Proskauer

The ERISA Litigation Newsletter

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Editors' Overview

This month, we feature two articles that examine the state of the law on two important areas in employee benefits. Last month, the Supreme Court issued its much anticipated decision regarding the Patient Protection and Affordable Care Act. Our lead article examines the impact of that decision on plans and plan fiduciaries, as those entities work towards compliance with the Act in the absence of significant regulatory guidance. Against that backdrop, the authors examine the risks and exposures that employers may face in adjusting their programs to the new requirements imposed by the Act. The authors also examine the litigation risks and potential causes of action that may arise in the wake of the Act's implementation.

Our second article examines deferred-compensation arrangements. Using recent judicial decisions as a guide, the author considers ERISA's relationship with deferred-compensation programs and ERISA's impact on disputes involving benefits payable under those programs. The author concludes with suggestions for employers considering such arrangements as part of their compensation programs.

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

PPACA Victory Sets The Stage For New Wave of Litigation[1]

Contributed by Howard Shapiro, James R. Napoli, Kara L. Lincoln and Brian S. Neulander

The Patient Protection and Affordable Care Act (PPACA) has largely survived its constitutional challenges, providing a degree of certainty to health care insurers, providers and consumers regarding the general coverage rules applicable to group health plans.

Although PPACA provides the general coverage mandates, uncertainty remains as to the specific rules that will govern employer-provided group health plans, because the various federal oversight agencies, such as the U.S. Department of Labor (DOL), have not yet issued those rules.

As such, plan sponsors and fiduciaries are left to implement PPACA's coverage mandates in an environment where "good faith" compliance is the standard, but where risks of litigation exist as to the manner in which the various coverage mandates are implemented and/or administered. This article explores some of these litigation risks.

Potential Causes of Action

PPACA amended several federal statutes, including the Employee Retirement Income Security Act of 1974, the Public Health Services Act (PHSA) and the Fair Labor Standards Act (FLSA). Litigation to enforce PPACA's mandates against employers, plan sponsors and fiduciaries could arise under any of these statutes.

Many of the suits challenging PPACA's coverage mandates are expected to be brought pursuant to ERISA's remedial provisions, because such mandates are incorporated into ERISA under PPACA.

Defendants are also likely to see a rise in actions brought pursuant to the FLSA. PPACA amended this statute to provide "whistleblower" protections to individuals reporting statutory violations, after filing a complaint with the U.S. Occupational Safety and Health Administration and exhausting administrative remedies.

Litigation Risks

PPACA's new coverage mandates are likely to generate both complex class actions and single-plaintiff cases. Such litigation may implicate ERISA's fiduciary duty to act for the exclusive purpose of providing benefits, plan communications regarding benefits, participants' expectations regarding the various coverage mandates and alleged cutbacks to accrued benefits, as well as alleged employment discrimination, retaliation or interference with benefits.

While it is uncertain how PPACA and its requirements will be challenged in the courts, several foreseeable examples are discussed below.

Mandated Benefits

First, participants and beneficiaries may bring various causes of action to enforce PPACA's coverage mandates. These coverage mandates include: coverage for preventive care, pre-existing conditions, and dependent children until age 26, as well as the elimination of annual and lifetime dollar limits on "essential health benefits."

It is anticipated that litigation seeking to enforce PPACA's coverage mandates will take one of two general forms; namely, claims that challenge (1) the manner in which a plan implements or administers a coverage mandate, and (2) the manner in which a coverage mandate has been communicated to participants.

For example, a participant may challenge an annual dollar limit or seek payment for an "essential health benefit," asserting that additional benefits are required by PPACA even if not provided by the governing plan's terms.

Likewise, a participant may be able to challenge a plan's grandfathered status on the grounds that the plan administrator failed to adequately communicate the plan's status. If successful, the loss of grandfathered status would subject the plan to certain additional coverage mandates, and could further subject the plan to claims for benefits pursuant to those mandates.

Work Force Realignments

Additionally, there could be litigation related to employers' work force realignments. Beginning in 2014, PPACA requires employers to provide affordable health care coverage to full-time employees or pay a penalty. For this purpose, a full-time employee is anyone who works 30 or more hours per week.

