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**in this issue**



A report to clients and friends of the firm

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## Editors' Overview

This month, we continue our examination of the Patient Protection and Affordable Care Act (ACA) with an article that addresses whether the coverage mandates under ACA create a risk of generating class action litigation. As we discussed last month, there are risks and exposures that employers may face in adjusting their programs to the new requirements imposed by ACA. In that article, we outlined generally the potential causes of action that may arise in the wake of ACA's implementation. Below we focus our analysis on whether an employer's failure to satisfy ACA's new coverage requirements may lead to "planwide" – hence potential classwide – litigation within ERISA's remedial framework, and offer some thoughts on potential defenses and strategies to minimize exposure to such lawsuits.

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

## The Affordable Care Act and Its Coverage Mandates for Employers: A Potent Recipe for ERISA Class Actions[1]

Contributed by Robert Rachal and Brian S. Neulander

Although the Patient Protection and Affordable Care Act (ACA) has engendered much controversy (pro and con) in the business community, one area that has received less discussion is whether ACA may increase employers' exposure to high-stakes class action litigation. If history is any guide, the answer is "yes." ACA created a host of complex coverage mandates for individual and group health plans. For group health plans that are "established or maintained" by employers, these mandates are incorporated into ERISA.

Historically, ERISA has been a source of substantial class action litigation because it authorizes private civil actions to enforce statutory requirements and benefit payments. Thus, an employer's failure to satisfy ACA's new coverage requirements may lead to "planwide" – hence potential classwide – exposure. ERISA's remedial framework includes contractual-type remedies and (recently enhanced) equitable relief, as well as attorney's fees. The Department of Labor (DOL) also can enforce ACA through ERISA, and has begun laying the groundwork for enforcement through inquiries about ACA compliance in its audits of employer-provided plans.

This article first addresses ACA's link to ERISA and what this may mean for ERISA-based employer health care litigation. It then discusses some of the coverage mandates that may be at issue in coming litigation, and ends with some thoughts on potential defenses and strategies to minimize exposure to this litigation.

### ACA's Enforcement Under ERISA's Remedial Provisions

Section 1201 of ACA amended the Public Health Services Act[2] (PHSA) and ERISA[3] to make its coverage mandates applicable to individual and group health plans, including self-insured employer-sponsored plans. The coverage mandates for private sector group health plans "established or maintained" by employers are incorporated by reference into Section 715 of ERISA.[4] Because ACA's coverage mandates were incorporated into Title I, Part 7 of ERISA, participants

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[1] Originally published by Bloomberg Finance L.P. Reprinted with permission.

[2] 42 U.S.C. § 300, *et seq*.

[3] 29 U.S.C. § 1001, *et seq*.

[4] *Codified at* 29 U.S.C. § 1185d.

of employer-provided health plans have a private cause of action to enforce their rights to these ACA benefits through ERISA's remedial provisions.[5]

Additionally, ACA grants broad enforcement powers to the DOL and the Department of Treasury (Treasury). DOL may bring suits against employers or plan fiduciaries for violation of ACA's provisions,[6] while Treasury may impose various excise taxes. In addition, ACA provides for the collection and reporting of data to DOL and Treasury to direct later enforcement activities.[7] Separately, via plan audits, DOL has commenced collecting data directly from plan sponsors regarding ACA implementation efforts.[8]

**ERISA's Remedial Framework**

ERISA authorizes various private causes of action by plan participants, including lawsuits to clarify their rights to benefits, to recover benefits owed, and for "appropriate equitable relief" to redress any other "act or practice" violating the plan or ERISA.[9] The plaintiffs' bar is most likely to invoke Sections 502(a)(1)(B) and 502(a)(3) of ERISA to enforce ACA's coverage mandates. Either provision can be used to seek redress for alleged violations of ACA's coverage mandates.

