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A Short Message from ERIC President Scott Macey:

In addition to the many matters before Congress and the federal agencies, the courts continue to decide a wide range of benefit disputes. It may be helpful to reflect that 40 years after the enactment of ERISA the courts are enunciating standards of first impression regarding preemption, fiduciary standards, procedural issues, and such substantive matters as retiree health vesting. Plan sponsors and fiduciaries are greatly impacted by these decisions.

Our lead article in this issue of the Benefits Litigation Update is by our guest author, Tony Shelley from Miller & Chevalier, discussing preemption issues in litigation. That topic has been of interest to the benefit community since the enactment of ERISA. And, of course, this issue of the Benefits Litigation Update summarizes the latest developments regarding ACA litigation, including the exchange subsidy case accepted for cert. by the Supreme Court. Finally, the most recent prudence case regarding employer shares in 401(k) plans is addressed.

Other articles in this issue include discussions of the current state of judicial deference to plan administrator decisions, a recent case regarding required disclosures concerning plan time limitations for participants to bring lawsuits, a recent decision awarding a participant attorney fees even though the plaintiff did not prevail on a substantive issue before the court (which remanded the matter to the plan administrator), and a circuit court decision upholding a plan’s forum selection provision limiting lawsuits to the court where the plan is administered.

Another article briefly summarizes litigation brought by the EEOC against sponsors of three wellness programs, including a pretty typical wellness program. The outcome of this litigation could be significant for ERIC member wellness plans. And, the litigation itself underscores the confusion caused by the lack of guidance and current aggressive litigation by the EEOC despite wellness plan support in the ACA.

What is obvious from all this are two things- the courts remain very active in addressing benefit policy and legal issues and the range of topics under litigation is very broad. We at ERIC are dedicated to keeping you informed and playing an active role with the courts to urge them to decide cases appropriately.

The Benefits Litigation Update is a joint endeavor of ERIC and our colleagues from Epstein Becker Green. We thank the firm for all their effort and insights. Also, in this issue we are joined by a guest author, Tony Shelley from the firm of Miller & Chevalier. My colleague, Debra Davis, and I thank all the contributors to this issue and hope you find it helpful and informative.

ERIC will hold a conference call discussing the cases addressed in this issue on Wednesday, December 10, 2014 from 2 to 3:30 pm ET.

ERIC members and trial members can register for the call by clicking [here](#). Epstein Becker Green and Miller & Chevalier clients who are not members of ERIC can register for the call by sending an email to benefitslitigationupdate@eric.org mentioning Benefit Litigation Update Call in the subject line of the email.

FEATURED ARTICLES

ERISA Preemption: Still Crazy About It After All These Years

By: Anthony F. Shelley, Miller & Chevalier Chartered

This year, of course, marks the fortieth anniversary of the enactment of the Employee Retirement Income Security Act (“ERISA”). The statute owes in no small measure its success to its venerable preemption provision and the many court decisions interpreting that provision expansively. Indeed, the Supreme Court has visited ERISA’s preemption regime more than any other ERISA topic. While many predicted a serious contraction of ERISA preemption after a trilogy of Supreme Court opinions in the mid-1990s, it turns out preemption’s demise was much exaggerated. Rather, ERISA preemption, albeit with some important qualifications, continues today to be a bulwark against state regulation of multistate ERISA plans, thereby fostering their formation and continuation. This article will review ERISA’s preemption regime and historical development, and then comment on four very recent Circuit court decisions that reflect the current state of the law.

A. ERISA’s Preemption Scheme and Its History

Section 514 of ERISA, 29 U.S.C. § 1144, which contains ERISA’s preemption scheme, is a complicated measure with three relevant parts. First and foremost is its “relate to” clause, establishing ERISA preemption’s overarching scope. It provides that ERISA “shall supersede any and all State laws insofar as they may now or hereafter relate to any [ERISA-governed] employee benefit plan.” ERISA § 514(a), 29 U.S.C. § 1144(a). Then comes the saving clause. It provides that, notwithstanding the general preemption provision, “nothing [in ERISA] shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, and securities.” *Id.* § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A). Last is ERISA’s “deemer” clause. It provides that an employee benefit plan carrying the risk associated with benefits payments – thus being self-funded or, stated differently, self-insured – shall not be deemed an insurance company for purposes of ERISA’s saving clause. *See id.* § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B). As a result of the interaction of the saving clause and the deemer clause, ERISA establishes a dichotomy whereby plans insured by insurance companies are subject (under the saving clause) to state insurance regulation, while self-funded plans (under the deemer clause) enjoy the full breadth of preemption (*i.e.*, without any dilution from the saving clause).

ERISA’s preemption regime was novel at the time of its enactment. Prior to that time, Congress had legislated about preemption in other statutory contexts, but most of the time required on the face of the express preemption provision some sort of conflict between federal and state requirements before preemption would ensue. In ERISA, Congress took a different tact, stating that state laws would be preempted if they simply “relate to” employee benefit plans. ERISA’s “relate to” approach has since been replicated in numerous other preemption provisions Congress has enacted, though less commonly in statutes enacted post-1990 with the resurgence of strong “states’ rights” views among some legislators.

Starting in 1981 with *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981), the Supreme Court began its foray into interpreting ERISA's preemption terms. The initial signals from that decision were that the Court would give the "relate to" clause an interpretation consistent with its literal language – namely, a reading that readily would find preemption, since (almost by definition) a relation of some manner can seemingly be found between a state law and an employee benefit plan when the state law was intruding on the plan sufficiently to prompt in the first place the litigation in which the Court was being asked to construe the preemption provision. It was in *Alessi* that the Court, out of the starting blocks in its preemption jurisprudence, announced that Congress in ERISA "meant to establish pension plan regulation as exclusively a federal concern." *Id.* at 523.

After *Alessi* came many celebrated preemption cases, among them *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983), in which the Court laid out for the first time the still-applicable test that state laws "relate to" employee benefit plans if they have a "connection with" or "reference to" an employee benefit plan. Soon to follow was *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), where the Court established the significant doctrinal point that state laws need not be specifically directed to employee benefit plans in order to "relate to" them; rather, even general state contract and tort law doctrines "relate to" plans where a litigant seeks to use them to assert liability against a plan. *Pilot Life* also addressed when a state law constitutes an insurance regulation, so as to be saved from preemption, with the current test as stated in *Kentucky Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 341-42 (2003) (internal citations omitted): "[F]or a state law to be deemed a 'law . . . which regulates insurance' under § 1144(b)(2)(A), it must satisfy two requirements. First, the state law must be specifically directed toward entities engaged in insurance. Second, . . . the state law must substantially affect the risk pooling arrangement between the insurer and the insured."

