RECENT DEVELOPMENTS IN EMPLOYEE BENEFITS LAW

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This article surveys recent developments in employee benefits law from Fall 2007 through Fall 2008. The first portion of the article reviews important judicial developments involving employee benefits and the Employee Retirement Income Security Act of 1974, as amended (ERISA).[1] The second part addresses noteworthy regulatory developments in employee benefits law.

I. CASES

A. *U.S. Supreme Court*

1. *LaRue v. DeWolff, Boberg & Associates, Inc.*[2]

James LaRue was a participant in a 401(k) plan administered by DeWolff, Boberg & Associates, Inc., defendant fiduciary in this case. LaRue directed DeWolff to make changes in how his plan account was invested in 2001 and 2002, but such instructions were never carried out. As a result, LaRue contended that his plan account lost over $150,000, and he brought suit against DeWolff under § 502(a)(2) and (3) of ERISA for breach of fiduciary duty.

DeWolff filed a motion for judgment on the pleadings, arguing that § 502(a)(2) only authorizes suits on behalf of the plan as a whole and LaRue was bringing an individual suit. DeWolff also argued that § 502(a)(3) only authorizes equitable relief and LaRue was seeking legal damages. The U.S.

1. 29 U.S.C. §§ 1001–1461.
2. 128 S. Ct. 1020 (2008).

District Court for the District of South Carolina granted defendants' motion for judgment on the pleadings, and the Fourth Circuit affirmed. Relying on *Massachusetts Mutual Life Insurance Co. v. Russell*,[3] the Fourth Circuit held that ERISA § 502(a)(2) provides remedies only for entire plans and not individuals. The Fourth Circuit's decision effectively left LaRue without a remedy under ERISA for obtaining the $150,000.

The Supreme Court held LaRue, a participant in a defined contribution plan, may sue a fiduciary under ERISA § 502(a)(2), 29 U.S.C. § 1132(a)(2).[4] The Court held that, although ERISA § 502(a)(2) does not provide a remedy for individual injuries distinct from plan injuries, it does authorize recovery for fiduciary breaches that impair the value of plan assets in a participant's individual account.[5] ERISA § 502(a)(2) provides for suits to enforce the liability-creating provisions of ERISA § 409, concerning breaches of fiduciary duties that harm plans. The principal statutory duties imposed by ERISA § 409 relate to the proper management, administration, and investment of plan assets, with an eye toward ensuring that the benefits authorized by the plan are ultimately paid to plan participants. The Court noted that the misconduct alleged by LaRue fell squarely within that category.[6]

Rejecting the Fourth Circuit's reasoning, the Court noted that the misconduct alleged in *Russell*, by contrast, fell outside this category.[7] In *Russell*, Russell received all of the benefits to which she was contractually entitled but sought consequential damages arising from a delay in the processing of her claim. Russell's emphasis on protecting the "entire plan" reflects the fact that the disability plan in *Russell*, as well as the typical pension plan at that time, promised participants a fixed benefit. Misconduct by such a plan's administrators would not affect an individual's entitlement to a defined benefit unless it created or enhanced the risk of default by the entire plan. For defined contribution plans, however, fiduciary misconduct need not threaten the entire plan's solvency to reduce benefits below the amount that participants would otherwise receive. Whether a fiduciary breach diminishes plan assets payable to all participants or only to particular individuals, it creates the kind of harms that concerned the drafters of § 409. Thus, Russell's "entire plan" references, which accurately reflected ERISA § 409's operation in the defined benefit context, are irrelevant in the defined contribution context. Therefore, the Court determined that, when the plan at issue is a defined contribution plan,

3. 473 U.S. 134 (1985).
4. *LaRue*, 128 S. Ct. at 1026.
5. *Id.*
6. *Id.* at 1024.
7. *Id.*

neither the number of participants nor the percentage of plan assets at issue is relevant.[8]

Although the Court granted certiorari on the ERISA § 502(a)(3) issue as well, the issue was not addressed because the majority opinion, authored by Justice Stevens, concluded that the case should be disposed of on ERISA § 502(a)(2) grounds.[9]

2. *Metropolitan Life Insurance Co. v. Glenn*[10]

Metropolitan Life Insurance Company (MetLife) is an administrator and the insurer of Sears, Roebuck & Company's long-term disability insurance plan. The plan gives MetLife (as administrator) discretionary authority to determine the validity of an employee's benefits claim and provides that MetLife (as insurer) will pay the claims. Wanda Glenn, a Sears employee, was granted an initial twenty-four months of benefits under the plan following a diagnosis of a heart disorder. MetLife encouraged her to apply for, and she began receiving, Social Security disability benefits based on an agency determination that she could not work. But, when MetLife itself had to determine whether she could work (in order to establish eligibility for extended plan benefits), it found her capable of doing sedentary work and denied her the benefits. Glenn sought federal-court review under ERISA, 29 U.S.C. § 1132(a)(1)(B).

The U.S. District Court for the Southern District of Ohio applied an "arbitrary and capricious" standard and upheld MetLife's denial of Glenn's claim.[11] In reversing, the Sixth Circuit used a deferential standard of review and considered there to be a conflict of interest because MetLife both determined an employee's eligibility for benefits and paid the benefits out of its own assets.[12] Therefore, the Sixth Circuit set aside MetLife's benefits denial.

The Supreme Court affirmed the Sixth Circuit and held that a plan administrator's dual role of both evaluating and paying benefits claims creates a conflict of interest.[13] The Court noted that a conflict of interest exists where it is an employer that both funds the plan and evaluates claims, but a conflict also exists where, as in *Glenn*, the plan administrator is an insurance company.[14] The Court held that such a conflict of interest should be a factor in determining whether to uphold the insurer's decision to deny a

8. *Id.* at 1025.
9. *Id.* at 1020.
10. 128 S. Ct. 2343 (2008).
11. *Id.* at 2344.
12. *Id.*
13. *Id.* at 2344–45.
14. *Id.*

claim for benefits; however, the significance of the conflict-of-interest factor will depend on the circumstances of the particular case.[15]

B. *Circuit Courts of Appeals Cases*

Over the past year, the courts of appeals have addressed several significant issues under ERISA, including participant standing to bring a claim under ERISA, preemption of state law, and breaches of fiduciary duties.

