suits alleging the improper payment of allegedly excessive administrative fees by 401(k) plans have plagued large companies for years. These cases allege that the plan fiduciaries failed to properly evaluate their plan's expenses and pay only reasonable fees. Many of these cases are coupled with additional allegations, such as failing to prudently select and monitor the plan's investment options and mismanagement of company stock funds.

While many of these cases were commenced a number of years ago, recently filed litigation and successful outcomes for participants may indicate that the future will bring additional cases. Although new guidance has been issued by the U.S. Department of Labor ("DOL") regarding fee disclosures by service providers to fiduciaries and from the plan to participants, some commentators speculate that this will only cause the number of excessive fee cases to increase. In this article, we evaluate the outcomes of recent fee litigation and consider its potential impact on plan sponsors.

### ERISA's Fiduciary Requirements for Fiduciaries

The Employee Retirement Income Security Act ("ERISA") requires plan fiduciaries to act in the best interests of plan participants. ERISA requires fiduciaries to act with the care, skill, prudence and diligence that a prudent person would use under similar circumstances. This prudence requirement has two components – "procedural prudence" and "substantive prudence." Procedural prudence requires fiduciaries to engage in a reasonable process designed to elicit relevant information, while substantive prudence requires fiduciaries to use the information they obtained to make a reasoned decision. Fiduciaries are required to act prudently when selecting their plan's investments and services providers. Furthermore, they must continue to monitor these arrangements to determine whether they remain prudent choices.

With respect to plan fees, fiduciaries are required to ensure their plans pay reasonable fees for services that are appropriate for their plans. The DOL has indicated that fiduciaries do not necessarily have to select the least expensive option, but must instead engage in a prudent process to make informed, reasonable decisions. Participants in the fee cases typically allege that the fiduciaries failed to engage in a prudent process when selecting and monitoring the plan's investments and service providers, which resulted in the plan paying excessive fees. The DOL has indicated that a relatively small difference in fees can have a significant impact at retirement. For example, the DOL states that a "1 percent difference in fees and expenses would reduce [a participant's] account balance at retirement by 28 percent."

### Courts Have Ruled in Favor of the Participants in Excessive Fee Cases

Some courts have held fiduciaries liable for failing to prudently manage the plan's investments and service providers, which resulted in the payment of excessive fees by the plan. For example, the Ninth Circuit ruled on March 21, 2013 in *Tibble v. Edison International,* 711 F.3d 1061 (9th Cir. March 21, 2013); amended 729 F.3d 1110 (9th Cir. August 1, 2013), that the plan fiduciaries breached their duties under ERISA by including certain investment options in the plan and by engaging in revenue sharing. Although Edison prevailed on most of the claims, the court held that the fiduciaries breached their duties by including retail-class shares of mutual funds in the plan without first exploring less expensive institutional-class alternatives. Participants were awarded damages of $370,000.

In *Tussey v. ABB, Inc*, Case No. 06-4305 (W.D. Mo.), a district court awarded participants $39.6 million to the participants plus attorney's fees. In *Tussey v. ABB, Inc.*, the court held that the plan fiduciaries failed to calculate the amount of the recordkeeping fees paid through the plan's revenue sharing arrangements. The court held that the fiduciaries should have evaluated the reasonableness of the fees sooner and ignored the advice they received when they compared the cost of their service provider to others. The case awaits a decision on an appeal to the Eighth Circuit Court of Appeals.

### Cases Continue to Settle for Millions of Dollars

Several large companies have recently settled lawsuits alleging excessive fees for millions of dollars. For example, in *Nolte v. CIGNA Corp.*, Case No. 07-2046 (C.D.Ill.), participants alleged, among other claims that fiduciaries breached their duties by allowing the plan to pay excessive investment management and other fees from which they benefitted. The court approved a settlement of $35 million on behalf of the participants in October 2013.

Similarly, participants alleged in *Beesley v. International Paper*, Case No. 06-703 (S.D.Ill.), that they paid $58 million in unreasonable recordkeeping and administration fees. The case settled in October 2013 for $30 million.

