Proskauer

The ERISA Litigation Newsletter

June 2012

Editors' Overview

This month, we feature two articles that examine the state of the law on two important areas of ERISA litigation – contractual vesting of retiree medical claims and the exhaustion requirement. First, we examine the evolution of the Sixth Circuit's "inference," as articulated in *Auto Workers v. Yard-Man, Inc.*, that an employer intended to provide retirees with lifetime benefits unless the language of the collective bargaining agreement provides otherwise. The case law over the past several years suggests a desire by at least some judges in the Sixth Circuit to find ways to pare back the application of this inference.

Next, we discuss how the Supreme Court's decision in *Conkright v. Frommert* may provide a basis for moving the law in a helpful direction for plans seeking to rely on the exhaustion defense. Although courts have universally embraced the requirement that a participant must exhaust his or her administrative remedies prior to bringing suit for benefit claims, they are divided with respect to its application to statutory claims under ERISA. Courts also are divided on whether or not the defense of failure to exhaust administrative remedies can be addressed on a motion to dismiss. The *Frommert* ruling indirectly supports a more aggressive approach to exhaustion on both points since exhaustion enables a plan administrator to create an administrative record and issue a determination to which a court can defer.

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

Retiree Benefits Litigation: A New Look at *Yard-Man*[1]

Contributed by Amy R. Covert & Lata P. Nott

Everyone knows that the cost of providing medical coverage for employees is an expensive proposition and the cost of providing retiree medical benefits is an extremely expensive proposition. As a result, many employers who had at one time offered their employees lifetime medical benefits have implemented various steps to cut back or eliminate these benefits. This has led to a virtual tsunami of retiree rights litigation. Many of these cases are brought by unionized employees because of the interplay between the language in the plan documents (governed by the Employee Retirement Income Security Act), and the language of the collective bargaining agreements (governed by the Labor Management Relations Act).

For employers operating in multiple jurisdictions, disputes over the employer's right to alter the benefits of union retirees often have been less about the relative merits of the legal positions of the parties than about which circuit's precedents would control. In most circuits, the courts overwhelmingly hold that there is no right to vested lifetime benefits unless the language of the collective bargaining agreement manifests a clear intent that they be nonforfeitable. The Sixth Circuit, however, has applied an "inference," sometimes referred to as a "presumption," that the employer intended to provide retirees with lifetime benefits unless the language of the collective bargaining agreement provides otherwise. Defending decisions to modify, cut back or eliminate retiree coverage for union retirees has been perceived to be most difficult for employers subject to the jurisdiction of the Sixth Circuit, as well as in a couple of other jurisdictions that have applied this presumption as well.

Over the past several years, however, the Sixth Circuit appears to have exhibited a change in approach that looks more favorably to employers defending these claims. At least some judges in the Sixth Circuit appear to be uncomfortable with existing precedent and to be looking for ways to pare back its application. If the trend continues, the disparity in rulings among the circuits in the retiree benefits arena may eventually yield to a more uniform approach, and the need for strategic jockeying for the "right" forum may be markedly diminished.

The "*Yard-Man*" Story – Where It All Began

The perceived divide between the law governing retiree benefits cases in the Sixth Circuit and elsewhere emanates from the Sixth Circuit's decision nearly thirty years ago in *Auto Workers v. Yard-Man, Inc.*,[2] one of the earliest decisions to consider collectively-bargained retiree medical benefits. The facts of *Yard-Man* are common enough: The company told the union that it was shutting down a factory and would end the payment of retiree medical benefits on the last day of the collective bargaining agreement. The union sued, claiming that the retiree medical benefits were lifetime benefits that could not be terminated. The company responded that retiree benefits did not outlive the termination of the union contract. The key provisions of the contract stated that "[w]hen the former employee has obtained the age of 65 years then…[t]he [c]ompany will provide insurance benefits equal to the active group benefits…for the former employee and his spouse." The Sixth Circuit found this language ambiguous as to whether or not it established a durational limitation of the benefits. Due to this ambiguity, the court stated that to determine "whether retiree insurance benefits continue beyond the expiration of the collective bargaining agreement depends upon the intent of the parties."

The court ultimately decided in favor of the union, holding that the retiree medical benefits were intended to outlive the collective bargaining agreement. In support of its conclusion, the court reasoned that

[b]enefits for retirees are only permissive not mandatory subjects of collective bargaining. . . As such, it is unlikely that such benefits, which are typically understood as a form of delayed compensation or reward for past services, would be left to the contingencies of future negotiations. . . . The employees are presumably aware that the union owes no obligation to bargain for continued benefits for retirees. If they forego wages now in expectation of retiree benefits, they would want assurance that once they retire they will continue to receive such benefits regardless of the bargain reached in subsequent agreements. Contrary to [the company's] assertions, the finding of an intent to create interminable rights to retiree insurance benefits in the absence of explicit language, is not, in any discernible way, inconsistent with federal labor law.[3]

Based on this reasoning, the Sixth Circuit pronounced what was subsequently perceived as a "rule" governing the adjudication of retiree benefits claims in that circuit:

Retiree benefits are in a sense "status" benefits which, as such, carry with them an inference that they continue so long as the prerequisite status is maintained. Thus, when the parties contract for benefits which accrue upon achievement of retiree status, there is an inference that the parties likely inferred those benefits to continue as long as the beneficiary remains a retiree.[4]

The Sixth Circuit's determination that an intent to vest union retiree benefits could be inferred when the ERISA plan document or collective bargaining agreement is ambiguous is commonly known as the "*Yard-Man* inference."

