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Editors' Overview

We begin this month with a review of several 2009 decisions in which courts considered whether state laws that bar discretionary clauses in plan provisions governing the administration of benefit claims were preempted by ERISA. As the authors discuss below, if the trend continues and these bars are enforced, they are likely to have a considerable impact on the creation and administration of ERISA plans.

The second article this month provides an update on *Noll ESOP* litigation where, in its latest ruling, the court concluded that a nonfiduciary, nonparty-in-interest's compensation agreement could be a prohibited transaction.

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

We wish all of you a happy and healthy new year.

A Year-End Review On The Enforceability Of State Bars To Discretionary Clauses

By Russell L. Hirschhorn & Charles Seemann III

In 2009, several courts considered whether state laws that bar discretionary clauses in plan provisions governing the administration of benefit claims were preempted by the Employee Retirement Income Security Act of 1974 ("ERISA") and, if so, whether they were saved from preemption by virtue of ERISA's savings clause. This article examines these decisions, and considers the impact they may have on plan sponsors and plan fiduciaries.

Two decades ago, the U.S. Supreme Court, in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), held that reviewing courts should apply a *de novo* standard of review to plan fiduciaries' decisions unless the benefit plan provides the fiduciary with discretionary authority to determine eligibility for benefits or construe the terms of the plan — a "discretionary clause" — in which case the decision should be reviewed for an abuse of discretion, *i.e.*, under an arbitrary and capricious standard of review.

Since *Firestone*, discretionary clauses have become commonplace in ERISA plans. The frequency in which such clauses are used has, however, generated debate on whether or not they are, in fact, beneficial. On the one hand, many state insurance regulators argue that a ban on discretionary clauses eliminates unfairness and misleading policy language, and also minimizes the conflicts of interest that exist when the claims adjudicator also pays the benefit. In fact, in 2002, the National Association of Insurance Commissioners ("NAIC") adopted the "Prohibition on the Use of Discretionary Clauses Model Act" (the "Act"). The Act broadly disapproves of any proposed insurance form containing a discretionary clause, typically defined as any clause that: (i) provides an insurer with sole discretionary authority to determine eligibility for benefits under, or interpret the terms and provisions of, an insurance policy; and (ii) purports to give the insurer's determination or interpretation binding effect as to the policy holder. The prohibition has been applied to life, disability, health, and long-term care policies purchased as part of a benefits plan established and maintained under ERISA. It appears that the Act was purposefully designed to reach insured ERISA plans. In an effort to curb the use of such clauses, many states have implemented the Act's provisions in one form or another, and several insurance commissioners have unilaterally refused to approve discretionary clauses. Supporters of the use of discretionary clauses, however, contend that such clauses keep costs manageable, and that the failure to control litigation costs will discourage employers from offering employee benefit programs in the first place.

The debate over the use of discretionary clauses has, unsurprisingly, led to litigation. Plan sponsors and fiduciaries have challenged several state laws on the grounds that they are preempted by ERISA. The starting point for any ERISA preemption analysis is Section 514 of ERISA, 29 U.S.C. § 1144, which states that ERISA expressly preempts all state laws "insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). The only exception, known as the "savings clause," is for laws that "regulate insurance, banking, and securities." 29 U.S.C. § 1144(b)(2)(A).

There generally is no dispute that the state laws barring the use of discretionary clauses relate to an ERISA plan. The issue before the courts has been whether these state laws regulate insurance within the meaning of Section 514(b)(2)(A), which is determined by reference to the test set forth in *Kentucky Ass'n of Health Plans v. Miller*, 538 U.S. 329, 342 (2003). In *Miller*, the Supreme Court held that a law regulates insurance if it: (i) is "specifically directed toward entities engaged in insurance," and (ii) "substantially affect[s] the risk pooling arrangement between the insurer and the insured."

The U.S. Circuit Court of Appeals for the Sixth Circuit was the first circuit court to address the preemption issue. In *American Council of Life Insurers v. Ross*, 558 F.3d 600, 46 EB Cases 1385 (6th Cir. Mar. 18, 2009), several national trade associations (the "Industry") representing health plans, health insurers and life insurers that conduct business in Michigan sought a declaratory judgment that Michigan's ban on discretionary clauses did not apply to the administration and enforcement of ERISA plans. The Sixth Circuit concluded that a state law ban on discretionary clauses was saved from preemption. In so holding, the court rejected the Industry's argument that the Michigan ban was not directed at regulating insurance because the regulation's effects were felt primarily by plan fiduciaries, not insurers. Relying on *Miller*, the court reasoned that "regulations directed towards certain entities that also happen to disable other entities from engaging in the regulated behavior will not remove such regulations from the scope of ERISA's savings clause." Next, the court held that the Michigan ban substantially affected the risk-pooling arrangement between insureds and insurers because the ban: (i) directly dictated which policy terms were prohibited; and (ii) eliminated plan administrators' "unfettered discretion" in making benefits determinations. The Sixth Circuit also rejected the Industry's argument that the ban did not affect the risk-pooling arrangement between insureds and insurers because the ban only had an impact after the risk had been transferred (*i.e.*, the state law had no impact until after the risk already was transferred to the insured), since the Supreme Court had not inquired into the timing of the substantial effect on the risk-pooling arrangement in prior decisions. Finally, the court concluded that the Michigan ban did not create any alternative remedies to ERISA and did not conflict with ERISA's goal of establishing uniform standards for adjudicating benefits claims; there was no state law at issue that implicated ERISA's civil enforcement scheme or any rule that authorized any relief in state court.

