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A report to clients and friends of the firm
Edited by **Heather G. Magier** and **Bridgit M. DePietto**

Editor's Overview

This month, we discuss the recent decision in *US Airways, Inc. v. McCutchen*, No. 10-3836, 2011 WL 5557411 (3d Cir. Nov. 16, 2011), wherein the Third Circuit refused to enforce a plan provision that expressly entitled the plan to reimbursement of medical expenses paid to a participant based on the participant's recoveries from a collateral litigation. In doing so, the court departed from existing case law in at least two significant respects. If adopted elsewhere, this ruling could substantially upset the expectations of plan sponsors, who until now were led to believe that they could limit their benefits costs through proper plan draftsmanship.

Next, we analyze the opinion issued in *Santomenno v. John Hancock Life Ins. Co. (U.S.A.)*, No. 2:10-cv-01655, 2011 WL 2038769 (D.N.J. May 23, 2011), and the potential effects of the Department of Labor's decision to file an *amicus curiae* brief in the Third Circuit in support of the plaintiffs' appeal. In *Santomenno*, the district court ruled that plaintiffs were required to allege a pre-suit demand (or allege that such a demand would have been futile) and join the plan's trustees as defendants prior to bringing their fiduciary breach claims under ERISA Section 502(a)(2). As we discuss below, by filing an *amicus curiae* brief, the DOL may have "raised the stakes" on a case that might otherwise have been limited to its unique circumstances.

Finally, we review the unresolved circuit split regarding whether ERISA's anti-retaliation provision set forth in Section 510 applies to internal workplace complaints. As it now stands, employers are subject to varying standards of liability depending on the circuit in which they are sued. Unfortunately, there appears to be no prospect for a near-term solution, as the Supreme Court recently denied *certiorari* in *Edwards v. A.H. Cornell & Son, Inc.*, 131 S. Ct. 1604 (2011), which last year held that Section 510 does not encompass unsolicited internal complaints.

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

Third Circuit Finds "Inequitable" The Enforceability of a Clear ERISA Welfare Plan Reimbursement Provision That Deprived a Participant of a Full Recovery[1]

Contributed by Russell L. Hirschhorn

It is well-established that the written employee benefit plan document is sacrosanct. Section 402(a)(1) of the Employee Retirement Income Security Act of 1974 (ERISA) requires plan documents to be in writing, and employers are free to provide in their plan documents whatever level of benefits they so choose. Only upon proof of the elements of an equitable claim have participants been able to recover benefits not provided for in plan documents.

Consistent with these principles, courts have generally enforced employee welfare benefit plan reimbursement provisions that provide to the plan the right to recover payments for medical expenses when a participant achieves a collateral recovery. When clearly written, these provisions have been enforced even if the participant has not been made whole by the third party recovery. Efforts by plan participants to limit such recoveries based on federal common law principles have generally been rejected as being inconsistent with ERISA's intent to enable plan sponsors to specify the benefits provided by their plans.

A recent decision from the U.S. Court of Appeals for the Third Circuit substantially departs from these principles. In *US Airways, Inc. v. McCutchen*, No. 10-3836, 2011 WL 5557411 (3d Cir. Nov. 16, 2011), the Third Circuit refused to enforce a plan provision that expressly entitled the plan to full reimbursement of the medical expenses it paid to participant James McCutchen, based on his recoveries from a collateral litigation. The Court found that because McCutchen had not received a full recovery for his injuries in the collateral litigation and US Airways had not exercised its subrogation rights (*i.e.*, it did not participate in the prosecution of the collateral litigation or contribute to the cost of obtaining a third party recovery), full reimbursement to the plan did not constitute "*appropriate* equitable relief." If adopted elsewhere, this ruling could substantially upset the expectations of plan sponsors, who until now were led to believe that they could limit their benefits costs through proper plan draftsmanship.

Background

The facts giving rise to the ruling in *US Airways* fit a familiar pattern. James McCutchen was seriously injured in a car accident. A plan administered by US Airways paid $66,866 for his medical expenses. Because the other driver was underinsured, McCutchen recovered only $110,000 from third parties: he settled with the other driver for just $10,000 and received an additional $100,000 in underinsured motorist coverage. McCutchen ultimately pocketed less than the amount paid by US Airways, however, as 40% of his recovery was due to his attorney. His attorney placed $41,500 of the amount he recovered in a trust account until it could be decided whether the plan's claim for reimbursement was valid.[2]

The summary plan description describing the US Airways plan stated the following with respect to subrogation and right of reimbursement:

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[2] The record before the Court did not establish the exact amount McCutchen ultimately received, or why his attorney only put $41,500 (as opposed to the full amount sought by US Airways) in a trust account.

> The purpose of the Plan is to provide coverage for qualified expenses that are not covered by a third party. If the Plan pays benefits for any claim you incur as the result of negligence, willful misconduct, or other actions of a third party, the Plan will be subrogated to all your rights of recovery. You will be required to reimburse the Plan for amounts paid for claims out of *any monies* recovered from a third party, including, but not limited to, your own insurance company as the result of judgment, settlement, or otherwise. In addition you will be required to assist the administrator of the Plan in enforcing these rights and may not negotiate any agreements with a third party that would undermine the subrogation rights of the Plan.