The Apparent Erosion of the *Yard-Man* Inference in the Sixth Circuit

For many years, the outcome of retiree benefits cases was perceived to be largely affected by whether the *Yard-Man* inference was applied. In addition to the Sixth Circuit, the inference was adopted by the Eleventh Circuit[5] and adopted in a more limited fashion by at least one other circuit.[6] Most other circuits have rejected application of the inference.[7] Recent rulings in the Sixth Circuit suggest, however, that the distinctions in the adjudication of retiree benefit cases among courts adopting and rejecting the *Yard-Man* inference may not be as pronounced as originally perceived.

There have been a number of rulings in the Sixth Circuit in recent years that, without purporting to overturn *Yard-Man*, significantly narrow its scope and application, and perhaps even undermine its premise and rationale. These cases fall into two different categories: those that limit the circumstances and the manner in which the *Yard-Man* inference applies in the first place, and those that limit the scope of the lifetime medical benefits to which union retirees are entitled where retiree benefits are determined to have vested under the *Yard-Man* standard.

Limits on the Applicability of the *Yard-Man* Inference

In recent years, the Sixth Circuit has taken care to draw strict boundaries concerning the type of cases to which the *Yard-Man* inference will apply. To start with, the Sixth Circuit has established that the *Yard-Man* inference does not apply outside of the context of retiree health benefits. In *Price v. Board of Trustees Indiana Laborer's Pension Fund*,[8] for example, the court declined to apply the *Yard-Man* inference to occupational disability benefits. Even with respect to retiree health benefits, moreover, the court has held that the inference only applies to individuals who have actually achieved retiree status by the time an employer attempts to modify the retiree benefits.[9]

Of greater significance has been the Court's recent instructions as to the limited impact of the inference in resolving disputes over contractual intent. The court already had cautioned some time ago that "[t]here is no legal presumption that benefits vest and that the burden of proof rests on plaintiffs,"[10] and that the *Yard-Man* inference is irrelevant where the collective bargaining agreement or plan documents expressly address the duration of retiree health benefits.[11] More recently, however, it went much farther in limiting the application of the rule in *Yolton v. El Paso.*[12] Although the court ultimately ruled in *Yolton* in the employees' favor on their claim for retiree benefits, it clarified that the *Yard-Man* rule in no way alters the normal rules of contract construction. The court stated in relevant part:

Under *Yard-Man* we may infer an intent to vest from the context and already sufficient evidence of such intent. Absent such other evidence, we do not start our analysis presuming anything. . . . This Court has never inferred an intent to vest benefits in the absence of either explicit contractual language or extrinsic evidence indicating such an intent. Rather, the inference functions more to provide a contextual understanding about the nature of labor-management negotiations over retirement benefits. . . . When other contextual factors so indicate, Yard-*Man* simply provides another inference of intent. All that *Yard-Man* and subsequent cases instruct is that the Court should apply ordinary principles of contract interpretation.[13]

Read literally, the court's analysis could call into question a generation of perceived conflict between the state of the law in the Sixth Circuit and elsewhere over retiree benefit claims. If *Yard-Man* did not alter the "ordinary principles of contract interpretation," and independent evidence of contractual vesting is needed to sustain a claim for retiree benefits, then what was all the fuss about?

Limits on the Impact of a Finding of Contractual Vesting

In addition to limiting the applicability of *Yard-Man*, the Sixth Circuit has significantly limited its impact by holding that even "lifetime" retiree medical benefits are not necessarily limitless or inalterable.

In *Reese v. CNH America,* ***[14]*** the court held that even "lifetime" benefits could be altered by the employer in the context of subsequently negotiated collective bargaining provisions. In that case, the court explained that it was effectively bound by the conclusion that the plaintiffs had contractually vested rights to retiree benefits under the *Yard-Man* inference, because the collective bargaining agreement at issue was nearly identical to the agreement addressed in *Yolton*, in which the court similarly found for the employees.[15] The Court significantly limited the application of the inference, however, noting that "nothing in the text of the [collective bargaining agreement] said that health-care coverage would be fixed and irreducible for all employees who retired under it."[16] The court significantly downplayed the importance of the *Yard-Man* inference, describing "[t]he precise weight of the *Yard-Man* 'inference [as] elusive" and "insufficient to find an intent to create interminable benefits."[17] The court further explained that "[i]n the end, [the *Yard-Man* inference] may come to nothing more than this: a nudge in favor of vesting in close cases."[18] The Sixth Circuit recently echoed this view in *Tackett v. M & G Polymers USA*,[19] relying on *Reese* in support of its holding that modifications and changes in benefits are permissible even for contribution-free lifetime benefits.