To avoid the penalty, some employers may realign their work forces with more employees working less than 30 hours per week. Any such workforce realignment inherently carries with it risks of litigation under ERISA § 510, which generally prohibits interference with a participant's benefits or other rights under ERISA.

In addition, such workforce realignments may implicate various other federal antidiscrimination statutes, e.g., the Age Discrimination in Employment Act and Title VII of the Civil Rights Act.

Retiree-Only Plans

PPACA generally does not apply to plans that cover fewer than two active employees, often referred to as "retiree-only plans." Thus, some employers have spun off retiree-only plans from plans covering both actives and retirees in order to avoid having to provide PPACA's various coverage mandates, i.e., enhanced benefits, to certain retiree populations.

There is already an extensive body of retiree-rights litigation under ERISA and the Labor Management Relations Act (LMRA), holding that retirees may not be deprived of "vested" benefits. The restructuring of existing plans to become or create new retiree-only plans is likely to follow the contours of the established ERISA and LMRA battle grounds.

Employer Use of State Exchanges

We expect litigation involving the interaction of employer-provided health benefits with the state-sponsored health insurance exchanges mandated by PPACA. Under PPACA, the exchanges must be operational by Jan. 1, 2014, to provide a set of standardized health insurance plans from which eligible individuals can purchase health insurance.

Employers may face litigation when utilizing the insurance exchanges as part of their overall benefit strategies. For example, an employer could terminate its retiree medical plan and use the insurance exchanges as a ''soft landing'' for the affected retirees. Litigation could ensue regarding the details, timing and implementation of strategies involving the exchanges.

IROs

PPACA mandates that non-grandfathered plans must provide an effective external review process by independent review organizations (IROs). Decisions by IROs are generally final, meaning that IROs may exercise discretionary authority as to the plan and could be subject to ERISA's fiduciary duties.

Thus, anticipated litigation regarding IROs could take one of two general forms: (1) challenges to a plan's implementation of the external review process, or (2) disputes over final IRO benefit determinations.

Under ERISA, courts generally defer to final benefit determinations. However, it is unclear whether that deferential standard of review could be impacted by the new external review process.

Conclusion

Although PPACA and its coverage mandates were upheld, the lack of regulatory guidance for many key areas of the statute creates uncertainty regarding implementation and enforcement.

It is clear that the future is not without risk of litigation — no matter how employers and plan fiduciaries adopt and implement the various coverage mandates under PPACA. Each situation is accompanied by its own unique risks, and many considerations should be carefully weighed to ensure well-reasoned and fully informed action — whether implementing PPACA or defending related litigation.

Treatment of Deferred Compensation Arrangements as ERISA Plans…Or Not [2]

Contributed by Michael D. Spencer

In these economic times, employers routinely explore ways to manage costs, including the costs of benefits. Deferred compensation arrangements provided pursuant to plans that employers established and maintained in a more robust economic environment may now be seen as unsustainable burdens that need to be limited or discontinued. In exploring their options, employers should first consider whether their deferred compensation arrangements fall within ERISA's coverage.

Employers should understand the consequences of a decision to modify or terminate a deferred compensation arrangement that may be governed by ERISA, since there are both positive and negative implications to ERISA coverage. Ordinarily, employers may regard deferred compensation arrangements that are not subject to ERISA as advantageous, because the employer may avoid ERISA's funding, vesting, and fiduciary requirements. With respect to arrangements limited to a select group of highly compensated employees, however, ERISA coverage may be viewed as an advantage. Such plans, known as "top-hat" plans, are exempt from ERISA's funding, vesting, and fiduciary requirements and are subject to minimal reporting and disclosure requirements. ERISA's preemption and enforcement provisions nevertheless still apply to these top-hat plans.[3] Thus, while an employer terminating top-hat plan benefits could be subject to potential common law claims under ERISA, state law claims—which could differ by state and entail more expansive remedies—would be preempted.