US Airways, as the plan administrator, commenced an action under Section 502(a)(3) of ERISA, seeking "appropriate equitable relief" in the form of an equitable lien on the $41,500 held in trust and on an additional $25,366 held personally by McCutchen. US Airways contended that the phrase "any monies" permitted it to recoup the full amount of medical expenses it paid to McCutchen whether or not McCutchen was made whole in his recoveries as a result of his legal expenses or otherwise.

McCutchen argued that it would be inequitable to require him to reimburse US Airways in full when he had not been fully compensated for his injuries, including pain and suffering, and that US Airways, which made no contribution to his attorneys' fees and expenses, would be unjustly enriched if it were now permitted to recover from him without any allowance for those costs. He thus contended that a full recovery for the plan would not constitute "appropriate equitable relief" within the meaning of Section 502(a)(3).

The Third Circuit's Decision

As the Third Circuit observed, the Supreme Court has on several occasions interpreted the phrase "appropriate equitable relief" in Section 502(a)(3) as referring to those categories of relief that were typically available in equity. While the Supreme Court has in two prior rulings established the circumstances under which equity provided a right of recovery for a reimbursement claim, it did not address the question presented here: whether the requirement that the equitable relief be "appropriate" could limit the scope of that recovery.[3]

The Third Circuit concluded that the requirement that "equitable relief" also be "appropriate" meant that a plan fiduciary's recovery from a beneficiary is limited by the defenses that were typically available in equity. The Court reasoned that, since the Supreme Court had held that "'equitable relief' means something less than all relief, "*appropriate* equitable relief" must be something less than all equitable relief. Observing that the word "appropriate" is defined by Webster's as meaning "specially suitable," "belonging peculiarly [to]," or "attached as an accessory possession," the Court concluded that "remedies that peculiarly belong to traditional categories of equitable relief would typically have been defeated by equitable principles and defenses."

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[3] In *Great–West Life & Annuity Insurance Co. v. Knudson*, 534 U.S. 204 (2002), the Supreme Court held that "for restitution to lie in equity, the action generally must seek not to impose personal liability on the defendant, but to restore to the plaintiff particular funds or property in the defendant's possession." The Court explained that a feature of equitable restitution was that it sought to impose a constructive trust or equitable lien over such funds and that this requirement had not been met because the funds had been placed in a "Special Needs Trust" under California law. In *Sereboff v. Mid Atlantic Medical Servs., Inc.*, 547 U.S. 356 (2006), the Court considered the same question, but this time ruled that the plan administrator could recover because it was able to identify specific funds within the beneficiary's possession and control.

Applying these principles to the facts of the case and, in particular, the equitable principle of unjust enrichment, the Court viewed the district court's ruling requiring McCutchen to fully reimburse the plan as "inappropriate and inequitable relief." The Court reasoned that McCutchen was left with less than full payment of his medical bills in light of the fact that the amount of the district court's judgment in favor of the plan exceeded the net amount of McCutchen's third-party recovery. The Court also determined that full reimbursement would amount to a windfall for US Airways since US Airways did not exercise its subrogation rights, and thus did not bear the cost of pursuing recovery from collateral sources. The Court therefore vacated the district court's ruling and remanded the case for further proceedings consistent with the Court's findings.

In rendering its ruling, the Court acknowledged that there were several rulings, both in the Third Circuit and elsewhere, that had strictly enforced the terms of plan reimbursement clauses, without regard to whether the plan participant was made whole.[4] In the Court's view, by categorically excluding the equitable limitations that Section 502(a)(3) necessarily contains, those decisions "depart[ed] from the text of ERISA."

Lastly, the Court found support for its ruling in the Supreme Court's recent decision in *Cigna v. Amara*, 131 S. Ct. 1866 (2011), which authorized equitable reformation under Section 502(a)(3) as a potential remedy for an intentional misrepresentation. Although the Third Circuit acknowledged that US Airway's conduct did not amount to an intentional misrepresentation, as it was neither fraudulent nor dishonest, the Court nevertheless found it appropriate to reform the US Airways plan to limit the plan's right to reimbursement. According to the Court, "the broader and more relevant point is that when courts were sitting in equity in the days of the divided bench (or even when they apply equitable principles today) contractual language was not as sacrosanct as it is normally considered to be when applying breach of contract principles at common law."

Proskauer's Perspective

The Third Circuit's ruling departs from existing case law in at least two significant respects. First, the Court applied equitable considerations in circumstances where the plan provisions specifically addressed the reimbursement issue and were not found to be ambiguous. Prior authorities applied equity only where plan terms were ambiguous or participants were misled as to what these terms were. Second, the Court used its equitable authority to reform the plan without finding that the conditions for reformation identified in *Amara* had been satisfied.

On a more fundamental level, the ruling potentially undermines ERISA's goal of encouraging employers to make benefits available to employees by enabling them to control and limit their exposure through plan design. Although the ruling may be limited to cases involving reimbursement provisions, the notion that benefit recoveries can be expanded beyond those contemplated by explicit plan provisions is troubling.