And there was along the way some retrenchment from the initial preemption victories. Most notably, in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995) ("*Travelers*"), in a case seeking to invalidate a state tax measure, the Court registered regret regarding its decisions that appeared to interpret ERISA's "relate to" language literally. "If 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course, for 'really, universally, relations stop nowhere.'" *Id.* at 655 (quoting Henry James, *Roderick Hudson* xli (N.Y. ed., World's Classics 1980)). In *Travelers*, the Court indicated it would now emphasize a presumption against preemption when considering ERISA's preemption of state laws and instructed courts to "go beyond the unhelpful text and the frustrating difficulty of defining its key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." *Id.* at 656. Two similar decisions a few years later – creating with *Travelers* a negative trilogy – seemed to herald a new era of narrow preemption. See *Du Buono v. NYS-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806 (1997); *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A.*, 519 U.S. 316 (1997).

But the Court then reached a new normal in the early 2000s with two decisions that today constitute the governing benchmark for ERISA preemption: *Egelhoff v. Egelhoff*, 532 U.S. 141 (2001), and *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004). In *Egelhoff*, the Court was back to emphasizing, with respect to the "relate to" clause, "that this broadly worded provision is clearly expansive"; but it now also tempered its analysis somewhat with the *Travelers* directive to ensure that any outcome applying ERISA's preemption provision is consistent with ERISA's underlying purposes. 532 U.S. at 146-47 (internal quotation marks omitted). *Egelhoff* likewise re-affirmed the *Shaw* standard that "a state law relates to an ERISA plan 'if it has a connection with or reference to such a plan.'" *Id.* at 147 (quoting *Shaw*, 463 U.S. at 97). In *Aetna*, the Court endorsed the principle concomitant to ERISA preemption – known as "complete" preemption – that ERISA disputes pursued under state law in state courts are straightforwardly removable to federal court and treated as ERISA controversies. In the process, in *Aetna*, the Court approvingly cited

Pilot Life and settled an additional controversy long rumbling in the ERISA preemption world: whether *remedies* contained in otherwise saved state insurance laws are preempted. In other words, what has greater power, the preemption principle itself or the saving clause? The Court emphatically sided with preemption, holding that ERISA preempts even saved state insurance laws, where that state law's remedies are being invoked. The Court in *Aetna* went beyond the "relate to" clause and instead sourced preemption additionally on ERISA's enforcement scheme (contained in ERISA § 502, 29 U.S.C. § 1132), which it said was exclusive and therefore could not countenance any state law remedies for ERISA grievances.

So, where do we stand currently? After forty years, and some back and forth, ERISA preemption is alive and well, and indeed still formidable. While an "uncritical literalism" (*Egelhoff*, 532 U.S. at 147) in interpreting the "relate to" language has now been disapproved, it is settled law that ERISA's preemption provision "has a broad scope, and an expansive sweep, and it is broadly worded, deliberately expansive, and conspicuous for its breadth." *Dillingham*, 519 U.S. at 324 (internal quotation marks and citations omitted). "ERISA pre-empt[s] state laws that mandate employee benefit structures or their administration," and "state laws providing alternative enforcement mechanisms also relate to ERISA plans, triggering pre-emption." *Travelers*, 514 U.S. at 658. Things get more dicey where a state law falls on the periphery of the administration of an ERISA plan – for instance, taxes applied to ERISA plans (such as in *Travelers*). In those instances, courts particularly pay attention, to determine if preemption follows, to the underlying purpose of ERISA preemption "to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans." *Id.* at 657.

B. Recent Circuit Court Cases on ERISA Preemption

This past year has seen a surprising number of important ERISA preemption decisions at the Circuit level. They have all involved state regulation of matters involving health benefits. Indeed, with the advent of the Affordable Care Act, and its invitation to the states to regulate in the individual coverage and insured group markets, we likely are entering a time of significantly greater friction between state laws and uniform federal standards under ERISA.

Four Circuit cases stand out from the past year. Two illustrate the traditional solicitude toward ERISA preemption; another shows the reluctance to extend ERISA preemption to state taxes; and the last is a potential challenge to the current preemption regime, with a petition for certiorari pending in the case.

1. *America's Health Ins. Plans v. Hudgens*, 742 F.3d 1319 (11th Cir. 2014) ("AHIP"). In *AHIP*, the Eleventh Circuit invalidated on ERISA preemption grounds a Georgia law that extended the state's prompt-pay requirements to self-funded ERISA plans. Prompt-pay laws require the processing of medical claims by health insurers and plans within a set period, at pain of paying usually high levels of interest should there be delay. Georgia had had on the books a state prompt-pay law for insured plans, and ERISA plans challenged Georgia when the legislature added self-funded ERISA plans to the statute's compass.

Citing and echoing *Egelhoff* and *Shaw*, tempered by *Travelers's* concern for grounding ERISA preemption on ERISA's purposes, the Eleventh Circuit "agreed with AHIP that [the Georgia statute] . . . impermissibly 'relate[s] to' ERISA plans," at least insofar as the law applied to self-funded plans. *AHIP*, 742 F.3d at 1331.

Specifically, the challenged provisions would require self-funded ERISA plans to process and pay provider claims, or notify claimants of claim denials, within fifteen or thirty days, depending on whether the claim is submitted electronically or conventionally. These timeliness requirements fly in the face of one of ERISA's main goals: to allow employers "to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits." If these provisions were to go into effect, employers offering self-funded health benefit plans would be faced with different timeliness obligations in different states, thereby frustrating Congress's intent.

Id. at 1331 (quoting *Egelhoff*, 532 U.S. at 147). The court added that preemption followed even if the Georgia law directly regulated only the behavior of third-party administrators (“TPAs”) of self-funded plans (as opposed to the self-funded plans themselves), for “the TPAs would be acting pursuant to the underlying self-funded ERISA plans.” *Id.* at 1333 n.18.

Interestingly, the most significant part of the decision may have come in dicta. Though unnecessary to do so in the case, the Eleventh Circuit took a swipe at the Georgia statute’s application even in the context of insured ERISA plans. Whereas one might think prompt-pay laws can qualify as saved insurance regulations so as to apply in the *insured* ERISA plan context, the Eleventh Circuit suggested prompt-pay laws would fail the saving clause test. The court noted the statute seemed aimed less at regulating the insurer-insured relationship than “directed toward the needs of medical providers.” *Id.* at 1333. Moreover, “the challenged provisions appear[ed] to be remedial,” as opposed to affecting the initial bargain – and thus the risk-pooling arrangement – between insurer and insured. *Id.* *AHIP* signals potentially an increased interest by the courts closely to scrutinize the real aim and effect of supposed insurance regulations under the saving clause inquiry.

2. *Liberty Mut. Ins. Co. v. Donegan*, 746 F.3d 497 (2d Cir. 2014), cert. pet. pending, No. 14-181 (filed Aug. 13, 2014). In *Liberty Mutual*, the Second Circuit considered whether ERISA preempts a genre of state laws requiring insurers, TPAs, and medical providers to report data regarding health benefits to state regulators, in order to assist the state in monitoring the state’s health care needs and to inform health care policy. Among the data that covered entities must report under a Vermont statute – the particular law here at issue – is claims and enrollment information and data relating to costs, prices, quality, utilization, or resources.