Section 502(a)(1)(B) provides for contractual-type remedies, *i.e.*, the failure to provide the benefits described by the terms of the plan. To the extent that ACA's coverage mandates are included in the terms of the plan, they can be enforced through this section. Section 502(a)(3) goes further, however, and authorizes suits for any "act or practice" that violates Title I of ERISA which, as noted, now incorporates ACA's coverage mandates. Although Section 502(a)(3) is limited to "appropriate equitable relief," in its recent *Amara* ruling, the Supreme Court indicated that this relief may, if certain requirements of equitable remedies are met, include plan reformation or monetary relief.[10] Thus, plaintiffs may attempt to invoke Section 502(a)(3) against plan fiduciaries to pursue claims that they failed to properly conform a plan to ACA's coverage mandates or that the fiduciaries

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[5] *See, e.g.*, § 502(a)(3) of ERISA, 29 U.S.C. § 1132(a)(3) providing that participants, beneficiaries and fiduciaries can sue for "appropriate equitable relief" for any act or practice that violates Title I of ERISA. Subject to limitations on suits against insurers, the DOL can sue under the parallel provision of § 502(a)(5) of ERISA, 29 U.S.C. § 1132(a)(5). For a general discussion of the enforcement issues, *see* Jennifer Staman, Cong. Research Serv., R41624, Enforcement of Private Health Insurance Market Reforms under the PPACA (2011), *available at* http://www.achp.org/themes/ACPH_Main/files/EnforcementofPrivateInsuranceMandateunderPPACA2-2011.pdf.

[6] *See supra* note 4.

[7] ACA § 1002 amends Section 2793 of the PHSA, 42 U.S.C. § 300gg-91, and provides in relevant part: "As a condition of receiving a grant under subsection (a), an office of health insurance consumer assistance or ombudsman program shall be required to collect and report data to the Secretary on the types of problems and inquiries encountered by consumers. The Secretary shall utilize such data to identify areas where more enforcement action is necessary and shall share such information with State insurance regulators, the Secretary of Labor, and the Secretary of the Treasury for use in the enforcement activities of such agencies."

[8] *See* Proskauer Client Alert: DOL Begins Enforcing ACA Through Plan Audits, Apr. 17, 2012, *available at* http://www.proskauer.com/news/detail.aspx?news=7622.

[9] ERISA § 502(a), 29 U.S.C. § 1132(a).

[10] *CIGNA Corp. v. Amara*, 131 S. Ct. 1866 (2011).

failed to communicate clearly with participants about these plan changes. Under either remedial provision, plaintiffs likely will contend that they can recover their out-of-pocket costs when plans fail to provide ACA's mandated benefits.

ERISA's fee shifting provision may also increase the likelihood of class litigation.[11] In contrast to the American rule, which provides that regardless of who wins, each side pays for its own attorneys' fees, ERISA allows the award of attorneys' fees to plaintiffs who show "some success on the merits."[12] Previous ERISA litigation has resulted in large "common fund" fee awards for class actions,[13] as well as large lodestar fee awards,[14] making ERISA class litigation particularly attractive to the plaintiffs' bar.

**Similar Pre-ACA ERISA Health Care Litigation**

Congress previously imposed certain health care mandates in the Consolidated Omnibus Budget Reconciliation Act (COBRA) and various provisions of the Health Insurance Portability and Accountability Act (HIPAA), but with no private cause of action. Thus, the area that may be most analogous to ACA from a litigation perspective may be the cases regarding "retiree rights" to health care benefits under ERISA. Unlike retirement benefits, there are no vested rights to health care benefits under ERISA. The "retiree rights" cases have been based on common law contractual vesting principles, estoppel, and breach of ERISA's fiduciary duties.[15]

In the "retiree rights" area, drastically rising retiree health care costs have created quandaries for employers. Even if prior commitments may preclude an employer from ceasing these benefits altogether, there may be legal issues as to what, if any, cost-shifting measures or changes in benefit structures, *e.g.*, managed care, an employer may impose on retirees consistent with the governing plan documents. For example, in *Devlin v. Empire Blue Cross and Blue Shield*, 274 F.3d 76 (2d Cir. 2001), promises of lifetime health benefits precluded the employer from shifting health care costs onto retirees. In contrast, in *Wood v. Detroit Diesel Corp.,* 607 F.3d 427 (6th Cir. 2010), the court held that the plan documents and collectively bargained agreements permitted the company to cap its total payments for retiree health costs.

