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The ERISA Litigation Newsletter

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Editor's Overview

This month's Newsletter covers a trio of interesting and controversial decisions from the Court of Appeals for the Ninth Circuit and one of the district courts that sits within the Ninth Circuit. We begin with a review of the Ninth Circuit's decision that the San Francisco Health Care Security Ordinance, which requires certain employers to pay either a specified rate towards health care expenditures or make payments to the City for the benefit of their covered employees, was not preempted by ERISA.

In another decision, the Ninth Circuit concluded that participants are not required to exhaust all of their theories during the administrative claims process, at least when the plan documents do not put participants on notice that failure to assert a theory could waive it. In the words of the dissent, "the majority allows an ERISA claimant to engage in a court-sanctioned game of Texas Hold 'Em against a plan playing with all of its cards face up."

We conclude with a review of a decision from the Eastern District of California, which suggests that there may be practical limits to corporate indemnification of ERISA fiduciary breach claims when the company at issue is wholly or substantially owned by an employee stock ownership plan.

Ninth Circuit Concludes that San Francisco's "Pay or Play" Ordinance Is Not Preempted by ERISA

by Peter Marathas, Robert Rachal and Russell L. Hirschhorn

On September 30, 2008, in *Golden Gate Restaurant Ass'n v. City of San Francisco*, 2008 WL 4401387 (9th Cir. Sept. 30, 2008), the Ninth Circuit held that the San Francisco Health Care Security Ordinance ("Ordinance") was not preempted by ERISA. In so holding, the Ninth Circuit determined that the Ordinance does not "effectively mandate[ ] that employers structure their employee healthcare plans to provide a certain level of benefits" (which would render it preempted) because it offers San Francisco employers a realistic alternative to creating or altering ERISA plans.

Description of the Ordinance

The Ordinance requires covered employers with at least 100 employees to pay $1.76 per hour for full-time employees, and employers with 20 to 99 employees to pay $1.17 per hour for full-time employees, for health care expenditures, or make payments to the City for the benefit of their covered employees (the "City-payment option"). The Ordinance also imposes reporting requirements on covered employers, mandating that employers maintain "accurate records of health care expenditures" and "proof of such expenditures" and annually report required information. A failure to maintain such records results in a presumption that the employer did not make the mandatory health care expenditures. Additionally, the Ordinance imposes penalties of up to $1,000 per week per employee for noncompliance with the Ordinance's disclosure requirements. Covered employers are for-profit businesses with 20 or more employees and nonprofit businesses with 50 or more employees.

The Ninth Circuit's Decision

In upholding the validity of the Ordinance, the Ninth Circuit rejected the two principal arguments advanced by the Golden Gate Restaurant Association (the "Association") and supported by the United States Secretary of Labor, which had filed an amicus brief in support of the Association's position: first, that the City-payment option under the Ordinance creates an ERISA plan, and thus is preempted because of its direct relationship to ERISA; and second, that an employer's obligation to make payments at a certain level, whether or not the payments are made to the City, sufficiently "relates to" the ERISA plans of covered employers, and is thus preempted by ERISA. In so ruling, the court applied a presumption against preemption, which it stated applies where, as here, the Ordinance "clearly operate[d] in a field that has been traditionally occupied by the States." The court defined the field in which the Ordinance operates as the provision of health care services to persons with low or moderate incomes.

The Ordinance Did Not Create an ERISA Plan

The Association argued that an employer's payment obligations to the City resulted in administrative obligations on behalf of employers, and reasonable expectations on behalf of their employees, with respect to the arrangement, sufficient to constitute an ERISA plan. Reviewing prior cases, the Ninth Circuit observed that an employer's obligation to make monetary payments (even directly to employees) based on the amount of time worked by an employee, over and above ordinary wages, does not necessarily create an ERISA plan. Here, the Ordinance only imputes a "modicum" of discretion on employers: employers' payments were made directly to the City, employers made the payments on a regular periodic basis and calculated those payments based on the number of hours worked by the employee. An employer's sole responsibility under the Ordinance, according to the Ninth Circuit, is to make the required payments for covered employees, and to retain records of such payments. Employers have no responsibility for ensuring that the payments are actually used for that purpose. The Ninth Circuit thus appears to have concluded that the employer's administrative obligations under the Ordinance are insufficient to rise to the level of an administrative scheme sufficient to create an ERISA plan.