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[4] *See*, *e.g.*, *Zurich Am. Ins. Co. v. O'Hara*, 604 F.3d 1232 (11th Cir. 2010) ("Applying federal common law to override the Plan's controlling language, which expressly provides for reimbursement regardless of whether [insured] was made whole . . . would frustrate, rather than effectuate ERISA's . . . purpose to protect contractually defined benefits") (internal quotation marks omitted); *Admin. Comm. of Wal–Mart Stores, Inc. Assoc. Health & Welfare Plan v. Shank*, 500 F.3d 834 (8th Cir. 2007) ("We are not persuaded that the Committee's full recovery according to the terms of the plan is not 'appropriate' relief within the meaning of ERISA" because "we generally adopt new rules of federal common law only if they are necessary to fill gaps left by the express provisions of ERISA and to effectuate the purposes of the statute.").

District Court Dismisses ERISA § 502(a)(2) Claim Based on Plaintiffs' Failure to Make Pre-Suit Demand — and DOL Takes Notice[5]

Contributed by Michael D. Spencer

In *Santomenno v. John Hancock Life Ins. Co. (U.S.A.)*, Civ. A. No. 2:10-cv-01655, 2011 WL 2038769 (D.N.J. May 23, 2011),6 the district court dismissed a putative class action lawsuit alleging that John Hancock USA and related entities violated ERISA and the Investment Company Act of 1940 (ICA) by charging excessive fees for the investment services it provided to employee benefit plans. The Court dismissed the plaintiffs' fiduciary breach claims under ERISA § 502, 29 U.S.C. § 1132, because plaintiffs failed to allege that they had made a pre-suit demand on the plans' trustees, and failed to sue the plan's trustees. The district court also dismissed plaintiffs' securities claims for lack of standing because plaintiffs no longer had an ownership interest in the defendants' funds.

Relying on trust law authorities, as well as case law pertaining to claims for recovery of delinquent contributions under ERISA § 502(g), 29 U.S.C. § 1132(g), the district court ruled that plaintiffs were required to allege a pre-suit demand or that such a demand would have been futile, and were required to join the plan's trustees as defendants.

The ruling with respect to the ERISA claims is premised on an analogy of claims brought under ERISA § 502(a)(2), 29 U.S.C. § 1132(a)(2), which authorizes participants to sue on behalf of the plan for breach of fiduciary duty, to claims under ERISA § 502(g)(2), which authorizes a plan's fiduciary to file suit on behalf of the plan for unpaid contributions, but, unlike Section 502(a)(2), does *not* extend the same authority to plan participants and beneficiaries. Even though ERISA §§ 502(a)(2) and 502(a)(3), 29 U.S.C. § 1132(a)(3), authorize the assertion of *direct* claims, the court may have considered the analogy to Section 502(g) appropriate because plaintiffs pled their complaint as a derivative action.

The decision has attracted the attention of the Department of Labor, which has filed an *amicus curiae* brief[7] in the Third Circuit in support of the plaintiffs' appeal. In its brief, the DOL asserted that the Court's decision is fundamentally at odds with the statutory language of ERISA because ERISA § 502(a)(2) does not impose any preconditions on plan participants' ability to bring an action against breaching fiduciaries. The DOL maintained that the Court's reliance on cases decided under ERISA § 502(g) was inappropriate because ERISA § 502(a)(2) expressly gives participants the right to bring a civil action to remedy alleged fiduciary breaches. The DOL also argued that the analogy to Section 502(g) was inappropriate with respect to the claim under Section 502(a)(3), which provides participants with a direct right of action for recovery of individual relief.

Given the Department of Labor's participation in the appeal, we thought the decision merited closer attention.

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[6] 2011 BL 134738.

[7] Brief for The Secretary of Labor, Hilda L. Solis, as *Amicus Curiae* Supporting Appellants, *Santomenno v. John Hancock Life Insurance Co.*, No. 11-CV-2520 (Sept. 30, 2011).

Plaintiffs' ERISA Claims[8]

The plaintiffs in this putative class action were participants in various 401(k) plans offered by their respective employers. The trustees of each of those plans contracted with John Hancock for certain products and services, which included the opportunity to invest in various funds affiliated with John Hancock and other non-John Hancock-affiliated funds and portfolios. The plaintiffs alleged that the fees charged to their plans (as well as to other plans in which they were not participants) by John Hancock USA (JHUSA) and its affiliated mutual fund adviser, John Hancock Investment Management Services, LLC (JHIMS), were excessive. On the basis of these allegations, the plaintiffs asserted seven counts under ERISA for alleged fiduciary breaches based on the imposition of sales, service, advisory, and fund distribution fees, and on the receipt of revenue sharing payments.

The plaintiffs asserted that the defendants were ERISA fiduciaries or otherwise knowingly participated in a breach of duty by a fiduciary, and sought relief under ERISA §§ 502(a)(2), 502(a)(3), and 502(g), including: (1) a declaratory judgment that the acts of John Hancock USA violated ERISA; (2) a permanent injunction prohibiting the defendants from engaging in the practices at issue; (3) disgorgement or restitution of the allegedly excessive and impermissible fees received by defendants based on investments made in JHUSA products; (4) disgorgement or restitution of alleged impermissible revenue sharing payments received by JHUSA; and (5) disgorgement of excessive fees charged by underlying, unaffiliated funds, representing the difference between the alleged unsuitable classes of funds that JHUSA selected for the plaintiffs' assets and the lowest cost alternative. Although plaintiffs cited ERISA § 502(g) as a basis for relief, they did not indicate in the separate counts which particular relief they believed was recoverable under Section 502(g).