In other contexts, the Sixth Circuit similarly has found that the *Yard-Man* inference does not grant retirees limitless benefits. In *Wood v. Detroit Diesel*,[20] for example, the company and the union had entered into a series of agreements purporting to cap the company's contributions to retiree health care benefits for workers who retired between 1993 and 2004. The company did not renew the capping agreements in a subsequent bargaining cycle. Although the court held that the *Yard-Man* inference applied, thereby vesting retiree healthcare benefits at the point of retirement, the court also concluded that the agreed upon caps should continue to apply to the retirees, because "the only coherent reading of the Cap Agreements establishes that [the company] retirees are entitled to lifetime, capped health care benefits. For a [company] employee who retired in a given year under one of the Cap Agreements, the cap amount applicable to that year both determined and limited the extent of [the company's] vested obligations to that retiree."[21]

The View from Proskauer

Given the numerous outcomes in the Sixth Circuit over the years favoring unionized employees in suits seeking lifetime retiree benefits, one cannot quarrel with employer counsel who seek to avoid adjudicating such claims in the Sixth Circuit. Insofar as the disparity in outcomes in the Sixth Circuit and elsewhere purport to emanate from the *Yard-Man* standard, however, it behooves employers and their counsel to take note of the significant evolution in the Sixth Circuit's articulation of that standard and its underlying rationale.

Whether or not the Sixth Circuit intended it all along, it now appears to be saying merely that, in determining how to construe an ambiguous collective bargaining agreement, a court should take note of the surrounding circumstances in which collective bargaining agreements are negotiated in evaluating a claim for vested retiree benefits – including the fact that retiree benefits are not mandatory subjects of bargaining. If the Court is to be believed, these considerations do not, in the absence of other extrinsic evidence, support a finding of contractual vesting, and do not negate the impact of extrinsic evidence favoring a finding that there was no contractual vesting.

Furthermore, the Sixth Circuit, like other courts, appears willing to make practical judgments as to the impact of a finding that employees are contractually vested in benefits. Some of the rulings cited certainly provide some hope that the Court will not conclude that "vesting" translates into an inflexible lock-in of benefits that will necessarily bankrupt employers as retiree benefits continue to rise.

Whether or not these developments will one day result in lessened concerns by employers about litigating retiree benefit claims in the Sixth Circuit remains to be seen. But at a minimum, they ought to provide employers with some basis to believe that, on the strength of favorable contractual or extrinsic evidence, they can present a defense in the Sixth Circuit with a reasonable prospect of success. This in turn ought to affect the evaluation of the relative merits of bringing declaratory judgment suits in other jurisdictions in advance of anticipated claims by employees and their unions in the Sixth Circuit, a strategy that has its own complexities and considerations.

One thing is certain: contractual vesting claims will continue to pose a substantial risk to employers seeking to cut back on retiree benefits, particularly in the collective bargaining arena. Therefore, well before devising their litigation strategy, employers should do their best when negotiating collective bargaining agreements to protect their rights to reduce or eliminate these benefits.

Deference and Exhaustion: A Contemporary Look in Light of Recent Supreme Court Pronouncements[22]

Contributed by Bridgit M. DePietto

The judicially created requirement of exhaustion of administrative claims has served as a valuable tool for plans and plan fiduciaries defending ERISA cases. The exhaustion requirement tends to limit the scope of court proceedings, while increasing the likelihood that a court will defer to the reasonable determination of the plan administrator.

Although courts have universally embraced the exhaustion requirement for benefit claims, they are divided with respect to its application to statutory claims under ERISA. The courts are also divided on whether or not the defense of failure to exhaust administrative remedies can be addressed on a motion to dismiss.

The U.S. Supreme Court's decision in *Conkright v. Frommert*, 130 S. Ct. 1640 (2010), may provide a basis for moving the law in a helpful direction for plans seeking to rely on the exhaustion defense. In *Frommert,* the Supreme Court held that ERISA's "interests in efficiency, predictability, and uniformity" are best served and protected by requiring judicial deference without "ad hoc exceptions." The ruling indirectly supports a more aggressive approach to exhaustion since exhaustion enables a plan administrator to create an administrative record and issue a determination to which a court can defer. Thus, plans defending both benefit and statutory claims should consider the best use that can be made of the *Frommert* decision and its underlying rationale when advancing the exhaustion defense.