Recent case law on ERISA coverage for deferred compensation plans should assist employers in navigating through these complex issues and in framing strategies on how best to reduce costs for their benefit coverage without incurring undue risk of liability exposure.

Statutory and Regulatory Criteria for ERISA Coverage of Deferred Compensation Arrangements

ERISA Section 3(2) defines an employee pension plan as any plan, fund, or program established or maintained by an employer providing, by its express terms or as a result of surrounding circumstances, for retirement income or for the deferral of income to termination of employment or beyond. As this definition makes clear, the express terms of the plan may not be determinative of this inquiry if the "surrounding circumstances" demonstrate that the plan meets the criteria to be covered under ERISA.

The Department of Labor has provided interpretive guidance on the types of "surrounding circumstances" that may result in a plan being covered by ERISA. In an advisory opinion, the DOL has opined that whether a plan is governed by ERISA may depend on four general factors relevant to the "surrounding circumstances." Applying these factors, a plan will not be governed by ERISA where: (1) the manner in which deferred amounts are determined does not, in effect, allocate the economic benefits earned in a year disproportionately to retirees and participants reaching retirement age as defined under the plan; (2) the group of eligible participants who benefit from the arrangement does not consist of an inordinate percentage of employees who are or are likely to be at or near retirement age; (3) payments under the plan or arrangement are not made often enough at periods before retirement so that they do not actually serve as retirement income; and (4) the plan is not communicated to participants in a manner that causes them to act under the plan as if they were only deferring income until retirement. [4] Notably, these considerations do not address whether the plan would be tax-qualified, but simply whether the plan would be governed by ERISA.

Judicial Interpretation of What Constitutes an ERISA-Governed Plan

In addition to the statutory text, the applicable regulations and DOL guidance, courts have also attempted to explain what criteria must be met for a deferred compensation arrangement to constitute an ERISA-governed pension plan. In *Fort Halifax Co. v. Coyne*, [5] the U.S. Supreme Court held that ERISA did not preempt a state statute requiring employers to provide a one-time severance payment in the event of a mass layoff. An employer closed its plant and laid off employees without providing the required severance payments. As a result, state authorities filed suit to recover unpaid severance on behalf of the employees affected by the plant closing. The employer argued that the statute was preempted by ERISA because it concerned severance benefits, and thus constituted the regulation of an employee benefit plan. The court rejected this argument, finding that the statute neither established, nor required employers to maintain, an employee benefit plan. The court explained that a plan covered by ERISA is a commitment to pay benefits systematically, which includes ongoing administrative responsibility to determine eligibility, calculate benefit levels, and monitor funding for benefit payments. Relying on *Fort Halifax*, later court decisions have emphasized the existence of ongoing plan administration to determine whether a deferred compensation arrangement constitutes an ERISA-governed plan.

Prior to the *Fort Halifax* decision, the U.S. Court of Appeals for the Eleventh Circuit set forth a test to determine whether a plan falls within the scope and coverage of ERISA, even in the absence of a written plan document, in the seminal case of *Donovan v. Dillingham*.[6] The issue in that case was whether an employer that purchased life insurance through a group policy had established and maintained a plan that was covered by ERISA. In finding that an ERISA-governed plan existed, the Eleventh Circuit held that a plan will constitute an ERISA-covered plan if, from the surrounding circumstances, a reasonable person could ascertain the intended benefits, the beneficiaries, the source of financing, and the procedures for obtaining benefits. This standard has been widely accepted and applied by numerous circuit and district courts, along with the Supreme Court's decision in *Fort Halifax*.

Recent Cases of Interest Involving Deferred Compensation Arrangements

Depending on the particular challenge to a deferred compensation arrangement (i.e., either under state law or ERISA), employers may take different positions on ERISA's application to their arrangement. For example, in *Gabelman v. Sher*, the court held that a "Salary Continuation Agreement" that provided a former executive employee with "monthly post-retirement payments" was not an ERISA-covered plan.[7] The agreement specifically provided that the plaintiff would receive salary continuation payments for 10 years after his retirement. The defendant-employer terminated the plaintiff's employment and advised him that he would not be eligible to receive the retirement benefits as provided in the agreement. Plaintiff brought suit alleging that the defendant violated ERISA by interfering with his right to receive the contemplated benefit payments.[8] The plaintiff also asserted a contract claim under state law. The defendant moved to dismiss the ERISA claim, arguing that the compensation arrangement was not subject to ERISA.