The Ninth Circuit also noted that the Secretary of Labor had raised the argument that the Ordinance itself constituted an ERISA plan. Acknowledging that this issue may not have been properly before the court because it was not raised below by the Association, the Ninth Circuit summarily found that the Health Access Plan created by the City's Ordinance and funded in part by employer contributions was not an ERISA plan. In so holding the Ninth Circuit noted its belief that only a "small portion" of the funding for the plan came from employers, and that the plan exists, and will continue to exist, whether or not any covered employer makes a payment to the City under the Ordinance.

The Ordinance Does Not Relate to an ERISA Plan

The Ninth Circuit concluded that the Ordinance does not have a connection with an ERISA plan because it does not require any employer to adopt an ERISA plan, and it does not require any employer to provide specific benefits through an existing ERISA plan.

Under ERISA, the U.S. Supreme Court has held that a law “relates to” to a covered employee benefit plan for purposes of ERISA’s preemption provisions if the law has a “connection with” or “reference to” an ERISA plan. In *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 115 S. Ct. 1671 (1995), and subsequent cases, the Supreme Court has held that “relate to” preemption is cabined by focusing on whether the state law at issue implicates core concerns under ERISA. The Ninth Circuit concluded that the Ordinance does not have a connection with an ERISA plan because it does not require any employer to adopt an ERISA plan, and it does not require any employer to provide specific benefits through an existing ERISA plan. The court reasoned that a covered employer may fully discharge its obligations under the Ordinance by making the required level of employee health care expenditures to either an ERISA plan or to the City. There thus was no direct mandate on an employer with respect to the establishment or maintenance of an ERISA plan. The Ninth Circuit reasoned that while a covered employer may choose to adopt or to change an ERISA plan in lieu of making the required health care expenditures to the City this does not render the ordinance related to a plan under existing Supreme Court precedent. Finally, the Ninth Circuit concluded that the Ordinance does not impose undue influence on plan administrators, reasoning the burden is on employers, not plans, to keep track of their obligations to make expenditures on behalf of covered employees and to maintain such records.

Finally, the Ninth Circuit sought to distinguish the contrary ruling of the Fourth Circuit in *Retail Industry Leaders Association v. Fielder*, 475 F.3d 180, 183 (4th Cir. 2007). In *Fielder*, Maryland enacted the so-called "Wal-Mart Law," which required employers with over 10,000 employees to spend at least 8% of their payrolls on health care expenditures, or pay the difference between what the employers spent on health care and 8% of their payrolls to the state (this law was referred to as the Wal-Mart Law because it is widely believed that Wal-Mart was the only employer in Maryland that would be subject to the law). The Fourth Circuit held that the Wal-Mart Law left the employer with no reasonable alternative, because any reasonable employer would use the money to contribute to its ERISA plan on behalf of its employees, rather than paying the money to the state as a penalty. Therefore, according to the Fourth Circuit, the statute functioned as a mandatory increase to the employer's ERISA plan. According to the Ninth Circuit, *Fielder* is distinguishable because, under the Ordinance, covered employers have a reasonable alternative: They could either amend their ERISA plans to meet the statutory minimum for health care expenditures, or they could pay the City, and the City would provide the minimum health care for the employees. The Ninth Circuit further observed that over 700 covered employers had elected the latter option.