Defendants' Motion to Dismiss

The defendants moved to dismiss plaintiffs' ERISA claims on the grounds that plaintiffs failed to make a pre-suit demand on the trustees of the plans on whose behalf the plaintiffs brought suit, and that none of the defendants was an ERISA fiduciary of any plan. The argument that plaintiffs failed to make a pre-suit demand on the trustees of the plans at issue was based on the fact that plaintiffs filed this action "as a derivative action on behalf of the Plaintiff Plans." Seizing on this characterization of the action, the defendants argued that the claims as pled belonged to the trustees as plan fiduciaries and it was therefore incumbent upon the plaintiffs to make a demand upon the trustees to file suit, or to allege that such a demand would have been futile. In support of this contention, the defendants also relied on the Restatement of Trusts and on case law from the Second Circuit applying trust law principles in the context of delinquent contribution claims and holding that a plan or trust beneficiary may sue a third party on behalf of a trust only if the trustee improperly refuses to bring that action. Thus, according to the defendants, it was necessary for the plaintiffs to make a demand upon those trustees to file suit challenging defendants' imposition of alleged excessive fees *prior* to filing suit.

Plaintiffs responded to this argument by asserting that ERISA § 502(a) does not contain a requirement for pre-suit demand, and that they had direct standing under ERISA § 502(a)(2) as participants and/or beneficiaries to bring suit on behalf of the plans against JHUSA because it was a fiduciary. Plaintiffs did not respond, however, to defendants' argument that pre-suit demand was required in this action because plaintiffs' ERISA

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[8] Plaintiffs also alleged that, because they were excessive, the advisory fees paid to JHIMS on funds offered by JHUSA violated ICA §§ 36(b) and 47(b). The Court dismissed these claims, but the DOL did not address this portion of the Court's opinion in its amicus brief and those claims are not discussed herein.

claims were characterized in their Second Amended Complaint as being "derivative" of the plans' claims.

The Court's Decision

In granting the defendants' motion to dismiss plaintiffs' ERISA claims, the Court noted that the Third Circuit had not addressed the "precise question" presented in this case, *i.e.,* whether plaintiffs must make demand upon plan trustees before bringing a derivative suit under Section 502(a)(2).[9] Even though there were authorities in other circuits holding that there was no demand requirement for claims brought under Section 502(a)(2), the court cited Second Circuit authorities involving claims under Section 502(g) and the common law of trusts suggesting that, to assert a derivative claim, it was necessary for plaintiffs to allege that the plans' trustees breached their fiduciary duties. Relying on *Diduck v. Kaszycki & Sons Contractors, Inc.*, 874 F.2d 912, 916 (2d Cir. 1989), a case addressing derivative standing for Section 502(g) claims, the Court stated that "a participant in a fund governed by ERISA can sue derivatively on behalf of the fund only if the plaintiff first establishes that the *trustees* breached their fiduciary duty." Based on this authority, the Court concluded that plaintiffs' suit was precluded because the complaint "fails to name the plans' trustees, fails to make well-pled allegations as to whether they joined in the alleged fiduciary breaches by the named Defendants, and fails to join the trustees as defendants." The Court also cited the common law of trusts principles that "ordinarily the *trustee*, and he alone, is permitted to sue the wrongdoer" and that "as long as the trustee is ready and willing to take the proper proceedings against … third persons [who wrong the trust], the beneficiary cannot maintain a suit in equity against [third parties]." *Santomenno*, 2011 WL 2038769 at *3, *citing* George T. Bogert, Trusts 610 (6th ed. 1987) (emphasis in original); Restatement (Second) Of Trusts § 282 cmt. a (1959).[10]

Against this legal backdrop, the Court stated that plaintiffs' claims should be precluded because "[p]laintiffs have made no allegations against the trustees (as opposed to the named Defendants who plaintiffs allege to be non-trustee fiduciaries) suggesting that they (trustees) violated any fiduciary duty or that demand is otherwise futile." The Court concluded that a broad construction of the terms "wrongdoer" and "third person" would seem to extend to the defendants in this case, even if they were non-trustee fiduciaries as alleged by plaintiffs, and therefore that the trust principles required pre-suit demand on the plans' trustees. The plaintiffs appealed this decision to the Third Circuit on June 6, 2011.