1. *Golden Gate Restaurant Ass'n v. City & County of San Francisco*[16]

On September 30, 2008, the Ninth Circuit held that the employer spending requirement of a San Francisco Health Care Security Ordinance is not preempted by ERISA.

In July 2006, the City and County of San Francisco passed the San Francisco Health Care Security Ordinance, codified at sections 14.1 to 14.8 of the City and County of San Francisco Administrative Code. The San Francisco Ordinance has two components: the Health Access Program (HAP), a city-administered health care program known as Healthy San Francisco, and the Employer Spending Requirement (ESR), which will fund a portion of the health care program. The San Francisco program is intended to provide access to care for uninsured adults living within the city limits who do not qualify for coverage under Medicaid. Once fully implemented, the program will be funded through taxpayer contributions, participant co-payments and monthly premiums based on a sliding scale, and the ESR. Under the ESR, for-profit employers with more than 20 employees and nonprofit employers with more than 50 employees will contribute $1.17 to $1.76 per hour per employee towards (1) employer-provided insurance; (2) health savings accounts; (3) direct payment of medical bills; or (4) payment towards the city program, Healthy San Francisco.[17]

In 2006, the Golden Gate Restaurant Association (GGRA), a group that includes many employers within the San Francisco area, filed an action seeking a determination that the Ordinance is preempted by ERISA. The U.S. District Court for the Northern District of California granted GGRA's motion for summary judgment holding that the Ordinance fails to withstand the expansive test of ERISA preemption in that it has both an impermissible "connection to" ERISA plans and makes an unlawful "reference to" such benefit plans.[18] The city appealed and immediately sought

15. *Id*. at 2345.
16. 546 F.3d 639 (9th Cir. 2008) (*GGRA II*).
17. *Id*. at 642–43.
18. GGRA v. City & County of San Francisco, 535 F. Supp. 2d 968, 980 (N.D. Cal. 2007).

a stay of an injunction that prohibited it from implementing the payment provisions. In January 2008, the Ninth Circuit granted the stay, allowing the program to go forward pending appeal.[19]

On appeal, the Ninth Circuit reversed the district court and confirmed that ERISA does *not* preempt the employer spending provisions of the San Francisco Ordinance.[20] The court held that the ordinance did not establish a "plan" within the meaning of ERISA, the ordinance was not preempted by ERISA based on any impermissible "connection with" employers' benefit plans, and the ordinance did not have an impermissible "reference to" employee benefit plans subject to ERISA. Significantly, the Ninth Circuit rejected arguments that its decision creates a circuit split with the Fourth Circuit's decision in *Retail Industry Leaders Association v. Fielder*,[21] where the Fourth Circuit found an employer-mandated health care law was preempted by ERISA.[22]

On October 21, 2008, the GGRA filed a petition for rehearing *en banc* to the Ninth Circuit asking the court to review the decision based upon the national importance of the case and the arguable conflict with previous rulings in the Fourth Circuit, the Ninth Circuit, and the U.S. Supreme Court.[23]

2. *Great-West Life & Annuity Insurance Co. v. Information Systems & Network Corp.*[24]

In *Great-West*, the Fourth Circuit held that claims for breach of contract and unjust enrichment brought by a third-party insurance company hired to perform nondiscretionary administrative services for an ERISA health care plan were not preempted by ERISA.[25]

Information Systems and Networks Corp. (ISN) established a health care benefit plan for the purpose of providing certain health care benefits to its covered employees and their dependents. ISN purchased insurance from Great-West Life and Annuity Insurance Company (Great-West) to cover some benefits under the plan, for example, accidental death benefits. ISN also contracted separately with Great-West to provide stop-loss coverage for the amount of any claims by an employee or dependent that exceeded $30,000.00 per month in the aggregate. In a separate and distinct contractual agreement between ISN and Great-West, ISN hired Great-

19. GGRA v. City & County of San Francisco, 512 F.3d 1112 (9th Cir. 2008).
20. *GGRA II*, 546 F.3d 639.
21. 475 F.3d 180 (4th Cir. 2007).
22. GGRA II, 546 F.3d 639, 659–60 (9th Cir. 2008).
23. As of the date of publication of this article, GGRA's petition for rehearing is still pending.
24. 523 F.3d 266 (4th Cir. 2008).
25. *Id.* at 272.

West to perform certain nondiscretionary administrative services under the plan.[26]

Great-West brought suit alleging state law claims of breach of contract and unjust enrichment against ISN arising from Great-West's performance of only one of these nondiscretionary administrative services, namely, Great-West's nondiscretionary duty to front the payment of claims made by ISN employees and their dependents for self-funded benefits under the plan. ISN, in turn, agreed to reimburse Great-West for any such payments.

ISN moved to dismiss Great-West's complaint on the grounds that Great-West's state law claims were preempted by ERISA, § 514(a), and that Great-West lacked standing to assert any claims under ERISA's civil enforcement provision, § 502. The U.S. District Court for the District of Maryland denied ISN's motion but noted that ISN would have the opportunity to reassert its ERISA preemption argument in a future motion for summary judgment.[27]

The Fourth Circuit agreed with Great-West and held Great-West's state law claims for breach of contract and unjust enrichment were not preempted by ERISA in this case. Neither claim required interpretation of the plan terms, nor were the claims in any way dependent upon the existence of an ERISA plan.[28] The Fourth Circuit found the claims to be "run-of-the-mill" state law claims alleging failure to pay a creditor and, thus, they were not preempted by ERISA.[29]

3. *Evans v. Akers*[30]

The First Circuit decided that former employees who receive lump-sum distributions of the entire balance from a defined contribution plan may still be "participants" in the plan with statutory standing to sue under ERISA § 502(a)(2).

Keri Evans and Timothy Whipps are former employees of W.R. Grace & Co. (Grace), a large manufacturing company. While employed at Grace, the plaintiffs participated in the W.R. Grace & Co. Savings and Investment Plan (Plan), a "defined contribution" plan under ERISA § 3(34), 29 U.S.C. § 1002(34). The Plan offered, as one choice on the menu of investment options available to Plan participants, the Grace Common Stock Fund (Fund), a fund invested primarily in Grace stock. Additionally, Grace automatically invested all employer contributions in the Fund, and employees

26. *Id*. at 268.
27. *Id*. at 269.
28. *Id*. at 272.
29. *Id*. at 271.
30. 534 F.3d 65 (1st Cir. 2008).

were not permitted to move those contributions out of Grace stock and into other investments until they reached age fifty. Evans and Whipps terminated their employment with Grace on August 30, 2002, and April 27, 2001, respectively, and received lump-sum distributions of the balance of their Plan accounts shortly after leaving the company.