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As states and municipalities increasingly look for creative solutions to the increasing cost of health care for the under- and uninsured, "pay or play" mandates continue to grow in popularity. The resulting impact on employers is substantial. Employers that operate in multiple states find themselves subject to conflicting state and city statutes that require them to pay varying amounts for employee benefits and/or penalties to the state or city government. Similarly, plan administrators are subjected to different state reporting requirements, creating confusion within the plan's recordkeeping procedures. One of the fundamental principles of ERISA is, of course, to create one national administrative scheme for benefits administration, and to avoid subjecting employers to multiple different requirements. For now, however, covered employers in San Francisco must comply with the Ordinance unless the Supreme Court (or the Ninth Circuit *en banc*) resolves the potential split in the federal circuits and concludes that such pay-or-play laws are preempted by ERISA. In fact, on October 21, 2008, the Association petitioned the Ninth Circuit to grant *en banc* review of the panel decision.

In addition to administrative uniformity, ERISA is designed to provide an employer "[t]he flexibility . . . to amend or eliminate its welfare plan." *Inter-Modal Rail Employees v. Atchison, Topeka & Santa Fe Railway Co.*, 520 U.S. 510, 515 (1997). *Golden Gate's* implicit assumption that states or cities can require employers to provide a certain minimum level of health benefits — either directly through an ERISA plan, or indirectly through compelled payments to the City — would thus seem to contradict this core ERISA concern, one that consistently has led to preemption in other contexts.

Ninth Circuit Rules Claimant Not Required To Exhaust Issues During ERISA Claims Review

By Brian Neulander & Robert Rachal

In *Vaught v. Scottsdale Healthcare Corp. Health Plan*, 2008 WL 4380616 (9th Cir. Sept. 29, 2008), the plan denied Vaught's claim for health benefits because the plan contained an exclusion for medical expenses related to drunk driving. Vaught had been hospitalized with serious injuries following a motorcycle accident in which it was determined that Vaught's blood alcohol level was three times the legal limit. During the administrative claims process, Vaught's attorney wrote an appeal letter, providing seven procedural grounds for further review. The claims administrator was unaware, however, that a letter had been submitted naming the attorney as the authorized representative, and thus determined (erroneously, it turned out) that the claimant had failed to timely appeal his claim denial. Thus, the plan took no further steps to review Vaught's claim other than to reiterate that the claim was denied because the plan excluded injuries related to drunk driving. Vaught filed suit in federal court, raising a new ground to challenge the denial of his benefits, i.e., that the collision, not the alcohol, was the claimed relevant "cause" of his injuries. The district court granted summary judgment to the plan, concluding that Vaught failed to exhaust his administrative remedies because the additional ground for relief had not been presented to the claims administrator.

On appeal, the Ninth Circuit observed that ERISA imposes a prudential exhaustion requirement, which forces plaintiffs to seek relief through a plan's internal review procedures before filing suit under ERISA. As an initial matter, the Ninth Circuit concluded that Vaught's appeal letter, raising seven grounds for relief, was sufficient to trigger additional internal review. The court held that the plan denied Vaught the opportunity for internal review, and thus administrative remedies were implicitly exhausted.

[T]he majority determined that a plaintiff need only establish a plan's final decision to deny benefits before bringing suit in federal court; new issues raised before a district court do "not retroactively erase [a plaintiff's] prior effective exhaustion of administrative remedies."

Next, the court considered whether Vaught could raise new issues before the district court. The court analyzed the distinction between "issue exhaustion" and "remedy exhaustion" based on the Supreme Court's ruling in *Sims v. Apfel*, 530 U.S. 103 (2000), a case involving an appeal of a Social Security Agency proceeding. Over a vigorous dissent, applying *Sims* the *Vaught* majority held that ERISA does not require "issue exhaustion." In so holding, the majority was persuaded by the fact that the summary plan description did not put participants on notice that a claimant would be barred from raising any issue not raised during the claims review. The *Vaught* majority stated that issue exhaustion may be appropriate in the ERISA claim review context, as "an analogy to the rule that appellate courts will not consider arguments not raised before trial courts," but that issue exhaustion could not be enforced without proper notice, and that the plan failed to notify participants, such as Vaught, of the requirement in this case. Therefore, the majority held plaintiffs need not exhaust all issues during a plan's administrative review of a denial of benefits. Stated another way, the majority determined that a plaintiff need only establish a plan's final decision to deny benefits before bringing suit in federal court; new issues raised before a district court do "not retroactively erase [a plaintiff's] prior effective exhaustion of administrative remedies." The Ninth Circuit remanded the case to the district court to consider Vaught's new theory and whether additional evidence should be admitted outside the administrative record.