In dismissing the plaintiff's ERISA claim, the court first noted that "the touchstone for determining the existence of an ERISA plan is whether a particular agreement creates an ongoing administrative scheme" to administer the benefits.[9] In conducting this analysis, the court applied a three-part test for determining whether an employer obligation or undertaking requires the creation of such an administrative scheme: (1) whether the employer's undertaking or obligation requires managerial discretion, (2) whether a reasonable employee would perceive an ongoing commitment by the employer to provide employee benefits, and (3) whether the employer was required to analyze the circumstances of each employee's termination separately to determine eligibility for compensation.

As to the first factor, the *Gabelman* court held that no managerial discretion was required because the payments were automatically triggered by the "one-time occurrence of specific events" explicitly set forth in the agreement. The court went on to explain that the payments were to be "doled out mechanically each month in an amount determined by `simple arithmetical calculation,' which is insufficient to show the presence of a discretionary administrative scheme."[10] The court concluded that the mere issuance of a check each month during the course of the installment-payment period was not enough to show an ongoing administrative scheme.

The court noted that the second criteria was arguably satisfied because the defendant agreed to assume a potentially long-lasting financial commitment; yet, the court also noted that the perception of such a long-term commitment was diminished by the fact that the defendant would have no responsibility other than sending checks to the plaintiff. As to the third factor, the court concluded that the agreement did not require the defendant to make an individualized analysis of the plaintiff's termination to determine his eligibility for the benefits at issue. The court found that an administrative scheme was absent because the plaintiff's eligibility for benefits was mechanically determined by objective factors. Ultimately, the court concluded that the agreement did not constitute a pension plan under ERISA, and it dismissed the plaintiff's ERISA claim. [11]

More recently, another court addressed a similar deferred compensation agreement and reached a similar conclusion. In *Mothe v. Mothe Life Ins. Co.*,[12] a widow filed a state contract claim to recover benefits under the terms of a deferred compensation agreement executed by her deceased spouse. The agreement suggested that the parties intended to provide the decedent "additional compensation for his services" in the form of "post-retirement income (or pre-retirement death benefits to his beneficiary) over and above what will be available to him" under the employer's existing pension and insurance programs.[13] The agreement further provided that the decedent would receive set monthly payments for a 10-year period following his retirement. The agreement also provided that the beneficiary designated in the decedent's will would receive these monthly payments in the event he died while employed by defendant. After the plaintiff's husband died while employed, the defendant made monthly payments to his widow, as the surviving beneficiary, but eventually ceased after 27 months.

After the payments ceased, the decedent's widow filed suit to recover the remaining amounts due under the plan. Unlike the defendant in *Gabelman*, who argued that its deferred compensation arrangement was not covered by ERISA, the defendant in *Mothe* argued that the agreement was an ERISA top-hat plan that could be unilaterally terminated and on that basis moved for summary judgment. Although the agreement clearly was intended to provide decedent with post-retirement income, the court held that this deferred compensation arrangement did not constitute an ERISA plan. Invoking the framework set out in *Donovan v. Dillingham*, the court analyzed "whether, from surrounding circumstances, a reasonable person could determine the intended benefits, beneficiaries, source of financing, and procedures for receiving benefits."[14] The court found that the agreement did not have any procedures for the administration of benefits and that it failed to constitute a plan because it did not provide enough guidance for a reasonable person to ascertain the procedures for receiving benefits, i.e., the fourth *Dillingham* factor. Consequently, the court found that the plaintiff's state law claims were not preempted by ERISA and she was allowed to continue her pursuit of state law claims.

Proskauer's Perspective

There are arguments counseling for and against wanting deferred compensation plans being governed by ERISA. In many instances, an employer may argue that its deferred compensation arrangement is not governed by ERISA in order to avoid potential compliance costs and fiduciary liability.