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[11] ERISA § 502(g), 29 U.S.C. § 1132(g).

[12] *See Hardt v. Reliance Std. Life Ins. Co.,* 130 S. Ct. 2149, 2157-58 (2010).

[13] *E.g., IBM Personal Pension Plan v. Cooper*, 2005 WL 1981501 (S.D. Ill. Aug. 16, 2005) (settling cash balance conversion case for $314.3 million, with attorney's fees of 29% of first $250 million, and 25% of remainder).

[14] *E.g.*, *Continental Group v. McClendon*, 872 F. Supp. 142 (D.N.J. 1994) (ERISA 510 claim settled for $415 million, with $33.3 million fee award based on "enhanced" lodestar method); *see also In re Unisys Corp. Retiree Med. Benefits ERISA Litig.,* 886 F. Supp. 445 (E.D. Pa. 1995) (applying lodestar/common fund hybrid approach in retiree rights case to award nearly $7 million in fees following a settlement of $111 million).

[15] *E.g.*, *Cates v. Cooper Tire and Rubber Co*., 607 F.2d 427 (N.D. Ohio 2008) (noting plaintiffs claimed entitlement to lifetime health benefits under three distinct legal theories: breach of contract, breach of fiduciary duties, and estoppel; and, granting plaintiffs' motion for judgment on the pleadings).

When these retiree health care cases turn on the scope of permitted costs or changes, they often require complex actuarial analyses of health care costs and benefit structures. These analyses are made even more complex by the fact that the state of best medical practices, and the benefit structures used to deliver these services, are constantly evolving. These cases thus may raise issues analogous to the ones expected to arise from litigation over ACA's coverage mandates.

### ACA Coverage Mandates at Risk of Generating Class Actions

With its constitutionality confirmed in pertinent part[16] and subject, perhaps, to the vagaries of the electoral process,[17] plaintiffs can begin using ERISA to enforce ACA's mandates against employers and plan fiduciaries. This litigation, often of a "planwide" and hence potential "classwide" nature, will focus on numerous issues, including whether employers and plan fiduciaries have made "good faith" efforts to comply with ACA's mandates.[18] Below, we discuss certain ACA implementation issues and mandates that are at risk of generating class litigation.

*Grandfathered Status*

ACA allows health plans that were in effect on ACA's effective date, March 23, 2010, to continue as "grandfathered" plans without having to comply with certain of ACA's coverage mandates. For example, grandfathered plans do not have to provide an external appeals process, nor do they have to provide coverage for preventative care without cost-sharing.[19] Under DOL's interim final regulations,[20] grandfathered plans must include a statement, in any plan materials provided to participants, noting the plan's grandfathered status, describing the plan's benefits, and providing contact information for questions and complaints.[21] A plan may lose its "grandfathered" status when:

- it eliminates all or substantially all plan benefits to diagnose or treat a particular condition;
- it increases a percentage cost-sharing requirement (measured from March 23, 2010);

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[16] *National Fed. of Indep. Bus. v. Sebelius*, ___ S. Ct. __, 2012 WL 2427810 (June 28, 2010).

[17] Republicans generally have promised to seek to repeal ACA if they win the November 2012 presidential election and a sufficient number of seats in the Senate. It is unclear what would happen to rights already accrued under ACA, and whether Republicans would or could retroactively eliminate those rights.

[18] Dep't of Labor's FAQs About the Affordable Care Act Implementation Part IV, *available at* http://www.dol.gov/ebsa/faqs/faq-aca4.html (discussing "good faith" standard applicable to review of implementation efforts).

[19] *See* Napoli & Hamburger, The New Health Care Reform Law: What Employers Need To Know ("Napoli & Hamburger") at pp. 6-7 & § 220 Q-24 (AHC Media, 2d Ed. 2011).

[20] 75 Fed. Reg. 34538 (June 17, 2010).