Principles Underlying the Exhaustion Doctrine

The exhaustion requirement is premised on ERISA's regulations,[23] which mandate that benefit plans establish and maintain an internal review procedure for plan participants that governs the filing of benefit claims, notification of benefit determinations, and appeal of adverse benefit determinations. As most courts have recognized, the exhaustion requirement gives plan administrators the first opportunity to apply their expertise to interpret plan documents, to reconsider initial decisions and correct mistakes, to collect facts, and to explain the rationale underlying the administrative decision before a claimant seeks court intervention. Exhaustion may render judicial review unnecessary because the plan's remedial procedures will resolve many claims. If the claims are not resolved, exhaustion enables the plan administrator to assemble a factual record that will assist a court in reviewing the plan administrator's decision. Conversely, allowing a participant's ERISA claim to proceed without exhaustion deprives the plan administrator of the right to deferential review of the plan's determination.

When is Exhaustion Required?

All courts agree that claims for benefits under ERISA Section 502(a)(1)(B) are subject to the exhaustion requirement where the plan at issue mandates exhaustion.[24] There is substantial disagreement, however, as to the role of exhaustion in statutory claims.

Currently, the U.S. Court of Appeals for the Third, Fourth, Fifth, Sixth, Ninth, and Tenth Circuits hold that the administrative exhaustion requirement does not apply to claims alleging a violation of ERISA itself, such as a claims for statutory notice violations, fiduciary breach claims, or claims for unlawful interference with ERISA rights.[25] The Seventh and Eleventh Circuits do not distinguish between statutory and plan-based ERISA claims, and instead require participants to exhaust their administrative remedies as a condition to bringing a claim in federal court, regardless of the nature of the claim.[26] The Second Circuit has acknowledged that the question of whether exhaustion is required for statutory claims remains open in that circuit.[27] "However, district courts within the [Second C]ircuit have drawn a distinction between claims relating to violations of the terms of a benefit plan, and claims relating to statutory violations of ERISA, finding that the former, but not the latter, claims must be administratively exhausted."[28] The First Circuit has not addressed this issue, and the district courts in that circuit are split.[29]

Exhaustion Defense Should Be Addressed Early

For claims to which the exhaustion doctrine applies failure to exhaust can be an effective defense if raised early in the litigation. If a defendant can prevail on this defense at the motion to dismiss stage, it may succeed in achieving the many goals of exhaustion, such as judicial efficiency and the right to deferential review of the plan administrator's determination. The courts are not of one view, however, as to whether this defense is available at the motion to dismiss stage.

Some courts will dismiss actions at the pleadings stage on the grounds that the claimant failed to exhaust the plan's administrative remedies.[30] Other courts, however, seem reluctant to consider exhaustion at the early stages of litigation. For the most part, this is because the failure to exhaust administrative remedies is an affirmative defense, and the burden is on the defendant to demonstrate that a plaintiff failed to exhaust the administrative remedies under the plan.[31] Some courts have stated that a district court should grant a Rule 12(b)(6) motion based on an affirmative defense only if the facts establishing that defense are definitively ascertainable from the complaint and other sources of information that can be considered on a motion to dismiss.[32] In many jurisdictions, therefore, plaintiffs can avoid a motion to dismiss simply by remaining silent with regard to whether they exhausted the administrative remedies under the plan.

If the plan is unable or unsuccessful in getting an unexhausted claim dismissed at the pleadings stage, the plan may be left with no alternative other than to complete discovery and present the issue on a motion for summary judgment. By this time many of the benefits of the exhaustion doctrine – creating an administrative record, deference to the plan administrator, and averting costly and time-consuming litigation of the merits – may effectively be undermined.

Potential Impact of *Frommert*

In *Frommert*, the Supreme Court held that, in determining an appropriate remedy for a violation of ERISA, a district court should defer to the determination of an administrator with discretionary authority to interpret a plan. The *Frommert* case was initiated by a group of retirement plan participants who left their employment, received lump-sum distributions of the retirement benefits they had earned up to that point, and were later rehired by the employer. The employees challenged the plan administrator's use of a "phantom account" method to account for their past distributions when calculating their current benefits, pursuant to which an income component was added to the benefits previously distributed. After the plan administrator denied the participants' administrative claim, they filed suit under ERISA Section 502(a)(1)(B). The district court granted summary judgment for the plan, applying a deferential standard of review to the plan administrator's interpretation. The Second Circuit, however, vacated and remanded, holding that the plan administrator's interpretation was unreasonable and that the participants had not been adequately notified that the phantom account method would be used to calculate their benefits.

On remand, the plan administrator and participants submitted different proposals to the district court as to how the court should adjust the participants' benefits. The district court refused to apply a deferential standard of review to the plan administrator's suggested approach, and instead, after finding the plan to be ambiguous, adopted an approach proposed by the participants. The Second Circuit affirmed in relevant part, holding that a court need not apply a deferential standard "where the administrator ha[s] previously construed the same [plan] terms and we found such a construction to have violated ERISA."