On January 1, 2001, with Grace stock becoming an increasingly risky investment due to mounting financial pressures from asbestos-related product-liability litigation, the Plan stopped investing employer contributions in the Fund and began allocating them instead in accordance with participants' investment elections. At this time, the Plan also permitted, but did not advise or require, participants to move past matching contributions out of the Fund and into other Plan investments. Despite these changes in the employer contribution policy, the Fund remained open to participants as one of the investment options for their own contributions under the Plan. Grace and its subsidiaries filed for bankruptcy protection on April 2, 2001.[31]

The plaintiffs filed a putative class action suit against various Plan fiduciaries, alleging that they breached their fiduciary duties by (1) continuing to offer Grace common stock as a Plan investment option for participant contributions, (2) utilizing Grace securities for employer contributions to the Plan, and (3) maintaining the Plan's preexisting heavy investment in Grace securities when the stock was no longer a prudent investment. The plaintiffs also alleged that other fiduciaries had breached their duty to monitor their co-fiduciaries and advise Plan participants. They brought these claims on behalf of the Plan to recover alleged losses to the Plan pursuant to ERISA § 502(a)(2), which permits the secretary of Labor, participants, beneficiaries, or fiduciaries to file suit to hold fiduciaries personally liable for fiduciary breaches.[32] The plaintiffs' proposed class included all participants and beneficiaries of the Plan between July 1, 1999, and April 19, 2004.

The U.S. District Court for the District of Massachusetts denied plaintiffs' motion for class certification and dismissed the action on the basis that the plaintiffs lacked standing. In the district court's view, plaintiffs were asserting claims for compensatory damages, rather than for additional Plan benefits, and, thus, had failed to meet the statutory definition of "participants" entitled to bring suit.[33]

The First Circuit vacated the decision and held that former employees who allege that fiduciary breaches reduced their lump-sum distribution

31. *Id*. at 67–68.
32. 29 U.S.C. §§ 1109, 1132(a)(2).
33. *Evans*, 534 F.3d at 68; *see also* Evans v. Akers, 466 F. Supp. 2d 371, 374 (D. Mass. 2006).

from a defined contribution plan have standing to sue as "participants" under ERISA.[34] This decision aligns the First Circuit with the Third, Sixth, and Seventh Circuits,[35] and now, as discussed herein, the Fourth and Eleventh Circuits.[36]

4. *Wangberger v. Janus Capital Group, Inc.*[37]

The Fourth Circuit joined the Third, Sixth, and Seventh Circuits (and now, as discussed herein, the First and Eleventh Circuits) in finding that a former employee who takes a lump-sum distribution of the funds in a defined contribution account may still qualify as a "participant" with standing to sue under ERISA § 502(a)(2).

In *Wangberger*, the plaintiffs were former employees who maintained accounts in § 401(k) defined contribution retirement plans sponsored by their employers. Upon retiring from their respective employments, they voluntarily "cashed out" their vested interests in the defined contribution plans that their employers had sponsored. The plaintiffs commenced their respective actions, seeking to represent a class of others similarly situated under ERISA against the fiduciaries of their respective retirement plans, for breach of their fiduciary duties to the plans based on the fiduciaries' knowing investment in mutual funds that allowed investors to practice market timing, an abusive form of arbitrage activity that favored the market timers and harmed long-term investors in the funds such as the plaintiffs. The plaintiffs sued the fiduciaries under ERISA §§ 502(a)(2) and 409(a), which allow for a derivative action to be brought by a retirement plan "participant" on behalf of the plan to obtain recovery for losses sustained by the plan because of breaches of fiduciary duties.

The defendants filed motions to dismiss the plaintiffs' claims, challenging their standing to assert the claims under both ERISA and Article III of the Constitution. The U.S. District Court for the District of Maryland granted their motions, finding that the plaintiffs did not fall within the class of individuals authorized to sue under ERISA § 502(a)(2) because, having cashed out of the plans, they were no longer seeking "benefits" as required to have statutory authority to sue, but rather money damages.[38]

The Fourth Circuit consolidated appeals to decide the single issue of whether the plaintiffs had statutory and constitutional standing. The

34. *Evans*, 534 F.3d at 68.

35. *See* Graden v. Conexant Sys. Inc., 496 F.3d 291 (3d Cir. 2007); Bridges v. Am. Elec. Power Co., Inc., 498 F.3d 442 (6th Cir. 2007); Harzewski v. Guidant Corp., 489 F.3d 799 (7th Cir. 2007).

36. *See* Wangberger v. Janus Capital Group, Inc., 529 F.3d 207 (4th Cir. 2008); Lanfear v. Home Depot, Inc., 536 F.3d 1217 (11th Cir. 2008).

37. 529 F.3d 207.

38. *Id.* at 210.

Fourth Circuit concluded that cashed-out former employees remain "participants" in defined contribution retirement plans for purposes of ERISA § 502(a)(2) when they seek to recover amounts that they claim should have been in their accounts had it not been for alleged fiduciary impropriety, and thus have "statutory standing."[39] In addition, the Fourth Circuit concluded that because the plans at issue were defined contribution plans, rather than defined benefit plans, plaintiffs satisfied the redressibility element of Article III standing.[40]

5. *Lanfear v. Home Depot, Inc.*[41]

Like the Third, Sixth, and Seventh Circuits (and now, as discussed herein, the First and Fourth Circuits), the Eleventh Circuit found that former employees who have received lump-sum distributions of the entire balance of their defined contribution plan may still have statutory standing to sue as "participants" under ERISA § 502(a)(2).