[21] *Id*. (providing model language to satisfy the disclosure requirements).

- a fixed-amount co-payment is increased above a certain amount;
- fixed-amount cost-sharing, other than a co-payment (e.g., deductible or out-of-pocket limit), is increased above a certain amount;
- the employer contribution to the cost of any tier of coverage decreases more than a certain amount; or
- the plan is amended to create new annual benefit limits.[22]

It is unclear whether technical notice failures will forfeit grandfathered status, and the hope is that good faith or substantial compliance on notice and changes in benefits will prevent loss of such status.[23] Because the loss of grandfathered status triggers compliance with certain of ACA's coverage mandates on preventative care and, beginning in 2014, imposes limits on cost sharing and deductibles, it is likely that plaintiffs will often look to challenge grandfathering on a class basis. Plaintiffs also will be expected to contend that the "appropriate equitable relief" section of ERISA allows them to seek recovery of benefits that otherwise would have been provided from the date that such status elapsed.

*Coverage Mandates Likely To Trigger Class Litigation*

All plans, including grandfathered plans, are prohibited from imposing certain preexisting condition exclusions and may not impose lifetime and annual[24] limits on essential health benefits (EHB).[25] Section 1302 of ACA notes that EHB will include items and services in the following benefit categories, but leaves to DOL and Department of Health and Human Services (HHS) the task of specifying the items and services falling into these categories:[26]

- ambulatory patient services;
- emergency services;
- hospitalization;
- maternity and newborn care;
- mental health and substance abuse;
- prescription drugs;
- rehabilitative services and devices;
- laboratory services;

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[22] *Id*. *See also* Napoli & Hamburger, pp. 2-5 & § 220.

[23] The governing interim final rules state that notices are required to "maintain status as a grandfathered health plan." 75 Fed. Reg. 34538, 34541. A representative of the Treasury Department, however, recently stated that failing to provide the required notices will not automatically revoke a plan's grandfathered status, and that the facts and circumstances surrounding a notice failure will be determinative as to continued grandfathering. *See* http://www.employersgroup.com/Content.aspx?id=1675 (last visited July 23, 2012).

[24] Restricted annual limits may be imposed until 2014. *See* Napoli & Hamburger, § 320 Q-4.

[25] ACA § 1001, PHSA § 2711.

[26] Center for Consumer Information and Insurance Oversight, *Essential Health Benefits Bulletin*, Dec. 16, 2011.

- preventive and wellness services and chronic disease management services; and
- pediatric services.

There is currently no list of EHBs issued by the agencies, and employers are left to implement EHBs in a regulatory environment in which "good faith" compliance is the standard. A DOL bulletin does state, however, that EHBs must equal the scope of benefits provided under a typical employer plan and that such coverage must be determined by considering the health needs of diverse segments of the population and may not discriminate based on age, disability, or expected length of life.[27] HHS also has already noted that:

> [A]cross the markets and plans examined, it appears that the following benefits are consistently covered: physician and specialist office visits, inpatient and outpatient surgery, hospitalization, organ transplants, emergency services, maternity care, inpatient and outpatient mental health and substance use disorder services, generic and brand name prescription drugs, physical, occupational and speech therapy, durable medical equipment, prosthetics and orthotics, laboratory and imaging services, preventive care and nutritional counseling services for patients with diabetes, and well child and pediatric services such as immunizations.[28]

Additionally, non-grandfathered plans must provide coverage for preventative care without cost-sharing.[29] Beginning in 2014, ACA also places limits on deductibles and out-of-pocket maximums for non-grandfathered plans.[30]

These coverage mandates can result in litigation exposure because of their sheer complexity and the uncertainty that surrounds implementation. In addition, many of these mandates will upset existing practices (*e.g.*, the potential lifting of annual limits on durable medical equipment, therapy services), and will impose substantial costs on employers. For example, plaintiffs may be expected to test whether limits on doctor visits, mental health sessions, and the like (which are often imposed by plans) are permitted, or instead constitute impermissible forms of annual limits. Finally, if a court later determines that the benefit at issue was required by ACA, the employer or plan fiduciary may face planwide exposure, with plaintiffs seeking to use ERISA's remedial provisions to acquire these benefits, including payment of money for any lost benefits.