A divided Second Circuit held that ERISA preempts the Vermont law. The Vermont statute failed *Shaw’s* “connection with” standard for determining when state laws “relate to” ERISA plans and breached ERISA’s goal “to avoid a multiplicity of burdensome state requirements for ERISA plan administration.” *Liberty Mut.*, 746 F.3d at 500. “[T]he reporting mandated by the Vermont statute and regulation is burdensome, time-consuming, and risky. Even considered alone, the Vermont scheme triggers preemption; considered as one of several or a score of uncoordinated state reporting regimes, it is obviously intolerable.” *Id.* at 509. The Second Circuit also emphasized that ERISA itself contains substantive provisions whereby ERISA plans must file reports with the federal Department of Labor. “[R]eporting’ is a core ERISA function shielded from potentially inconsistent and burdensome state regulation.” *Id.* at 508. Similar to *AHIP*, the court here saw it as “of no moment” that the state law was “being applied to . . . Liberty Mutual’s TPA rather than Liberty Mutual itself.” *Id.* at 508 n.10. “[T]he objective of uniformity in plan administration is not for some reason inapplicable simply because a plan has contracted with a third party to provide administrative services.” *Id.* (internal quotations marks omitted).

Liberty Mutual is notable because the state law at issue was somewhat afield from the day-to-day administration of a plan’s benefits, but the court nonetheless found preemption. The Vermont statute, for instance, did not mandate the provision or payment of certain health benefits, or even affect the procedures for administering benefit claims; rather, the state law burdened – as a dissenting judge accused – “general administration.” *See id.* at 510 n.13. Nevertheless, the “massive amount of claims information” required to be reported under the Vermont law – coupled with the prospect of other states having differing requirements – tipped the scale toward preemption. *Id.*

3. *Self-Ins. Inst. of Am., Inc. v. Snyder*, 761 F.3d 631 (6th Cir. 2014). In *Snyder*, the Sixth Circuit considered whether ERISA preempts a newly enacted Michigan tax designed to fund the state’s obligations under Medicaid. The tax is a one-percent assessment on all “paid claims” to health care providers for services rendered to Michigan residents, and taxpayers need to file quarterly returns and keep certain records and documents to support their tax payments. *Snyder*, 761 F.3d at 633. The tax applies to insurance carriers and TPAs, including TPAs for self-funded ERISA plans.

Rejecting the preemption challenge, the Sixth Circuit largely parroted the *Travelers* analysis. That is, just as *Travelers* upheld a tax, so did the Sixth Circuit in *Snyder*. The Sixth Circuit stated:

ERISA guarantees uniformity only with regard to the administration of *employee benefit plans*. Neither the Act's definition of "paid claims" nor its reporting and record-keeping requirements conflict with the administrator's standard procedure to guide processing of claims and disbursements of benefits. The state's definition of "paid claims" applies, and the state's reporting and record-keeping requirements come into play, only when the carriers compute the tax – a function entirely divorced from plan administration. The Act's provisions simply do not conflict with the plan or impact its administration.

Snyder, 761 F.3d at 636 (internal quotation marks and citations omitted; emphasis in original). The Sixth Circuit then disagreed with the approach adopted by the Second Circuit in *Liberty Mutual*, where burdensome general administrative obligations can sink a state law. Quoting the dissent in *Liberty Mutual*, the Sixth Circuit said that "the [*Liberty Mutual*] majority's argument . . . ignores the case law's focus on whether the *administration of benefits to beneficiaries* is impacted, an issue on which there is no showing." *Id.* (quoting *Liberty Mut.*, 746 F.3d at 512 (Straub, J., dissenting)) (emphasis in original).

Snyder's holding against preemption is not remarkable, given the *Travelers* holding against preemption in arguably a similar tax setting and given the Sixth Circuit's finding that the incidence of the tax does not skew a plan's administration. Still, the Sixth Circuit's disagreement with the Second Circuit's holding on preemption of reporting requirements in *Liberty Mutual* does illustrate the unpredictability of preemption once the state law's operation exits core benefits administration areas.

4. *Wurtz v. Rawlings Co.*, 761 F.3d 232 (2d Cir. 2014), cert. pet. pending, No. 14-487 (filed Oct. 17, 2014). *Wurtz* involves the issue of whether ERISA preempts a New York anti-subrogation law as applied to insured plans, and whether a controversy about that law is removable under ERISA's "complete" preemption doctrine from state court to federal court. Under the concept of reimbursement (which is a species of subrogation), a health plan participant who receives benefits in connection with treatment for an injury, and who then obtains a recovery from a third party in connection with the injury, must pay back the benefits received from the health plan. New York prohibits plans from seeking reimbursement, and a putative class of ERISA participants in *Wurtz* sought in state court to enjoin the defendant insurers of ERISA plans from seeking reimbursement in violation of the New York law. The district court upheld removal and found the New York law to be preempted.

The Second Circuit reversed. It first held that it had removal jurisdiction based on the Class Action Fairness Act, which relaxes diversity jurisdiction standards in class action settings. Turning then to ERISA preemption, the court held that New York's anti-subrogation law was an insurance regulation saved from ERISA preemption, when applied to insurers. In fact, the Supreme Court had two decades earlier found the same with respect to a Pennsylvania anti-subrogation law, and thus the saving of the New York law seemed naturally to follow. See *FMC Corp. v. Holliday*, 498 U.S. 52, 60-61 (1990). In a footnote, the Second Circuit noted that the New York law would be preempted as against self-funded plans, as likewise *FMC* had instructed. See *Wurtz*, 761 F.3d at 241 n.6.

But then – when it did not need to – the Second Circuit addressed whether, absent the Class Action Fairness Act, the case was removable to federal court under the complete preemption doctrine. Disagreeing with at least three other Circuits, the Second Circuit said that the Supreme Court's *Aetna* decision countenanced no removal where a plaintiff seeks to enforce a saved state insurance law, because that law is not a term of the ERISA plan or a provision of ERISA itself. The Second Circuit nowhere grappled with the central conclusion of the conflicting Circuit decisions that a saved state insurance law actually becomes part of the ERISA plan (somewhat metaphysically) once saved, so that a plaintiff's effort to avoid subrogation via enforcement of the state law amounts to an attempt

to enforce the terms of an ERISA plan. And state law claims seeking to enforce the terms of an ERISA plan have historically been subject to complete preemption and removal of the claims to federal court.

Wurtz now sits at the Supreme Court awaiting the Court's decision as to whether to grant certiorari. Notwithstanding the conflict created by the Second Circuit with the decisions of other Circuits, a grant of certiorari may not be in the offing, since the Second Circuit's comments on removal jurisdiction based on ERISA complete preemption really were dicta. They were dicta because the Second Circuit had already sustained removal jurisdiction based on the Class Action Fairness Act. Frankly, the Second Circuit seemed to want to pick a fight on complete preemption, when none was necessary. Hence, though the Circuit-splitting issue presented in *Wurtz* is doctrinally important, the case may not be properly postured for Supreme Court review.