In *Lanfear*, former employees filed a complaint against Home Depot and its officials for breach of fiduciary duty in the administration of the retirement plan by allowing the retirement plan to invest in Home Depot stock even though corporate officials were allegedly backdating stock options and making fraudulent transactions, which artificially inflated the value of Home Depot stock. The former employees had received their benefit payments, but they complained that the payments were less than they should have been. In their request for relief, the former employees sought to compel the defendants to restore to the plan all losses that resulted from a breach of fiduciary duty, all profits that a breach of fiduciary duty prevented the plan from realizing, and all profits made through the misuse of plan assets. They requested that the court allocate to their individual accounts a proportionate amount of the restitution of plan losses. The former employees filed their complaint on behalf of all plan participants for the period on and after June 30, 2001.[42] Defendant Home Depot moved to dismiss the complaint on the grounds that the former employees did not qualify as "participants" of the plan under ERISA, failed to exhaust their administrative remedies, and failed to state a claim on which relief could be granted.

The U.S. District Court for the Northern District of Georgia dismissed the complaint with prejudice for lack of subject-matter jurisdiction because the plaintiffs did not qualify as "participants" of the plan pursuant to ERISA

39. *Id.*
40. *Id.*
41. 536 F.3d 1217 (11th Cir. 2008).
42. The complaint was filed in the Eastern District of New York, but the action was transferred to the Northern District of Georgia.

§ 502(a)(2), and, as a result, lacked statutory standing to sue for breach of fiduciary duty.[43] The district court concluded that the former employees asserted a claim for damages, not benefits, and did not qualify as "participants" based on the decision of the Fifth Circuit in *Sommers Drug Stores Co. Employee Profit Sharing Trust v. Corrigan*.[44] The *Sommers* court stated that "a plaintiff alleging that his benefits were wrongly computed has a claim for vested benefits" but that "a plaintiff who seeks the recovery for the trust of an unascertainable amount, with no demonstration that the recovery will directly effect payment to him, would state a claim for damages."[45] The district court reasoned that the former employees sought damages because their complaint did not seek a readily ascertainable amount that would directly effect a payment to the plaintiffs.[46]

Reversing the district court, the Eleventh Circuit held that the former employees did qualify as "participants" of the plan because, under ERISA, their complaint asserts a claim for benefits instead of damages.[47] The court held that a complaint for the decrease in value of a defined contribution account due to a breach of fiduciary duty is not for damages because it is limited to the difference between the benefits actually received and the benefits that would have been received if the plan management had fulfilled its statutory obligations.[48] Therefore, because the complaint is for benefits, not damages, the former employees qualify as participants.[49]

6. *Shearer v. Southwest Service Life Insurance Co*.[50]

Plaintiff Shearer was the fifty percent owner of Intercontinental Materials Management, Inc. (IMMI), as well as an employee of the company. His mother, Christal Shearer, owned the other fifty percent of IMMI. Shearer applied for health insurance for himself and his family from defendant Southwest Service Life Insurance Company (SWSL). The premiums for the policy were paid by IMMI. Shearer and his mother both stated in affidavits that this was done for bookkeeping purposes. Some time later, Shearer's son suffered an injury requiring hospitalization and surgery, and Shearer submitted a claim under his policy to SWSL. Although SWSL paid for a portion of the claim, Shearer contends that the policy required SWSL to pay for the entire amount.[51]

43. *Lanfear*, 536 F.3d at 1219–20.
44. 883 F.2d 345 (5th Cir. 1989).
45. *Id*. at 350.
46. *Lanfear*, 536 F.3d at 1222.
47. *Id*. at 1222–23.
48. *Id*.
49. *Id*.
50. 516 F.3d 276 (5th Cir. 2008).
51. *Id*. at 277–78.

Shearer filed suit against SWSL and its agent, defendant Richard Sanders (Sanders), in Texas state court, bringing state law claims of misrepresentation, breach of contract, unfair and deceptive trade practices, and unfair claim settlement practices. SWSL, with Sanders' consent, removed the case, claiming that the insurance policy at issue was covered by ERISA and thus Shearer's claims were preempted by ERISA and removable pursuant to 28 U.S.C. § 1331 (federal question jurisdiction).[52]

Shortly after removal, the district court struck Sanders as a defendant. Shearer then filed a motion to remand, arguing that his insurance policy was not an ERISA plan. The U.S. District Court for the Southern District of Texas denied the motion without comment, then granted SWSL's motion for summary judgment, ruling that Shearer's claims failed to meet the ERISA standard for relief. Shearer appealed, contending that the district court lacked jurisdiction over the case because the insurance policy was not an ERISA plan.[53]

The Fifth Circuit noted that if an employer does no more than purchase insurance for its employees and has no further involvement with the collection of premiums, administration of the policy, or submission of claims, the employer has not established an ERISA plan.[54] The court held that here, IMMI's payment of insurance premiums alone was not enough to create an ERISA plan that would give the district court jurisdiction over the case when IMMI had purchased insurance for only two individuals.[55] Thus, the Fifth Circuit vacated the judgment of the district court and remanded for further proceedings consistent with its opinion.[56]

7. *Kirschbaum v. Reliant Energy, Inc.*[57]

Brad Kirschbaum (Kirschbaum), an employee of Reliant Energy, Inc. (REI) and a participant in the Reliant Energy Savings Plan (Plan), brought an ERISA class action against REI and the REI Benefits Committee (REI defendants) representing current and former plan participants on whose behalf the Plan purchased or held shares of the Reliant Energy Common Stock Fund from August 2, 1999, to May 16, 2002. In the REI Plan, participants could invest in a number of funds, ranging from riskier, growth-oriented funds to more stable mutual funds. One investment option under the Plan was the REI Common Stock Fund (Common Stock Fund). With the exception of a small cash component for liquidity purposes, the Common Stock Fund was invested entirely in REI common stock. The value

52. *Id.*
53. *Id.*
54. *Id.* at 280.
55. *Id.*
56. *Id.*
57. 526 F.3d 243 (5th Cir. 2008).

of the Common Stock Fund fell when the price per share of REI common stock dropped about forty percent, from $24.60 on May 9, 2002, to $14.50 a week later. The drop was occasioned by the disclosure that some REI employees had engaged in "round-trip" energy trades between 1999 and 2001.[58]

Plaintiff, on behalf of himself and all others similarly situated, brought a class action alleging that Plan fiduciaries breached their fiduciary duties by permitting participants to invest in company stock even though the company stock had become an imprudent investment alternative. Plaintiff alleged that the REI defendants were responsible under ERISA to make good the losses the Plan sustained on REI common stock. Counts I and II both alleged the REI defendants should have known, based on information available to them, that REI stock was not a prudent investment. Count I focused on information available to the public, while Count II focused on nonpublic information (the "round-trip" trades). Both counts asserted that because REI common stock became an imprudent investment, the REI defendants had a fiduciary duty to (a) halt all Plan purchases of REI common stock, (b) sell the Plan's holdings in REI common stock, and (c) terminate the Common Stock Fund. Count III alleged that the REI defendants breached their fiduciary duties by negligently misrepresenting REI's financial condition to Plan participants in documents that incorporated the company's SEC filings.[59]