However, there may be instances in which ERISA's coverage may be advantageous for an employer—for instance, to invoke ERISA's preemption provisions to avoid claims based on state law. Although the employer may still face claims under ERISA, those claims (and the corresponding remedies) should be uniform throughout the country.

Thus, when an employer has multistate operations, preemption would at least diminish the risk of being subject to different requirements and claims in different states. In other contexts, avoiding ERISA may prove to be more advantageous, as was the case in *Gabelman* when the employer was able to avoid exposure to a claim for unlawful interference with ERISA rights.

Whether the objective is to be governed by ERISA or not, it is important for employers to consider, in advance of litigation, whether their plan in fact satisfies the criteria for being governed by ERISA. The recent case law discussed in this article, and the underlying statutory and regulatory rules, provides useful guidance for making that assessment.

Rulings, Filings, and Settlements of Interest

Petition for *Certiorari* Granted:

- In *U.S. Airways Inc. v. McCutchen,* U.S., No.11-1285, *cert. granted* (June 25, 2012), the U.S. Supreme Court granted U.S. Airways' petition for certiorari, deciding to revisit the issue of what constitutes "equitable relief" under Section 502(a)(3) under ERISA. This case arises out of the Third Circuit, which ruled that a health plan sponsored by U.S. Airways could not seek reimbursement from a plan participant who reached a settlement in his personal injury case because it was not a form of "appropriate equitable relief" under ERISA. U.S. Airways argued that this Third Circuit decision departed from decisions in several other circuits, creating a conflict among the circuits as to the meaning of "appropriate equitable relief." A more detailed description of the Third Circuit's decision is available in the December 2011 edition of the Newsletter.

Subrogation:

- In *CGI Technologies & Solutions Inc. v. Rose*, 11-35127-cv, --- F.3d ----, 2012 WL 2334230 (9th Cir. June 20, 2012), the Ninth Circuit ruled that ERISA plans cannot exempt themselves from paying attorneys' fees and costs relating to a participants' personal-injury action when seeking reimbursement for medical expenses the plan paid to a participant. The plan language expressly provided the plan with: (i) the right to reimbursement for medical expenses if the participant recovers funds from a third-party tortfeasor; (ii) an exemption from any responsibility for attorneys' fees paid in connection with any tort recovery by the participant; and (iii) the right to full reimbursement irrespective of whether the participant was made whole. As to the fee issue, the Court held that, even though the plan document clearly provided that the plan would not be responsible for the participant's attorneys' fees (*i.e.*, from the tort action), the plan's equitable lien placed on the fees being held in trust by the attorney was unenforceable because the participant's attorney was a "nonsignatory" to the plan. The Court also remanded for further consideration of whether the plan could enforce plan terms providing it full reimbursement, notwithstanding equitable defenses, when the participant had not been made whole by her tort recovery.

Claims for Benefits:

- In *Spradley v. Owens-Illinois Hourly Employees Welfare Benefit Plan,* --- F.3d ----, No. 10-7100, 2012 WL 1959553 (10th Cir. June 1, 2012), the Tenth Circuit affirmed the district court's decision that that the plan administrator's denial of disability benefits was an abuse of discretion because it relied on an inapplicable SPD section regarding health, not disability, benefits. The court refused to consider the administrator's post hoc interpretation of plan terms to deny benefits. Defendant argued that the court should overturn the district court's decision because it failed to apply the appropriate deference to the plan administrator's interpretation of the plan's life insurance coverage provisions. The court disagreed, finding that the district court was not required to defer (and should have not deferred) to defendant's after-the-fact interpretation, which it relied upon only after plaintiff filed his claim, because such interpretation was not a basis upon which the plan administrator relied in its administrative denial of benefits. Having rejected the sole basis upon which the plan administrator grounded its denial of plaintiff's claim during the administrative process, the court remanded the case with directions for the district court to enter judgment in favor of the plaintiff.