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[27] Department of Health & Human Services, Essential Health Benefits Bulletin, p. 2 (Dec. 16, 2011), *available at* http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf.

[28] *Id.* at pp. 4-5.

[29] *See* Napoli & Hamburger, § 220 Q-24.

[30] *See* Napoli & Hamburger, § 360.

## Proskauer's Perspective: Avoiding or Defending ACA-Based ERISA Litigation

Because of the complexity of ACA and its coverage mandates, the first and most important line of defense is to consult with your health plan counsel and advisers. This can build the record on compliance efforts, including establishing defenses of "good faith" or "substantial" compliance. For example, one obvious point of exposure is maintaining grandfathered status. The key to limiting this exposure is documenting (i) the plan terms in effect on March 23, 2010, (ii) the notices to participants regarding grandfathered status, and (iii) the efforts to maintain compliance with the grandfathering rules, including how any plan changes were permitted under those rules. Working with counsel and advisers, employers and plan fiduciaries should analyze and memorialize any cost-sharing increases or any decreases in employer contributions to show that such changes fall within the permissible limits for grandfathered plans.

Another area of potential high exposure is the yet undefined contours of EHBs. Because the extent of what qualifies as an EHB is not yet clear, plaintiffs may challenge annual or lifetime limits on certain items and services, *e.g.*, durable medical equipment as violating the prohibition on such limits for EHBs. Again, employers and plan fiduciaries should work closely with counsel and health plan advisers during the implementation phase to, among other reasons, show compliance with the "good faith" implementation standard set forth in the governing regulations.[31]

If and when litigation does come, it is important to hire experienced litigation counsel, knowledgeable both on the substance of ACA and on the defenses to employ against complex ERISA class litigation. Defenses may include establishing "substantial" and "good faith" compliance and what constitutes reasonable fiduciary conduct under the circumstances, including protecting the plan from unreasonable costs. This may require engaging health plan actuaries and consultants to support these defenses by building the record on standard plan practices and on the current state of medical procedures and costs. There are also critically important procedural defenses to consider, such as whether the plaintiff has properly exhausted his administrative remedies, whether the plaintiff has standing to bring the claims alleged, and whether individualized issues, conflicts, or defenses defeat any attempt by the plaintiff to bring class claims. With regard to remedies, under the ERISA provision most likely used to enforce ACA (Section 502(a)(3)), there are substantial defenses to limit the scope of "appropriate equitable relief." Finally, there may be defenses that an agency regulation is inconsistent with ACA or even unconstitutional in certain instances.

In conclusion, using ERISA's enforcement mechanisms, ACA has imposed substantial, complex, planwide coverage mandates on employers. ERISA did this for pension benefits when it was originally enacted, and ACA has now extended this to the even more complex and evolving world of health benefits. In this

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[31] Dep't of Labor's FAQ's About the Affordable Care Act Implementation Part IV, *available at* http://www.dol.gov/ebsa/faqs/faq-aca4.html.

environment, it is quite likely that the plaintiffs' bar, or perhaps even DOL, will test the limits of grandfathered status, as well as of the employers' and plan fiduciaries' good faith efforts to comply with ACA's myriad of coverage mandates. By seeking sound advice and documenting compliance efforts, however, employers can take actions now to avoid, or at least limit, their exposure to these claims.