After certifying the class, the U.S. District Court for the Southern District of Texas granted summary judgment to the REI defendants on all three counts.[60] The Fifth Circuit affirmed. The Fifth Circuit dismissed plaintiffs' claim that the fiduciaries allowed the Plan to become too heavily weighted in company stock, citing ERISA's provision exempting employer securities from the diversification requirement.[61] The Fifth Circuit also dismissed plaintiffs' claim that REI stock had become an imprudent investment due to fraud artificially inflating the stock price because, under the facts of the case, the fiduciaries did not have the ability to override the Plan's requirement of company stock.[62] The company's viability as a going concern was never threatened, nor was the company stock ever in danger of becoming "essentially worthless."[63] Finally, the Fifth Circuit dismissed plaintiffs' claim for misrepresentation because plaintiffs failed to identify any misrepresentation made in a fiduciary capacity.[64]

58. *Id.* at 246–47.
59. *Id.* at 247–48.
60. *Id.* at 248.
61. *Id.* at 249.
62. *Id.* at 253.
63. *Id.* at 255–56.
64. *Id.* at 256–57.

8. *Pugh v. Tribune Co.*[65]

In this consolidated appeal, the Seventh Circuit reviewed two cases arising out of a fraud that occurred at a New York subsidiary of the defendant Tribune Company. Certain employees at the subsidiary falsely boosted the circulation figures of two newspapers, *Newsday* and the Spanish-language *Hoy*, increasing the amount that they were able to charge advertisers and, in turn, inflating revenues. Tribune ultimately discovered and publicly disclosed the fraud, which resulted in a $90 million charge against earnings. As a result of the fraud, two cases were filed: a securities class action brought by purchasers of Tribune common stock against Tribune, four of its executive officers, and five employees, and an ERISA class action against the alleged plan fiduciaries brought by participants in Tribune's pension plans who held stock in the employee stock ownership plan.[66]

Plaintiffs in the ERISA class action alleged three overlapping claims: the defendants violated ERISA § 404 by failing to prudently and loyally manage assets held by the plans, the defendants violated ERISA §§ 404 and 405 by failing to provide complete and accurate information to the participants in the plans, and the defendants Tribune and its board failed to properly appoint, monitor, and inform the company Employee Benefits Committee. The thrust of plaintiffs' allegations was that defendants breached fiduciary duties by continuing to offer and maintain company stock in the plans at a time when it was imprudent to do so. Although plaintiffs did not contend that defendants knew of the underlying fraud, they argued that available information raised "red flags" that obligated defendants to investigate the prudency of the company stock as an investment alternative.[67]

The plaintiffs first contended that a lawsuit filed by the advertisers constituted a "red flag" of misconduct and, therefore, there was some reason to suspect investing in company stock may be imprudent.[68] The Seventh Circuit found that the advertisers' lawsuit could not be a basis for liability because, when it was filed, Tribune *did* commence an investigation and it would have made little sense for the plan fiduciaries to commence an independent investigation at the same time.[69]

Plaintiffs alleged a second red flag was the purported inaccuracy of Tribune's internal controls, specifically, the absence of a requirement that circulation managers certify their figures. The Seventh Circuit rejected plaintiffs' attempts to use subsequent remedial measures as a basis for al-

65. 521 F.3d 686 (7th Cir. 2008).
66. *Id.* at 690.
67. *Id.* at 700.
68. *Id.*
69. *Id.*

legations of this kind.[70] Furthermore, there was no reason to infer that the absence of this specific procedure should have alerted defendants to the misconduct, especially because Tribune's circulation figures were being audited by a third party.[71] Finally, the court found plaintiffs' claim to be speculative because the managers were the same people who concocted the fraudulent scheme and, therefore, they likely would have certified the fraudulent numbers. The court concluded that just because a fraud occurred and was eventually discovered does not mean that defendants were on notice of potential problems beforehand and, therefore, plaintiffs' purely speculative allegations fail as a matter of law.[72]

In addition, the court rejected plaintiffs' argument that defendants should have known of the fraud by virtue of their positions with the employer. However, even assuming defendants did know of the fraud, the Seventh Circuit found that a reasonable fiduciary would not have discontinued the company stock fund.[73] To reach this conclusion, the court compared publicly available stock prices to the allegations in the complaint and conducted a hindsight analysis, finding that disclosures regarding the alleged improprieties had a minimal effect on the stock price.[74] The court also found that, even if defendants possessed the power of "clairvoyance," they would have foreseen only a small charge against earnings due to the fraud and such circumstances would not have warranted ceasing investment in the company stock.[75] Thus, the defendants did not act imprudently by not discontinuing the company stock fund.[76]

II. REGULATORY DEVELOPMENTS

A. *Amendments to the Mental Health and Parity Act of 1996*

The Emergency Economic Stabilization Act of 2008 (EESA),[77] signed into law on October 3, 2008, contains significant amendments to the Mental Health Parity Act of 1996 (MHPA). The amendments to the MHPA become effective on January 1, 2010, for most group health plans.

The MHPA generally prohibits group health plans from applying lower annual or aggregate lifetime dollar limits to mental health benefits than the dollar limits for medical and surgical benefits offered by a group health

70. *Id.*
71. *Id.*
72. *Id.*
73. *Id.* at 701–02.
74. *Id.*
75. *Id.*
76. *Id.*
77. Pub. L. No. 110-343 (2008), Division C.

plan or health insurance issuer offering coverage in connection with a group health plan. The MHPA provisions were originally set to expire on September 30, 2001, but have been extended numerous times with the most current extension running through December 31, 2008.