The DOL's Amicus Brief

On September 30, 2011, the Department of Labor filed an *amicus curiae* brief, in support of plaintiffs-appellants, arguing in favor of reversal of the District Court's decision. Echoing the plaintiffs' positions in the District Court, the DOL argued that ERISA §§ 502(a)(2) and (3) give participants rights to directly file suit against allegedly breaching fiduciaries and do not impose any preconditions on those rights, and that the District Court erred in relying on cases involving claims under ERISA § 502(g) to recover delinquent plan contributions. The DOL acknowledged that a "demand rule" would apply to enforce a trust's contractual rights against a non-fiduciary third party, but contended

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[9] Other courts have held that no demand is required for claims brought under Section 502(a)(2). *See, e.g., Coan v. Kaufman*, 457 F.3d 250, 257-58 (2d Cir. 2006); *In re Polaroid ERISA Litigation (In re Polaroid II)*, No. 03-CV-8335, 240 F.R.D. 65 (S.D.N.Y. Sept. 29, 2006); *In re Marsh ERISA Litigation*, No. 04-CV-8157, 2006 WL 3706169 (S.D.N.Y. Dec. 14, 2006).

[10] 2011 BL 134738.

that the "demand rule" was inapplicable in this case because plaintiffs' claims were asserted against an alleged fiduciary. In making this argument, the DOL's brief did not address the fact that plaintiffs' claim was framed as "a derivative action on behalf of the plans," and instead focused on the plain language of ERISA §§ 502(a)(2) and (3), which allow for direct actions by beneficiaries and participants. The DOL thus argued that the District Court's opinion is fundamentally at odds with the statutory text of ERISA and is directly contrary to the rights granted to participants under ERISA §§ 502(a)(2) and (3).

Proskauer's Perspective

By filing an *amicus curiae* brief, the DOL may have "raised the stakes" on a case that might otherwise have been limited to its unique circumstances. The lower court's requirement of a pre-suit demand, and its reliance on analogous case law addressing derivative delinquent contribution claims, appears to have been in nature, when the language of ERISA's civil enforcement provisions would appear to have allowed them to assert their claims directly. The Third Circuit thus could render a narrow ruling limited to these facts. The DOL's entrance into the case, however, may provoke the Third Circuit to render a broader ruling that provides more clarity as to the circumstances in which the demand requirement will apply to ERISA claims for fiduciary breach.

Even with the invitation provided by plaintiffs' characterization of the claims as "derivative," the Court's invocation of trust law principles to impose a demand requirement can be questioned. As plaintiffs and the DOL pointed out, trust law appears to require a demand only for claims against non-fiduciaries, and here the complaint purported to assert claims for fiduciary breach. If the defendants were in fact fiduciaries - regardless of whether they were trustees - there would be no reason to ignore the clear language of ERISA § 502(a)(2), which allows a participant to bring an action against a fiduciary. Thus, it would appear that the Court's reliance on the common law of trusts may have been unnecessary and inconsistent with the clear language of ERISA § 502(a)(2).

Application of ERISA Section 510 to Internal Workplace Complaints: A Review of Circuit Court Decisions[11]

Contributed by Christopher L. Williams

When enacting ERISA, Congress included a comprehensive enforcement regime "to preclude abuse and to completely secure the rights and expectations brought into being by this landmark reform litigation." *Ingersoll-Rand Co. v. McClendon,* 498 U.S. 133, 137 (1990) (citation omitted). One important component of this enforcement scheme is ERISA's anti-retaliation provision, which is set forth in Section 510 of the statute. In relevant part, Section 510 provides that it is unlawful "to discharge, fine, expel, or discriminate against any person because he has given information or has testified or is about to testify in any inquiry or proceeding relating to" ERISA. 29 U.S.C. § 1140.

Although Section 510 is clearly understood to apply to an employee who testifies in court or gives information to a regulatory agency, such as the Department of Labor, it is less clear whether and how Section 510 applies to internal workplace complaints. Even though the federal courts of appeals have been sharply divided on this issue, the United States Supreme Court recently declined an invitation to resolve the conflict. *Edwards v.*

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A.H. Cornell & Son, Inc., 131 S. Ct. 1604 (2011). As a result, we can expect that the issue will remain a point of contention among the lower courts.

Given the unresolved circuit split regarding the proper interpretation of ERISA's anti-retaliation provision, we take this opportunity to review the case law that has provoked the conflict.

Ninth Circuit

The Ninth Circuit was the first circuit court to address whether Section 510 protects employees who make unsolicited complaints and objections to company management regarding alleged ERISA violations. In *Hashimoto v. Bank of Hawaii*, 999 F.2d 408 (9th Cir. 1993), the plaintiff alleged that she was discharged in retaliation for raising potential ERISA violations to her supervisors and objecting to directives to engage in conduct that she believed would violate ERISA. The Ninth Circuit determined that the plaintiff's allegations fell squarely within the scope of Section 510, reasoning that an employee who "present[s] the [ERISA] problem first to the responsible managers of the ERISA plan" is entitled to the protections the statute. *Id.* at 411.

In reaching this conclusion, the court first observed that the statutory text of Section 510 "may be fairly construed to protect a person in [the employee's] position if, in fact, she was fired because she was protesting a violation of law in connection with an ERISA plan." The court further reasoned that construing ERISA's anti-retaliation provision to exclude internal workplace complaints would render its protections a nullity:

> The normal first step in giving information or testifying in any way . . . would [be to] present the problem first to the responsible managers of the ERISA plan. If one is then discharged for raising the problem, the process of giving information or testifying is interrupted at its start: the anticipatory discharge discourages the whistle blower before the whistle is blown.