## Rulings, Filings, and Settlements of Interest

**Section 404(c):**

- In *Bidwell v. University Med. Ctr. Inc.*, No. 11 CV 5493, 2012 WL 2477588 (6th Cir. June 8, 2012), the Sixth Circuit Court of Appeals affirmed the district court's ruling that a plan administrator who transferred assets of a 403(B) plan from a stable value fund to a Qualified Default Investment Alternative (QDIA) did not breach his fiduciary duty and was insulated by ERISA's 404(c) safe harbor provision. Plaintiffs were participants in the 403(B) plan who directed one hundred percent of their contributions to a stable value fund. In an effort to comply with Department of Labor regulations, the plan administrator transferred the assets invested in the stable value fund to a QDIA and notified the plan participants that if they desired to have their investments remain in the stable value fund, they must notify the plan. Plaintiffs alleged that they never received the notices from the plan and that since they suffered investment losses as a result of the transfer of their investments, the plan administrator breached his fiduciary duty under ERISA. The Court ruled that the plan fiduciary was protected from liability by ERISA's safe harbor provision, reasoning that whenever a participant has an opportunity to direct investment, the fiduciary is insulated from liability. In this case, where the plan administrator asked participants who previously elected an investment vehicle "to confirm their investment election or to have their investment transferred to a new investment mechanism in the interest of aligning the administration of the fund with new federal regulations," there was an instance where the participants had an opportunity to "direct investments." Accordingly, ERISA's safe harbor provision applied. Also, in response to plaintiffs' claim that they never received the notice of the change in investment vehicles, the Court noted that by mailing the notices to participants by first class mail, the plan took actions that were "reasonably calculated to ensure actual receipt" of the notice, and thus, complied with the notice requirement for the Safe Harbor provision to apply.

**Section 510 Claims:**

- In *Cameron v. Idearc Media Corp*., --- F.3d ---, 2012 WL 2866099 (1st Cir. July 13, 2012), the First Circuit affirmed the district court's decision dismissing plaintiffs' Section 510 interference claims and claims of unlawful retaliation and held that Idearc lawfully terminated several of its sales personnel under an objective and negotiated merits-based plan without the specific intent required to support Section 510 or unlawful retaliation claims. Plaintiffs were part of a bargaining unit covered by a 2002 collective

bargaining agreement (the "2002 CBA"), which included a Minimum Standards Plan ("MSP"). The MSP authorized termination of employees who fell below certain sales performance goals set forth in the 2002 CBA. Idearc and the union amended the CBA in 2007 (the "2007 CBA") to broaden the class of employees who could be terminated under the MSP. After the revised MSP became effective, Idearc terminated the plaintiffs in July 2007. At the time, two of the plaintiffs were only two years from qualifying for service pensions; two other plaintiffs were four years and seven years, respectively, from qualifying for service pensions. Citing their proximity to vesting, plaintiffs asserted that they were fired to prevent these pension rights from accruing, in violation of ERISA Section 510. Plaintiffs also complained that the company unlawfully retaliated by refusing to reinstate them, as it had with other employees who successfully appealed their terminations, even though the plaintiffs did not appeal their terminations. Plaintiffs predicated their retaliation claims primarily on their contention that Idearc concealed a letter attached to the 2007 CBA, which purported to exempt employees from underperformance during certain time periods, and then failed to reinstate them. The Union rejected the letter, which would have mandated a performance improvement plan prior to termination. The district court dismissed both claims, noting that the MSP afforded a legitimate basis for plaintiffs' terminations. The First Circuit agreed, noting that an employer's "desire to keep the stronger and discharge the weaker performing members of a group is not the purposeful age discrimination condemned by the ADEA or interference with pension rights under ERISA." The court also rejected the retaliation claim, noting that all parties to the 2007 CBA agreed that the letter, on which plaintiffs based their retaliation claims, was a "moot document" that never became effective as part of the 2007 CBA.

**Remedies:**

> In *ACS Recovery Servs. Inc. v. Griffin*, 676 F.3d 512 (5th Cir Apr. 2, 2012), *reh'g granted*, --- F.3d ---, 2012 WL 2874243 (5th Cir. July 13, 2012), the Fifth Circuit granted rehearing en banc to a heath plan fiduciary seeking to recoup medical benefits paid to a participant who received a settlement payment from a third-party tortfeasor. After suffering serious injury in a car accident, the participant (Griffin) received approximately $295,000 in a personal-injury settlement. Griffin's attorney, seeking to avoid any equitable lien, structured the settlement so the driver's insurer would purchase an annuity making monthly payments into a trust established on Griffin's behalf. Griffin's employer, the Plan fiduciary (FKI Industries (FKI)), and its collection firm (ACS) sued Griffin, the trustee and the trust seeking reimbursement for medical benefits paid by the Plan on Griffin's behalf. The court concluded that ERISA's provision authorizing "equitable relief" would permit a restitutionary recovery or relief under a constructive trust or equitable lien theory, but did not authorize personal liability for breach of contract. Applying these principles, the court rejected the recoupment claims, reasoning that Griffin never possessed the settlement funds because they were placed directly into a special-needs trust. In doing so, the Fifth Circuit observed the possession requirement was evaluated at the time equitable relief is sought. On