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Although it is unclear how broad *Vaught* should be read in light of the confused administrative claims review record that led to the decision, *Vaught* risks creating an unfortunate road map for participants seeking to evade abuse of discretion review. The necessary consequence of allowing plaintiffs to "hold their cards" and raise new issues in district courts is that the district courts will be considering issues *de novo*. Another concern is that *Vaught* builds on the Ninth Circuit's recent decision in *Wilcox v. Wells Fargo and Co. Long Term Disability Plan*, 2008 WL 2873735 (9th Cir. July 23, 2008), in which the Ninth Circuit remanded a disability claim to the district court to permit a plaintiff to obtain discovery beyond the administrative record. *Vaught* implicitly affirms an expansion of the administrative record in the district court because new issues often cannot be considered absent additional information.

Vaught did suggest, however, that proper notice of the need to exhaust issues (preferably in the summary plan description, and perhaps also in claims denial letters) may change the calculus on whether to impose issue exhaustion. In light of this, a prudent practice may be to add such notice to summary plan descriptions, and possibly also to any claims denial letter.

Court Bars ESOP-Owned Company from Advancing Defense Costs of Officers Accused of ERISA Fiduciary Breach

By Robert Rachal

In *Johnson v. Couturier*, 2008 WL 4443085 (E.D. Cal. Sept. 26, 2008), a district court issued an injunction barring an employee stock ownership plan (ESOP)-owned company from advancing the costs of defense under the corporate officers' indemnification agreements with the company. The lawsuit alleged that the corporate officers had breached their ERISA fiduciary duties by engaging in a "scheme to defraud" the ESOP-owned company by paying themselves grossly excessive compensation. The court found that plaintiffs had shown a substantial likelihood of success on this claim.

On the issue of whether it was proper to enjoin the company from advancing fees . . . the court concluded that such payment would violate ERISA § 410 because of the lack of recourse if defendants were found to have breached their fiduciary duties.

On the issue of whether it was proper to enjoin the company from advancing fees (which the Department of Labor had joined as *amicus*), the court concluded that such payment would violate ERISA § 410 because of the lack of recourse if defendants were found to have breached their fiduciary duties. The court reasoned that, as a practical matter, the assets of the ESOP would be wasted if the wholly owned company were allowed to expend its funds to defend this lawsuit. As the court explained:

> If Defendants are advanced their legal expenses and judgment is rendered against them, the Court finds it highly unlikely that the ESOP, and therefore the Plaintiffs, will ever be fully compensated for the depletion of funds from the [company]. The Court is well aware that the Defendants have used up fully $5 Million in insurance funds to defend this suit. The Court has no doubt that this litigation has the potential to deplete all or most of [the company's] remaining liquid assets. The prejudice to the Plaintiffs would be immense.

The court also concluded that, even if the company's assets were not considered plan assets under ERISA, since the company was wholly owned by the ESOP, the ESOP had an equitable interest in the company's assets sufficient to support an injunction.

* * * *

ERISA § 410 has long been understood to permit indemnification of fiduciaries using corporate assets, including through the Department of Labor's guidance at 29 C.F.R. § 2509.75-4. *Johnson* illustrates, however, that there may be practical limits to corporate indemnification when the company at issue is wholly or substantially owned by an ESOP. In these circumstances, fiduciary insurance previously purchased with the defendant's or employer's funds may be the only secure source of money to defend the suit or cover any liability.