The EESA amendments to the MHPA eliminated the sunset provision of the MHPA so that it is no longer set to expire on December 31, 2008. The MHPA amendments require equality in coverage of mental health and "substance use disorder" benefits; however, the amendments do not require a group health plan (or health insurance offered in connection with such plan) to provide mental health and substance abuse coverage. If a group health plan provides mental health and substance use disorder benefits, then the financial requirements and treatment limitations for mental health or substance use disorder benefits must be equivalent to those applied to medical and surgical benefits covered under the plan. Financial requirements include deductibles, copayments, coinsurance, and out-of-pocket expenses. Treatment limitations include frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

The EESA amendments to the MHPA also add a new disclosure provision to ERISA. The disclosure of criteria for medical necessity decisions with respect to mental health or substance use disorder must be made by the plan administrator (or claims administrator as applicable) upon request to any current participant, beneficiary, or contracting provider, and the reason for any claim denial or reimbursement request denial for such coverage must be available upon request or as otherwise required.

Under the amendments, a voluntary opt-out is available for a group health plan (or health insurance offered in connection with such plan) if, as a result of offering this coverage, the cost of coverage with respect to medical and surgical benefits and mental health and substance abuse disorder benefits rises more than two percent in the first year and one percent annually thereafter. However, a determination of this cost increase must be made by an actuary in a written report, and a filing for exemption must be made with the Department of Labor.

As the EESA is amending the existing law, its provisions generally apply to a group health plan that is subject to the existing MHPA requirements.

B. *Final Interim Rule Regarding Executive Compensation Provisions Applicable to Participants in the Troubled Assets Relief Program Capital Purchase Program*

On October 20, 2008, the Department of the Treasury issued an interim rule, pursuant to sections 101(a)(1), 101(c)(5), and 111(b) of the Emergency Economic Stabilization Act of 2008 (EESA), providing guidance on the executive compensation provisions applicable to participants in

the Troubled Assets Relief Program (TARP) Capital Purchase Program (CPP).[78] Section 111(b) of EESA requires financial institutions from which the Department of the Treasury is purchasing troubled assets through direct purchases to meet appropriate standards for executive compensation and corporate governance.

The interim final rule includes the following standards for purposes of the CPP: (a) limits on compensation that exclude incentives for senior executive officers (SEOs) of financial institutions to take unnecessary and excessive risks that threaten the value of the financial institution; (b) required recovery of any bonus or incentive compensation paid to an SEO based on statements of earnings, gains, or other criteria that are later proven to be materially inaccurate; (c) prohibition on the financial institution from making any golden parachute payment to any SEO; and (d) agreement to limit a claim to a federal income tax deduction for certain executive remuneration. These rules generally affect financial institutions that participate in the CPP, certain employers related to those financial institutions, and their officers. These regulations became effective on October 20, 2008.

C. *Final Rules Regarding Newborns' and Mothers' Health Protection Act of 1996*

On October 20, 2008, the Department of Labor, the Department of Health and Human Services, and the Department of the Treasury issued final rules for group health plans and health insurance issuers concerning hospital lengths of stay for mothers and newborns following childbirth, pursuant to the Newborns' and Mothers' Health Protection Act of 1996 and the Taxpayer Relief Act of 1997.[79]

The Newborns' and Mothers' Health Protection Act of 1996 (Newborns' Act)[80] was enacted to provide protections for mothers and their newborn children with regard to hospital lengths of stay following childbirth. Interim final rules implementing the group and individual market provisions of the Newborns' Act were published in the *Federal Register* on October 27, 1998[81] (the interim final rules). The final rules (codified at 29 C.F.R. Parts 54 and 2590; 45 C.F.R. Parts 144, 146, and 148) implement changes to ERISA and the Public Health Service Act (PHS Act) made by the Newborns' Act, and parallel changes to the Internal Revenue Code of 1986 (IRC) enacted as part of the Taxpayer Relief Act of 1997 (TRA).

78. Tarp Capital Purchase Program, 73 Fed. Reg. 62,205–10 (Oct. 20, 2008).

79. Final Rules for Group Health Plans and Health Insurance Issuers Under the Newborns' and Mothers' Health Protection Act, 73 Fed. Reg. 62,410–29 (Oct. 20, 2008).

80. Pub. L. No. 104-204 (1996).

81. Interim Rules for Group Health Plans and Health Insurance Issuers Under the Newborns' and Mothers' Health Protection Act, 63 Fed. Reg. 57,546 (Oct. 27, 1998).

Section 9811 of the IRC, § 711 of ERISA, and §§ 2704 and 2751 of the PHS Act (the Newborns' Act provisions) provide a general rule under which a group health plan and a health insurance issuer may not restrict mothers' and newborns' benefits for a hospital length of stay in connection with childbirth to less than forty-eight hours following a vaginal delivery or ninety-six hours following a delivery by cesarean section. The interim final rule

- Provided that the attending provider makes the determination that an admission is in connection with childbirth;
- Determined when the hospital stay begins for purposes of application of the general rule;
- Provided an exception to the forty-eight-hour (or ninety-six-hour) general rule if the attending provider decides, in consultation with the mother, to discharge the mother or her newborn earlier;
- Clarified the application of authorization and precertification requirements with respect to the forty-eight-hour (or ninety-six-hour) stay;
- Explained the application of benefit restrictions and cost-sharing rules with respect to the forty-eight-hour (or ninety-six-hour) stay;
- Clarified the prohibitions with respect to a plan or issuer offering mothers incentives or disincentives to encourage less than the forty-eight-hour (or ninety-six-hour) stay;
- Clarified the prohibitions against incentives and penalties with respect to attending providers; and
- Included the statutory notice provisions under ERISA and the PHS Act.