* * *

As the recent Circuit cases show, ERISA preemption – after forty years – still occupies, and sometimes divides, the federal courts. But secure at this date is the principle that ERISA's preemption provision is a broad one, regularly authorizing the preemption of state laws that intrude on the administration of ERISA plans. If ERISA plans are to exist forty years from now, no doubt ERISA preemption will continue to deserve some of the credit.

Should Fiduciaries Be Granted Deference for Breach of Fiduciary Claims?

By: Debra A. Davis

In two recent cases, plan participants asked the Supreme Court to decide whether fiduciaries should receive deference from the courts for their decisions on claims involving their breach of fiduciary duties under the Employee Retirement Income Security Act of 1974, as amended (ERISA). The Supreme Court declined both requests to hear this issue, in *Tibble v. Edison International*, 711 F.3d 1061 (9th Cir. 2013), cert. granted in part, 2014 U.S. LEXIS 4901 (U.S. Oct. 2, 2014), and *Tussey v. ABB, Inc.*, 746 F.3d 327(8th Cir. 2014), cert. denied, 2014 LEXIS 7513 (U.S. Nov. 10, 2014). (The Court, however, did agree to hear a statute of limitations issue in the *Tibble* case.)

The principle of deference to fiduciaries' decisions has long been established in the area of benefit claims determination. In *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), the Supreme Court held that deference should be given to the conclusions reached by the plan fiduciaries in a denial of benefits claim if the benefit plan confers discretionary authority on the fiduciary to interpret the terms of the plan. Courts review the exercise of this discretion for abuse, a highly deferential standard that is equated with arbitrary and capricious action, even when the fiduciary may have a conflict of interest.

The application of the *Firestone* deference principles to claims that a fiduciary breached its fiduciary duties has received considerable attention in the appellate courts. The Sixth, Seventh, Eighth and Ninth Circuits have all clearly held that courts should grant deference to fiduciaries' decisions even when a claim alleges breaches of fiduciary duties. The Second and Third Circuits, however, have been less clear, with both holding that in at least some instances such deference should not be accorded to fiduciary decisions. (The Third Circuit, it should be noted, appears to have decided cases that can be placed on either side of this issue.)

Amidst these mixed holdings, the plan participants in *Tibble* asked the Supreme Court to decide the deference issue. In *Tibble*, the participants alleged that the payment of revenue sharing by mutual funds to the plan's service provider violated the terms of the plan document, giving rise to a claim for breach of fiduciary duty for failing to follow the terms of the plan. The fiduciaries, however, had interpreted the plan to allow the payment of revenue sharing. The Ninth Circuit Court of Appeals held that the fiduciaries' interpretation of the plan terms as to whether

the revenue sharing was permitted was entitled to deference. The court further found that the fiduciaries did not abuse their discretion in interpreting the plan this way, even in the face of the contention that the fiduciaries had a conflict of interest that led them to reach that interpretation. The participants asked the Supreme Court to decide whether deference applies when the fiduciary allegedly violated the terms of the governing plan document in a manner that favors the financial interests of the plan sponsor at the expense of plan participants.

(The Supreme Court was also asked to hear the issue of whether a claim that ERISA plan fiduciaries breached their duty of prudence by offering higher-cost retail-class mutual funds to plan participants, even though identical lower-cost institution-class mutual funds were available, is barred by ERISA's statute of limitations when fiduciaries initially chose the higher-cost mutual funds as plan investments more than six years before the claim was filed.)

The Supreme Court asked the Solicitor General of the United States ("SG") for the government's opinion regarding whether to hear the case. The SG's brief recommended that the Supreme Court hear the statute of limitations issue, but not this deference issue. The Supreme Court agreed. It will decide the statute of limitations issue, but not the deference issue.

The SG's brief in *Tibble* described the Eighth Circuit's decision in *Tussey* as a better case for the Court to address the deference issue. The Supreme Court, however, also quite recently declined to hear *Tussey*, despite this encouragement from the SG to hear the case.

In *Tussey*, participants claimed that the revenue sharing payments and other aspects of plan administration amounted to breaches of fiduciary duties. The participants alleged that the plan sponsor overpaid for recordkeeping services, which they claimed subsidized costs for services related to the plan sponsor's defined benefit, health and welfare plans as well as corporate matters, that the mapping of certain investments from the former mutual fund manager to a new one had cost participants considerably, and that the mutual fund manager (and recordkeeper) had profited off the "float" of money that sat overnight as part of participant transactions. The plan gave broad discretion to the fiduciaries, to determine eligibility regarding benefits and to take any other actions with respect to the plan, including interpreting of the terms of the plan.

The District Court held that the fiduciaries violated their duties to the plan. The District Court awarded damages of \$21.8 million for losses the plan suffered as a result of the fiduciaries' decision to map investments from one manager's fund to another manager's fund. The District Court also held that the fiduciaries were liable for failing to control plan expenses (including the failure to select less expensive share classes for the investments) and awarded \$13.4 million for the failure to control recordkeeping costs.

The Eighth Circuit affirmed the judgment in favor of the participants on the recordkeeping claim. It found that the District Court provided ample support for its factual findings and that the District Court's legal conclusion that the fiduciaries breached their fiduciary duties to the plan was not in error. On this claim, the Eighth Circuit concluded that any failure by the District Court to give discretion to the fiduciaries' interpretation of the plan in this regard would constitute harmless error under the circumstances.

The Eighth Circuit Court of Appeals vacated the judgment in favor of the participants on the mapping claim. The deference issue sat at the center of its decision. The Eighth Circuit generally held that, with respect to providing deference to the plan fiduciaries, the deference provided for fiduciaries' decisions (when supported by appropriate plan language) should not be limited to benefit claims. The District Court thus should have given deference to the fiduciaries' determinations under the plan documents, rather than construing those documents *de novo*. Having so concluded, the Eighth Circuit determined that the District Court may have ruled differently if it had conferred deference on the fiduciaries' selection of investment options and mapping. That conclusion required a remand to the District Court, to determine whether it would reach a different result once it gave that deference to the fiduciaries.

Both parties asked the Eighth Circuit to rehear the case, but it declined. The participants thereafter petitioned the Supreme Court. On November 10, 2014, the Supreme Court denied their petition for review.

As a result of the Supreme Court's decisions not to hear either case, fiduciaries are left with the divided status quo, whereby several Circuits instruct their District Courts to defer to fiduciary plan interpretations in breach of fiduciary duty cases while others do not. The determination of the plaintiffs' bar to press this issue to the Supreme Court, however, should prompt its review at some point in the future.

The Obligation to Disclose Plan-Imposed Time Limits in Benefit Claim Denial Letters

By: John Houston Pope

In a prior issue of this *Update* (No. 5, Winter 2014), we highlighted the Supreme Court's opinion in *Heimeshoff v. Hartford Life & Acc. Ins. Co.*, 134 S. Ct. 604 (2013), in which the Court endorsed the use of contractually-based plan provisions to place reasonable time limits on the filing of benefit claim litigation. We observed then that the use of best practices would call for disclosing the time limit in the final appeal denial letter sent to participants. Recently, in *Moyer v. Metropolitan Life Ins. Co.*, 762 F.3d 503 (6th Cir. 2014), the Sixth Circuit held that this "best practice" is, in fact, required by statute.