application for rehearing, FKI and ACS argued that, under Supreme Court jurisprudence interpreting ERISA's equitable remedies, the Plan's reimbursement provision created an "equitable lien by agreement," which in turn supported a claim for restitution. FKI and ACS further argued this claim should be enforceable as to funds in the possession of non-participant defendants, such as the trust and the trustee, notwithstanding dissipation or commingling of those funds.

**Anti-Backloading:**

> In *McCorkle v. Bank of Am. Corp*., No. 11-1668, 2012 U.S. App. LEXIS 15346 (4th Cir. July 25, 2012), the Fourth Circuit affirmed the district court's judgment that the normal retirement age employed by the pension plan was valid under ERISA's anti-backloading provisions. Under the terms of the plan, a participant attained normal retirement age after five years of vesting service, or upon turning age 65 for participants who left the plan before five years or joined the plan after age sixty, whichever occurred first. Plaintiffs conceded before the district court that the plan's normal retirement age was "definitionally" valid under ERISA Section 1002(24), but nevertheless argued that the normal retirement age was invalid under ERISA's backloading rules. The court found plaintiffs' argument lacked merit, both because of plaintiffs' concession, and because ERISA's backloading rules only restrict benefit accrual calculations prior to normal retirement age. The court accordingly concluded that, plaintiffs could not plausibly claim that a benefit calculation *after* normal retirement age runs afoul of ERISA's backloading provisions. The court also disagreed with plaintiffs' argument that the SPD affirmatively misled participants by describing a normal retirement age different from that actually utilized by the plan, finding: (i) plaintiffs failed to show that the SPD's language differed from the terms of the plan; the SPD clearly set forth the Plan's vesting and benefit eligibility standards; and (iii) there was no authority requiring the SPD to use terms of art, such as "normal retirement age," in describing benefit accrual. Noteworthy, the court did not address plaintiffs' argument that after *CIGNA Corp. v. Amara*, 131 S. Ct. 1866 (2011), plaintiffs are not required to plead reliance or prejudice in support of their disclosure claim.

**Class Certification**:

> In *Matz v. Household Int'l Tax Reduction Inv*. *Plan*, No. 12–8010, --- F.3d ---, 2012 WL 2930183 (7th Cir. July 19, 2012), the Seventh Circuit denied the parties' cross-petitions for leave to appeal an order partially decertifying the class. In the underlying suit, plaintiffs claimed that the 401(k) plan was partially terminated, and that they were entitled to additional matching contributions, when the company was reorganized. Following the Supreme Court's decision in *Wal-Mart Stores Inc. v. Dukes*, 131 S. Ct. 2541 (2011), the district court re-examined its initial class certification and modified the class definition, eliminating 57% to 71% of the class members. Defendants argued that plaintiff's appeal should be denied because modification of an order certifying a class is not appealable under Rule 23. The Seventh Circuit disagreed, ruling that the language in Fed. R. Civ. P. 23, "permit[ting] an

appeal from an order granting or denying class-action certification," provided jurisdiction for any "order materially altering a previous order granting or denying class certification . . . even if it doesn't alter the previous order to the extent of changing a grant into a denial or a denial into a grant." Nevertheless, the court ruled, without explanation, that plaintiffs' challenge to the class modification order did not satisfy Rule 23(f)'s criteria for interlocutory appeal. The court also denied the defendants' appeal as untimely.