Hashimoto, 999 F.2d at 411. Thus, the court's holding in *Hashimoto* was premised on the policy rationale that a failure to protect internal workplace complaints would undermine the remedial purposes of Section 510 because it would allow an employer to avoid ERISA's anti-retaliation provision simply by discharging a complaining employee before the commencement of *formal* proceedings.

Fifth Circuit

The Fifth Circuit was the next federal appellate court to address whether Section 510 applies to internal complaints and it likewise concluded that it does. In *Anderson v. Electronic Data Systems Corporation*, 11 F.3d 1311 (5th Cir. 1994), the plaintiff, who was responsible for administering pension plan investments, contended that he was demoted and later terminated for reporting a colleague's violations of ERISA and for refusing to engage in similar conduct. Without relying on (or even citing) the Ninth Circuit's decision in *Hashimoto*, the Fifth Circuit reached the same conclusion: the protections of ERISA § 510 protect individuals retaliated against for "reporting [ERISA] violations to management…." *Id.* at 1314.

Although the Fifth Circuit in *Anderson* embraced a broad interpretation of ERISA's anti-retaliation provision, its holding gave cursory treatment to the statutory text and provided little analysis to support its conclusion that the provision applies to internal complaints. Instead, the *Anderson* court simply stated that Section 510 "broadly prohibits . . . the discharge or other adverse treatment of any person because he has given information or testimony relating to ERISA" and summarily concluded that the plaintiff's claim "falls squarely within the ambit" of the statute. *Id.* at 1315. Notwithstanding the absence of any

meaningful analysis, it is at least arguable that the Fifth Circuit's determination that Section 510 should be liberally construed to provide expansive protections is grounded on the same policy considerations espoused by the Ninth Circuit in *Hashimoto*.

Fourth Circuit

Faced with the same issue, the Fourth Circuit became the first federal appellate court to conclude that ERISA's anti-retaliation provision does not apply to internal workplace complaints. In *King v. Marriot International*, *Inc*., 337 F.3d 421 (4th Cir. 2003), a human resources manager was allegedly terminated after complaining to management about planned transfers of assets from the company's medical plan into its general corporate reserve account. In concluding that the plaintiff was not entitled to invoke the protections of Section 510, the Fourth Circuit's analysis focused on the provision's statutory text. *Id.* at 427-428.

The Fourth Circuit first addressed the scope of the phrase "inquiry or proceeding." Relying on its interpretation of a similar provision in the Fair Labor Standards Act (FLSA), the Fourth Circuit found that these terms "referred only to administrative or legal proceedings, and not to the making of an intra-company complaint." *Id.* at 427. Additionally, *King* found that the use of the phrase "testified or is about to testify" in Section 510 buttressed its determination that the "inquiry or proceeding" referenced in the statute contemplated more formal actions "than written or oral complaints made to a supervisor." *Id.*

Although the Fourth Circuit acknowledged its decision conflicted with the Ninth Circuit's holding in *Hashimoto* and the Fifth Circuit's decision in *Anderson*, it criticized the reasoning of those cases as "unpersuasive." *Id.* at 428. In particular, *King* found that the Fifth Circuit's decision was flawed because it "merely recited section 510 without even addressing the facial inapplicability of section 510 to intra-office complaints." *Id.* The *King* panel also considered the Ninth Circuit's reasoning to be equally unpersuasive because its holding was grounded on policy preferences rather than the statutory text of Section 510. *Id.*

Second Circuit

In *Nicolaou v. Horizon Media, Inc.*, 402 F.3d 325 (2d Cir. 2005), the defendant's former director of human resources claimed that she was demoted and discharged because she informed her supervisors that a payroll discrepancy was causing the company's 401(k) plan to be underfunded. Adopting a middle ground between the Ninth and Fifth Circuits' broad view and the Fourth Circuit's narrow construction, the Second Circuit held that Section 510 protects internal complaints, but only when made in response to an inquiry *initiated by the employer*. *Id.* at 329-330. Thus, an employee-initiated internal complaint falls outside the reach of Section 510 under the reasoning articulated by the *Nicolaou* court.

Departing from the Fourth Circuit's analysis in *King*, the Second Circuit determined that the plain language of Section 510 was "unambiguously broader" than its FLSA counterpart because it includes the less formal term "inquiry."[12] *Id.* at 328. Thus, the *Nicolaou* court found it inappropriate to rely on previous interpretations of the FLSA's anti-retaliation provision when determining the reach of Section 510. *Id.* at 328-329.

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[12] The anti-retaliation provision of the FLSA protects any person who "has filed any complaint or instituted or caused to be instituted any proceeding under or related to" the FLSA. 29 U.S.C. § 215(a)(3). In contrast, Section 510 applies to "any inquiry or proceeding relating to" ERISA. 29 U.S.C. § 1140 (emphasis added).

Given the inclusion of the term "inquiry" in Section 510, the Second Circuit reasoned that "the proper focus is not on the formality or informality of the circumstances under which an individual gives information, but rather on whether the circumstances constitute an 'inquiry.'" *Id.* at 330. Accordingly, *Nicolaou* concluded that the plaintiff's allegations could support a claim under Section 510 if she could demonstrate that her employer requested she meet with management to provide information about potential ERISA violations.