Rulings, Filings and Settlements of Interest

- In *Kennedy v. Plan Administrator for DuPont Savings and Investment Plan,* 497 F.3d 426 (2007), the Fifth Circuit concluded that because a QDRO was never submitted to the plan when the Kennedys divorced, the plaintiff did not eliminate her interest

in her ex-husband's plan benefits. The court found that requiring the plan to recognize a waiver would conflict with ERISA by purporting to determine rights to pension plan benefits in a way that was not authorized by the QDRO, and therefore was not permitted by ERISA's anti-alienation provision. The Supreme Court granted *certiorari*, No. 07-636, agreeing to decide whether a QDRO is the sole means by which a pension plan participant can assign his or her benefits in a divorce without violating the anti-alienation clause of ERISA. At oral argument, the Court questioned why the estate would want to limit its challenge to the Fifth Circuit's discussion of QDROs and ignore the plan documents rule. Under this rule, which has been adopted by many courts (and rejected by others), plan administrators are required to look only at plan documents on file in determining the rightful beneficiary of a participant's benefits. After oral argument, the Court requested additional briefing on the plan documents rule.

- In *Frulla v. CRA Holdings, Inc.*, 2008 WL 4399440 (11th Cir. Sept. 30, 2008), the Eleventh Circuit held that a retiree medical plan providing lifetime benefits could not be amended to require monthly contributions from retirees, because the contributions would have the effect of reducing or modifying vested benefits. In so holding, the court rejected defendants' argument that imposing a contribution requirement was a funding decision that does not modify or reduce benefits, and observed that "[b]ecause the level or existence of an employee contribution thus directly affects the value of the benefits received, we hold that not having to pay a contribution is a benefit of a health care plan." The court was not persuaded by the fact that both parties acknowledged in their briefs that the plan sponsor, which was no longer actively engaged in business, was unable to make contributions to the plan and therefore the plan would run out of money "sooner, rather than later" if the monthly contributions from the retirees were deemed impermissible. In another case involving a plan sponsor that amended a retiree medical plan to increase the portion of the plan's costs borne by retirees, the Northern District of Ohio in *Moore v. Rohm & Hass*, 2008 WL 449407 (N.D. Ohio Sept. 30, 2008), rejected defendants' argument that there is a distinction between the vesting of retiree health benefits and the vesting of the cost of these benefits. The court held that "[i]f retiree health benefits are vested, those benefits cannot be changed, including changes to the cost of those benefits."
- In *Leister v. Dovetail, Inc.*, 2008 WL 4659364 (7th Cir. Oct. 23, 2008), the Seventh Circuit (Posner, J.) addressed the statute of limitations and remedies applicable to a small company's failure to deposit funds into a participant's 401(k) account. The court concluded that this violation could be remedied as a claim for benefits, holding that the benefits to which the participant was entitled were the assets that would have been in her 401(k) account had the defendants complied with their

fiduciary duties. The court thus applied Illinois's 10-year statute of limitations for written contracts (not ERISA's 3- or 6- year statute of limitations for fiduciary breaches) to this claim. On estimating the investment return that would have been earned had the contributions been made, the court observed that *Donovan v. Bierwith*, 754 F.2d 1049 (2d Cir. 1985), should *not* be read to permit use of a return based on the most profitable investment allocation determined in hindsight, as this would engender a windfall; rather, the court noted an appropriate benchmark was the return made on the investment allocation actually used by the participant for the money that was in her account. Finally, the court reasoned that the tax benefits from investing in a 401(k) plan are part of the "benefits" provided by the 401(k) plan, and thus should be included in calculating the value the unpaid contributions would have had if the contributions had been paid as they should have been.

- In *Orth v. Wisconsin State Employees Union Council 24*, 2008 WL 4646051 (7th Cir. Oct. 22, 2008), the collective bargaining agreement in force when plaintiff retired required the employer to provide health insurance, with 90% of the premiums to be borne by the employer and 10% by retired employees from their sick-leave accounts. Nevertheless, the plan actually deducted 100% of the retired employees' health insurance premiums from their sick-leave accounts. The Seventh Circuit concluded that the alleged modifications by subsequent dealings were not enforceable on an ERISA plan because they were not in writing. In so holding, the court rejected several arguments by defendants, including that that there was a latent ambiguity in the contract and that the existence of a collective bargaining agreement permitted the plan terms to be modified by oral subsequent dealings among the employer and the union.

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