Moyer involves a long-term disability benefits claim in which the claimant challenged the revocation of his LTD benefits. The plan document included a provision, similar to the one in *Heimeshoff*, stating that "[n]o lawsuit may be started more than 3 years after the time proof [of a claim] must be given." The SPD did not disclose this limitation. Nor did the correspondence with the claimant about the revocation of his benefit inform him of the plan's time limit. The claimant commenced his lawsuit after the expiration of this plan-imposed limitations period. He contended he was unaware of it and had relied upon the statute of limitations that would have been borrowed from Michigan law.

The District Court barred the claim as untimely; the Sixth Circuit reversed. According to the appeals court, ERISA Section 503 (29 U.S.C. § 1133) authorized the Secretary of Labor to promulgate regulations to promote full and fair review of claims determination and those regulations (29 CFR § 2560-503-1) require that benefit denial letters include "[a] description of the plan's review procedure and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action ... following an adverse benefit determination review."

Benefit administrators recognize this regulation as imposing the requirement that they inform claimants about the time limits for each step in internal plan review of a benefits claim. The Sixth Circuit took the regulations one step farther, to the judicial review stage. Simply put, *Moyer* held that this regulation requires a statement in the last adverse benefit determination letter disclosing any plan-based time limitation for commencing a lawsuit. If the letter does not contain this disclosure, the courts will not enforce the limitation. *Moyer* presents this requirement as a bright-line rule that does not bend if the circumstances otherwise might indicate that the claimant had notice of the Plan's limitation period.

The *Moyer* decision prompted a dissent that argued for "substantial compliance" based on the totality of communications provided to the participant. The dissenting judge agreed that disclosing the time limit in the benefit denial letter would be a sufficient reason to enforce it, but it was not a necessary step. While his critique has an intellectual appeal, the majority's holding makes the sort of appeal to "fairness" that may attract other courts to join it. The burden of disclosure seems slight, relative to the perceived need to give adequate information to a claimant to permit a timely lawsuit.

Notably, a recent ERIC survey of members found that over one-half of respondents imposed time limitations on benefit claim litigation through the plan. Overwhelmingly, the SPDs disclosed the limits. One-half measured the date for filing in court from the last stage of the administrative process. For this group, it would seem simple to apprise claimants of their time limit in the final denial letter.

Plan administrators understandably do not want to encourage litigation over adverse benefit determinations. It may seem that informing claimants of the plan's limitation period might prompt an unsuccessful claimant to seek out a lawyer and file suit. The value of the limitation might be lost if the disclosure is not made, however, and therefore the risk of prompting some litigation may have to be endured in order to ensure that the plan is protected fully from stale claims.

NOTEWORTHY PENDING CASES

Status of Litigation under the Affordable Care Act

*By: Gretchen Harders and Daniel J. Green**

The Affordable Care Act ("ACA") and its implementation continue to be a hot topic of litigation more than four years after it was initially passed and two years after it was upheld by the Supreme Court. Although some of the issues being litigated mainly implicate issues of political philosophy, other lawsuits have the potential to greatly impact health and welfare plans and plan sponsors.

Premium Subsidies Challenges

The first area of litigation most likely to have a major impact on plan sponsors are challenges to regulations implemented by the IRS that provide insurance premium tax credits and subsidies ("credits") to individuals who purchase health coverage on federally established exchanges. A number of key provisions of the ACA, most notably employer shared responsibility taxes and the individual mandate, are only triggered when a full-time employee becomes entitled to a credit or subsidy for purchasing coverage on an exchange. This area of litigation challenges the availability of credits to individuals who purchase coverage on exchanges, but only with respect to exchanges that were established by the federal government. If such litigation is successful, the ACA will be significantly curtailed in the 34 states that have not elected to establish their own exchange and therefore have exchanges run by the federal government.

Thus far there are three decisions on this issue: *King v. Burwell* (4th Cir. 2014) and *Halbig v. Burwell* (D.C. Cir. 2014), both decided on July 22, 2014; and *Pruitt v. Burwell* (E.D. Ok. 2014) decided on September 30, 2014. Plaintiffs in all three cases rely on a relatively simple argument, the ACA provides credits to people who purchase coverage on exchanges "established by the State under § 1311" of the ACA, and federal exchanges are not established by "the State" but by the federal government, pursuant to a different section of the ACA. The Fourth Circuit in *King* summarized plaintiff's argument as "the language says what it says." The government argues that the language of the statute is broad enough to support many different interpretations, including the interpretation adopted by the IRS/Treasury regulations, which do not differentiate between federal and state exchanges for subsidy purposes.

In *King*, the Fourth Circuit Court of Appeals ruled in favor of the government and against a group of private citizen plaintiffs. The *King* plaintiffs argued that they did not want to be entitled to credits because credits would make

health insurance affordable to them. However, the *King* plaintiffs did not want to be able to afford health insurance because it would subject them to the individual mandate. *Halbig* went the other way, finding in favor of business groups challenging the regulation, and the District Court in *Pruitt* cited to the same finding in *Halbig* by the D.C. Circuit Court of Appeals. *Halbig* was discussed in more detail in the ERIC Summer 2014 Benefits Litigation Update.

The *King* plaintiffs in August, 2014 filed a cert petition to the Supreme Court to reverse the Fourth Circuit's decision. The entire D.C. Circuit was scheduled to review *Halbig en banc* and hear oral arguments on December 17, 2014. Somewhat unexpectedly, on November 7, 2014, the Supreme Court granted cert and will hear the case later this term. On November 13, 2014, the D.C. Circuit stayed action on its case pending the Supreme Court's consideration of the cert petition in *King*.

Earlier this year, on August 1, 2014, the IRS released a statement that it will continue to advance payments for premium subsidies and it will not take any action in response to *Halbig* and *King*. If the IRS' interpretation is not upheld, the entire landscape of the individual mandate and employer penalties in states with federally-established exchanges will change.

Contraceptive Coverage

The second area of litigation involves one of the most highly publicized cases of the Supreme Court's last term, *Burwell v. Hobby Lobby Stores*, 134 S. Ct. 2751 (2014). As outlined in more detail in the ERIC Summer 2014 Benefits Litigation Update, in *Hobby Lobby*, the Court held that closely held corporations are protected by the Religious Freedom Restoration Act ("RFRA"). It went on to find that regulations penalizing closely held corporations who failed to provide certain forms of contraceptive coverage substantially burdened the exercise of religion in violation of RFRA.

On August 27, 2014, in response to *Hobby Lobby*, the Administration issued a new set of proposed regulations designed to accommodate the religious opposition to certain types of contraceptive coverage. (79 Fed. Reg. 51,118.) Under the proposed regulations, employers who: (1) are organized as closely held corporations with a limited number of shareholders; (2) oppose the provision of contraceptive coverage due to the sincerely held religious beliefs of the corporation's owners; and (3) self-certify their objection to providing such coverage by the first day of the plan year for which an exemption is requested; will not be penalized for failing to provide contraceptive coverage. The same rules are proposed to apply to student health insurance sponsored by closely-held for-profit institutions of higher education. The deadline for comments ended October 21, 2014.