Third Circuit

The Third Circuit is the most recent circuit court to consider whether an employee's internal complaints are entitled to the protections of Section 510. In *Edwards v. A.H. Cornell & Son, Inc.*, 610 F.3d 217 (3d Cir. 2010), the defendant's former human resources manager allegedly discovered that the company was: (i) administering its group health plan on a discriminatory basis, (ii) misrepresenting the cost of group health plan benefits to dissuade some employees from enrolling, and (iii) fraudulently enrolling non-citizens in its benefit plans. According to the plaintiff, she was discharged from her position in retaliation for complaining about and objecting to these practices. A divided panel of the Third Circuit held the plaintiff's allegations were not protected on the grounds that the unambiguous language of ERISA's anti-retaliation provision did not encompass "unsolicited internal complaints." *Id.* at 225-226.

The *Edwards* majority first concluded that the plaintiff had clearly "given information" by objecting and/or complaining to management and thus the sole question presented was whether she had done so in the context of an "inquiry or proceeding." *Id.* at 222-223. Citing Black's Law Dictionary definition of an "inquiry" as a "request for information," the majority determined that the plaintiff's allegations did not constitute an "inquiry" within the meaning of Section 510 because no one "approached her requesting information regarding a potential ERISA violation." *Id.* at 223. Because the plaintiff "made her complaint voluntarily, of her own accord[,]" the information she relayed to management was not part of an "inquiry" within the meaning of Section 510. *Id.* The majority also rejected the plaintiff's contention that her complaints and objections themselves amounted to an "inquiry" for purposes of ERISA's anti-retaliation provision. *Id.* According to the majority, because Section 510 protects employees who have "given information" and not those who have "received information," an ERISA "inquiry" includes only inquiries made *of* an employee, not those made *by* an employee. *Id.*

In reaching this conclusion, the *Edwards* court acknowledged the circuit split as to whether ERISA's anti-retaliation provision encompasses unsolicited internal complaints, but rejected the holdings of the Fifth and Ninth Circuits because "[n]either court examined the statutory language of Section 510 in detail." *Id.* The Third Circuit also criticized the Ninth Circuit's decision in *Hashimoto* as being driven by improper policy considerations based on what it considered to be a "fair" interpretation of the statute. *Id.* Given the Third Circuit's view that the clear statutory language of Section 510 does not encompass unsolicited internal complaints, it refused to consider any policy arguments that a failure to protect them would thwart the purposes of the statute.

The precise contours of the Third Circuit's holding in *Edwards* are unclear because the majority quotes passages from the Second Circuit's decision in *Nicolaou* holding that *solicited* internal complaints should be protected, as well as passages from the Fourth Circuit's decision in *King* concluding that Section 510 only extends to formal processes outside of the workplace. *Id.* For example, *Edwards* specifically notes that the plaintiff "made her complaint voluntarily, of her own accord" and thus "*[u]nder these circumstances*, the information that [the plaintiff] relayed to management was not part of an inquiry" protected by Section 510. *Id.* (emphasis added). At the same time, however, the Third Circuit seemingly endorses the Fourth Circuit's reasoning in *King*, which

concluded that the "inquiry or proceeding" referred to in the statute is limited to "more formal actions" than internal workplace complaints. *Id.* Notwithstanding this apparent ambiguity, the Third Circuit's holding in *Edwards* makes one thing clear: *unsolicited* informal employee complaints are *not* protected.

Proskauer's Perspective

As it now stands, employers are subject to varying standards of liability depending on the circuit in which they are sued. The risks are particularly acute for companies with national or regional work forces since these companies may wind up subject to different rules for different employees. Subjecting employers to differing rules in different locations undermines the stated Congressional rationale for enacting ERISA in the first place: to provide a "uniform regulatory regime over employee benefits plans." *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004).

Unfortunately, there appears to be no prospects for a near-term solution that will restore uniformity to the law governing these claims under Section 510. Given how entrenched the circuit courts appear to be in their positions, it would appear that a uniform application of these rules can be restored only by Congressional or Supreme Court intervention. The Supreme Court's recent denial of *certiorari* in *Edwards* renders it unlikely that it will be an available vehicle for resolution, and there is no indication that the issue will get on Congress's radar screen any time soon.

In the absence of uniformity, we can expect that the plaintiffs bar will engage in a considerable amount of forum shopping when bringing these types of claims. Employer defendants will wish to consider the prospects of a motion to transfer venue to a friendlier forum.