In general, the final rules do not change the interim final rules.[82] However, the final rules incorporate a clarifying statement that the definition of "attending provider" does not include a plan, hospital, managed-care organization, or other issuer.[83] The final rule also makes a small clarification with respect to state law applicability.[84]

In addition, the final rules make minor clarifications to the notice requirements for nonfederal governmental plans. The interim final rules specified that the notice of post-childbirth hospitalization benefits must be included in the plan document that described plan benefits to participants and beneficiaries. The final rules specify that any notice a nonfederal governmental plan must provide under these regulations can be included either in the plan document that describes benefits or in the type of document the plan generally uses to inform participants and beneficiaries of plan benefit changes. The final rules also specify that any time a plan distributes one or

82. Final Rules for Group Health Plans and Health Insurance Issuers, 73 Fed. Reg. at 62,410.
83. *Id.*
84. *Id.*

both of these documents after providing the initial notice, the applicable statement must appear in one or both of these documents.[85]

These final rules are effective December 19, 2008. The final rules for the group market apply to group health plans and group health insurance issuers for plan years beginning on or after January 1, 2009. The final rules for the individual market apply with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after January 1, 2009.[86]

D. *Final Rule Regarding Plan Termination Disclosure Requirements*

The Pension Benefit Guaranty Corporation (PBGC) has issued a final rule, implementing § 506 of the Pension Protection Act of 2006 (PPA),[87] which amends §§ 4041 and 4042 of ERISA.[88]

Sections 4041 and 4042 of ERISA govern the termination of single-employer defined benefit pension plans that are subject to Title IV. A plan administrator may initiate a distress termination by sending a notice of intent to terminate to all affected parties pursuant to § 4041(a)(2). Under § 4042 of ERISA, PBGC may itself initiate proceedings to terminate a pension plan if it determines that certain conditions are present. Under § 4041(c) a single-employer plan may terminate in a distress termination if PBGC determines that the requirements of § 4041(c)(2)(B) are met. Before PBGC can make this determination, the plan administrator must provide certain information to PBGC pursuant to § 4041(c)(2)(A).[89]

On August 17, 2006, the president signed into law the PPA. Section 506 of the PPA adds disclosure provisions to both §§ 4041 and 4042 of ERISA. These provisions allow an affected party to request information related to a plan termination from the plan administrator in the case of a distress termination under § 4041, and from the plan administrator, plan sponsor, and PBGC in the case of a termination under § 4042. "Affected party" is defined in § 4041(a)(21) of ERISA to include each participant in the plan, each beneficiary under the plan, each employee organization representing plan participants, and PBGC.[90]

Section 506 of the PPA generally requires that information be provided to an affected party upon request. The new final regulations require that all requests to the plan administrator, plan sponsor, or PBGC be made in

85. *Id.*
86. *Id.*
87. Pub. L. No. 109-280 (2006).
88. Disclosure of Termination Information, 73 Fed. Reg. 68,333 (Nov. 18, 2008).
89. *Id.*
90. *Id.*

writing, and contain information relating to the plan and the requestor's status as an affected party.[91]

The new final regulations provide that, upon written request of an affected party, a plan administrator must provide copies of any information submitted to the PBGC not later than fifteen business days after receipt of the request.[92] If PBGC Form 600 has not been filed with PBGC at the time of the request, the final regulation requires the plan administrator to provide the information not later than fifteen business days after PBGC Form 600 is filed.[93] In addition, the final regulation requires that if the plan administrator has provided information in response to a request and later submits additional information to PBGC in connection with the proposed distress termination, the plan administrator must, not later than fifteen business days after the submission, provide copies of that information to any affected party that has made a previous request.[94] If a plan administrator fails to provide information under § 4041(c)(2)(D)(i) of ERISA and the implementing regulation within the specified timeframe, PBGC may assess penalties under § 4071 of ERISA.[95]

ERISA § 4042(c)(3) imposes disclosure requirements on the plan sponsor, administrator, and PBGC in connection with a PBGC-initiated termination. Under this provision, a plan sponsor or administrator of a single-employer plan that has received notice from the PBGC of a determination that the plan should be terminated must provide to an affected party information in connection with the plan termination. Under the new final regulations, "receipt" by the plan administrator is assumed *three business days* after PBGC issues the Notice of Determination.[96] After that point, the information must be provided not later than fifteen business days after receipt of the request.[97] As in the case of a distress termination, if new information relating to the request is submitted to the PBGC, copies must be provided, not later than fifteen business days after the submission, to any affected party that has made a previous request.[98] If a plan administrator or plan sponsor fails to provide information under § 4042(c)(3) of ERISA and the implementing regulation within the specified timeframe, PBGC may assess penalties under § 4071 of ERISA.[99]

The final regulations use analogous rules to determine disclosure time limits for the requirement that the PBGC, upon the request of an affected

91. *Id.*
92. *Id.*
93. *Id.*
94. *Id.*
95. *Id.*
96. *Id.*
97. *Id.*
98. *Id.*
99. *Id.*

party, must provide a copy of the administrative record, including the trusteeship decision record of a termination of a plan, not later than fifteen days after receipt of the request.[100]

Under ERISA §§ 4041 and 4042, plan administrators and sponsors involved with distress or PBGC-initiated terminations are prohibited from disclosing information that may directly or indirectly be associated with, or otherwise identify, an individual participant or beneficiary. They also may restrict the disclosure of confidential information that would be exempt from disclosure under the Freedom of Information Act (FOIA), such as trade secrets or information obtained from privileged sources. The final regulations provide that plan administrators and sponsors that have received a request for information in connection with terminations may seek a court order under which confidential information will be disclosed only to authorized representatives that agree to ensure the confidentiality of such information, such as employee organizations representing pension plan participants.[101]

The PBGC is prohibited from disclosing personally identifiable information with regard to a participant or beneficiary without the individual's written consent. However, the position of the PBGC is that information it receives under ERISA that becomes part of the administrative record is not exempt from disclosure under ERISA § 4042(c)(3), even if it would otherwise be exempt from disclosure under the FOIA. The final regulations provide that the PBGC will notify the plan administrator and sponsor within two business days upon receipt of a request for the administrative record from an affected party.[102] The plan administrator and sponsor may then seek a court order under which disclosure of those portions of the administrative record that contain confidential information will be made only to authorized representatives that agree to ensure the confidentiality of such information, and will not be disclosed to other affected parties.[103]

The final regulations, which have an effective date of December 18, 2008, are applicable to terminations initiated on or after August 17, 2006, but only to requests for information made on or after December 18, 2008.[104]

E. *Proposed Rule Regarding Reasonable Contract or Arrangement Under Section 408(b)(2)—Fee Disclosure*

Section 406(a)(1)(C) of ERISA generally prohibits the furnishing of services between an ERISA plan and a party in interest to the plan. However, § 408(b)(2) of ERISA exempts certain arrangements between plans

100. *Id.*
101. *Id.* at 68,335–36.
102. *Id.* at 68,336
103. *Id.*
104. *Id.*

and service providers that otherwise would be prohibited transactions under § 406 of ERISA. Specifically, § 408(b)(2) of ERISA exempts service contracts or arrangements if (i) the contract or arrangement is "reasonable," (ii) the services are necessary for the establishment or operation of the plan, and (iii) no more than "reasonable compensation" is paid for the services. Currently, the regulation issued under ERISA § 408(b)(2)[105] states only that a contract or arrangement is not "reasonable" unless it permits the plan to terminate without penalty and on reasonably short notice.