In another turn of events, in *Priests for Life v. U.S. Dep't of Health & Human Services* (D.C. Cir. 2014), the D.C. Circuit Court of Appeals upheld religious accommodation for contraceptive coverage under the ACA, holding that the opt-out procedure does not substantially burden the employer's religious beliefs. The opt-out procedure allows religious organizations to elect not to participate in the offer of contraceptive coverage, which is then left to the insurer or administrator to provide. The opt-out relieves the employer from any penalty for failure to comply with the ACA's mandates on contraceptive coverage.

ACA Implementation

On November 21, 2014, the United States House of Representatives ("House") filed a lawsuit, *U.S. House of Representatives v. Burwell*, (D.C. Cir. 2014) alleging that the manner in which executive branch agencies (the

“Administration”) in implementing the ACA violated the Constitution and federal laws. The Complaint alleges two instances in which the Administration acted unlawfully: (1) the Administration made direct payments to insurance companies pursuant to Section 1402 of the ACA when Congress had not specifically appropriated funds for that purpose; and (2) transitional relief delaying implementation of the employer shared responsibility penalties constituted an amendment to the ACA, a power the Constitution assigns to Congress. The Complaint asks the court to enjoin the Administration from making further Section 1402 offset payments to insurance companies absent specific Congressional appropriations.

This is the first time the House has sued a sitting President and this lawsuit raises a variety of constitutional and procedural issues of first impression. The practical impact of the lawsuit is likely to be limited, however. The allegations of the Complaint that could have directly impacted plan sponsors are the challenges to IRS transitional relief delaying implementation of employer shared responsibility penalties. The text of the ACA imposes employer shared responsibility penalties for plan years beginning on and after January 1, 2014. IRS transitional relief generally delayed enforcement of the penalties for employers with 100 or more employees until plan years beginning on and after January 1, 2015 (and delayed enforcement of the penalties for employers with between 50 and 99 employees until plan years beginning on and after January 1, 2016). By not filing the Complaint until late November 2014, the House minimized the possibility that the lawsuit would result in the earlier imposition of employer shared responsibility penalties. The timing of the lawsuit, as well as the Complaint’s focus on declaratory relief, supports the possibility that the lawsuit is more focused on making a political statement than on obtaining concrete redress for a legal wrong.

ACA Enactment

The final major area of litigation concerns the D.C. Circuit’s dismissal of a novel constitutional challenge to the ACA. The Plaintiffs in *Sissel v. U.S. Department of Health and Human Services* (D.C. Cir. 2014) argued that the ACA was passed in violation of Article I Section 7 of the US Constitution, commonly known as the Origination Clause. The Origination Clause provides that “all bills for raising revenue shall originate in the House of Representatives.” The *Sissel* Plaintiffs argued that due to a procedural error in its passage, the ACA originated in the Senate rather than the House. Although *Sissel* was dismissed on July 29, 2014 by the D.C. Circuit Court of Appeals, well-funded groups such as the Pacific Legal Foundation have expressed a desire to litigate this issue in other jurisdictions, so we may see new origination clause cases in the future.

*Daniel J. Green is a contributing author on this issue.

EEOC Claims Wellness Programs Violate ADA and GINA

The U.S. Equal Employment Opportunity Commission (“EEOC”) recently initiated litigation against several companies, claiming that their wellness programs violate the Americans with Disabilities Act (“ADA”) and, in one case, the Genetic Information Nondiscrimination Act (“GINA”). [*EEOC v. Orion Energy Servs.*, E.D. Wis., No. 1:14-cv-1019-WCG, complaint filed, 8/20/14](#); [*EEOC v. Flambeau, Inc.*, W.D. Wis., No. 3:14-cv-00638-bbc, complaint filed, 9/30/14](#); and [*EEOC v. Honeywell Int’l Inc.*, D. Minn., No. 0:14-cv-04517-ADM-TNL, injunction denied 11/3/14](#). See [Memorandum Opinion and Order](#) and [Memorandum in Opposition to Plaintiff’s Motion](#).

In the first two cases, the EEOC is alleging that the wellness programs violated the ADA. One of the EEOC’s arguments is that the programs do not fit within the exception for voluntary programs because of the purported consequences of non-participation (such as total loss of employer premium contribution or actual termination from

employment). In the third case, the EEOC claimed that Honeywell violates the ADA because it penalizes employees who do not undergo free biometric screenings, which are considered medical examinations that are not job-related or consistent with business necessity for purposes of the ADA. Although there is an exception for “voluntary” health exams, the EEOC claimed that these exams are not voluntary because Honeywell imposes a penalty on employees who decline to participate. EEOC also alleged that Honeywell violates GINA because it provides incentives to employees, conditioned on obtaining medical information about the employee’s spouse.

Although the EEOC continues to investigate, there is currently no open case in the Honeywell litigation as the district court denied the EEOC’s only filing (a request for a temporary restraining order and a preliminary injunction).

The ERISA Industry Committee’s (“ERIC”) has been actively addressing these developments through its health committee and wellness task force. ERIC members and trial members are urged to participate and can read more by clicking [here](#).

NOTEWORTHY RECENT DECISIONS

Fourth Circuit Imposes a Greater Burden of Proof on 401(k) Fiduciaries For Lack of “Procedural Prudence”

By: Kenneth J. Kelly

The Fourth Circuit’s recent 2-to-1 decision in *Tatum v. RJR Pension Investment Committee, et al.*, No. 13-1360 (4th Cir. August 4, 2014), illustrates once again the perils of 401(k) plan fiduciaries’ failing to conduct a proper investigation and evaluation of investment options before making decisions. (See discussions of *Tibble* and *Tussey* in this and earlier editions of the *Benefits Litigation Update*.) In the *Tatum* decision, the Fourth Circuit made it very difficult, if not impossible, for the fiduciaries to avoid personal liability by imposing on them the burden of proving that a prudent fiduciary would have made the *exact same* investment decision even if a proper investigation and evaluation of investment options had been conducted.

RJR Nabisco, the product of the 1985 merger of the food company (Nabisco) and the tobacco company (RJR), decided in 1999 to spin off the tobacco business in light of the negative effect of pending tobacco liability lawsuits. A new 401(k) plan was spun-off from the RJR Nabisco 401(k) Plan for the benefit of RJR employees. A benefits committee and an investment committee were created to manage the spun-off 401(k) plan. The RJR 401(k) plan offered both standard diversified funds and an employer stock fund consisting of Nabisco stock in which RJR employees were invested. RJR employees holding Nabisco stock at the time of the spin-off were permitted to sell the Nabisco stock, but no additional investments in Nabisco stock could be made. The RJR 401(k) plan also maintained an RJR stock fund spun-off from the RJR Nabisco 401(k) plan, which permitted continued investment by participants.