A few months later, in *McClenahan v. Metro. Life Ins. Co.*, 621 F. Supp. 2d 1135, 46 EB Cases 2408 (D. Colo. May 7, 2009), a district court ruled that a Colorado statute that prohibited discretionary clauses was saved from preemption. Here too, the court relied on *Miller* and concluded that "enforcement of the Colorado statute would dictate 'to the insurance company the conditions under which it must pay for the risk it has assumed.'" In so ruling, the court rejected MetLife's argument that the statute conflicted with ERISA insofar as it would preclude application of the arbitrary and capricious standard of review in all Colorado ERISA cases. Relying on the Supreme Court's decision in *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002), the court concluded that ERISA itself provides nothing about the standard of review and thus the statute did not conflict with ERISA.

The Ninth Circuit, in *Standard Insurance Co. v. Morrison*, 584 F.3d 837, 47 EB Cases 2697 (9th Cir. Oct. 27, 2009), followed the reasoning of *Ross* and concluded that a Montana state law prohibiting any insurance contract from containing a discretionary clause was saved from preemption. In addition to rejecting many of the same arguments advanced by the Industry in *Ross*, the Ninth Circuit rejected Standard's argument that the ban is not specifically directed at insurers because it was nothing more than an attempt to apply the common law rule that ambiguous contract terms are interpreted against their drafters. While finding that the ban achieves some of the same ends as the common law *contra proferentem* rule, the court observed that the commissioner did not require approval of most contracts and its requirement that insurance forms be approved is an expression of its special solicitude for insurance consumers. Because Montana insureds may no longer agree to a discretionary clause in exchange for a more affordable premium, the court concluded that the scope of permissible bargains between insurers and insureds had been narrowed. In other words, the ban on discretionary clauses "dictates to the insurance company the conditions under which it must pay for the risk it has assumed."

On different facts, the Tenth Circuit reached a different conclusion in *Hancock v. Metropolitan Life Insurance Co.*, 2009 WL 5103121 (10th Cir. Dec. 29, 2009). In *Hancock*, the court concluded that Utah's rule, which authorized discretion-granting clauses as long as they disclose certain matters and conform to the rule's font requirement, was preempted by ERISA. Because the rule related to the form, and not the substance, of ERISA plans and thus did not remove the option of insurer discretion from the scope of permissible insurance bargains in ERISA plans, it had no impact on risk-pooling and was therefore not within ERISA's savings clause. On that basis, the Tenth Circuit found Utah's rule distinguishable from the state bans on discretionary clauses in *Ross* and *Standard Insurance*.[1]

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The courts' willingness to enforce state bans of discretionary clauses will increase the incentive to move to self-funded plans for employers large enough to undertake this risk. Since ERISA § 514(b)(2)(B) exempts self-insured plans from insurance regulation, a self-funded format will permit larger plan sponsors to continue using discretionary clauses as a means to control the scope of the benefits to be provided. Smaller employers may, however, be forced into an unappetizing choice of paying higher premiums or terminating employee-benefit programs they can no longer afford.

Bad Facts Making Bad Law: Courts Continue to Expand ERISA's Scope in the *Noll ESOP* Litigation

By Robert Rachal

Our **September 2009** and **November 2008** Newsletters discussed earlier rulings in the *Noll ESOP* litigation. This litigation involves exigent circumstances in which the CEO/fiduciary was alleged to have looted the ESOP by setting his compensation at $34.8 million, or two-thirds of the company's total value. In those earlier rulings the courts held that, at least under these extreme facts, the setting of executive compensation was an ERISA fiduciary function, and that the remaining company assets could not be used to indemnify the costs of defense since this payment was effectively being made from plan assets (the assets were being held in escrow to distribute to the ESOP pending the indemnification ruling).