The Supreme Court reversed and remanded, holding that a "single honest mistake in plan interpretation" does not justify stripping a plan administrator ofdeference for subsequent related interpretations of the plan. The Court explained that adherence to the deference rule protects and promotes "efficiency, predictability, and uniformity," factors that keep administrative and litigation expenses in check and induces employers to offer ERISA benefit plans. The Court observed that, with the benefit of a deferential standard of review, the case would have been concluded more efficiently, without the need for the district court to interpret the plan itself.

Although the circumstances leading to the Supreme Court's ruling in *Frommert* were unique, the Court's broad endorsement of the concept of deferring to plan administrative determinations has potentially broad ramifications in connection with the exhaustion defense. First, the fact that the Court deferred to the plan administrator even in the aftermath of a statutory violation may cause some courts to reexamine their previous rulings that exhaustion of statutory claims is not required. At a minimum, the decision indicates that, sooner or later, the plan administrator must be heard before a court can impose relief for an alleged statutory violation. Secondly, the recognition that deference promotes efficiency in the judicial process could increase the likelihood for courts to evaluate the exhaustion defense at the earliest stages of litigation.

Proskauer's Prospective

The current law on exhaustion has not caught up to the Supreme Court's broad endorsement of deference principles in *Frommert*. In those jurisdictions that have been unwilling to address the exhaustion defense on a motion to dismiss, or to apply the defense to statutory violation claims, defense counsel should cite *Frommert,* and other authorities applying the decision, in an effort to persuade the court to reconsider its position. They should argue that the deference mandated by the Supreme Court, both for claims for benefits and for statutory claims, is meaningless absent a complete administrative record, which will be available only if a plan participant is required to administratively exhaust his or her claims before proceeding to court.

Additionally, defense counsel should consider how best to make use of *Frommert's* requirement of administrative deference in fashioning relief for statutory ERISA violations. One strategy would be to try to persuade a court that since, upon a finding of liability, the court will be required to refer the claim to the plan administrator, it would be best to do so at the outset. Another strategy would be to consider whether, in situations where the participant has a strong claim on the merits, the administrator is better off granting the claim so that it can immediately go on record with respect to the appropriate form of relief and seek deference to that determination.

Finally, regardless of the type of claim being exhausted, practitioners should not lose track of the importance of developing a "bullet proof" administrative record. To warrant deference, the administrative determination must appear from the administrative record to be reasonable. Absent an appropriate record, no degree of deference will protect the plan.

Rulings, Filings, and Settlements of Interest

Retiree Medical Benefits:

- In *Bender v. Newell Window Furnishings, Inc.*, No. 11-1335, 2012 U.S. App. LEXIS 9003 (6th Cir. May 3, 2012), the Sixth Circuit held that the defendant was bound as a successor liable under earlier collective bargaining agreements, which provided certain retirees with vested rights to company-paid health insurance and/or Medicare Part B premium reimbursements. First, the Sixth Circuit affirmed the district court's ruling that the defendant was a successor-in-interest to prior collective bargaining agreements because, in related litigation, the defendant admitted that it was a successor-in-interest with respect to healthcare benefits under the prior collective bargaining agreements, and certain agreements reflected the employer's assumption of "all collective bargaining agreements and all Liabilities associated therewith," expressly including liabilities associated with employee benefit plans. Next, the court determined that the right to company-paid health insurance had vested for certain employees. The Sixth Circuit rejected the defendant's argument that the CBAs incorporated by reference reservation-of-rights language in the summary plan descriptions. The court also rejected the defendant's claim that such language in the SPDs was operative in and of itself because competing language in the SPDs reaffirmed that the CBAs would control in the event of a conflict. In addition, the court found that full reimbursement of Medicare Part B premiums vested for certain employees as evidenced by a written settlement agreement and extrinsic evidence, including deposition testimony, affidavits, letters to employees, and a due diligence memorandum. Finally, the Sixth Circuit affirmed the district court's rejection of the defendant's statute of limitations defense because there had not been a "clear repudiation" of the promised health benefits within the analogous state statutory period.
- In *Alday v. Raytheon Co.*, No. 08-16984, 2012 U.S. App. LEXIS 10169 (9th Cir. May 21, 2012), the Ninth Circuit reaffirmed its 2010 opinion, holding that Raytheon expressly agreed to provide 100% company-paid healthcare coverage for eligible retirees and that this obligation survived the expiration of the collective bargaining agreements that originally gave rise to the obligation. The applicable collective bargaining agreements from 1990, 1993, 1996, and 1999 required Raytheon to pay

100% of the health insurance premiums for employees who retired under the plan's "contributory option," whereby they contributed three percent of their compensation, until the retiree reached age 65. In 2004, Raytheon amended the policy and began charging retirees monthly premiums for their health insurance coverage. In finding that the CBAs' terms unambiguously established a contractual right to premium-free health insurance until the retirees reached the age of 65, the Ninth Circuit dismissed Raytheon's argument that reservation-of-rights clauses in the applicable plan documents allowed for Raytheon's unilateral modification or termination of the premium payments for the retirees. Specifically, the court concluded that the CBAs did not incorporate the plans' reservation-of-rights clauses with respect to Raytheon's payment of the health insurance premiums. Instead, the Ninth Circuit found that these provisions related to the employer's right to change the benefits provided under the plan - *i.e.*, the terms of payment for medical services - rather than the payment of the health insurance premiums themselves.