The committees, no doubt familiar with “stock drop” litigation and well aware of their potential liability from investing in a single, non-employer stock potentially subject to rapid and dramatic fluctuations, decided to liquidate the Nabisco stock funds shortly after the corporate spinoff. This decision was found by the trial and appellate courts to be “procedurally imprudent” for the following reasons: (1) the decision was made by an informal working group that did not have any authority under the plan; (2) the principal (if not the only reason) for the divestiture decision was to avoid fiduciary liability for maintaining a single stock investment that could (and had) dropped in value, and not the interests of the plan participants; (3) the group’s incorrect belief that other companies involved in spin-offs

divested former employer's stock as a matter of course; (4) an apparently mistaken conclusion that a single stock would be costly and complex to administer; and (5) there had not been any analysis of any time frame for effecting the divestiture. The decision to sell out and to do so arbitrarily in six months was made in less than an hour. The benefits committee adopted the working group's recommendation without even holding a meeting.

A few months later, before the divestiture was effected, the committees' members reconsidered the decision, but did not engage any financial consultant, outside counsel or an independent fiduciary to assist in the review, in order to save the plan professional fees. They adhered to the decision – despite the fact that the Nabisco stock had fallen 60% from the date of the spinoff to the date of the committees' decision, and in face of both the company's and outside analysts' optimistic view that casting off the tobacco business would enhance the value of the Nabisco stock. (The fact that senior management held on to their stock did not help.) The Nabisco stock was sold in January 2000, near or at its lowest price. By year end, however, after a bidding war instigated by Carl Icahn (who had been trying to take over the company for years), the price of the Nabisco stock had soared. Mr. Tatum, who had pleaded with the management not to sell the Nabisco stock, lost 60% of his 401(k) holdings, and brought a class action.

Neither the District Court nor the Court of Appeals had any difficulty in finding that the process by which the decision was made, and then reaffirmed, violated the committees' fiduciary duty of "procedural prudence" by liquidating the Nabisco stock on an arbitrary timeline without conducting any, let alone a thorough, investigation of the surrounding circumstances (such as the analysts' views and Icahn in the wings). There was no recognition of the nuances of the settlor's decision in retaining employer stock or the unique issues relating to the retention of an employer stock fund in the context of a corporate transaction. Relying on DOL regulations, the Court of Appeals also rejected RJR's argument that a non-employer, single stock fund was "imprudent per se" due to the inherent risk in such holdings. And the majority of the panel agreed with the trial court that once the plaintiff established a failure of "procedural prudence" and a related loss occurred, the burden shifted to the fiduciary to disprove causation, that is, that the loss would have occurred in the absence of the breach. The court reasoned that shifting of the burden of proof to the fiduciary was fair and in line with traditional trust law which underlies ERISA.

Then the majority held that RJR had to establish that the investment decision was "objectively prudent," that is, that a "hypothetical prudent fiduciary" *would* have made the same decision had he undertaken a proper investigation. RJR, the District Court and the dissenting judge were of the view that an "objectively prudent" decision was one that the hypothetical fiduciary *could* have made. This distinction is far from semantic, as the majority explained: "Could" describes what is merely possible, while "would" describes what is probable, the latter being a far more difficult standard of proof for a fiduciary to meet. In view of the facts in this case, it would seem that this standard would be impossible for RJR to meet. Indeed, the majority's view seems to lead to liability even where the facts of a case presented a close call where a reasonable "hypothetical prudent fiduciary" *could* have gone either way on an investment decision had he made a thorough investigation, but in hindsight, made the wrong choice.

The dissenting judge pointed out in a sharply worded opinion that this standard trends toward a definition of objective prudence as the "single best or most 'likely' decision rather than a range of reasonable judgments in the uncertain business of investing." Investing is as much an art as a science, noted the dissenter, and there will be cases where there may be many options with uncertain outcomes, any number of which may be prudent, but only one of which in hindsight might be one the prudent fiduciary would select. If he doesn't pick the right one, the dissenter says, "good luck." The dissenter also questions shifting the burden of proof to the fiduciary in a case not involving self-dealing, such as this.

It is not clear whether other Circuits will adopt the majority's view in light of prevailing case law, the strong arguments of the dissenting judge as to what is an objectively prudent decision, and the exception to the rule that the plaintiff has the burden of proving his case. The lesson of this decision, however, is obvious. The difficult task of proving that a prudent fiduciary "would have" come to the same conclusion, can be avoided altogether if the fiduciaries take care to follow "procedural prudence," by strictly adhering to the plan terms, thoroughly analyzing the pros and cons of an investment decision, seeking the advice of investment consultants on close calls, and documenting the decision-making process. Given the teaching of decisions in *Tibble* and *Tussey*, and commentators advising fiduciaries to take pains to take such steps, failure to do so (as least going forward) will put fiduciaries who do not follow such advice at great risk. The decision in *Tatum* indicates that, in the Fourth Circuit, the failure to establish procedural prudence will put plan fiduciaries in a position of liability under a standard of proof requiring them to prove that a prudent fiduciary would have made the *exact same* investment decision.

First Circuit Awards "Interlocutory" Attorneys' Fees to Plaintiff Prior to Final Determination of the Claim

By: Kenneth J. Kelly

In a decision that prompted an unusually sharp debate between the two-judge majority and the dissenting judge, the First Circuit held in *Gross v. Sun Life Assurance Co. of Canada*, 734 F. 3d 1 (1st Cir. 2014), that a plaintiff suing for long-term disability benefits who succeeded in having a benefits denial remanded for further proceedings for reasons unrelated to the merits, is entitled to an "interlocutory" attorneys' fee award. This decision seems at odds with the Supreme Court's holding in *Hardt v. Reliance Standard Life Ins. Co.*, 560 U.S. 242, 245 (2010), that an ERISA plaintiff must have achieved "some degree of success on the merits" before fees can be awarded. The Supreme Court did not address whether a remand order, without any decision on the merits, constitutes "some degree of success on the merits,"

Ms. Gross's complaint for LTD benefits arising from fibromyalgia, a largely subjective pain condition, was initially dismissed. In its 2013 decision, the First Circuit reversed and remanded on two procedural grounds: (1) in vacating its own First Circuit precedent, the court held that a policy requiring proof of disability "satisfactory to us" did not confer discretionary authority on the claims administrator, and therefore, required a *de novo* review by the court and (2) the administrative record was inadequate to allow a full and fair assessment of the plaintiff's entitlement to disability benefits. Ms. Gross then applied to the District Court for an award of more than \$250,000 in attorneys' fees and costs under 29 U.S.C. § 1132(g)(1). Under *Hardt*, ERISA does not require the fee-seeker to be a prevailing party, but requires "some degree of success on the merits." Given the fact that Ms. Gross could eventually wind up recovering nothing, Sun Life argued that she was not entitled to an attorneys' fee award, and that an interlocutory award before a final decision was rendered, was premature.