In the latest ruling in this litigation, in *Stanton v. Couturier*, Case No. 2:09-cv-00519 (E.D. Cal. Dec. 16, 2009), the district court addressed whether a *non*-fiduciary, *non* party in interest's compensation agreement could be a prohibited transaction under ERISA. The defendant was Bruce Couturier, the brother of Claire Couturier, who was the one accused of looting the ESOP by paying himself the excessive compensation. The court agreed that Bruce was not a fiduciary or party-in-interest at the time Bruce's compensation was set. The court nonetheless held that his compensation could be a prohibited transaction because it was allegedly paid so that Bruce would support Claire in his alleged scheme to defraud the ESOP, and thus was paid to "ultimately benefit" the fiduciary, Claire.

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Under the "ultimate benefit" reasoning applied by the court, the lines defining when a person is a fiduciary or a party-in-interest are obliterated. It does not take much creativity to allege that a subordinate took actions to curry favor with his boss. Under the reasoning applied in this case, the subordinate's pay could be deemed to be a prohibited transaction if that boss is a fiduciary. There is reason to expect, however, that the rulings in the *Noll ESOP* litigationwill be limited by their extreme facts.

Rulings, Filings and Settlements of Interest

- In *In re Schering Plough Corp. ERISA Litig.*, 2009 WL 4893649 (3d Cir. Dec. 21, 2009), the Third Circuit vacated the district court's ruling granting class certification in an ERISA stock-drop litigation. In so ruling, the court made three principal findings. First, the court ruled, contrary to the district court's decision, that ERISA Section 410(a) does not prohibit parties from releasing claims for breach of fiduciary duty because that section applies only to instruments that purport to alter a fiduciary's statutory duties and responsibilities, whereas an individual release or covenant not to sue merely settles an individual dispute without altering a fiduciary's statutory duties and responsibilities. Second, the court concluded that the release plaintiff signed did not bar her from commencing an action under Section 502(a)(2) on behalf of the plan, although it may bar the plaintiff from obtaining any recovery. Third, the court ruled that, on remand, the district court should conduct a "rigorous analysis" to determine whether the release signed by plaintiff will cause her claims to be atypical of the class or cause her to be an inadequate class representative. Because the district court had concluded that the release was invalid under Section 410(a), it had not conducted this analysis.

- In*Loomis v. Exelon Corp.*, 2009 WL 4667092 (N.D. Ill. Dec. 9, 2009), a district court dismissed an excessive fee case for failure to state a plausible claim because its claims alleging nondisclosure of revenue-sharing and excessive fees were "indistinguishable" from those in *Hecker v. Deere*. Exelon's plan offered nineteen retail and wholesale investment funds with fees from 0.03% to 0.96%, whereas the plan in *Hecker* offered twenty-five retail funds with fees from 0.07% to just over 1%, as well as access to a brokerage window. Plaintiffs alleged, unlike in *Hecker*, that the funds were "far more expensive than what Defendants could have obtained for the same investment management services" and plaintiffs received no "additional benefits" from the retail fees. Observing that there was no allegation that the funds offered were "unsound or reckless," the court concluded that these allegations were insufficient to distinguish the case from *Hecker*. The court also concluded that this case provided stronger support for dismissal on the pleadings because the fees in this case were lower than those in *Hecker*.

- In *Hochstadt v. Boston Scientific Corp.*, 08 Civ. No. 12139 (D. Mass.), plaintiffs asserted various fiduciary breach claims in connection with maintaining the company stock fund as an investment fund option in the 401(k) plan. On December 1, 2009, plaintiffs submitted a motion for an order preliminarily approving a settlement that requires Boston Scientific to pay $8.2 million into a settlement fund. The proposed settlement also states that plaintiffs' attorneys' fee application will not seek more than one-third of the settlement fund.

A district court approved a $15.9 million settlement in the U.S. Sugar ESOP litigation, in which plaintiffs alleged that U.S. Sugar breached its fiduciary duties by not informing them of an offer to buy the company's stock for around $300 per share, or considering that offer in valuing the stock, while repurchasing retirees' stock at around $200 per share. *In re United States Sugar Corp. Litigation*, No. 08-80101 (S.D. Fla. Jan. 4, 2010). The settlement, in a suit that reportedly sought $150 million, calls for a payment of $8.4 million to plan participants ($5.5 million after fees and expenses), and another $7.5 million as long as U.S. Sugar sells its assets in the next two years as expected.

[1] Prior to *Hancock*, a district also held that Utah's rule was preempted because it did not substantially affect the risk-pooling arrangement between insurers and insureds. *See Lucero v. Hartford Life and Accident Ins. Co.*, 2009 WL 2170048 (D. Utah Jul. 17, 2009). In so holding, the court reasoned that risk-pooling is "the means by which insurers cover individuals of all risk levels across a variety of adverse event probabilities" and Utah's rule applied "only to the administrative function of interpreting the insurance plan's terms and judicial review of the use of that administrative function" and was unrelated to either the "risk of adverse events occurring or their potential magnitude."

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