On December 13, 2007, the Department of Labor, Employee Benefits Security Administration (EBSA), published a proposed amendment to the regulation to further clarify what constitutes a "reasonable" contract.[106] The proposed regulation seeks to clarify that, in order for a contract or arrangement to be "reasonable," it must require that the service provider furnish, and the service provider must actually furnish, certain detailed information to the responsible plan fiduciary regarding its compensation received and conflicts of interest that may affect its performance under the contract.

The proposal focuses on disclosure of the direct and indirect compensation received by service providers and potential conflicts that may affect their objectivity. The proposal only affects certain service providers whose contracts or arrangements are most likely to raise concerns about the receipt of indirect compensation, the fiduciary nature of the services provided, or conflicts of interest that might affect the provision of services. Specifically, upon adoption, the proposal would require contracts and arrangements between employee benefit plans and certain service providers to be in writing and to include provisions to ensure certain disclosures to enable plan fiduciaries to assess the reasonableness of the compensation or fees, and evaluate potential conflicts of interest that may affect the service providers' performance under the contract.

F. *Proposed Rule Regarding Fiduciary Requirements for Disclosure in Participant-Directed Individual Account Plans*

On July 23, 2008, the Department of Labor, Employee Benefits Security Administration (EBSA), issued a proposed regulation that, upon adoption, would require the disclosure of certain plan and investment-related information, including fee and expense information, to participants and beneficiaries in participant-directed individual account plans (e.g., 401(k)

105. 29 C.F.R. § 2550.408b-2(c).

106. Reasonable Contract or Arrangement Under Section 408(b)(2)—Fee Disclosure, 72 Fed. Reg. 70,988–71,005 (Dec. 13, 2007).

plans).[107] This proposal is intended to ensure that all participants and beneficiaries in participant-directed individual account plans have the information they need to make informed decisions about the management of their individual accounts and the investment of their retirement savings. This proposal also contains proposed conforming changes to the regulations applicable to ERISA § 404(c) plans.[108] Upon adoption, these proposals will affect plan sponsors, fiduciaries, participants, and beneficiaries of participant-directed individual account plans, as well as providers of services to such plans.[109]

G. *Employee Benefits Security Administration Field Assistance Bulletin 2008-04 Regarding Fidelity Bonding Requirements*

Section 412 of ERISA and related regulations[110] generally require all persons, including fiduciaries, who handle funds or other property of an employee benefit plan (otherwise referred to as plan officials) to be bonded, unless they are covered by an exemption. ERISA's bonding requirements are intended to protect employee benefit plans from risk of loss due to fraud or dishonesty on the part of persons who "handle" plan funds or other property. ERISA refers to persons who handle funds or other property of employee benefit plans as "plan officials." Each plan official is required to be bonded for at least ten percent of the amount he or she handles, but in no event less than $1,000 per plan.[111] The maximum bond amount required under § 412 with regard to any one plan is $500,000.[112] Effective for plan years beginning on or after January 1, 2007, however, the maximum required bond amount is $1 million per plan official of plans that hold employer securities.[113]

On November 25, 2008, the EBSA released Field Assistance Bulletin (FAB) 2008-04, which provides guidance to the agency's national and regional offices on the fidelity bonding requirements. The guidance in FAB 2008-04 (provided in a question-and-answer format) covers a variety of issues related to compliance with ERISA's fidelity bonding requirements, including, among other things: what losses must an ERISA bond cover; who must be bonded; who is responsible for ensuring compliance; exemptions from the bonding requirements; whether a bond may use an omnibus clause to name insured plans; how to calculate the bond amount when

107. Fiduciary Requirements for Disclosure in Participant-Directed Individual Account Plans, 73 Fed. Reg. 43,014–44 (July 23, 2008).
108. 29 C.F.R. § 2550.404c-1.
109. Fiduciary Requirements for Disclosure, 73 Fed. Reg. at 43,014–44.
110. 29 C.F.R. § 2550.412-1 and 29 C.F.R. pt. 2580.
111. *Id.*
112. *Id.*
113. Pension Protection Act of 2006, Pub. L. No. 109-280 (2006).

multiple plans are covered under a single bond; whether the $1 million bond maximum applies in the case of plans that hold employer securities solely as a result of investments in pooled investment funds; and whether third-party service providers are subject to the bonding requirements if they handle plan funds.

H. *Internal Revenue Service Revenue Procedure 2008-67*

On November 12, 2008, the Internal Revenue Service (IRS) issued Revenue Procedure 2008-67 to further clarify how multiemployer plans may request extended deadlines for repaying unfunded pension liabilities. The procedures apply only to multiemployer plans, not to single-employer plans. The timing of the new procedure was linked to the March 30, 2009, deadline for multiemployer plans to certify their funding status under tax code § 432.

The new procedures allow multiemployer plans to seek two types of amortization period extensions totaling ten additional years.[114] Multiemployer plans can request an automatic extension for a maximum of five years under tax code § 431(d)(1) and an additional alternative extension for a maximum of five years under tax code § 432(d)(2).[115] Plan sponsors can use a single submission to apply for both types of extensions.[116] Requests to extend amortization periods must be submitted by a plan sponsor or its authorized representatives and signed by an authorized trustee of the multiemployer plan.[117] Plan sponsors must submit additional documents, which are identified in Revenue Procedure 2008-67, and they must notify employee organizations, contributing employers, participants, beneficiaries, and alternate payees of the plan that they have applied to the IRS to have their plans' amortization period extended. The procedures apply to plan years that begin after December 31, 2007. The new revenue procedure supersedes Revenue Procedure 2004-44.

III. CONCLUSION

Although it seems that there have been important developments in the employee benefits arena nearly every year, in light of the change in administration, the increased democratic majority in Congress, all against the backdrop of the financial crisis gripping the nation's economy, there will undoubtedly be a number of significant legislative and regulatory developments in employee benefits law in the coming year.

114. Rev. Proc. 2008-67, 2008-48 I.R.B. 1211.
115. *Id.*
116. *Id.*
117. *Id.*