The two-judge majority rejected Sun Life's position that the remand of this case did not constitute any degree of success on the merits. Noting that cases have gone both ways on the issue, the court held that a remand to the claims administrator for reconsideration of benefits entitlement "ordinarily will reflect the court's judgment that the plaintiff's claim is sufficiently meritorious" to be reconsidered, and it appears that in the majority's view, that is a sufficient "degree" of "more than trivial" success to warrant an attorneys' fee award. The court also gave credit to the plaintiff for achieving a reversal of the standard of review for "satisfactory to us" clauses, which "in effect . . . strengthened Gross's claim." The majority also seemed to be influenced by the fact that, unless ERISA plaintiffs' counsel are "compensate[ed] . . . along the way," beneficiaries may have difficulty initially securing

and then retaining counsel. Lastly, the majority reviewed the five factors considered by courts in reviewing fee requests in ERISA cases, and pointedly noted that an award of fees “may have a desirable deterrent” effect by demonstrating that claim administrators’ “excessive hostility to claims involving subjective symptoms” such as Ms. Gross’s fibromyalgia “is ill-advised.”

The dissenting judge emphasized that the plaintiff had not achieved any success on the merits in that the remand was purely procedural. Even though the standard of review was changed to *de novo* review, the remand was still procedural and did not address the merits of the claim. The dissenting judge conceded that a plaintiff might be able to come within the *Hardt* rubric of “some degree of success on the merits” by vindicating a substantial right established by ERISA, such as reversing a benefits denial due to lack of full and fair review by the claims administrator. The dissenting judge noted that this was not, however, the basis for the initial 2013 reversal. Recall that in *Hardt*, the District Court directed the claims administrator to act on Ms. Hardt’s application by considering all of the evidence within 30 days, or else judgment would be entered in her favor. The anomalous result, the dissenting judge noted, might well be that Ms. Gross eventually recovers nothing after a *de novo* review, but her counsel fees will be, in large part, borne by the defendant. This is not what section 1132(g)(1) envisioned, at least as interpreted in *Hardt*. In the dissenting judge’s words, “[s]urviving to fight another day is not the same as winning the war.”

Whether the decision in *Gross* will lead to “interlocutory” attorneys’ fee applications (at least in the First Circuit) after rulings where the merits are not even addressed is an open question. No doubt the decision in *Gross* will inspire similar applications in many ERISA cases – and not necessarily only in disability insurance cases. The First Circuit’s apparent willingness to find “some degree of success on the merits” where the plaintiff obtained a remand, but not much else, will inspire imaginative plaintiffs to discern something of “merit” in every opinion reversing or remanding a claims administrator’s decision. This could lead to increased litigation over attorneys’ fees before the final decision on the claim is rendered.

Appellate Court Endorses Selection-of-Venue Clauses in ERISA Plans

By: John Houston Pope

Many plan sponsors would prefer to steer all plan-related litigation to a single venue, to obtain consistency in litigation outcomes, to avoid having to reargue important issues anew, and to economize on the defense of the claims. The mechanism for doing this is a venue selection clause. The Department of Labor (DOL) contends that such clauses conflict with ERISA’s statutory scheme. A recent Sixth Circuit case, *Smith v. Aegon Companies Pension Plan*, 769 F.3d 922 (6th Cir. 2014), disagreed, and enforced a forum selection clause set forth in a pension plan.

In *Smith*, a retiree sued over the suspension of a monthly benefit he was receiving; it was suspended as a recoupment of overpayments he allegedly received in his first ten years of retirement. Seven years after the participant had retired, the plan sponsor amended the plan to add a “venue provision” or “forum selection clause” directing that any action “in connection with the Plan” had to be brought in the federal district court located in Cedar Rapids, Iowa, where the plan was administered. The retiree commenced suit in state court in Louisville, Kentucky; the plan removed the action to federal court and moved to dismiss based on the venue selection clause. The district court ultimately granted the motion and the appellate court affirmed.

Smith represents the logical progression of two lines of legal thought. One involves venue and forum selection clauses in general, which have received increasingly greater deference from the courts in ordinary contract actions.

The other involves the primacy of contract principles in ERISA. Recent Supreme Court cases such as *US Airways, Inc. v. McCutchen*, 133 S. Ct. 1537 (2013), and *Heimeshoff v. Hartford Life & Acc. Ins. Co.*, 134 S. Ct. 604 (2013), emphasize the importance of reliance on the face of written plan documents and the plan sponsor's right to include reasonable terms that facilitate uniform, efficient administration of national plans.

Smith rejected an argument by the DOL that ERISA's express venue provision forecloses the use of forum selection clauses in plans. The statute identifies three types of venues for ERISA actions: the districts (1) where the plan is administered, (2) where the breach occurred, or (3) where a defendant may be found. The court said the statute is permissive, authorizing the use of these various venues without limiting the plan from selecting one as the exclusive venue. In *Smith*, the Iowa venue was the district where the plan was administered. The Sixth Circuit gratuitously suggested that the plan did not have to select one of the permissive venues under the statute, but given that the facts showed that it did, this further discussion might later be rejected as "dicta" not necessary to the decision of the case. A plan selecting one of the three options in the statute as its exclusive litigation venue fits squarely within the holding of this case.

Moreover, choosing one of the statutory options, such as the district in which the plan is administered, allows the plan to better defend the venue provision against the one argument still available to participants, that the inconvenience imposed on them by the designated venue is unjust or unreasonable. The relationship of a venue to plan administration, for example, provides a rational reason for the selection that promotes the goals (uniformity, cost, efficiency) that warrant judicial deference to the plan provision. If the venue selected appears seriously inconvenient and arbitrary (*e.g.*, the District of Hawaii, for a company that operates on the East Coast but does not operate in Hawaii), a court might refuse to enforce it.

Smith also produced other important and instructive holdings related to venue selection clauses. A court might not apply a clause if the claims accrued before the plan adopted it. However, *Smith* applied the clause to a retiree who had left employment seven years before the plan adopted it. His claims accrued after the amendment date; his retirement date did not control.

Even more interestingly, *Smith* endorsed the enforcement of the venue selection clause against breach of fiduciary claims. (This ruling also may be dicta.) The language of the clause did not narrow its application to benefit claim denial litigation. It reached any litigation "in connection with the Plan." The potential to use forum selection clauses to steer fiduciary breach litigation to a particular forum presents an opportunity to avoid the more legendary courts that have been especially pro-participant and forum selection pursued by many plaintiffs' counsel.

Smith also addressed the DOL's practice of using amicus litigation to advance its agenda. DOL argued that its litigation positions deserved deference comparable to its various rule making or interpretative processes. The Sixth Circuit disagreed, describing the amicus brief as "an expression of mood," rather than the equivalent of regulations or other formal rule-making, which is generally given some or significant deference. To borrow a term coined on a popular legal blog, that's a benchslap.

Smith probably will not be the last word on any of these issues. A spirited dissent disagreed with the majority and certainly will provide fodder for arguments when the issue arises elsewhere. DOL will continue to press its position in other Circuits. We will continue to follow and report on this promising development.

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Please send questions, comments, and related requests to Scott J. Macey or Gretchen Harders.

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