- In *Koehler v. Aetna Health Inc*., --- F.3d ----, No. 11-10458, 2012 WL 1949166 (5th Cir. May 31, 2012), the Fifth Circuit reversed the summary-judgment dismissal of a health plan participant's claim for healthcare benefits. The court held that it could not find that, as a matter of law, Aetna did not abuse its discretion in denying coverage because the plan was ambiguous and the need for pre-authorization was not clearly stated in the summary plan description. In so ruling, the court explained that Aetna's discretion to resolve ambiguities in the plan did not extend to the summary plan description, as ambiguities in a summary plan description are resolved in favor of the beneficiary. The court noted that a plan's terms are controlling, but courts may "look outside the plan's written language," such as to the summary plan description, "in deciding what those terms are." Also, ambiguous plan language should be given a meaning as close to the summary plan description as possible, considering the applicable statutes and regulations, including ERISA's requirement that summary plan descriptions must adequately disclose "restrictive plan provisions" such as pre-authorization requirements. The court also noted that Aetna's inadequate disclosure of the pre-authorization requirement was evidence of bad faith, and that the participant's administrative remedies should likely be deemed exhausted if the pre-authorization requirement was not known to the participant or her doctors, explaining that administrative remedies are deemed exhausted if a plan's claims procedures "unduly inhibit[] or hamper the initiation of claims for benefits." Thus, the court remanded the case to the district court to determine whether the plan administrator abused its discretion in denying coverage for the out-of-network treatment, and whether the claim should be remanded to the plan administrator for exhaustion of administrative remedies.

Employer Stock:

- In *Taylor v. KeyCorp*, 680 F.3d 609 (6th Cir. 2012), the Sixth Circuit affirmed dismissal of a purported class action, agreeing with the district court that the plaintiff lacked Article III standing because she benefited from the sale of the allegedly artificially inflated company stock. The court held that the plaintiff had no "injury in fact" because she sold her stock for more than it was worth, thereby benefiting from defendants' alleged breach of fiduciary duty. In so holding, the court found that an inflated purchase price will not itself constitute economic loss. Instead, the stock must be purchased at an inflated price and sold at a loss for an economic injury to occur. The court also held that plaintiff's gains and losses during the class period must be netted to determine whether she suffered actual injury, and that the appropriate measure of damages is out-of-pocket loss – the difference between the investment as taken and the investment as it would have been if not tainted by withheld information. The court rejected plaintiff's position that her injury should be measured against what she would have earned in an alternative investment, and the DOL's position that plaintiff suffered an "out-of-pocket" loss because some of her stock was sold at a loss. The court did not consider the DOL's argument that the plaintiff could have standing to pursue her fiduciary breach claims, even in the absence of injury, simply because defendants breached duties owed to her under ERISA, as the argument was not raised by the parties in their appellate briefs.

Fiduciary Litigation:

- In *McLemore v. Regions Bank*, Nos. 682 F.3d 414 (6th Cir. 2012), the Sixth Circuit held that a bank, which was alleged to have negligently or knowingly allowed a third-party administrator (TPA) of employee benefit plans to steal from plan accounts held by the bank, was not liable as a fiduciary under ERISA and that ERISA preempted the related state law claims. The TPA for various employee benefit plans was convicted of stealing more than $19 million dollars from plans serviced by the TPA. The TPA went into bankruptcy, and the bankruptcy trustee and plan participants brought suit against the bank where the accounts were held, alleging that the bank had advised the TPA to structure the accounts in such a way as to facilitate the fraud. After finding that the bankruptcy trustee had standing to bring claims against the bank, the district court granted the bank's motion to dismiss, finding that the bank did not qualify as a fiduciary under ERISA and that ERISA preempted related state law claims. The Sixth Circuit affirmed the district court's judgment in all aspects, first finding that the bankruptcy trustee had standing to bring suit as a fiduciary because it had sufficiently pleaded its authority to manage or dispose of the assets belonging to the plans. Next, the court concluded that the bank did not qualify as a fiduciary under ERISA because it merely held plan funds

on deposit, and did not exercise unilateral control over the assets of the plans. Finally, the Sixth Circuit held that the related state law claims were preempted by ERISA because the bank's liability turned on the existence of the plans and the substance of ERISA. One judge dissented, arguing that the ERISA preemption clause is so broad and lacking in specific meaning and application that the court was acting "basically as a common law court in creating [the preemption clause's] meaning in individual cases."