Earlier fee litigation that settled with payments made to participants include *George v. Kraft Foods*, Case Nos. 07-1713 & 08-3799 (N.D.Ill.), in October 2012 for $9.5 million; *Braden v. Wal-Mart Stores, Inc.*, 6:08-cv-03109-GAF (W.D. Mo.), in October 2011 for $13.5 million; *Will v. General Dynamics Corp.*, Case No. 06-698 (S.D.Ill.), in November 2010 for $15.15 million; *Kanawi v. Bechtel Corp.*, Case No. 06-5566 (N.D.Cal.); in October 2010 for $18.5 million; and *Martin v. Caterpillar Inc.*, Case No. 07-1009 (C.D.Ill.), in November 2009 for $16.5 million.

### Several Fee Cases Are Ongoing or Resolved in Favor of the Fiduciaries

Not all of the ERISA fee cases have been resolved in favor of participants. For example, in *Hecker v. Deere & Co.*, 556 F.3d 575, as supplemented, 569 F.3d 708 (7th Cir. 2009), the Seventh Circuit Court of Appeals held the plan offered a sufficient mix of investments so that inclusion of allegedly expensive funds in the plan did not result a fiduciary breach. Similar decisions were reached in other cases, such as *Taylor v. United Technologies Corp.,* 2009 WL 4255159 (2d Cir. 2009).

Other cases have yet to reach final resolution. For example, in *Spano v. Boeing Co.*, No. 3:06-cv-00743-DRH-DGW (S.D. Ill.), participants have alleged that the fiduciaries caused the Plan to pay excessive fees and expenses. They allege that the fees were imposed on the plan through hard dollar costs as well as revenue sharing. They also allege that the stock fund incurred unnecessary fees. The Seventh Circuit Court of Appeals has not ruled on the merits, but, in November 2013, refused to block the district court's ruling that that the case may proceed as a class action suit.

As discussed above, the district court in *Tussey v. ABB, Inc*, Case No. 06-4305 (W.D. Mo.), ruled in favor of the participants. However, the case has been appealed to the Eighth Circuit Court of Appeals and oral arguments were heard on September 24, 2013.

Also, in *Abbott v. Lockheed Martin Corporation,* Case No. 06-cv-701 (S.D. Ill.), the participants allege, among other claims, that the fees and expenses paid by the plans were unreasonable and excessive. They claim that the fiduciaries should have selected institutional mutual fund shares for the plans, which would have charged substantially lower fees than the retail shares selected by the fiduciaries. ERIC filed an amicus brief with the Seventh Circuit Court of Appeals on a related issue in the case. After appeals to address other issues, the case is expected to proceed at the District Court.

### Cases Alleging Excessive Fees Continue to be Filed

Although many of the fee cases were filed in a number of years ago, cases continue to be filed against large companies. For example, participants filed suit on November 5, 2013 in *Gordan v. Massachusetts Mutual Life Insurance*, Case No. 3:13-cv-30184 (D. Mass.). Employees of MassMutual are alleging that the fiduciaries failed to engage in a prudent process to select the plan's investments. They claim that the fiduciaries selected and retained investments which are unreasonably expensive and on which they make a profit and earn unreasonable compensation.

To the extent that cases are resolved in favor of participants, additional litigation is likely to be filed.

### Next Steps for Plan Sponsors

The increased focus on plan expenses in recent years motivated many plan fiduciaries to re-evaluate the fees associated with the investments offered in their plans and the service providers to their plans. However, it is important for plan fiduciaries to remember that ERISA requires them to both prudently select and monitor their plans' investments and service providers. These cases serve as a reminder that fiduciaries should implement procedures to regularly review their arrangements and determine whether they continue to be prudent for their plans.

## NOTEWORTHY PENDING CASE

### *Fifth Third Bancorp, et al. v. Dudenhoeffer et al.* Case No. 12-751 (Supreme Court)

- This case involves the thorny issue of the application of the Moensch presumption in ESOP cases and the conflict between the Circuits regarding the application of the presumption. In expressing a minority view among the Circuits, the Sixth Circuit ruled that the allegations in a complaint need not rebut the Moensch presumption. This view was contrary to those of the Second, Third, Fifth, Seventh and Eleventh Circuits which had ruled that the allegations in the complaint must rebut the Moensch presumption.
- In an amicus brief, the Solicitor General asserted the position of the Department of Labor that a court should never apply a presumption that an ESOP fiduciary had acted prudently at any stage of the proceedings. The Solicitor General argued that the issue before the Supreme Court should be reformulated to address if an ESOP fiduciary should ever be afforded a presumption of prudence, secondly if such a presumption is afforded at what stage of the case the presumption applies and finally what is required to rebut it.

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**Please send questions, comments, and related requests to Scott J. Macey or Joan Disler.**