- In *Beaty v. Continental Auto. Sys. U.S. Inc.*, No. 10-cv-2440, 2012 WL 1886134 (N.D. Ala. May 21, 2012), the district court granted final approval of a $23.8 million settlement in a class action alleging that defendant failed to provide retiree medical benefits guaranteed by agreements reached between the participants' union (UAW) and the participants' predecessor employers. In 2004, Chrysler sold its Huntsville, AL plant to Siemens. Prior to the sale, the UAW and Siemens agreed that the sale was contingent upon Siemens providing health benefits that "mirrored" those provided to UAW-represented Chrysler employees; this agreement included any successors to Siemens. In 2007, Continental acquired Siemens and the Huntsville plant. Plaintiffs claimed that Continental had not provided "mirrored" health benefits to Huntsville retirees. The settlement agreement between Continental and the participants requires that the settlement funds be added to a voluntary employee benefit association trust established between the UAW and Chrysler for the benefit of Huntsville retirees. The settlement also requires that benefits flowing from the trust for Huntsville retirees "mirror" the benefits provided to other UAW-represented Chrysler retirees.

Employer Stock:

- In *Lanfear v. Home Depot, Inc.*, --- F.3d ----, 2012 WL 1580614 (11th Cir. May 8, 2012), the Eleventh Circuit affirmed dismissal of an ERISA class action related to a company-stock fund offered in a retirement plan sponsored by Home Depot. After the company's share price dropped on news that insider misconduct may have overstated earnings, participants sued various plan fiduciaries asserting that they (1) breached their duty of prudence by permitting ongoing investments in company stock, and (2) breached their duty of loyalty by making misleading statements in company SEC filings, which were incorporated by reference in participant

communications. The district court granted defendants' motion to dismiss, applying the so-called "*Moench* presumption" (named for the Third Circuit decision first adopting it) that ongoing company-stock investments were prudent if plan terms required a company-stock investment option. Joining several other circuits, the Eleventh Circuit held that the *Moench* presumption limits judicial review of company-stock investments to an abuse-of-discretion standard. Significantly, the court endorsed application of *Moench* to a motion to dismiss, although the court emphasized that the presumption had no evidentiary weight. The court held that the *Moench* presumption "embodies the notion of an outcome favored by the law; it prescribes who is to win in almost all of the circumstances that can be envisioned – not all, but almost all." The court thus rejected plaintiffs' prudence claims based on substantial short-term fluctuations in the company's share price, observing that the settlor's directions, as embodied in plan terms, reflect an intent to invest in company stock over the long term. The court also rejected the participants' claims for breach of the duty of loyalty, which were based primarily on allegedly misleading information in SEC filings, because defendants were not acting as fiduciaries when they drafted, filed and distributed these materials. Finally, the court rejected class complaints that defendants should have informed them about the improper activities, concluding that there is no general duty to disclose nonpublic corporate information.

- In *Fisher v. JP Morgan Chase & Co.*, 10-1303-cv, 2012 WL 1592208 (2d Cir. May 8, 2012), the Second Circuit Court of Appeals (by summary order) upheld the district court's decision dismissing plaintiffs' ERISA "stock-drop" case. Plaintiffs alleged, among other things, that defendants negligently permitted participants of the JP Morgan Chase & Co. 401(k) plan to purchase and hold company stock at a time when the fiduciaries of the plan knew or should have known that it was imprudent to do so and that defendants misrepresented/failed to disclose material facts to plan participants about the company stock. In affirming the lower court's dismissal of the lawsuit, the Second Circuit applied the *Moench* presumption of prudence at the pleadings stage, finding that the complaint did not allege "dire circumstances" that warranted the plan fiduciaries removing the company stock as an investment option under the plan. Moreover, the court held with respect to plaintiffs' disclosure claim that plan fiduciaries have no duty to disclose non-public information about company stock to plan participants. Furthermore, even if there were misrepresentations made in the company's SEC filings, the "defendants who signed or prepared the SEC filings were acting in a corporate, rather than ERISA fiduciary, capacity…" and as such, they could not be liable under ERISA.