Settlements:

- In *In re Schering-Plough Corp. Enhance ERISA Litig.*, No. 2:08-cv-01432, 2012 WL 1964451 (D.N.J. May 31, 2012), the court approved a $12.25 million settlement to resolve allegations that defendants breached their fiduciary duties by continuing to hold company stock in the 401(k) plan knowing that the company faced "dire circumstances." Specifically, plaintiffs claimed that defendants failed to properly disclose problems with Vytorin – a cholesterol drug – resulting in artificial inflation to the company's stock. When unfavorable Vytorin laboratory reports were disclosed to the market, the company's stock dropped 55%, resulting in the loss of millions of dollars in retirement savings. In light of the attendant risks of litigation, and the fact that no class member filed objections to the settlement, the court ruled that the proposed settlement class satisfied the requirements for certification, and that the settlement agreement was fair, adequate, and reasonable. Because the proposed settlement was deemed to be in the best interests of both parties, the court granted final approval.

- In *Beaty v. Continental Automotive Systems, U.S. Inc.*, No. 11-S-890-NE, 2012 WL 1886134 (N.D. Ala. May 21, 2012), the district court approved a final class settlement providing $23.8 million to finance retiree healthcare benefits for a class of retired workers. Chrysler (which operated the facility prior to defendant Continental) agreed to provide retirees at a Huntsville, Alabama facility with medical benefits pursuant to a collective bargaining agreement (CBA) with the UAW. Siemens acquired the plant from Chrysler, after agreeing that it would provide UAW employees (and retirees) with benefits that "mirrored" those under the prior UAW-Chrysler CBA. Continental acquired the facility in 2007, assuming Siemens' contractual responsibilities. However, Continental asserted it had no obligation to continue the retiree-medical benefits furnished by its predecessors. The parties reached a settlement after separate suits were filed by the union and a class of affected retirees. The settlement agreement provided that Continental will pay $23.8 million to finance retiree healthcare benefits in three separate payments and will have no further obligation to provide retiree medical coverage to the class or to administer the payments of the funds. The court approved the settlement,

noting that the parties' negotiations had provided them with a meaningful basis for settling, and further, noting that all parties faced the risk of adverse judgment

[1] This article originally appeared in *Law360* as an "Expert Analysis" column on July 6, 2012.

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

[3] Top-hat plans are generally subject to the requirements of Section 409A of the Internal Revenue Code, which governs elections and distributions with respect to nonqualified deferred compensation plans. All nonqualified deferred compensation benefit plans, including supplemental or excess benefit plans limited to a select group of highly compensated executives, should be reviewed for Section 409A compliance.

[4] Advisory Opinion 98-02A (March 6, 1998).

[5] 482 U.S. 1 (1987).

[6] 688 F.2d 1367 (11th Cir. 1982) (en banc).

[7] No. 11-CV-2718, 2012 WL 1004872 at *1 (E.D.N.Y Mar. 23, 2012).

[8] ERISA Section 510 (29 U.S.C. §1140) prohibits an employer from, among other things, discriminating against or interfering with a participant's right to recover benefits under a plan.

[9] *Gabelman*, 2012 WL 1004872 at *3.

[10] *Gabelman*, 2012 WL 1004872 at *4.

[11] The court also declined to exercise jurisdiction over the plaintiff's state law claim.

[12] No. 10-cv-02008, 2012 WL 1565290 at *1 (E.D. La. Apr. 30, 2012).

[13] *Id.* at *4.

[14] *Mothe*, 2012 WL 1565290 at *3. In a prior decision in the case, the court noted that the U.S. Court of Appeals for the Fifth Circuit adopted the analytical approach from *Donovan v. Dillingham. See Mothe v. Mothe Life Ins. Co.*, No. 10-cv-02008, 2011 WL 1113284 at **1-2 (E.D. La. Mar. 23, 2011).

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