Rulings, Filings, and Settlements of Interest

Affordable Care Act:

- On November 14, 2011, the Supreme Court granted *certiorari* in *Florida v. United States Dep't of Health and Human Servs.*, 648 F.3d 1235 (11th Cir. 2011). The Obama administration, 26 state plaintiffs (including Florida), and the National Federation of Independent Business filed petitions for review of the Eleventh Circuit's opinion. At the request of the Obama administration, the Court will review the Eleventh Circuit's ruling that Congress impermissibly exceeded its constitutional authority by passing the individual mandate of the Affordable Care Act (the "Act"), which requires that all applicable individuals maintain minimum essential health insurance coverage or pay a fine. The Court also will consider whether lawsuits challenging the individual mandate are barred by the Anti-Injunction Act, which precludes "pre-enforcement" lawsuits that contest the government's collection or assessment of a tax. Furthermore, as requested by the states and the National Federation of Independent Business, the Court will consider whether the Eleventh Circuit properly ruled that Congress' failure to include a severability clause did not invalidate the entire Act, based on the reasoning that courts in general should attempt to save acts of Congress by "severing any constitutionally infirm provisions while leaving the remainder intact" in an effort to avoid frustrating the will of the elected representatives of the citizens. For a more detailed description of the Eleventh Circuit's decision, please see the September 2011 edition of *The Newsletter.*

- In *Seven-Sky v. Holder*, No. 11-5047-cv, 2011 WL 5378319 (C.A.D.C. Nov. 8, 2011), the D.C. Circuit upheld the constitutionality of the Affordable Care Act's individual mandate. The Court reasoned that because the "likelihood" is that most uninsured Americans will eventually need healthcare, the regulation of their entrance into the health insurance market "is merely imposing the mandate in reasonable anticipation of virtually inevitable future transactions in interstate commerce." The Court also ruled that the Anti-Injunction Act did not prevent the Court from hearing the merits of the case because the Act exacts "penalties" rather than taxes. In a lengthy dissenting opinion, Circuit Judge Kavanaugh reasoned that the Anti-Injunction Act bars the lawsuit because, if successful, the suit would prevent the IRS from "assessing or collecting tax penalties from citizens [who] do not have health insurance," which is the "only sanction for failing to have health insurance" under the Act.

Anti-Alienation:

- In *Milgram v. Orthopedic Assocs. Defined Contribution Pension Plan*, --- F.3d ---, No. 10-862-cv , 2011 WL 5924387 (2d Cir. Nov. 29, 2011), the Second Circuit concluded that ERISA's anti-alienation provision, which mandates that an ERISA pension plan "shall provide that benefits provided under the plan may not be assigned or alienated," did not preclude a participant's monetary judgment against a pension plan, where the plan mistakenly transferred half of the participant's account to his ex-wife and had not yet succeeded in recouping those funds from the ex-wife. In affirming the district court's ruling, the Second Circuit approved the award of $1,571,723.72, which included accumulated earnings and interest on the principal amount — more than double the $763,847.93 that was erroneously transferred to the participant's ex-wife. Defendants argued that the funds held by the plan were "benefits" of other participants and, therefore, the judgment could not be paid until the appropriate funds were recouped from the ex-wife, lest the plan violate ERISA's anti-alienation provision. Rejecting this argument, the court concluded that ERISA's anti-alienation provision did not apply because the defined contribution assets at issue were not "benefits" under ERISA. In so ruling, the Second Circuit reasoned that, by design, defined contribution plan participants bear the risk that the value of their accounts may be reduced by poor management decisions that would expose the plan's assets to liability.

Deference:

- In *Frommert v. Conkright*, , --- F. Supp. 2d ---, No. 00-cv-0631, 2011 WL 5599524 (W.D.N.Y. Nov. 17, 2011), upon remand from the Supreme Court, the district court deferred to the administrator's proposed formula for calculating the benefits of re-hired employees, following the Supreme Court's instruction that administrative deference was required if the proposed interpretation was reasonable. In its decision last year, the Supreme Court held that it was erroneous for the Second Circuit to hold that the district court could refuse to defer to the administrator's plan interpretation simply because the circuit court previously found a related interpretation by the administrator to be invalid. Specifically, the Supreme Court ruled that there is no exception to *Firestone* deference without a showing of bad faith. 130 S. Ct. 1640 (2010). On remand, the district court rejected the arguments advanced by plaintiffs to support their position that their proposed alternative benefit formula was reasonable, noting that the key issue was whether the administrator offered a reasonable plan interpretation, and not whether plaintiffs' proposed interpretation was more reasonable. The court thus directed the plan to make benefit payments based on the formula proposed by the plan administrator.

Preemption:

- In *Access Mediquip L.L.C. v. UnitedHealthcare Ins. Co.*, --- F.3d ----, No. 10-20868, 2011 WL 5344302 (5th Cir. Nov. 8, 2011), the Fifth Circuit held that ERISA did not

preempt a medical provider's state-law promissory estoppel, negligent misrepresentation, and Texas Insurance Code claims against a plan administrator arising from misleading statements concerning expected reimbursements for devices and services provided to over 2,000 participants in various ERISA plans. The court determined the claims were not preempted because they were based on the plan administrator's independent statements, and the merits of the claims did not depend on whether the services were covered under the ERISA plans. In contrast, the court held that ERISA did preempt unjust enrichment and quantum meruit claims because resolution of those claims would depend upon whether the ERISA plans' terms provided a right to coverage for the services provided.

Our ERISA Litigation practice is a significant component of Proskauer's Employee Benefits, Executive Compensation & ERISA Litigation Practice Center. Led by Howard Shapiro and Myron Rumeld, the ERISA Litigation practice defends complex and class action employee benefits litigation.

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