Claims for Benefits:

- In *Fleisher v. Standard Insurance Co.*, --- F.3d ----, 2012 WL 1739710 (7th Cir. May 17, 2012), the Third Circuit affirmed dismissal of a participant's claim thatdefendant Standard should not have offset long-term disability benefits by amounts he was receiving under another disability policy. At issue was whether the Standard plan, which allowed reductions for amounts received under another "group insurance policy," authorized deductions for disability payments received under a separate disability policy held by plaintiff. Since the plan terms gave the administrator interpretive discretion, the court applied an abuse-of-discretion standard of review, and held that the plan administrator reasonably concluded that the other policy, which plaintiff obtained through his trade association, was "group insurance." This, the court concluded, also made application of the deduction an appropriate use of the administrator's discretion. One judge dissented, arguing that the case should be remanded for the lower court "to explore and determine the equitable factors in play," such as whether to apply the doctrine of *contra proferentem* (*i.e.*, the premise that ambiguous terms in contracts are construed against the drafter) and whether the administrator's determination frustrated reasonable expectations of the insured. Addressing the dissent's vigorous disagreement, the majority noted that these principles were not germane to abuse-of-discretion review, and stated that "[w]hether we would reach a different interpretation under *de novo* review is … irrelevant."
- In *Hamburg v. Life Ins. Co. of N. Am.*, 2012 WL 1698160 (5th Cir. May 15, 2012), the court rejected a disability claimant's appeal seeking a remand to the plan administrator to take additional evidence, because plaintiff failed to present the evidence during a protracted administrative review. The district court had limited its consideration to the record before the plan administrator, instead of considering a determination by the Social Security Administration (SSA) that plaintiff was disabled. On that record, the district court dismissed plaintiff's claim. Noting that plaintiff had several opportunities to furnish the SSA decision to the administrator, the Fifth Circuit held that the administrative record "consists of relevant information made available to the administrator … in a manner that gives the administrator a fair opportunity to consider it." Given the administrator's offer to reconsider the claim and its request for new documentation, the Fifth Circuit characterized as "simply inexcusable" plaintiff's failure to furnish the administrator with the SSA determination letter, and affirmed dismissal of the denial of disability benefits.

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

[2] 716 F.2d 1476, 1482 (6th Cir. 1983).

[3] *Id.* at 2112.

[4] *Id*. at 2112-2113.

[5] *See, e.g., Carriers Container Council, Inc. v. Mobile S.S. Ass'n Inc.-Intern. Longshoreman's Ass'n, AFL–CIO Pension Plan and Trust*, 896 F.2d 1330, 1339 (11th Cir.1990).

[6] *See, e.g., Keffer v. H. K. Porter Co*., 872 F.2d 60, 64 (4th Cir. 1989).

[7] *See, e.g., Bidlack v. Wheelabrator Corp*., 993 F.2d 603, 606-609 (7th Cir. 1993) (presumption that CBA ceases to obligate employer when term ends is rebuttable, and if CBA is vague or ambiguous, parties should be permitted to present evidence "that they claim will disambiguate it"*); Rossetto v. Pabst Brewing Co., Inc*., 217 F.3d 539, 543 (7th Cir. 2000) (presumption that entitlement to benefits under CBA expires with CBA can be defeated by showing of ambiguity, beyond silence); *Auto Workers v. Skinner Engine* Co., 188 F.3d 130, 139-41 (3d Cir. 1999) (explicitly rejecting the Sixth Circuit's "status" benefit analysis); *Machinists v. Masonite Corp*., 122 F.3d 228, 231-32 (5th Cir. 1997) (restating that *Yard-Man* inference is inappropriate but "bearing in mind the flexibility accorded in the interpretation of labor contracts"); *Paperworkers v. Champion Int'1 Corp*., 908 F.2d 1252, 1261 n.12 (5th Cir. 1990) (rejecting *Yard-Man*'s inference of intent that retiree benefits vest because they are "status" benefits); *Anderson v. Alpha Portland Indus*., 836 F.2d 1512, 1517 (8th Cir. 1988) (rejecting "status" inference).

[8] 632 F.3d 288 (6th Cir. 2011).

[9] *Winnett v. Caterpillar*, 553 F.3d 1000 (6th Cir. 2009).

[10] *Maurer v. Joy Tech., Inc.,* 212 F.3d 907, 917 (6th Cir. 2000).

[11] *Linville v. Teamsters Miscellaneous and Indus. Workers Union*, 206 F.3d 648 (6th Cir. 2000).

[12] 435 F.3d 571 (6th Cir. 2006).

[13] *Id*. at 580.

[14] 583 F.3d 955 (6th Cir. 2009).

[15] *Id*. at 322.

[16] *Id.* at 325.

[17] *Id.* at 321.

[18] *Id*. at 321.

[19] 52 EBC 1935 (S.D. Ohio 2012).

[20] 607 F.2d 427 (6th Cir. 2010).

[21] *Id*. at 431.

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

[23] *See* 29 C.F.R. § 2560.503-1.