**Benefit Claims:**

- In *Shappie v. Minster Machine Co. Restated Non-Bargaining Employees' Retirement Plan*, 11 CV 3405, 2012 WL 2819280 (6th Cir. July 11, 2012), the Sixth Circuit affirmed a district court ruling granting summary judgment in favor of a plan on the grounds that the plan's decision not to take into account a participant's housing allowance in the participant's benefit calculation was not arbitrary and capricious. The terms of the plan stated that a participant's monthly earnings were to be included when calculating the participant's retirement benefit. The plan defined "monthly earnings," in part, as "the Participant's regular monthly rate of earnings as reported for Form W-2 purposes divided by the applicable number of months in the calendar year." Plaintiff argued that his housing allowance was included on his W-2 as a taxable fringe benefit, and thus, should be taken into account when calculating his retirement benefit as provided for by the unambiguous terms of the plan. The Sixth Circuit held that the terms of the plan were not "unambiguous," and, as such, deferred to the plan to interpret the definition of "monthly earnings." The court also found that a conflict of interest existed because the members of the plan committee making the benefit determination were also the company executives, but determined that the conflict did not result in the plan's decision being arbitrary and capricious.
- In *Walker v. Fed. Exp. Corp*., No. 11–5201, 2012 WL 285580 (6th Cir. July 11, 2012), the court determined that plaintiff's claim for life insurance benefits was not viable under ERISA § 502(a)(2) because plaintiff sought individualized relief, and not relief relating to the plan as a whole. When plaintiff's husband, Mr. Walker, worked for FedEx, the company paid his life insurance premiums. After suffering a stroke, Mr. Walker took a leave of absence, and began remitting premiums on his own behalf. Mr. Walker was terminated because his illness prevented him from returning to work. Upon termination, he had the right to convert to an individual life insurance policy. Plaintiff alleged that Mr. Walker did not receive the conversion notices, and sued for breach of fiduciary duty after the window to convert the policy expired. The court unequivocally rejected plaintiff's claims that the Supreme Court's ruling in *LaRue v. Dewolff, Boberg and Assoc., Inc*., 552 U.S. 248 (2008), allowed recovery, holding that *LaRue* is limited by its facts to permit individualized relief under Section 502(a)(2) only for fiduciary breach claims relating to defined contribution plans. Because plaintiff's claims did not concern a 401(k) plan, and were individualized in nature, the court ruled that recovery was not available under Section 502(a)(2). The court also affirmed the lower court's conclusion that ADP was not a fiduciary within the meaning

of ERISA because (i) the terms of the service provider agreement did not grant discretionary authority to ADP over the management of the plan, and (ii) ADP did not perform a fiduciary function with respect to any aspect of its involvement with the plan. Finally, the court affirmed the district court's finding that ERISA does not contain any provision that requires a plan administrator to provide notice to plan participants other than a summary plan description and information of the benefits plan as set forth in 29 U.S.C. §§ 1021(a)(1) and 1022, and therefore rejected plaintiff's argument that ERISA required defendants to notify individuals of their life insurance conversion rights.

> In *Killian v. Concert Health Plan*, No. 11-1112 (7th Cir. July 12, 2012), the Seventh Circuit granted rehearing en banc to revisit whether plan representatives have a fiduciary duty to affirmatively disclose information on the plan's out-of-network providers to a plan participant (Killian). In its April 2012 decision, the panel affirmed summary judgment in favor of the plan, concluding that a denial of benefits for out-of-network treatment could not be an abuse of discretion, even though the plan's customer-service representatives failed to inform the participant that the provider at issue was out-of-network. The court distinguished an earlier decision in a similar case, reasoning that Killian had offered no evidence that he had inquired as to the provider's status, or that an affirmative duty to disclose was otherwise triggered. In requesting rehearing, plaintiff maintained the panel's April ruling creates an intra-circuit conflict, noting the dissent's emphasis on evidence suggesting the plan's representatives should have known the participant's inquiries related to the provider's in-network status. A more detailed description of the April panel opinion in *Killian* is in the May 2012 edition of the Newsletter.

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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