[24] *See, e.g., Wert v. Liberty Life Ins. Co. of Boston*, 447 F.3d 1060, 1062, 37 EBC 2261 (8th Cir. 2006) (97 PBD, 5/19/06; 33 BPR 1302, 5/23/06); *Diaz v. United Agric. Employee Welfare Benefit Plan*, 50 F.3d 1478, 1483 (9th Cir. 1995) (an ERISA plaintiff challenging a denial of benefits "must avail himself or herself of a plan's own internal review procedures before bringing suit in federal court").

[25] *See Smith v. Snydor*, 184 F.3d 356, 364-65 (4th Cir. 1999); *Chailland v. Brown & Root, Inc*., 45 F.3d 947, 19 EBC 1369 (5th Cir. 1995); *Richards v. General Motors Corp*., 991 F.2d 1227,16 EBC 1977 (6th Cir. 1993); *Held v. Manufacturers Hanover Leasing Corp* ., 912 F.2d 1197, 28 EBC 1354 (10th Cir. 1990); *Zipf v. American Telephone & Telegraph Co*., 799 F.2d 889, 891-9, 7 EBC 2289 (3d Cir. 1986); *Amaro v. Continental Can Co*., 724 F.2d 747, 749-50, 5 EBC 1215 (9th Cir. 1984).

[26] *See Lanfear v. Home Depot, Inc*., 536 F.3d 1217, 1224, 44 EBC 1614 (11th Cir. 2008) (148 PBD, 8/1/08; 35 BPR 1822, 8/5/08); *Lindemann v. Mobil Oil Corp*., 79 F.3d 647, 650 (7th Cir. 1996) (''Thus the law of this Circuit remains that the decision to require exhaustion as a prerequisite to bringing a federal lawsuit is a matter within the discretion of the trial court and its decision will be reversed only if it is obviously in error.").

[27] *See Nechis v. Oxford Health Plans, Inc*., 421 F.3d 96, 102, 36 EBC 2071 (2d Cir. 2005) (157 PBD, 8/16/04; 31 BPR 1812, 8/17/04).

[28] *See Role v. Johns Hopkins Bayview Med. Ctr*., No. 06 CV 2475 (DLI) (LB), 2008 U.S. Dist. LEXIS 11743 (E.D.N.Y. Feb. 15, 2008) (collecting cases).

[29] *Cf., e.g., Morales-Cotte v. Cooperativa de Ahorro v. Credito Yabucoena*, 73 F. Supp. 2d 153, 160 (D.P.R. 1999) (holding plaintiff is not required to exhaust pension plan remedies before bringing his § 510 action to court), with *Santana v. Deluxe Corp*., 12 F. Supp. 2d 162, 174 (D. Mass. 1998) (''This Court agrees with the Seventh and the Eleventh Circuits that strong public policy reasons—most prominently to render meaningful the Congressional mandate that all ERISA plans include an appeal process—compel plaintiffs to exhaust all benefit denial claims, regardless of their nature.'').

[30] *See, e.g., Bennett v. Prudential Insurance Company*, No. 05-5033, 39 EBC 1578 (3d Cir. Aug. 17, 2006); *Werner v. Liberty Life Assur. Co. of Boston*, No. 08-55127, 2009 WL 1956235 (9th Cir. June 23, 2009).

[31] *See, e.g., Crowell v. Shell Oil Co*., 541 F.3d 295, 309, 44 EBC 1909 (5th Cir. 2008) (158 PBD, 8/15/08; 35 BPR 1919, 8/19/08) (exhaustion is an affirmative defense); *Metro. Life Ins. Co. v. Price*, 501 F.3d 271, 280, 41 EBC 1673 (3d Cir. 2007) (171 PBD, 9/5/07; 34 BPR 2111, 9/11/07) (''The exhaustion requirement is a nonjurisdictional affirmative defense.''); *Paese v. Hartford Life & Accident Ins. Co*., 449 F.3d 435, 446, 37 EBC 2797 (2d Cir. 2006) (103 PBD, 5/30/06; 33 BPR 1380, 6/6/06) (holding that ''a failure to exhaust ERISA administrative remedies is not jurisdictional, but is an affirmative defense'').

[32] *See ALA, Inc. v. CCAIR, Inc*., 29 F.3d 855, 859 (3d Cir. 1994) (finding that "a complaint may be subject to dismissal under Rule 12(b)(6) when an affirmative defense . . . appears on its face'') (citing *Cont'l Collieries, Inc. v. Shober*, 130 F.2d 631, 635 (3d Cir. 1942)); *Hecker v. Deere & Co*., 556 F.3d 575, 588, 45 EBC 2761 (7th Cir. 2009) (28 PBD, 2/13/09; 36 BPR 700, 3/24/09) (affirming dismissal of complaint based on affirmative defense where the plaintiff ''included in its complaint 'facts that establish an impenetrable defense to its claims.'") (citation omitted).

Related Professionals

- **Russell L. Hirschhorn**
  Partner
- **Myron D. Rumeld**
  Partner